Editorial Commentary

Primary hospitals in China: current state, challenges, and solutions

Ziyi Wang[1], Ge Zhang[2]

[1]Liaoning University of Traditional Chinese Medicine, Shenyang, China; [2]Kaiyuan Central Hospital of Liaoning Province, Kaiyuan, China

Correspondence to: Prof. Ge Zhang, MD. Kaiyuan Central Hospital of Liaoning Province, Kaiyuan 112300, China. Email: Pumch-liver@hotmail.com.

Keywords: Primary hospitals; primary healthcare services; healthcare systems; healthcare reform

Submitted Oct 31, 2023. Accepted for publication Nov 10, 2023. Published online Nov 13, 2023.
doi: 10.21037/hbsn-23-571
View this article at: https://dx.doi.org/10.21037/hbsn-23-571

When it comes to primary healthcare services, China's primary medical system stands out with its unique attributes, shaped by China's existing framework, cultural heritage, and the rapid growth of its economy and healthcare sector. Unlike established systems in the West, the healthcare landscape of China is in a constant state of evolution, adapting to its ever-changing society. It's no surprise that challenges abound, especially given that it's been only a few decades since nearly one-fifth of the Chinese population collectively lifted themselves out of poverty and required access to healthcare coverage. Navigating the complexities of primary healthcare in China feels akin to crossing a river blindly, stepping on stones people can't see.

The current state of primary hospitals in China

In contrast to the robust healthcare systems in developed Western nations, China's primary healthcare system still requires significant improvements. Among them, county-level public hospitals serve as the leading constitutions that connect with higher-level hospitals, leading township hospitals and village clinics to form a three-tiered primary healthcare network. Since 2012, county-level public hospitals have undergone continuous reforms, striving to improve their capabilities. Various initiatives like "Comprehensive Reform of County-level Public Hospitals on Breaking the Pharmaceutical-Driven Model", "Capacity Improvement Project for County Hospitals", "Establishment of Five Centers", and "Development of Medical Alliances and Medical Communities" have been introduced. The goal behind these reforms is to bolster the service capabilities of county hospitals, ensuring that 90% of patients can receive proper treatment within their own counties, even for complicated diseases.

While these policies have undoubtedly bolstered several county hospitals, transforming them into tertiary institutions, some measures have fallen short. Particularly in economically disadvantaged regions, county hospitals grapple with financial constraints, a dearth of skilled professionals, sluggish departmental growth, and limited capacity to treat major diseases. Consequently, a considerable number of patients seek healthcare elsewhere. Achieving the objective of providing comprehensive local treatment for major diseases remains an arduous and prolonged journey or may never be achieved.

Challenges in primary healthcare

Inadequate funding

County-level hospitals rely on varying government subsidies. Apart from self-operated income, these hospitals need financial aid from county governments to bridge the operational gap. However, financially disadvantaged regions struggle to allocate ample funds, burdening these hospitals. Responsibilities such as infrastructure, equipment procurement, and personnel training, typically government-led, are transferred to hospitals, intensifying their challenges. To cope with regular expenses, hospitals resort to loans, creating additional financial strains. Many hospitals operate under significant debt, with debt ratios exceeding 50% and sometimes reaching 100%.

Loss of healthcare professionals

Insufficient funding directly affects the recruitment and training of healthcare professionals. County-level hospitals mainly recruit doctors with undergraduate degrees. These young doctors face two exams: the medical practitioner exam and specialized physician standardized training, a process lasting 4 to 5 years. During this period, hospitals bear training costs with little clinical contributions. Due to low salaries and limited specialism development of primary hospitals, many graduates leave for higher-tier hospitals or prosperous regions after certification. Over the last decade, the trained healthcare employees' outflow rate exceeded 60%. Skilled doctors also migrate to economically developed regions, attracted by lucrative offers from private hospitals. This, coupled with retirements, contributes to a scarcity of healthcare personnel in county-level hospitals. Daily clinical duties make it hard for hospitals to send staff for advanced training, further hindering medical discipline growth.

Slow progress in discipline development

To achieve the goal of providing comprehensive local healthcare, primary healthcare centers are striving to upgrade to higher-tier or tertiary hospitals. This necessitates the establishment of new disciplines and various centers. Discipline development requires substantial financial investment and the recruitment of relevant professional staff. Hospitals are willing to incur debts to purchase expensive large-scale equipment for new disciplines. However, professional training is a long-term endeavor. Consequently, the operation and diagnosis using new equipment cannot reach a high level immediately, limiting project implementation. For instance, in centers for chest pain or stroke, a lack of specialized operators and doctors often persists after equipment installation. This necessitates temporary collaboration with doctors from higher-tier hospitals to assist in operations and address diagnostic challenges. This interim arrangement, coupled with the need for synergy between hospital staff and external experts, often leads to suboptimal patient outcomes and low patient satisfaction. The underutilization of equipment results in inefficiencies. The slow pace of discipline development is inevitable. Consequently, although some hospitals have elevated their levels, their operational capacity and medical standards do not fully align with their hospital levels.

Due to these challenges, patients tend to seek healthcare elsewhere. Additionally, after the healthcare reformation, several policies were issued to facilitate medical treatment in non-local areas, providing patients with more options. In fact, despite the ability of primary healthcare centers to handle common diseases, patients prefer seeking treatment in large hospitals. Large hospitals readily admit patients, leading to the outflow of patients from primary healthcare centers.

To retain patients, primary healthcare centers attempt to perform a number of major surgeries and high-tech procedures. However, due to limited staff capabilities and disease awareness, their efforts fall short of the actual need. Although these attempts are convenient for patients and reduce their medical expenses, ensuring the quality of major surgeries and high-tech procedures remains a challenge. Postoperative outcomes and complications are not comparable to those in large hospitals. Some hospitals attempt to address this by forming alliances with larger institutions. However, this approach has shown limited success, as higher-tier hospitals struggle to invest significant resources and staff across all primary healthcare centers. A solution in this direction appears increasingly unlikely.

Thoughts about primary healthcare reform

Is every county-level hospital in China truly progressing toward the goal of becoming a tertiary institution? Is this feasible? If all primary healthcare centers in the nation aspire to be comprehensive, the essence of primary healthcare would lose its fundamental nature. Furthermore, do the county-level "tertiary hospitals" possess the expertise and service to compete with large tertiary A hospitals?

Should tertiary A hospitals perform basic surgeries that primary healthcare centers can manage, causing an unbalanced distribution of patients?

The tiered healthcare policy points out the direction for us. However, the functional roles of hospitals at different tiers remain unclear, and there are no specific guidelines for admitting different types of diseases. Patients largely decide which hospital level to visit, despite certain restrictions based on various medical insurance reimbursement rates. Implementing the tiered healthcare policy effectively is difficult.

How can large tertiary A hospitals collaborate with primary healthcare centers? Can patients be categorized for treatment? Can patients be carried out in stages for major surgeries and chronic diseases throughout the entire treatment process? For example, post-operative recovery

and supportive treatment could occur at primary healthcare centers, and patient follow-ups as well.

From this standpoint, is it reasonable to solve 90% of patients' healthcare needs within the county, ensuring major diseases are not referred to outside the county? Can this goal be realistically achieved?

The future of primary healthcare

To be honest, the specific path for reforming primary healthcare in China remains uncertain. However, the ultimate objective is clear: to establish a primary healthcare service system tailored for the Chinese people, that is, the public receives excellent care, and cutting-edge medical exploration and research are fully utilized. Certain large tertiary A hospitals are gradually aligning with global standards in advanced medical fields, with some even surpassing these standards. Meanwhile, the fundamental healthcare needs of the public should be met conveniently and swiftly. Each component within the system should have well-defined roles and responsibilities. We are confident in anticipating this prospect.

Acknowledgments

Funding: None.

Cite this article as: Wang Z, Zhang G. Primary hospitals in China: current state, challenges, and solutions. HepatoBiliary Surg Nutr 2023;12(6):909-911. doi: 10.21037/hbsn-23-571

Footnote

Provenance and Peer Review: This article was commissioned by the editorial office, *Hepatobiliary Surgery and Nutrition*. The article did not undergo external peer review.

Conflicts of Interest: Both authors have completed the ICMJE uniform disclosure form (available at https://hbsn.amegroups.com/article/view/10.21037/hbsn-23-571/coif). The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

