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What future for traditional Chinese medicine outside China?

In certain countries of east and south-east Asia, traditional Chinese medicine continues to be used by many people. However, the pattern of use favours the advance of the drug-retailing side of this sector rather than medical care, and there is consequently some concern about the professional status of practitioners in the long term.

Ethnic Chinese medicine is used in the health care delivery systems of several countries in east and south-east Asia. Certain institutions provide traditional Chinese medical care and also represent the interests of its practitioners or *zhong-i*. There is a vigorous trade in traditional Chinese herbal medicines and patent forms of them, which are exported from China to Hong Kong, Malaysia, Singapore, Taiwan and other places. The trade in Singapore alone is worth more than 80 million Singaporean dollars (US$ 49 million) a year. Several medicine-retailing and wholesaling firms with branches in both Singapore and Malaysia have reported annual turnovers exceeding two million Singaporean dollars. (nearly one and a quarter million US dollars).

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It is hardly surprising that various associations have been organized to defend business as well as professional interests. A number of these bodies lobby for improved terms and conditions governing the importation of traditional medicines from China.

Two strands of medicine

The numbers of people using traditional Chinese medical care in Singapore, although still considerable, have declined in recent years. For example, in 1981 the Chung Hwa Free Clinics had 119 000 patients, whereas in 1990 they had only 104 000 *(1)*.

The combined use of traditional Chinese and Western (or modern) medicine is widespread. In 1984 it was reported that 60% of patients in traditional Chinese medical practitioners' clinics in Singapore also consulted doctors trained in Western medicine *(2)*.

Both the exclusive and nonexclusive use of traditional Chinese medicine can be explained by people's belief in its effectiveness, particularly for specific types of illness. In Hong Kong, 70% of adults thought that traditional Chinese medicine was better than Western medicine for the promotion and maintenance of health, and 60% believed that Chinese remedies were less likely to have adverse side-effects *(3)*. Among Chinese people in a number of countries, self-medication appears to be at least as common as the combined use of Western and ethnic Chinese medicine.

Traditional Chinese practitioners have to compete for a dwindling pool of patients.

Choice: a varied picture

A survey of the use of Chinese and Western medicine in 100 households was conducted in Georgetown, Malaysia. Twenty households were selected in each of five areas of different income levels and housing types.

- In a squatter settlement close to the city centre, families occupied houses that they had constructed themselves. There was no sewerage, and in some cases no piped water or electricity. The mean household monthly income was less than 300 ringgit (US$ 120). On average there were eight people in a family. The nearest Western-type medical facilities were in the city centre and in a nearby township. Traditional Chinese free clinics near the settlement were only open at limited times; services of this kind were obtainable in the city centre during less restricted periods. Traditional Chinese medicine retailers were available in the vicinity. Only two individuals were found who relied solely on traditional practitioners; one was a child whose parents took her to a *zhong-i* whenever self-medication proved ineffective, and the other was a woman aged 52 who consulted a *zhong-i* for treatment of rheumatism. Fourteen persons in nine households combined the use of Chinese and Western medicine. Some 80% of the people, however, never consulted traditional practitioners.
- The pattern of use of traditional Chinese medicine among tenement slum households was similar. The families lived in one-room units, usually rented, in buildings that had been partitioned and divided between up to 20 households. The monthly incomes of the households ranged from 300 to 500 ringgit (US$ 120–200), and the families ranged in size from five to fourteen. The households were within walking distance of free traditional Chinese clinics, traditional medicine shops, government clinics offering modern medical services, and Western-style pharmacies. Only an 11-year-old schoolboy relied entirely on ethnic Chinese medicine. There were 37 nonexclusive users in 14 households. Non-users of traditional Chinese medicine comprised two-thirds of the people in the survey.
- The households in a public low-cost estate consisted of families relocated from squatter and slum areas. Their flats were mostly rented, and monthly household incomes ranged from 250 to 500 ringgit (US$ 100–200). The average family size was seven. A *zhong-i* ran a weekly free clinic on the estate, and there were traditional Chinese medicine shops

nearby. Modern medical services were, however, only obtainable in the city centre. No exclusive users of traditional medicine were found. Twenty-six people in eight households used both traditional Chinese and modern medicine. Three-quarters of the people had never consulted a *zhong-i*.

- In a private modern suburban estate the households had monthly incomes ranging from 1500 to 2000 ringgit (US$ 600-800). On average there were five members to a family. A general hospital and a number of private hospitals offering modern medical services were in the neighbourhood. The households were also within walking distance of a Chinese free clinic and several traditional Chinese medicine shops. Doctors trained in modern medicine had private practices in the area. Almost every household owned a car. One household made exclusive use of a *zhong-i* practising in a free clinic nearby, the young children being taken there whenever they fell ill. Twenty-two people from twelve households said they used both Chinese and modern medicine. Three-quarters of the people, however, did not use traditional Chinese medicine at all.
- The 20 high-income households surveyed were also near the general hospital and the private hospitals. The average family size was about four and the mean household monthly income exceeded 3000 ringgit (US$ 1200). All the house-holds owned at least one car. There were no exclusive users of traditional Chinese medicine, but 14 nonexclusive users were found in eight households. Non-users of traditional Chinese medicine comprised 82% of the people.

Thus non-users of traditional Chinese medicine predominated in all five types of household. There was no definite pattern of decline in the use of traditional medicine from low- to high-income households. Instances of the exclusive use of Chinese medicine were found in both low- and middle-income households. No exclusive users of traditional medicine were found among either the high-income households or the low-income households in public low-cost housing.

The prevailing pattern was of nonexclusive consultation of practitioners of both kinds. Self-medication with prescriptions from both the Chinese and modern sectors was widespread. Those who did not consult traditional practitioners obtained drugs from retailers of traditional medicine for self-medication. The products used were either self-prescribed or were recommended by the retailers. These customers were not concerned as to whether the retailers were qualified *zhong-i*, pharmacists, businesspeople or sales assistants. They were, however, selective in their choice of medicine shops and usually went to ones that were well established or reputable.

Some results of case studies carried out in Malaysia in order to discover whether there were within-household differences in the use of traditional Chinese medicine are described below.

Unlike doctors of modern medicine, traditional Chinese practitioners have little opportunity for salaried employment in state-sponsored institutions.

A *low-income household* with five members occupied a rented room in a building that housed 18 other families. One member relied exclusively on the *zhong-i*, two were

nonexclusive users and the rest were non-users. The household monthly income was 450 ringgit (US$ 180), of which an average of only about 30 ringgit (US$ 12) went on medical care. The head of the household was a 48-year-old trishaw operator. He also ran a stall outside the building with the help of his wife. The wife additionally did house-cleaning, washing and other jobs. The husband had consulted a *zhong-i* whereas neither his wife nor their elder daughter had ever done so. A younger daughter, however, was taken exclusively to a free clinic providing Chinese medical services. Another daughter had consulted doctors in modern medical facilities as well as a traditional Chinese medical practitioner. As a rule, family members had tried self-medication with both Chinese and Western drugs purchased from a traditional Chinese medicine retailer that they had used for 20 years; a doctor or *zhong-i* was consulted only after self-medication had failed.

The relative rarity of the exclusive use of ethnic Chinese medicine suggests that the survival of the tradition requires either a boost to its trading side or specialization in the medical problems of particular categories of patient.

Four of the five members of a *middle-income family* were nonexclusive users of Chinese medicine, whereas one had never consulted a *zhong-i*. The monthly household income was 1500 ringgit (US$ 600). The head of the household, a 35-year-old proprietor of a sundry goods shop, had never consulted a traditional medical practitioner and went to a doctor trained in modern medicine when he fell ill. His wife consulted both a doctor trained in modern medicine and a *zhong-i*. She usually saw the same traditional Chinese practitioner at a clinic near her home. The three young children had been to this practitioner whenever doctors trained in modern medicine had not provided effective treatment. Five years earlier the first choice had been the *zhong-i*. The reason for the change was that the time spent waiting to see the traditional practitioner had increased, and that it was not necessary to wait so long before seeing doctors of modern medicine. Other traditional Chinese medical practitioners had been tried but their fees were considered too high. The whole family had tried self-medication with both traditional Chinese medications and common modern drugs bought from a traditional Chinese medicine retailer in the city centre.

In a *high-income household* with four members the monthly income was 2500 ringgit (US$ 1000). Three members had never consulted a *zhong-i* and only the 32-year-old wife, a nurse trained in modern medicine, used traditional and modern medicine in combination. Her husband, a 35-year-old engineer, worked for a firm and relied entirely on its panel of doctors for medical care. Common modern drugs like aspirin were kept at home. The family regularly took expensive Chinese herbal medicines for the promotion and maintenance of health. Such medications are often too expensive for low-income families.

The exclusive and nonexclusive users of Chinese medicine have similar backgrounds to people who do not consult ethnic medical practitioners. In other words the use of ethnic Chinese medicine is not confined to a group of people with particularly traditional inclinations, nor is it limited to people of relatively low income and little schooling. A higher proportion of non-users have access to employer-subsidized medical care than is the case with users of ethnic Chinese

medicine. Chinese medicine is not resorted to because it provides lower-cost care than modern medicine. However, since ethnic Chinese medicine is often not recognized or sponsored by employers or the state, those using it commonly have to pay the full fees charged by the *zhong-i*, which may be higher than those of doctors trained in Western medicine.

Clientele

A survey was conducted among the clients of *zhong-i* comprising a representative cross-section of the traditional practitioners in Georgetown, Malaysia. Two of the *zhong-i* were based in medicine shops; five were in free clinics, three of these in the city centre and two in the suburbs; and the remaining six had fee-for-service practices, four in the city centre and two in the suburbs. Five clients of each practitioner were interviewed.

Sixteen were exclusive users of traditional medicine and had been so for at least five years. They included workers on low incomes, small businessmen, housewives, young children and elderly people. Clients who were interviewed in private clinics where higher fees were charged tended to be on higher incomes, better educated, and younger than those interviewed at free clinics, where, in fact, a nominal fee was generally charged for both consultations and medications. These users found traditional medicine effective and the services easily accessible.

The remaining clients combined the use of Chinese and Western medicine, some consulting the former first. Most visited *zhong-i* after Western-type doctors had not provided satisfactory results. These non-exclusive users were found in both the free clinics and the private ones where full fees were paid. There were, however, no pronounced distinctions between the socio-economic backgrounds of the people using the two kinds of establishment. Those attending included people whose ages and incomes varied widely, people who were salaried or self-employed, and housewives. There were even a few members of employer-subsidized medical schemes, which, however, provided only for the reimbursement of costs of Western medicine. The reasons for consulting traditional Chinese practitioners included a belief in their effectiveness, the promise of fewer adverse side-effects, their low cost and easy accessibility, and the alternative to be tried after modern medicine had been ineffective.

Obstacles

Clearly, traditional Chinese medicine now has only a subsidiary role in the provision of medical care. This is true even in China, where traditional Chinese medicine has official support. In the 1960s, Chinese medicine was being not so much integrated with Western medicine as relegated to a supplementary, somewhat inferior, position despite the support of research centres and the training of dual-system doctors *(4)*.

In many countries of east and south-east Asia the *zhong-i* are not recognized as medical professionals but rather as businesspeople. They can therefore be prosecuted for using any title, name or description likely to mislead the public into thinking that they are doctors with official authorization to see patients and provide medical services. Traditional Chinese medical practitioners are also prohibited from prescribing most modern drugs, performing surgery, treating eye diseases and using X-rays.

Traditional Chinese medicine has established itself in most countries of the region largely without government support and funding. Its practitioners were tolerated in the past in many former colonies because they provided medical care for Chinese communities, thus allowing the authorities to avoid this responsibility. In setting up free clinics, medical schools and associations, the *zhong-i* have had to rely on funds given by members of the public. There is no state-financed infrastructure to support either students or qualified practitioners in traditional Chinese medicine, and consequently they have to be self-supporting by earning wages and charging fees. Finally, difficulties are presented in some countries by taxes on medical supplies imported from China and by bureaucratic delays in the processing of import permits.

The widespread custom of purchasing drugs from Chinese medicine retailers for purposes of self-treatment tends to perpetuate the shop-based aspect of the tradition and to undermine its practitioners.

Traditional Chinese practitioners have to compete for a dwindling pool of patients. Unlike doctors of modern medicine, they have little opportunity for salaried employment in state institutions. Moreover, relatively few people are exclusive users of traditional Chinese medicine. The non-exclusive use of traditional medicine has the drawback of delays that occur when patients seek help first from *zhong-i* and then from Western-type doctors, or vice versa, before the necessary help is forthcoming.

As a rule, retailers of traditional Chinese medicines are far more numerous than traditional practitioners. The retailers may know about traditional prescriptions but may not be trained in Chinese medicine. The memberships of some medical associations that represent the *zhong-i* include medicine retailers and other distributors of traditional Chinese medications. Various associations representing *zhong-i*, retailers and distributors have evolved to defend the interests of these groups. Thus in Malaysia the Negri Sembilan Chinese Physicians' and Druggists' Association campaigns against taxes on Chinese medications. The weight given to the retailing of medicines has meant that matters concerning traditional Chinese medical practice, such as the professional status of the *zhong-i* and the standardization of their training and qualifications, have not always received adequate attention. For this reason a number of bodies have been founded to address the specific interests of the *zhong-i*. For example the North Malaya Chinese Physicians' Association was established to unite *zhong-i* as a group distinct from traders and to foster traditional Chinese medicine.

The popularity of self-medication could well persuade more *zhong-i* to opt for shop-based practices in order to cope with the competition for a diminishing clientele. While trading in traditional Chinese medicines is potentially lucrative, it can also lead to the neglect of patients. Already there are signs that the business side is assuming overwhelming importance, and some practices have been undermined by retailing activities. Distributors and firms involved in medicine retailing and wholesaling rely on old therapeutic techniques and traditional sources of herbal supplies. Unlike Western pharmaceutical companies that fund research and development on new drugs and therapies, Chinese medicine distributors contribute little in this way and thus do

little to upgrade the work of the *zhong-i*. Some *zhong-i* provide free consultations but charge for prescriptions sold in the shops where their practices are located. Another trend has been for the owners of medicine retailing shops to send their sons to medical schools to be trained in traditional Chinese medicine, probably with a view to gaining increased social standing.

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The nature of the use of traditional Chinese medicine points to its tenuous market position and the comparative success of Western medicine. Chinese medicine supplements modern Western medicine and fills a gap where modern medicine has proved ineffective or inadequate. The widespread custom of purchasing both traditional Chinese and modern drugs from Chinese medicine retailers for purposes of self-treatment tends to perpetuate the shop-based aspect of the tradition and to undermine its practitioners. Chinese medicine is no longer solely controlled by the *zhong-i* nor is it their exclusive prerogative: entrepreneurs with a knowledge of Chinese medications and medical supplies also provide health care services.

Total reliance on traditional Chinese medicine is rare relative to its use in combination with Western medicine. Self-medication explains why retailing and wholesaling are the more vigorous elements in ethnic Chinese medicine. The situation is such as to raise serious doubts about the future of traditional Chinese medical practice. □

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The "three cleans" for safe delivery

The essential minimum requirements for a safe delivery are the "three cleans": clean hands, a clean delivery surface, and the clean tying and cutting of the cord. Essential supplies are clean cloths for drying and wrapping the baby, and a sterile instrument for cutting the cord after it has been tied. The position of the woman during labour and delivery, the timing of the tying and cutting of the cord, and the immediate putting of the child to the breast are important components of a safe delivery.

— R. H. Hart, M. A. Belsey, & E. Tarimo, *Integrating maternal and child health services with primary health care: practical considerations.* Geneva, World Health Organization, 1990, p. 45.