

Community Health Services in China: the experience of Tianjin City

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Abstract

China's excellent community health system was seriously damaged during the early years of economic reform after 1982, and its reconstitution has become a major policy goal of the government since 1996. This article provides a brief overview of experiences in implementing the policy of community health care in a large Chinese city, Tianjin. I outline the policy setting and describe Tianjin's experiences. Some initial benefits of the new system are summarised and the difficulties and barriers are noted. I conclude with some suggestions for further improvement.

Introduction

International experience with community health care (CHC) demonstrates that as an integrated component of a health care system, it can be a cost-effective way of providing basic health care services and addressing the health problems of a community in a comprehensive epidemiological, socio-economic, and cultural context (United Nations Development Program 1997).

The World Health Organisation (WHO) believes that the introduction of CHC programs should be aimed at providing services that are '... free of economic barriers, unlimited by social or cultural distinctions and within reasonable easy reach' of the whole population (WHO 1974:5, cited in Smith 1999). WHO argues that it would be feasible for all countries and all communities, even the most rural and impoverished, to develop effective health care based on a system that reflects the inherent characteristics of the community. WHO further maintains that such a community health system must '... evolve from the community it serves; it should involve the community in all aspects of its organisation, such as in the planning, delivery and evaluation of care; it must be inter-related with other operating social systems within the community; and it must support as well as be supported by the community for which it exists. Moreover, the health system must be flexible in its approaches to health care ... (and) ... those responsible for operating it should be aware that the primary avenue to health may be through education, economic progress, legislation, or other aspects of society rather than through organised health structures.'

CHC programs are likely to be most successful where they concentrate on primary health care. Moreover, primary health care is unlikely to be successful unless it embodies the ideas of community health care. The Ottawa Charter (WHO 1986, cited in Smith 1999) offered a framework for restructuring and orienting health systems to give people more control over their own decision-making on health issues. It was emphasised that primary health care should be integrated into all levels of the health system as well as into the educational, social, environmental, industrial, commercial and legislative functions of community life. Primary health care is a philosophical approach to health care that requires a reorientation of thinking about health and illness, as well as commitment to an ideology of social justice, community participation and responsibility for health practices across all levels of society (WHO 1986; Wass 1994, cited in Smith 1999). A commitment to

implement CHC programs therefore requires some courageous policy decisions from government and considerable resolve from all sections of the health industry.

It is fair to say that China was one of the first countries to adopt and then implement CHC programs founded on primary health care. Its experiences with traditional medicines, barefoot doctors, community self-help in handling schistosomiasis, and so on were models for many other countries around the world.

However, health care in Chinese society has changed dramatically over the past 20 years in adapting to the new socio-economic environment (United Nations Development Program 1997). Smith (1999) argues that in Western countries, escalating health care costs, due in part to a domination of the health industry by large institutions and powerful medical and pharmaceutical interests, have forced a reappraisal of health care delivery methods. This has also been a critical factor in China.

In December 1996, the Central Committee of the Party and the State Council of China held a National Health Conference that resulted in a "Resolution of Health Reform and Development" (RHRD). In the RHRD, the Central Committee announced that there was a need to reform the health service system in the urban areas, and community health care services needed to be encouraged and developed. Primary health care sectors should provide illness prevention, health promotion, family planning, treatment of common diseases, and rehabilitation based on communities and families. Women, children, elderly, and disabled should be important target groups.

The community health care services need to be linked to health insurance schemes, and a two-way referral system needs to be established between community health services with secondary and tertiary services. According to the plan, some health professionals need to be relocated to work in community health centres as part of the health care system (The Health Department of Jiangsu Province 1998). Under this national health policy, community health became a central point for health system reform all over the country, and several pilot studies have been conducted in major cities including Tianjin.

Policy context

China has developed a three-tiered organisation for the delivery of health care. This three-tiered system is a vertically organised network of community, district and provincial (or city) health units in the urban areas, and of village, township and county health units in the rural areas (Pei 1998). The system was designed to promote the efficient allocation of health care resources between primary and tertiary care facilities. For several decades it has provided a structure for efficient referral for treatment of health problems in the most appropriate setting.

However, the system was seriously affected by the change from a command to a 'socialist market' economy after 1980 (United Nations Development Program 1997). In rural areas, agricultural reforms led to the disintegration of the co-operative enterprises that made use of the 'Co-operative Medical System' (CMS) insurance schemes. The government adopted a laissez-faire policy, and rural health care reverted to primarily private financing (user-pay). CMS membership fell rapidly, and currently fewer than 10% of China's villages have a CMS. Access to health care in many areas is now governed by the ability to pay, and many cannot afford health care. For example, the cost of one average hospitalisation would exceed the annual income of 50% of the rural population. Illness-induced poverty continues to be a serious problem (United Nations Development Program 1997).

In urban areas, the government and enterprises faced increasing difficulties in maintaining the two main insurance schemes, the Government Insurance Scheme (GIS) and the Labor Insurance Scheme (LIS). China experienced rapid health care cost inflation due to rapid introduction of high-technology medical services, increasing incomes feeding demand for health care, and the absence of any significant constraints on supply or demand (Hindle 2000).

One important consequence has been an imbalance of utilisation of health care services. In particular, tertiary and secondary hospitals are over-crowded. However, primary level providers, such as the first-level hospitals and community health centres (or street clinics) are increasingly underutilised (United Nations Development Program 1997). Consumers face few constraints on where they seek care, and flock to the providers with assumed higher technical quality of care, even for minor injuries and illnesses that are more appropriately and

cost-effectively dealt with in lower level facilities. Primary care providers trained under the traditional clinical model of medicine have been inadequately prepared to market and provide patient-focused and community-based health services under a model of integrated prevention and treatment. Family medicine is still a young discipline, yet to be developed in China (United Nations Development Program 1997).

There has been a downward spiral. Consumers seek higher quality care even if it is more expensive and less convenient, and primary level facilities are underutilised and find it increasingly difficult to attract and retain skilled personnel, thus further reinforcing consumers' perceptions that only tertiary facilities have the technical capacity to address their health needs. As a result, health resources are inefficiently allocated. First and second level facilities are idle, while overcrowding at expensive tertiary facilities becomes worse. Patients do not necessarily receive higher quality care, but costs are definitely higher. Thus, inefficient utilisation exacerbates health care cost escalation, frustrating China's policy goal of cost containment. The policy commitment to rejuvenation of community health care services was intended to resolve these kinds of problems.

Service design

Tianjin is a municipality directly under the Central Government, with a population of 9.52 million. It started to implement a CHC system in 1993, using two main types of models (both of which eventually became the current set of primary health care stations). The first, called the General Practitioner (GP) Station comprised an outreach service of the primary (street) and secondary (district) hospitals. Staff who worked in these Stations continued to be employed by the hospitals (Bureau of Health 1997a). Around 70 GP stations were set up around the city of Tianjin between 1993 and 1996.

The second, called the Community Participation Model, originated in the street administrative offices. These offices are multi-purpose political facilities directly under the leadership of local government, and thus represented an initiative of the community at large rather than the formal health care system. These Community Participation Model services were staffed for the most part by retired health professionals and other people with no previous health care background - and who were therefore provided with basic training in health care (Bureau of Health 1997a). However, some general guidance was provided by staff from the district and street hospitals. Services were financed by the local government, the street administrative office, hospitals which were located in the area, and patient payments.

These local initiatives were further encouraged by the central government's RHRD policy after 1996. One consequence was that the city government more clearly defined CHC functions to comprise measurement and monitoring of health status; the establishment of health records based on the family; provision of basic health services to the community, such as diagnosis, treatment, family visits, consultation, mother and childcare, and aged care; and health education and health promotion (Bureau of Health 1997a).

The city government also issued directives regarding management, work standards, job descriptions and appraisal of general practitioners, training of general practitioners, type of services provided, and basic information for statistical purposes. In order to encourage health professionals to work in community health care, the city government developed criteria for the professional title of general practice medicine, which meant that the CHC professionals would get the same opportunity for further promotion as other health professionals (Bureau of Health, 1997b, Bureau of Personnel 1997).

Initial experiences

By the end of 1998, Tianjin had 1064 primary health care stations, which covered about half of the total population. 1.35 million people have developed their own health records in the primary health care stations, with 10,000 outpatient visits each month. There were 1013 staff members working in the CHC areas, about 13.14% of the total work force of the first level hospitals in the city (Bureau of Health, 1997).

According to information provided by the Bureau of Health of Tianjin City, 43% of consumers are over 60, and 6% were under the age of seven. 50% were retired, 30% were workers and cadres, 10% were housewives, and 6% were children.

In late 1997, the Health Bureau of Tianjin City carried out a random survey of 1060 users of the community health care services. 923 patients (87.08%) were satisfied with the care they received, 127 (11.98%) were neither satisfied nor dissatisfied, and only 10 patients (0.94%) were dissatisfied (Bureau of Health 1997a). The main benefits of the system were considered to be as follows.

Easy access to health services

The service stations or GP services were set up so that the consumers could reach them within a 15-minute walk. These facilities also provided an on-call service, and consumers could ring if they needed any help.

Effective use of health resources

Community health care gives attention not just to medical needs, but also to illness prevention, health promotion and education. This has reduced the rate of illness, and improved the health status of citizens. At the same time, it has slowed down the increase in health costs. According to a report from the Health Bureau, the cost per prescription has fallen by 11 yuan (about 9.5%) on average since the service began. One of the main reasons which increased the health cost was overuse health resources in the secondary or tertiary health care sectors, for example, over prescription and unnecessary tests. The CHC enabled the services to use low-cost medicine which has same treatment result as those new and high-cost drugs.

Furthermore, the development of CHC services created an opportunity for the first-tier sectors in the health care system to redirect their efforts from providing only specialised medical services to primary health care. Under these circumstances, the over-crowding of tertiary facilities has been reduced, and limited health service resources are being better utilised.

The CHC program has also contributed in terms of providing appropriate employment opportunities for newly trained general practitioners, and by ensuring that under-utilised primary health care workers have additional employment opportunities.

Benefits to disadvantaged groups

Women, children, the aged, and those in poverty are high-risk groups in relation to health care needs. According to statistics provided by the Ministry of Health, approximately 50% of the urban population are uninsured, and thus exposed to the risk of catastrophic loss from major illnesses. Usually women are the primary carers for ill or injured family members and bear a disproportionate share of the economic and emotional burden of home-care for the aged and frail.

It was intended that the innovations in community health care with lower costs should be of special benefit to these groups in China (United Nations Development Program, 1997). Results from Tianjin show that they have in fact benefited to a greater extent than other, more advantaged sections of the population.

Contribution to economic development

One significant advantage is that CHC services are not linked to particular employers (unlike most previous schemes). Thus they have made a contribution to ensuring there is a more mobile urban labour market since workers are now less likely to avoid changing their employment through fear of loss of access to health care (United Nations Development Program, 1997).

Community participation

A relatively stable link between the family and the GP has been built through the investigation of health status and establishment of family health records. This has not only enabled the CHC sectors to provide continuing and comprehensive health care to the individuals and the communities. It has also provided an opportunity for the communities and individuals to participate in primary health care processes, and enhance the awareness of self-responsibility for the individual's health.

Difficulties facing community health services

The CHC service is a new concept, and it is not easily integrated with the existing infrastructure and practices. There are several consequential problems, as follows.

First, existing facilities are poorly related to current needs. For example, some districts have more CHC clinics than they need, whereas many new residential areas have none.

Second, it is difficult to generate income. This is partly a consequence of the dominance of tertiary services, as noted above. Most citizens have come to believe that high-quality services can only be obtained in tertiary hospitals, and most of the funds they are able to devote to health care are consumed in this way. The problems for new services are exacerbated by additional expenses they have to bear. For example, whereas most of the long-established services have premises for which there is no capital charge, the new CHC facilities have to pay rent. According to a report from The 9(3 Society (1999), some primary care stations in Nanjing City (the capital city of Jiangsu Province) were forced to close because they could not afford commercial rents.

Third, the health insurance schemes are currently being reformed and this has led to uncertainty with regard to health care revenues. At the time of writing, the two main schemes (the GIS and the LIS as noted above) are being replaced by a new scheme covering almost all employees (Hindle 2000). The old schemes tended to encourage or require their members to seek care in selected tertiary hospitals, thus further exacerbating the problem of expectation of high technology and high cost (Luo et al 1999).

Also as noted above, CHC staff lack training. It is unclear whether the new urban insurance scheme will be able to redress the balance in the short term.

Suggestions for improvement of the CHC policy

Based on the experiences in Tianjin, there are a number of areas where the policy needs to be further developed. Some of the most important are noted below.

Integrated regional health planning

The mismatch of needs and facilities can only be resolved through a regional strategic plan within which the CHCs are a key component. Clear roles and responsibilities need to be defined for the different levels of health services, including an attempt to establish a role for CHC service providers as the 'gate-keepers' to hospital services.

This last point is important. At present, there is no reliable source of advice for people with regard to the services they need, and where those services may be obtained. Most of the best doctors are almost wholly based in the most sophisticated and expensive hospitals, and they have strong financial motives to encourage the use of their own hospitals.

Upgrading of CHC management

Management skills need to be upgraded. Important aspects include monitoring and evaluation, personnel management, and standardised methods of care.

It is also important to address some of the cultural constraints. The 9(3 Society (1999) has argued that emphasis must be given to the education of CHC staff in concepts of the priority of social benefits - to make greater efforts to meet the basic health needs of the society, rather than being driven exclusively by profit. Many medical staff did not have personal involvement in the health care system that existed before the market reforms, and there has been little discussion about the benefits of more socially conscious ways of providing health care.

An important related point is that the value of primary health care (and general practice medicine in particular) needs not only to be stated but also rewarded appropriately. Many highly skilled doctors might be willing to work outside hospitals, if the only issue were whether they could provide good health care. However, there is currently a significant financial disincentive to work outside hospital-based specialist medicine.

Establishment of incentive structures to encourage efficient health care provision and utilisation

Consumers, providers, and insurers must be given more appropriate incentives to increase efficiency (for example, by encouraging patients to seek care in the appropriate setting) while also ensuring quality of care. Particular attention needs to be given to the incorporation of CHC services in the benefit packages of the new urban health insurance scheme, and reform of methods of payment of care providers.

Furthermore, as the characteristics of the health service have been defined as a public service with social welfare features, the government needs to provide financial support to the CHC services. Luo, et al (1999) have argued that a continually increasing budget for CHC services needs to be considered each year, and more health funding needs to be provided for prevention and primary health care services as distinct from the present hospital orientation.

Training CHC service personnel

While there are large numbers of hospital-based and specialist doctors, there is a serious shortage of GPs. Few medical faculties have training programs for GPs, and doctors currently employed in CHC services lack relevant skills.

The 9(3 Society (1999) suggested that some doctors can be transferred to the CHC services from other medical specialities after they receive proper training in CHC services and, in the long term, formal training programs need to be enhanced in all universities to cover not only general practice but also general practice nursing and social work.

Conclusion

China is a developing country with limited health resources. Tianjin's experience has provided an evidence that the implementation of CHC services will enable the government to use present resources more effectively and efficiently. It will also benefit consumers by making access to health services more convenient and equitable.

Tianjin's difficulties have not been a consequence of poor policy, but rather of the difficulties of breaking down the constraints within the existing health care system. China had many successes in primary health care between 1950 and 1980, but direction was lost during the 1980s and 1990s as a consequence of the economic reforms of the 1980s and 1990s. While market ideas have generally caused a major improvement in financial wellbeing as a consequence of increased efficiency, they do not work well in the health care sector. By emphasising primary care again, and the need to maintain and further develop a welfare perspective on health care, the government has indicated a more sensible direction in the long term. However, many challenges remain to be overcome.

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