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Evaluating community health centers in the City of Dalian, China: How satisfied are patients with the medical services provided and their health professionals?

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ABSTRACT

Around 58 community health centers (CHCs) were investigated to evaluate their performance, and 372 residents were surveyed randomly about their satisfaction towards these centers. State-owned CHCs gained the least benefits and received most patient visits. Residents' opinions about health professionals working in these centers showed marked distrust due to their insufficient work experience and low education level; however, affordability, availability and access to services and drugs among CHCs generated comparatively high satisfaction. Therefore, enhancing CHCs' service delivery is a necessity to improve the quality of community doctors and nurses, increase enrolment and training programs, and augmenting hospitals' support to CHCs.

1. Introduction

The key in attaining social and economical productive lives – according to the Alma-Ata Declaration – lies in the availability of and accessibility to appropriate primary health care. Primary care is considered the most innovative health care sector as a whole in China, and the CHCs specifically due to the absence of primary care private practice. However, various studies from different parts of China have shown the existence of geographical inequity in delivering medical services to their populations, where the medical services that are provided in the urban areas are much better than those in the rural areas, and tertiary hospitals located in the major cities in China are much better able to provide good quality and efficient services than the urban community health centers. Hence, with the open up and reform policy and the rapid growth of health expenditures associated with the irrational distribution of medical resources the central government was forced to embark on implementing several innovative plans affecting the community health service (CHS). The first reform commenced in the 1990s, the support was expanded in 2002 and their major effects were realized in 2006.

Our work is situated in China—an emerging powerful economic developing country which is still facing with many challenges, following the collapse of the commune system, in providing basic medical coverage to its whole population. In narrowing our study to a manageable scale, we have chosen the City of Dalian, in the northern part of China, and have selected community health centers (CHCs) as the basic health care setting that this paper will examine. We shall explore the extent of progress of the CHCs in the City of Dalian in delivering services to their residents subsequent to the health care sector having passed through several phases of innovation since the open up and reform policy adopted by Chairman Deng Xioaping.

The objective of this paper is to investigate (a) how different kinds of ownerships of CHCs in the four districts of Dalian, Liaoning province, China, are affecting the delivery, quality and

Abbreviations: HP, health professionals; CHSC, community health system centers; CHS, community health service; CHSt, community health stations; CHCs, community health centers; CHDs, coronary heart diseases; MC, management center; BHI, basic health insurance; GIS, government insurance scheme; NRCMS, new rural cooperative medical system; CBCD, complete blood count differential; OB/GYN, obstetrics and gynecology; ECG, electrocardiogram; GP, general practitioner; U/S, ultrasound; SO-CHCs, state-owned CHCs; FS-CHCs, factory-sublet CHCs; FO-CHCs, factory-owned CHCs; PO-CHCs, private-owned CHCs

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efficiency of medical services and (b) what are the attitudes and perception of communities, chosen from the parameters of the CHCs, towards these centers? We hypothesized that there is a general satisfaction with the health care services delivered by these CHCs and their health professionals (HPs) in the City of Dalian. Nonetheless, to test this hypothesis we must first compare the whole functions and performance of the four different kinds of CHCs ownership; then we will support our primary data by evaluating people's opinions, perceptions, and satisfaction with the services and the quality and efficiency of HPs. Finally, we will provide some policy recommendations towards improving the functions and the delivery of health care services by these CHCs.

However, before we proceed it is a necessity to explore the influence of neoliberal market-oriented policies that have affected many countries in the developing world and left a strong impact on the innovation of the health care sector in China as a whole and the CHCs specifically.

2. Emerging of neoliberal market-oriented health care sector in developing countries

With the global economic growth as well as the emergence of neoliberal movements in many developing countries in the early 1990s and the strong aid and support from the World Bank and the international community in the late 1990s under the"post-conflict[5] rehabilitation" policy had forced many developing countries to shift from a commune system to a market economy. This made it inevitable for these countries to re-evaluate their social and economic structuring systems. The reforms had overtaken the restructuring and reorganization of the civil service as well as decentralized the political, administrative and financial sectors. Also, economic recovery programs were implemented and privatized and administered constitutional reforms that shifted all the administrative authority from the national to the local government authorities. Meanwhile, many developing countries' health care provision became an integral part of the health care reform movements; thus, moving from fees-for-services to a combination of mixed health coverage programs, while a few adopted the capitation system or the universal coverage system. The implementation of fees-for-services resulted in an unaffordable health care, especially among the low income and impoverished populations. Every country reformed and adjusted their health care systems according to its own socio-economic framework. Such examples can be seen in Brazil in the form of organizational and financial restructuring towards decentralization (Lopez-Acuña, 2000). Such changes had a strong influence on the promotion and development of preventive measures (Atkinson et al., 2005). In Colombia a new social insurance program replaced the previous segmented model (Castano et al., 2002; Londoño and Frenk, 1997); in Zambia and South Africa there was the creation of resource allocation mechanisms; primary care user fee removal (South Africa), user fee implementation (Zambia); prepayment mechanisms (Zambia) and social health insurance (South Africa) (Gilson et al., 2003). In Cambodia the Health Equity Fund for the impoverished population was established and contract management between government health institutions and the private sector were established to run and reduce corruption and bureaucracy, and deliver better health care services (Soeters and Griffiths, 2003); and in Vietnam a public health insurance coverage (social health insurance (SHI)), health care funds for the poor (HCFP), voluntary health insurance (VHI), and a program composed of free health care for children under 6 years of age were formed (Ekman et al., 2008).

[5] Post World War II (1945 till 1989), the world was divided into the Eastern Bloc (headed by the Soviet Union) and the Western Bloc (headed by United States). During that period the world was faced with many international conflicts as a result of the tensions between the two camps. The Eastern Bloc countries are the ones that faced with large consequences due to the adoption of the communist ideology that depended too much on the commune system rather on the market economy and the same time the arms race that affected their shattered economies and touched every aspect of their social, economic and health care aspects.

3. China's health care system background

In the mid-1970s, nearly 90% of the population in the rural areas was covered by the Rural Cooperative Medical System (RCMS) (Liu, 2004). However, as China started to move away from a centrally planned economy to a market economy, inequities in receiving health care services among the population became evident (Liu, 2004). The transition from the agricultural collectivity towards the household system had weakened the financial base of the RCMS, which caused the collapse of the rural commune clinics and eroded the delivery of basic medical services. In the urban areas, more public companies were sold to the private sector, causing the dismissal of large numbers of employees, which left them without medical insurance coverage (Gao et al., 2001). By late 1997, the central government revised the previous health reform after they had realized that the enrolment of the rural population dropped to less than 12%, and 8% by 1993 (MOH, 1994), and by 1998 only 9.5% of the rural population was insured (MOH, 1999). In the urban areas, the central government acknowledged the existing flaws in the old urban health insurance system (the Government Insurance Scheme (GIS) and the Labor Insurance Scheme (LIS)) (Liu, 2002) and replaced them with a new urban social insurance coverage model. In 2003, a third reform was implemented due to the failure of the RCMS to attract and enroll more rural population into that insurance coverage (Yip and Hsiao, 2009; Dib et al., 2008; Wagstaff et al., 2007), and in the urban areas Community Health System Centers (CHSC) – known before as basic hospitals – were totally neglected. Reviving their role; therefore, became a necessity after being recognized as the frontline of primary care.

4. National Health Policy affecting CHCs

Before the reform and open up policy in China, community health centers (CHCs) were more funded by the central government then by the local authorities. From 1978 to 1998, the central government implemented several new policies towards the funding of CHCs by shifting the responsibilities from the provincial to the local authorities, thereby forcing them to provide financial support through local taxation and the informally sanctioned privatization of hospitals and clinics. Meanwhile, the central government continued their tight control over the amount of services, number of public-owned hospitals and clinics. Facilities were permitted to charge fees for routine visits and services (such as surgeries, standard diagnostic tests, and routine pharmaceuticals), and to earn more profits from new drugs, laboratory and hi-tech procedures with a profit margin up to 15% (Wang et al., 2007). During that period, the national health care spending in China witnessed a sharp decrease from 32% to 15% of GDP, a devastating policy that affected both CHCs from receiving regular funding and communities from receiving appropriate care (Liu et al., 2000; Blumenthal and Hsiao, 2005). By the beginning of 1998, the government encouraged communities to establish their own public health networks in order to fulfill the six main functions by providing basic clinical services, prevention, health education, women and children's care, elderly care, immunizations,