Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ) 123-124 (2017) 32–35

Contents lists available at ScienceDirect

Z. Evid. Fortbild. Qual. Gesundh. wesen (ZEFQ)

journal homepage: http://www.elsevier.com/locate/zefq

Special Issue / Schwerpunkt

Call for shared decision making in China: Challenges and opportunities

Aufruf zu partizipativer Entscheidungsfindung in China: Herausforderungen und Chancen

Mi Yao[a,b], Samuel Finnikin[c,*], K.K. Cheng[a,c]

[a] *Department of General Practice, Peking University Health Science Center, Beijing, China*
[b] *Beijing Xicheng District Xinjiekou Community Health Service Center, Beijing, China*
[c] *Institute of Applied Health Research, University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK*

ARTICLE INFO

Article History:
Available online: 19 May 2017

Keywords:
shared decision making
chinese healthcare
doctor patient relationships

ABSTRACT

China's healthcare system has undergone extensive changes over recent years and the most recent reforms are designed to shift the emphasis away from hospital based services towards a more primary care based system. There is an increasing recognition that shared decision making needs to play a central role in the delivery of healthcare in China, but there are several significant barriers to overcome before this aspiration becomes a reality.

Doctor-patient relationships in China are poor, consultations are often brief transactions and levels of trust are low. Implementing a shared decision making process developed in the Western World may be hampered by cultural differences, although this remains an under-researched area. There is, however, a suggestion that the academic community is starting to take an interest in encouraging shared decision making in practice and indications that the Chinese public may be willing to consider this new approach to healthcare.

ARTIKEL INFO

Artikel-Historie:
Online gestellt: 19. Mai 2017

Schlüsselwörter:
partizipative Entscheidungsfindung
chinesisches Gesundheitssystem
Arzt-Patient-Beziehung

ZUSAMMENFASSUNG

Das chinesische Gesundheitssystem hat sich im Laufe der letzten Jahre stark gewandelt; die jüngsten Reformen sollen den Schwerpunkt von einer krankenhausbasierten Versorgung hin zu einem stärker auf dem Konzept der Primärversorgung beruhenden System verlagern. Die Erkenntnis wächst, dass partizipative Entscheidungsfindung in der chinesischen Gesundheitsversorgung eine zentrale Rolle wird spielen müssen, doch bevor sich diese Bestrebungen realisieren lassen, gilt es, einige wesentliche Hürden zu überwinden.

Um die Arzt-Patient-Beziehung ist es in China schlecht bestellt; der Arztbesuch ist häufig eine kurze Angelegenheit mit niedrigem Vertrauensniveau. Die Implementierung des Prozesses der partizipativen Entscheidungsfindung, wie er in der westlichen Welt entwickelt wurde, könnte aufgrund der kulturellen Unterschiede auf Schwierigkeiten stoßen, wobei dieses Thema bislang allerdings noch unzureichend erforscht ist. Es gibt jedoch Hinweise darauf, dass die akademische Community sich für die Förderung von partizipativer Entscheidungsfindung in der Praxis zu interessieren beginnt, und auch Anhaltspunkte dafür, dass die chinesische Öffentlichkeit möglicherweise bereit ist, über diese neue Herangehensweise an die Gesundheitsversorgung nachzudenken.

* Corresponding author: Dr Samuel Finnikin; Institute of Applied Health Research, University of Birmingham, Edgbaston, Birmingham, B15 2TT, UK.
E-mail: finniksj@bham.ac.uk (S. Finnikin).

http://dx.doi.org/10.1016/j.zefq.2017.05.004
1865-9217/

An overview of medical and health services in China

There are four important stages in the development of China's healthcare.

Between 1949 and 1984, the government owned and operated all healthcare facilities and employed the healthcare workforce. In this system, China used community health workers to provide basic public and personal health services at the village level. In the 1980s, the Chinese government initiated a major reform of the medical and healthcare systems. The role of the government in healthcare was dramatically reduced and a free-market approach was adopted. However, most of the population remained uninsured and therefore people were suddenly exposed to the full burden of healthcare costs [1].

In 2009, China launched reforms that accomplished nearly universal insurance coverage, especially in rural areas [2,3]. In addition, new medical and healthcare systems were implemented [4]. Firstly, a public health service was established. This is responsible for disease prevention and control, health education, maternity and child care, and a medical and healthcare system based on community-level healthcare networks. The second tier service is the medical care system. In the rural areas, this refers to a three-level medical service network that consists of the county hospital, the township hospitals and village clinics. In the cities and towns, a new type of urban medical health service system was established that features division of responsibilities as well as cooperation among various types of hospitals at all levels and community healthcare centers.

During this period, government investments in healthcare infrastructure and activities were heavily concentrated in hospitals. This resulted in rapid improvements in secondary and tertiary care in China, but has also created new problems [5]. A heavy focus on more expensive healthcare resulted in problems of affordability, over-investigations, over-treatment, uncoordinated healthcare provision, and associated increased tensions in doctor-patient relationships [6] as well as declining interest among school leavers to pursue a medical career [7].

In 2015, in recognition of these problems, the *National Health and Family Planning Commission* of the People's Republic of China set out their plans for the future of healthcare [8]. Local authorities were tasked with optimizing medical resources by restructuring systems to reverse the over reliance on hospital care and strengthen primary care. These changes are due to be fully implemented by 2020.

Doctor-Patient relationships

Structural imbalances and ongoing system transformation have had an important effect on the doctor-patient relationship. A large, national survey in 2008 found that 80% of medical professionals considered the doctor-patient relationship to be poor or very poor [9]. An unfortunate manifestation of this is seen in the large number of violent incidents perpetrated against doctors. One survey in 2012 found that 96% of medical staff reported abuse or injury [10] and concerns over violence are a major source of low job satisfaction amongst Chinese doctors [6]. Violence towards healthcare workers is an extreme demonstration of the mistrust that exists between patients and doctors [11]. This mistrust stems from patient perceptions of injustice within the healthcare system and concerns over the inherent knowledge imbalance that exists [12,13]. However, when the doctor-patient relationship is examined from the perspective of patients a more positive view has been found, with 67% of patients reporting that they trust or strongly trust physicians [13].

Whilst there has been unprecedented economic grown in China over the past three decades, health literacy amongst patients has not improved at the same rate and most patients regard healthcare services as commercial transactions [14]. This exacerbates the knowledge imbalance between patients and doctors which is a major contributing factor to the mistrust that exists in this relationship. Against this background, shared decision making is a mechanism that has the potential help to decrease the informational and power asymmetry between doctors and patients [15] and as such should be seen as an important aspect of restoring trust in the Chinese healthcare system. However, shared decision making can only be built on a foundation of trust and mutual respect [16]. So whilst shared decision making may improve trust, implementing this in practice may be difficult without other strategies to promote trust in the system. Rebuilding trust will require a concerted effort involving changes in medical education, healthcare system, legal and ethical systems, and public education [17].

Shared decision making in China

In 2015, a review by Huang et al searched multiple sources for evidence of shared decision making in China, but could not find any sign of the development, testing, or implementation of shared decision making tools for patients in Mainland China [18]. They concluded that shared decision making may be out of China's reach in the current environment due to insufficiencies and inequities in the healthcare delivery system, low health literacy of the Chinese populations, extremely brief clinical encounters, and the state of distrust and disrespect between patients and clinicians. This review included the literature up to 2014. To update this, we searched several Chinese databases and media reports from 2014 to 2017.

Huang and colleagues have gone on to demonstrate the feasibility of using a decision aid (the Statin Choice decision aid) to implement shared decision making in a referral cardiology practice in China [19] and further research is planned [20]. Other clinical areas are also demonstrating an interest in shared decision making. In colorectal cancer, 60% of patients prefer to be actively involved in the decision making process [21]. Another research group showed that shared decision making was effective in boosting treatment compliance and efficacy amongst Chinese patients with schizophrenia resulting in improved social functioning and reduced relapse rates [22]. Several other papers have been published on the theoretical aspects of SDM which demonstrates an academic interest in this area [23–26]. Some shared decision making questionnaires, such as the OPTION scale and the SDM-Q-9 have been translated into Chinese [27,28]. However, only OPTION is in Simplified Chinese (used in mainland China). Validation studies have not been undertaken and there is no research using these tools in mainland China.

A conference about shared decision making, that is widely thought to be the very first such meeting in China, was held in Beijing on June 24th, 2015 and this attracted considerable media interest [29]. Chinese and overseas delegates at this conference agreed on the value of shared decision making but also identified several challenges faced in changing current practice, not least the fact that many clinical consultations currently only last 2-3 minutes. The conference was also ranked by the website of Xinhua News Agency (the official press agency of China and also China's biggest and most influential media organization) as the event that had made the greatest constructive contribution to improving doctor-patient relationship in China in 2015 [30]. However, it is very clear that there is still a long journey to travel before shared decision making can start to take root in China. We anticipate considerable challenges and difficulties in the journey.