Lessons from the intravenous room in Hangzhou

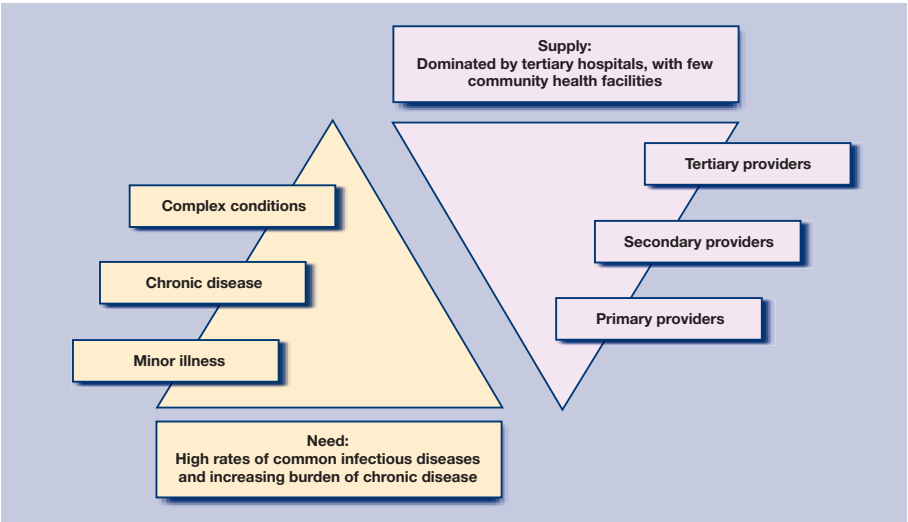
In 2006 I went with a delegation from Queen Mary and City Universities to a community health conference in Hangzhou, the university town of Zhejiang Province on the east coast of China. There is a great interest in developing primary health services in this vast continent of 1.3 billion people, and we took a team which included primary care researchers, a clinical effectiveness group, and educationalists.

When China began to open up in 1986 there was a rapid growth in hospital provision. In urban areas there is an oversupply of technology-rich hospitals, with high prices and competitive policies. Although official national policy since 1997 has been to develop community health centres this has been constantly undermined by a failure to regulate new entrants to the hospital market, and by the low status and education of community health staff. At present only about 4000 primary care doctors have postgraduate training of any sort, and 6% of clinical staff have no formal training at all. In 1999 a 3-year family medicine training programme started in Beijing, but the course closed in 2004 due to lack of applicants. The few successful graduates became specialists due to lack of jobs in general practice. (Figure 1).

Zhejiang Province is one of the most affluent areas in China, with 48 million people. It is a progressive province where there is a determined attempt to implement the new national policy of promoting primary care.[1] Community services are arranged in a hub and spoke pattern, the hub often being a secondary hospital requisitioned as a community facility with smaller clinics in the surrounding neighbourhood.

On visiting the well-equipped demonstration project in Hangzhou the first thing we saw was the price list. Funding remains an area of policy confusion. Only 20% of community health services are even included in health insurance schemes, and only one in 10 get their full budget allocation from the provincial government. So, although the total health spend for China in 2004 was 5.5% of GDP, some 60% of this was borne by patients.[2] The combination of using high technology hospitals and high co-payments means that among hospitalised patients nearly half seek discharge because of their inability to pay, with many citing healthcare costs as a major cause of debt and poverty.

Figure 1. The mismatch between health needs and the supply of health service facilities in urban China.



Watching consultations illustrated a number of other obstructions to service development. There is no registered list, so patients move between hospital, pharmacy, and primary care providers with no constraint. This undermines the emerging attempts to develop computerised records, audit, and recall for chronic disease.[3] Clinicians consult in cubicles two to a room, with low glass screens to separate stations (page 755). Privacy is simply not considered a priority. In contrast we were shown vigorous programmes of neighbourhood health education and kerbside case finding for hypertension.

My major epiphany came when we visited a small community clinic. Here we were shown a room with a row of plastic chairs placed beneath hooks in the ceiling (page 755). Difficult to understand its purpose, the doctor eventually explained that most people want an IV infusion of antibiotics if they have a pharyngitis or other infection. She agreed that there was little evidence to support this, but pointed out wryly that if her clinic didn't do this, patients would go to the nearest hospital for this treatment.

The difficulties in developing high-quality primary care services in a system without a strong tradition of family medicine, and without firm control of the market for high-cost drugs and technology seem immense. The NHS still provides a model for this — at present. We should support China on its challenging journey to transform health services; and we should reflect on all we have to lose if market forces become too dominant in our own patch.

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