The current status and challenges of community general practitioner system building in China

X. KONG and Y. YANG

From the Department of Neurosurgery, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences. No. 1 Shuaifuyuan Hutong of Dongcheng District, Beijing 100730, People’s Republic of China

Address correspondence to Y. Yang, Department of Neurosurgery, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences. No. 1 Shuaifuyuan Hutong of Dongcheng District, Beijing 100730, People’s Republic of China. email: yangyipumch@sina.com

Introduction

China has made great efforts to improve the health of its huge population. One vital task is to find the best way to build community general practitioner (GP) system across the country. Although the government has done a lot, multiple challenges still exist. It’s necessary to enact detailed protocols, further increase investment and promote the standardized training for GPs.

Chinese GPs’ current status

The services of GP system in China were originally described as ‘six aspects of care in one location’. The location is the community health service (CHS) institution, including CHS center and CHS station; the six aspects contain basic clinical services, prevention, health education, women and children’s care, elderly care, immunizations and physical rehabilitation. Today, the CHS includes more. GPs are the backbone of the CHS centers. They provide common diseases management; immunization and primary community health prevention; rehabilitation and family planning. Chinese government plans to train 150 thousand GPs by 2015 to meet health demands, but consistently high-quality standardized medical training for GPs is still lagging.

Three GP training models are being used. The first one is free training program for students serving underdeveloped areas. The program is 5 year long, and will grant a bachelor degree. The second one is 5 years of undergraduate clinical medicine plus a 3-year standardized general practice postgraduate residency training program. Nationally, only a limited number of trainees have enrolled in this type of program, achieving little sizable impact on the demand for top notched GPs. The third model involves retraining the majority of less-educated doctors currently practicing in CHS centers, and transforming them into GPs. Due to lack of national standards, the quality of these programs is quite variable.

Though China has released large numbers of policy documents to help create a favorable environment for GP system’s growth, there are some differences between what are called for and what are actually done partly because the policies are not strictly enforced. It will also take time for governments of all levels to be deeply aware of the importance of constructing GP system. Additionally, considering China’s 1.3 billion people and 9.6 million square kilometers area, the investment is still far from enough.

Issues and challenges for GPs in China

Although more and more medical colleges in China have started developing General Practice, its teaching at undergraduate level was not well allocated in regions with different economic levels. Moreover, GP residency training programs cannot attract enough students due to GP’s low salary, social status
and limited career opportunities. Even if they choose to work as GPs, brain drain is another problem. According to a study, the average annual income of a Chinese GP is less than half the earning of a hairdresser, and far lower than that of specialists. Poor working conditions, occupation recognition and worrying vocational outlook also contributed. Currently, qualified GP trainers for teaching are also in great shortage. It’s believed that the specialists are not able to teach the clinical thinking and skills in general practice and the teachers must be GPs themselves.

CHS are plunging into a crisis of confidence. First, the quality difference between GPs and specialists is big. Second, China’s current reforms still do not emphasize enough the value of GP led primary care. Patients not only worry about GPs’ care quality but also the outdated equipment for CHS. Third, lack of funding support forces GPs to count on the sales of medications or technologies to boost their salaries, discouraging patients’ trust. Lastly, no effective primary care institution and system has been established in China, leading to top hospitals’ overuse and GPs’ poor utilization.

Some advice on speeding up China’s GP system building

The poor clinical skills of current GPs and the shortage of GPs in China can only be solved step by step through establishing GP education system and training programs. First, policy makers should not only take advantage of foreign experiences in training the trainers, textbook writing and institutional improvement, but also help ordinary Chinese people study and accept ideas and principles about GP system that have endured for decades in western developed countries. Second, like Capital Medical University, more medical colleges should function as the back bone to bridge the noticeable gap in the quality of GPs and specialists. The expertise of general hospitals should be made best use of to establish a large number of clinical medical teaching bases and build up high-quality teacher teams. Lastly, the so-called barefoot doctors who function as the main primary care providers in China’s remote and underdeveloped regions should be urged to receive further training before becoming licensed doctors.

To achieve the success of GP system, the first-visit care system and the two-way referral system between GPs and specialists are necessary. GPs are the gatekeepers of medicine that patients will see first. Only when a patient’s condition is beyond GP’s expertise, he can be referred to a specialist. After his condition stabilizes, he should return to be seen by the GP. These systems help the vast majority of patients be triaged reasonably in an effective way and are helpful for a better allocation of resources, a more efficient system and synergistic benefits.

China can gradually help families establish stable contract-based ties and form long-term one-to-one relationships with specific GPs. This can result in shorter visit time and reducing unnessasory or duplicate tests for the majority of patients. If residents are not satisfied with one GP, they have the right to choose another. In addition, GPs shall be solely responsible for money, using it to pay referral fees and so on, which prompts GPs to put more emphasis on prevention and avoid overuse of medical resources.

More stimulus programs should be introduced. GPs’ multi-site licensed, flexible practice can be gradually allowed. Those who are willing to work in remote areas must be assured of sufficient subsidies. These policies will help to promote better distribution of medical talents among hospitals at different levels.

In conclusion, setting up a sophisticated GP medical system is a systematic task. In order to accelerate the sustainable development of CHS, the following must be considered: (i) GP training approaches must be multi-level, multi-channel, multi-form; (ii) A series of improved medical policies must be in place and (iii) China’s multidimensional national situations must be considered.

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References


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