A British Medical Student's Perspective on the Chinese Healthcare System

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PERSONAL VIEW

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As a British medical student, my first experience of healthcare outside the UK came towards the end of my final year of study. I spent one month working with Burmese migrants in Thailand and two months in China, largely based with a research team in Fuwai Hospital, Beijing. At the end of the placement I reflect on the similarities and differences between healthcare in China and in Britain. This article will not be exhaustive but will focus largely on the differences, as these are what stand out to the observer.

Fuwai Hospital is a tertiary centre specialising in cardiovascular medicine. The facilities for diagnosis and the treatment protocols resembled those in Britain. Likewise, the hierarchical structures of the medical professions were very similiar. In addition, in both countries it was perceived that support for the research community was part of a hospitals remit.

I was interested to hear about the experiences of my medical student peers in China. The overall structures of our degrees and the core curriculum are similar in both countries. We shared many of the same interests and worries, for example the balancing act of achieving academic success and practical clinical competence. This was a particular concern to some in China whose medical degrees were combined with a foreign language for example Japanese or English. In the UK, medical degrees involve solely studying medicine. Notably, in Britain, medicine is largely a 'run-through' course from high-school to qualification as a doctor whereas, in China, many universities first admit students for a 'foundation' medical degree then they must reapply for a second more advanced course in order to gain full qualification.

Overall, I noted two main differences between the healthcare in Britain and China. The first relates to cultural differences and the second relates to the healthcare system. Broadly speaking, the culture in China, places more importance on the family and less on privacy. Both in terms of privacy during physical examinations and sharing patient information with family members. In addition, significant reliance on traditional Chinese medicine can impact on treatment strategies.

In recent years strong family ties have declined in Britain. Divorce rates in the UK in 2005 were 2.6 per thousand[1]. Often generations live in different parts of the country, and may rarely see one another. The inpatient population of British hospitals is dominated by the elderly; for example, the average age of a patient in Oxford's John Radcliffe hospital general medical wards is 81 years old. Such older patients may see little, or nothing, of their relatives during a hospital stay. Discharge of these patients is regularly delayed, as they have no one at home to care from them as they convalesce. The British people often expect the State to provide this care. By contrast, in China divorce rates are considerably lower, 1.4 per thousand[1] and the impact of geographical separation are only just being felt. There seems to be a stronger sense of duty to older relatives. It is extremely rare to see patients in hospitals without at least one family member. Even as the younger Chinese generation move away from their hometowns there is still an expectation that they will help their relatives. I regularly saw entire families queuing to secure an appointment for their older relative, sitting with the patient everyday whilst they are in hospital and actively discussing their relative's condition with the medical staff. When a patient is ready for discharge it is expected that the family will provide the care needed in their home, despite inconvenience this may cause the family, or their place of work. Colleagues greeted the suggestion that older people could live and be cared for in nursing homes with surprise. In Britain, it is estimated that 5.5% of those aged over 65 live in residential or nursing homes[2], compared to approximately 1.5% in China[3].

The wards resembled British hospital wards with one notable exception. In China there were no curtains separating the beds. This was particularly evident in the Emergency Room, where over 50 patients filled a large hall containing no partitions. The bulk patient clerking was done in the "Interview Room", although I observed abdominal examinations and cannulations occurring in the main hall. From my observations the patients did not

appear embarrassed, and no one refused to be examined. In the UK, patients have preferences for privacy and thus maintaining privacy is considered very important in all encounters with patients, for example for physical examination, bedside procedures and investigations or discussion of medical matters. Drawing curtains around the bed do this.

My final point relating to cultural differences is the importance placed on traditional Chinese medicine. For many Chinese people the ideas of traditional Chinese medicine (TCM) underpin their healthcare beliefs. Most Chinese people I have met have an understanding of this approach. Commonly, patients seeking Western medical care will simultaneously be using traditional Chinese medicine. Furthermore I was warned that western medical advice is liable to be ignored by some patients if it contradicts traditional advice. The paradigms underlying TCM differ significantly from those of Western medicine and Chinese doctors needed to have a familiarity with both, in order to communicate effectively with their patients. The remedies used in TCM sometimes contain compounds, which are, or will interact with, Western drugs[4, 5]. A working knowledge of these interactions is also important. By contrast, although the use of alternative therapies has grown in popularity in Britain, Western medicine remains the mainstay of first line therapy. British pharmacies stock almost exclusively Western medications whereas in China there is a more even division of traditional remedies and Western ones.

The other class of differences I noted related to the organisation and provision of the healthcare system. The founding principle of Britain's National Health Service (NHS) is that it is a universal service, free of charge at the point of delivery for UK residents, funded through taxation by the government. By contrast, in China, patients pay upfront for treatments, with varying degrees of re-imbursement from the state at a later date. The level of re-imbursement depends on a number of factors, including geographical location and type of employment[6] The result of this, on occasion, was late presentations of disease, where patients had delayed seeking medical attention as medical expenses were unaffordable compared to income. I understand that China is moving toward universal healthcare coverage, as this happens this difference will diminish.

In Britain, for all but emergency presentations, primary care physicians, GPs, are the first point of contact with the healthcare system. They act as gatekeepers to more specialist services. For example if they judge specialist input to be necessary, but not urgent, they will arrange a referral for this. If the case is urgent they will send the patient directly to hospital. In China it seems the patient's first point of contact is often the hospital outpatient department. Patients will arrive and wait for an appointment that day. In Fuwai I observed some extreme versions of this behaviour where patients would travel from distant home-cities to Fuwai, without seeking advice at their local hospital. On occasion this delayed their treatment, and incurred unnecessary expenses for the patient. An additional implication is that local hospitals are relatively underused[7].

In Britain, doctors no longer wear white coats, male doctors do not wear the traditional tie, and all staff must have bear arms below the elbows, i.e. no long-sleeves, watches or ring. These measures, alongside rigorous hand-washing protocols, have been instituted in response to the problem of hospital-acquired infections (HAI). In China doctors continue to wear white coats, with no dress code related to infection control. It was at each doctor's discretion to keep his or her coat clean. However, as in the UK, above sinks, the six-step hand washing technique was displayed. On discussion with my colleagues, hospital acquired infections do not feature heavily in their workload. However, it is likely this is because there was less focus in China on identifying and reporting HAIs.

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CONFLICTS OF INTEREST
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