

China, Britain, and Delivery of Health Care *Some background to this month's supplement to the BJP*

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Isolated for centuries by barriers of deserts, mountains, and sheer distance from contact with the West, and occupying a varied land measured in thousands of miles, human beings with needs and desires like our own have developed a civilisation of high achievement and distinct attitudes to religion, philosophical ideals, and social relationships. Although they seem to have lacked the missionary and empire-building spirit, in spite of their secrecy and idiosyncratic form of writing they have given us fine silk, china, spaghetti, tea, fireworks, wheelbarrows, umbrellas, paper money, and civil service examinations; and perhaps they still have something to teach us.

Even since 1949, in spite of a new openness to things and ideas from the West, it has been difficult to know what is really going on in China, partly because at times it changes very rapidly, partly because of continuing secrecy, Marxist dogma, and a fear of 'losing face' before an international public, partly because the many visitors to China confuse aspirations with facts, and attribute Western meanings to familiar words. Take 'doctor', for instance: does it mean someone with a six-year medical training like our own, or with a three-year training in a health school, or a Chinese traditional doctor, or folk doctor, or 'barefoot doctor' of yore, or just anyone undertaking diagnostic/treatment work? Surely a communist country will have a national health service? No. There is no service offered to everyone, it is not usually free at the point of delivery, and patients (or their insurance) pay for hospital admission, even if it is subsidised. There is no central directorate in Beijing, and regional bureaux of at least four ministries collaborate in service provision. Thus the Ministry of Public Health provides about 470 institutions, the Ministry of Civil Affairs (Welfare) 190, the Ministry of Public Security (police) 23, the Ministry of Industry and Mining 81 – many large state industries have in effect their own medical services, with clinics and beds, and so on. Such a large country with geographically difficult and poor communications has variety in living styles and wealth, and it is not surprising that health planning and services are largely dependent on local committees and local finance. This means they are extremely patchy, and what the visitor sees are a few gems from the country as a whole.

When it comes to psychiatric services, whole professions are unrepresented. There are no clinical psychologists, no social workers, no occupational therapists, or trained psychiatric nurses. There are people performing some of their functions, who may have experience and even some training for their specific work. Even Western-style physicians practising psychiatry have quite often had no training in the speciality. China is desperately short of trained personnel of all kinds, and has the policy of selecting people for jobs first, and trying to give them the training they need afterwards. We train people first, and then let them find jobs, which leads to professional rivalries and to a waste of training since some take no appropriate job or even leave the health service.

The psychiatric hospitals themselves are far too few in number, which forces community care, and they are in principle all acute hospitals for stays of up to three months only. Chinese families are still large and ready by tradition to care for their ill relatives, and to try to marry off the mentally ill, increasing the carers. It was Western missionaries who introduced the idea of hospitalisation, which has now become the Chinese preference, if there was only the money to provide it. In China, mental illness is shameful to the family and to be hidden. Alternatively, in others it is frightening, and the idea of a hostel for the mentally ill in an ordinary street is unacceptable. The prime purpose of a mental health service is to keep the ill out of sight and off the street, and to protect the community from arson, homicide, suicide and such antisocial acts. The purpose of treatment and rehabilitation, at least for the state, is not for the individual, to relieve suffering, improve quality of life or develop talents, but for the community, to produce another productive worker; or failing that someone who can at least look after themselves, without being disruptive.

Psychiatric rehabilitation has crept in on the tail of rehabilitation from disability in general, which in turn has become important in China thanks to the personal work of Deng Xiao Ping's son, who became a wheelchair paraplegic when he was thrown out of a third-floor window during the Cultural Revolution. What there is of it is devoted to the improvement of schizophrenics and of the mentally retarded (learning disabled) on discharge from hospital, and fits

well with the community care of those treated at home and unable to gain admission. Hospital treatment tends to be narrowly biomedical (i.e. mostly drugs); rehabilitation is on some biopsychosocial model.

Thanks largely to the careful editing and extended commentary by Drs Phillips and Pearson, the supplement to the *BJP* on psychiatric rehabilitation in China provides one of the most up-to-date and balanced accounts available in English. It allows us to see common problems tackled from a different point of view, with a different organisation. It makes us question the details of our own practices, and sometimes see a possible solution which was previously hidden. Our health practices have grown up haphazardly, piecemeal, over a long period, and the occasional 'rationalisations' that take place are themselves quick fixes. The present reorganisation in the NHS is one such, an attempt by accountancy and factory management methods to improve the service from outside, rather than rethinking the philosophical basis and the practical aims within it.

The Chinese provoke one question straight away: should a free state service treat only those who will work again or at least care for themselves, and leave quality of life to the private sector? Should hospitals for the chronic sick be the responsibility of charities, the induction of pregnancy in the sterile be available only on personal payment of cost, most plastic surgery a private affair? A closer look at Shanghai will suggest other thoughts.

Shanghai is a city of almost 13 million people, 8 million of them in 12 urban districts and the rest in 9 adjacent rural counties. For administrative purposes each urban district is subdivided into 'streets' (perhaps Parisians would call them '*quartiers*'), and each street into 'lanes', 2783 of them in urban Shanghai. Each adjacent rural county is correspondingly divided into townships (with up to 40 000 people) and villages, 3461 in all. Lanes and villages represent the level of primary care, but medical care comes from the township or street level. Each township primary general hospital (341 in all) has a general doctor who provides out-patient supervision on a monthly basis, particularly for skin diseases, tuberculosis and mental illness, for the last of which he may receive 3 to 6 months' training, to help him make diagnostic assessments, control medication, and guide the family in the patient's care. If a patient fails to appear at a clinic, the doctor is required to do a home visit. In 1989, 58 000 patients were recorded as seen this way, through 197 000 clinic and 155 000 home visits. At lane and village level there are guardianship networks of volunteers, about 20 or so per locality covering one patient each. These people are chosen by local officials from neighbours and the retired to visit (usually quarterly) and help families with encouragement about medication and

general hygiene, and act as a contact with the doctor, who may meet the keenest of them, and to whom they can take a patient who is not doing well.

Above this organisation there are about 50 psychiatric institutions (totalling 8500 beds), one-quarter owned by individuals or societies (collectives) and three-quarters run by boards representing the Ministries of Public Health, Civil Affairs, and Public Security, which also run the township hospitals. The Ministry of Civil Affairs also runs 141 rehabilitation workshops, paying the director but expecting the workshop to pay its way (including something to its patients) from the packaging, assembly work, and sorting it undertakes for local factories. In 1989 they served 3870 patients, two-thirds mentally handicapped, and only one-fifth schizophrenic. Quite separate from all this, over 900 factories in the region are said in 1989 to have had their own health clinics, rehabilitation workshops, and doctors who do home visits and support guardianship networks. This has arisen naturally where factories have created their own housing and dormitories for their workers, and provide schools and medical services. They treated nearly 8500 mental cases in 1989.

There are several interesting points about all this. The first is that different ministries are expected to collaborate formally in boards at two or three levels of government. This improves the chance that they will work together. Our hospital service and our social services are free to work quite separately and squabble over responsibilities and money; they do not have to join at local level, and be answerable to a joint board at a higher level. Likewise our Ministry of Health can close or amalgamate teaching hospitals without considering the effect on training: that is a matter for the Ministry of Education, or perhaps the Royal Colleges, or perhaps someone else. Again, in the Chinese way, training and education are a responsibility down the local hierarchy: the district hospital teaches the street or township hospital staff, they in turn teach in the lane or village – not just physicians, but nurses and others, and even families.

Our system is no system. There are no responsibilities, and we are free to arrange any course, or not, as we like, and each profession works separately, without coordination of teaching and common experience, although the pupils have now or later to work together. Should we introduce guardianship networks in Britain, mobilise our many volunteers in a slightly more formal way, as we have begun to do in hospitals? The many troubles of community care today might not be occurring if we had had joint boards and voluntary guardians. We need to start thinking more about how we are disorganised, and whether we have something to learn from the experiences of others. The papers in the Supplement are a good start.

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