

Serve the People or Serve the Consumer? The Dilemma of Patient-Centred Health Care in China

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Abstract

Patient-centred medicine is being adopted as national policies in many countries, encouraged by positive outcomes of the practice at clinical and organisational levels. This study examines the patient-centred health care reform in China, which has adopted the approach as a national policy for two decades but has yet to achieve the intended goals. Focusing on conflicting interpretations of the nature of patients at national, organisational, and individual levels, this article argues that such conflicts lead to clashes between the political agenda of the state, priorities of health organisations, professional choices of individual practitioners, and expectations of patients in the process of implementing, practicing, and receiving patient-centred health care in China. It reveals that the national health authority has intended patient-centredness as a universal, anti-market, people-centred approach, based on the health ideology of serving the people. But hospitals, compelled by financial restraints, have implemented it as a market approach centring on patients as consumers. Medical professionals and patients also possess contradictory views towards whether a patient should be perceived as a consumer. The discordance in the interpretation of the patient identity has caused great confusion in the implementation and provision of patient-centred health care. The study points out that the success of patient-centredness as national policy cannot be assumed on the basis of its success at clinical and organisational levels. More efforts are needed to coordinate the fundamental understanding of patient-centredness by different actors.

Keywords

Patient-Centred Health Care, Patient-Centredness, Patient Identity

1. Introduction

In China, it is widely observed that patients are in tense relationship with doctors. The tension is usually attributed to the damaging effect of economic reform to the health care system, while another health reform—patient-centred reform—is largely overlooked. As a result, it is not well understood why patient-centredness, which has been implemented as a national health policy for two decades to enhance doctor-patient relationship and to offset the deleterious effects of the economic reform, has not fulfilled its policy goal. Patient-centredness is a multi-dimensioned approach. This article focuses on the conflicting interpretations of the nature of patients at national, organisational, and individual levels, and argues that such conflicts lead to clashes between the political agenda of the state, priorities of health organisations, professional choices of individual practitioners, and expectations of patients in the process of implementing, practicing, and receiving patient-centred health care in China.

Patient-centredness has become a buzzword in medicine and the health care systems of many countries, both developing and developed. It was first promoted in the 1950s in the West as a clinic-based practice emphasising a holistic approach toward the patient and promoting a biopsychosocial model of understanding disease [1] [2] [3]. In recent decades, the concept has evolved into a world-wide health care trend that is eagerly embraced by not only practitioners and but also medical organisations, and has gradually caught the attention of national policy makers in many countries which have adopted or are about to implement the approach as a major reform to their health delivery systems [4] [5] [6].

The promotion of patient-centredness as a national health policy has been encouraged by findings from empirical studies carried out in hospitals and clinics, between health care providers and patients [7] [8]. Numerous studies have reported positive findings across a wide range of dimensions in patient-centred care [9] [10] [11] [12] [13]. Despite encouraging evidence produced at clinical level, however, its implementation as a national policy is unlikely to be as straightforward as it has been practiced by individual clinicians and organisations in much smaller scales, because the agenda of national health policy may be inconsistent with providers' goals in their pursuit of patient-centredness.

Conceptual ambiguity is a major reason behind the inconsistency. Available research shows that after several decades, a consensus on the definition of patient-centeredness is yet to be achieved [8] [14] [15] [16]. Nonetheless, scholars have reached extensive agreement on the moral ground, the technical core and the ultimate purpose of the concept in their definitions. In terms of the moral ground, all the definitions advocate respect for patients' values, preferences, needs, and, ultimately, patients as persons. Technically, communication between the patient and the doctor is the core. Such practices as sharing power, patients' participation in decision-making, and informed consent are linked to this technical core. The ultimate purpose of patient-centred healthcare is to enhance the healing relationship between doctors and patients, and to improve the outcomes

of health [7] [17].

These common grounds, however, have not aided the clarification of the conceptual ambiguity. Bensing [18] points out that patient-centred medicine is firstly a fuzzy and global concept, because “everybody will recognize in its overall meaning, but yet [it] can have a quite different connotation for different people when going into more detail” (p. 21). Secondly, it is a “container concept” in that “[it] contains several elements that maybe all point in the same direction, yet refer to different phenomena and different processes in the medical consultation ...” (p. 21). Bensing attributes the concept’s ambiguity to different aims and agenda that actors in medical encounters pursue, and calls for “the mutual tuning of doctors’ and patients’ agenda” as a solution (p. 22).

Patient-centredness, however, remains a fuzzy concept to date [19], and the situation has become more complicated with more actors having entered the picture. The complexity is captured in Tanenbaum’s typology [20], which analyses patient-centredness into four types based on their epistemological orientations, practical accommodations, and policy tools. These types are not necessarily incompatible with each other, but each type originates from a unique philosophical base, evolves into a different policy orientation, and serves different political, organisational, professional, and patient agenda. Even within a type, different actors pursue discrete agenda for distinctive purposes. For example, Type II “Patients versus Providers” represents an effort to check the power of the medical professions (p. 284), but its origin lies in several distinctive sources, such as health care consumerism, women’s health movement, mental health recovery movement, and “shared decision-making” in medical encounter. The only common ground they share is emphasis on each individual patient’s “experiential knowledge and personal preferences” (p. 277). However, the two policy initiatives—the Patient-Centred Outcomes Research Institute (PCORI) and Value-Based Purchasing (VBP) scheme—which are believed to reflect these movements, tend to treat patients not as individuals but as aggregates, and tend to utilise techniques of evidence-based medicine to inform policy making. Echoing the finding of Bensing [18], Tanenbaum notes that “the goal of both PCORI and VBP is better termed *patients*-centered care; they introduce the power of patients as a group into larger processes such as effectiveness research and health care reimbursement” (p. 279).

The studies of Bensing and Tanenbaum suggest that even within a relatively homogeneous situation or model, health care actors have different perceptions of what the concept means and what it entails at individual, organisational, and national levels. The discrepancy indicates that how the concept is unfolded in national policy may not reflect what patients and health care providers expect and practice. Consequently, the success of patient-centred health care as a national policy cannot be assumed on the basis of its success at individual and organisational levels.

It is in this context that patient-centredness in the Chinese health care system

constitute an interesting case in point that has the potential to offer valuable lessons to other health systems. There is no evidence to indicate that the Chinese healthcare authorities have ever thought of patient-centred healthcare in China as part of the global movement. But, at clinical level, patient-centredness shares the same grounds as in the West. In China, patient-centred healthcare means respect for and responsiveness to patients' needs and preferences, and takes communication as the central technique to achieve the ultimate goal of harmonised doctor-patient relationship [21]. Since 1997, patient-centred health care has been adopted in China as a national policy and the core of a consistent health reform to improve the quality of medical services and to enhance the relationship between doctors and patients. But after two decades the patient-centred reform has not produced the intended results.

2. Chinese Health Reform and Its Problems

Anyone who has some knowledge of the Chinese health care system would agree that patients are on bad terms with doctors. Numerous studies have revealed a deep distrust and widespread hostility between them [22] [23]. An extremity of the distrust and tension is reflected in escalating medical violence. "Hospitals have become a battlefield and being a doctor in China is a dangerous job" [24]. The number of medical professionals being physically assaulted or even brutally murdered by their patients has increased rapidly in recent years [25] [26] [27]. Although medical violence is not unique to China, its scale and severity has become an international concern [28].

Existing studies usually attribute the violence and the strained doctor-patient relationship to market-oriented health reform, which have produced two adverse results. One is the drastic shrinkage of public health insurance coverage, which resulted in patients financing their health expenditure mainly from private sources [29] [30] [31] [32]. Although the coverage has expanded significantly recently, patients' co-payment is not unsubstantial and their financial burden remains heavy ([33] [34], p. 205). The other adverse outcome of the economic reform is the drastic decrease in the public financing of health and medical institutions. Since the early 1980s, public hospitals received remarkably reduced government funding that is too small to cover the payroll, still less operative expenditures ([35], p. 408, [36], p. 101, [37], p. 105). Compelled to generate the mainstay of revenues from users, hospitals have encouraged and incentivised doctors to over-provide services and overprescribe drugs that have high profit margins [32] [38] [39].

Commentators believe that as the clinical behaviours of medical professionals are increasingly profit-driven, patients' distrust of doctors has grown and their relationship fallen apart [32] [38] [40]. Most patients pay a substantial proportion or even the entirety of fees arisen from using the public health care system and are understandably discontented with the ever-inflating bills. Many scholars claim that public hospitals and their medical staff have abandoned the service

purposes under the pressure of market-oriented health reform, and organise their professional activities around economic goals [32] [41] [42]. Patients therefore have every reason to believe that doctors are more interested in their wealth than health [43] [44]. Commercialisation is blamed on as the culprit of the tension in the doctor-patient relationship and the violence haunting the health care system [45].

Doubtless the economic reform to the health care systems has deleterious effect on doctor-patient relationship, but little is known about the impact of patient-centred health reform which has been intended to redress the adverse influence of the economic reform.

3. Patient-Centred Health Care in China

Patient-centred health care has never been clearly defined in both academic and policy circles in China, but health authorities have identified goals that patient-centred campaigns strove to achieve. For example, the action plan of the Patient-centred Hospital Management Year campaign launched by the Chinese Ministry of Health (MOH) in 2005 identified six patient-centred goals [21]. They were:

- 1) Improve medical quality and ensure medical safety, guarantee and consolidate medical and caring quality, and lift safety and efficiency of medical services.
- 2) Improve service flow, ameliorate clinical environment, and facilitate patients to seek services.
- 3) Improve the sense of service, better service attitudes, enhance doctor-patient communication, change service practices, emphasise honest services, construct harmonious doctor-patient relationship, and provide warm, attentive, compassionate, and patient services.
- 4) Strengthen financial management and legally economic activities, perfect the methods of accounting and distribution, improve economic management, control health care costs, and lower medical and drug fees.
- 5) Strict the management of medical and drug fees, and put an end to irrational charges.
- 6) Promote Norman Bethune's spirit, strengthen the construction of professional ethics and practices, establish good medical ethics and practice, and keep up the tradition of healing the wounded and rescuing the dying, and curing the sickness to save the patient.

Under the six goals are 33 detailed requirements specifying what need to be done. These goals and requirements overlap with the core dimensions that are central to many definitions given in other health care contexts, such as emphasis on safety and quality, respect for and responsiveness to patients' needs and preferences, involving patients' in decision making, communication and education, physical comfort and convenience, and so on (see, for example, [8] [46]). It is in this connection that comparison can be made between the Chinese and other health care systems promoting patient-centred care and lessons can be drawn.

4. Patient-Centred Health Care: The Dilemma

Major actors in the Chinese health care system, namely, health authorities, hospitals, health professionals, and patients, have different perceptions of what a patient is, and thus have different interpretations of patient-centredness.

4.1. Patient-Centredness as National Policy

At national level, Chinese patient-centred health care emerged from a political discourse that is deeply rooted in socialist ideology, which determines how patients are perceived in national health policy. Patient-centred health care was formally put forward by Peng Peiyun, State Councillor, in December 1996, at the National Health Conference, which was to establish the goals of health reform for the remaining years of the 20th century and the new millennium. In her speech concluding the Conference, Peng, who had presided over the drafting of the new health reform policy, explicitly criticised marketisation in health care. She asserted that “public health institutions must not be pushed into the market to ‘find a way out for themselves,’ as this will lead to lopsided pursuit of economic interests. Such behaviours deviate from the principle of serving the people, and result in social inequality” ([47], p. 11). Instead, she stated that “the reform to medical organisations must ‘put patients at the centre.’ Hospitals should strive to improve medical quality, better service attitudes, reduce medical costs, facilitate patients on every aspect ...” ([47], p. 12).

In response to Peng’s call, the MOH launched a campaign called “One Hundred Patient-Centred Model Hospitals” in 1997 to promote patient-centred health care. In the circular announcing the action plan of the campaign, patient-centred health care was described as a long-term endeavour to serve the people and provide quality services to the masses [48]. In 2005, the MOH implemented the “Patient-centred Hospital Management Year” campaign, which was succeeded by the “Long March to Medical Quality” in 2009. The advancement of patient-centred health care continued in the “Three Goods and One Satisfaction” campaign between 2011 and 2014, and then replaced by another patient-centred campaign called “Action to Further Improve Medical Services” launched in 2015 and was planned to continue up to 2017. All these campaigns were waged to promote patient-centred health care, which was consistently motivated by the core of the CCP’s ideology of serving the people [21] [49] [50] [51].

Since “serving the people” is the fulcrum of the philosophy behind all these campaigns, it is important to understand what the concept entails in the Chinese political discourse. “Serving the people wholeheartedly” was first proposed by Mao Zedong in 1945 ([52], p. 315), and has since been accepted as the fundamental mission of the CCP. It demands that policies and actions of the CCP not be based on concerns of private interests and gains of the Party and its members, but on fighting for and advancing the interests of the people. The principle conveys a strong hostility to market and commercialism. Therefore, at national level, patient-centred health care is advanced as a people-centred program. It denotes strong anti-marketisation and anti-commercialism.

4.2. Patient-Centredness in Hospitals

At organisational level, patient-centredness is construed differently. Upon its adoption as a national health policy that advances the ideology of serving the people, hospital management immediately interpreted patient-centred care as an approach to further marketisation and commercialism, and embraced it as a business strategy and marketing hype [53]. While acknowledging the origin of the policy in the CCP's ideology, some commentators claim that patient-centredness suits market economy better in that it pressures hospitals into enhancing their competitiveness in a medical service market [54]. They argue that patient-centred health care compels the hospital to operate in accordance with the laws of the market by reforming in flexible and backward service modes inherited from the command economy and turning previously passive patients into respected consumers [54]. Other commentators opine that after years of economic and health care reform, a buyer's market is in the formation. Patients have gained significant power and leeway. Hospitals must base their business on a thorough understanding of the health care market and the behaviours of patients as consumers. Only when patients' consumption needs are met and interests maximised can hospitals win the market, generate more incomes, and survive fierce competition [55] [56]. In the all clamour for patient-centredness, patients are accorded a god-like status, as epitomised in the slogan that "the patient is God" [53] [54], which echoes "the consumer is God"—"the most oft-quoted expression in the Chinese marketplace" ([57] p. 16).

For hospitals, implementing patient-centred health care policy does not prevent them from commercialisation. On the contrary, aligning the approach with the economic reform opens a window for them to adopt market devices in their services. A most often used device is differential pricing. Hospitals are advised to segment patient-consumers by their incomes and ability to pay, and then differentiate their services in terms of quality and accessibility, price them accordingly, and offer them to consumers from different socioeconomic backgrounds [58]. In other words, the patient-centredness implemented at organisational level is a pro-market, consumer-centred approach.

On surface, the pro-market, consumer-centred approach does not seem different from the anti-market, people-centred national policy, and what is implemented in hospitals is not divergent from what is demanded by the national health authority. Evidence indicates when implementing patient-centred health care, hospitals strive to improve their physical environment. Some even built patient-centred buildings to provide comfortable settings for patients [59]. Sophisticated (and usually expensive) equipment is purchased to ensure diagnostic accuracy and the therapeutic efficacy [60]. The procedures of seeking medical services are greatly simplified to save time and trouble for patients [61]. Medical staff is required to carry out regular on-job training to maintain and ameliorate their skills and upgrade their professional knowledge to ensure their professional services are of high quality [56]. Safety rules are persistently emphasised and moni-

tored [60] [62]. Medical professionals are demanded to improve their attitudes toward patients and behave politely in their professional activities [53] [62].

Patient-centred medicine, however, involves substantial investment. As government investment in public hospitals has been kept low and extremely inadequate, hospitals have to finance patient-centredness through self-raised funds, a major source of which is user fees. That is, patients will eventually bear the costs associated with the implementation of patient-centred medicine. Although reducing the financial burden of patients and improving affordability are a major goal of the patient-centred health policy (see, for example, [21] [51]), and some hospitals did claim the average expense of each patient dropped [56] [63], patient-centred medicine is likely to increase financial burden on patients and is unlikely to improve affordability.

The chasm between the policy goal based on the ideology of serving the people and its actual implementation under financial constraints constitutes a major source of conflict in the process of implementation. As a national policy, hospitals are required to fulfil their political commitment to serving the people wholeheartedly, and to provide universal, quality, and equal people-centred services to patients. But hospitals, constrained by inadequate state investment and compelled to follow market principles, provide consumer-centred, discriminated, and unequal medical services only to those who can afford. This dichotomy can be illustrated in two sets of statistics. One is the number of patients who avoid hospitalisation. The other is the number of patients who self-discharge against medical advice.

There are various reasons which prevent patients from being hospitalised when they should be. Among these reasons, affordability of hospital services has always been a major deterrent, as shown in **Table 1**.¹

Compared with those who shunned hospitalisation for economic reasons, the rate of self-discharge against medical advice is more telling, as shown in **Table 2** and **Table 3**.

According to the 2003 and 2008 surveys, self-discharge against medical advice constituted a major reason for hospital discharges, and financial difficulties were always the top reason deterring patients from continuing treatment. The Fifth National Health Services Survey conducted in 2013 did not report the result of this set of questions, but other recent surveys of smaller scales reveal that financial difficulties continue to be a major reason forcing patients to leave hospital before recovery or without treatment [68] [69].

These figures demonstrate that hospitals have never materialised the fundamental principle of the patient-centred health care as embedded in national policies. Patients' ability to consume has always been the prerequisite for receiving medical service, be it patient-centred or doctor-centred or illness-centred.

¹The number of patients who avoided hospitalisation because of financial difficulties was in decline between 2003 and 2013, but it is unlikely to be related to affordability of health care, as the cost of medical services rose sharply during the period ([64] pp. 514-515, [65] pp. 107-108). The decline is likely to be resulted from the increase of disposable incomes on the part of the patient, and the expanding coverage of health insurance schemes.

Table 1. Patients' avoidance of hospitalisation.

	Total number of patients failing to hospitalize (%)	Reasons for non-hospitalization (% of total number of respondents)				
		Financial difficulties	Self-perceived as unnecessary	No time	Hospital beds unavailable	Other
2013	17.1	7.4	4.1	2	0.3	3.4
2008	25.1	17.6	2.7	1.9	0.3	2.6
2003	29.6	20.7	5.8	1.2	0.14	1.8

Source: Adapted from an analysis of national health services survey in China 2013 [34], pp. 76-77.

Table 2. Discharge from hospitals.

	Fully recovered and discharged on medical advice	Reasons (%)			Other
		Not recovered but discharged on medical advice	Discharge against medical advice		
2008	52.1	7.2	36.8	3.9	
2003	46.1	7.4	43.3	3.2	

Sources: Adapted from the third analysis report of national health services survey in China [66], p. 43, and an analysis report of national health services survey in China 2008 [67], p. 45.

Table 3. Reasons for self-discharge against medical advice (%).

	Prolonged illness without recovery	Self-perceived recovery	Financial difficulties	Limited resources of the hospital	Other
2008	5.9	27.6	54.5	0.8	11.3
2003	5.6		63.9	3.8	26.6

Sources: Adapted from the third analysis report of national health services survey in China [66], p. 43, and an analysis report of national health services survey in China 2008 [67], p. 46.

Although the MOH explicitly opposes the idea of treating patients as consumers [70], constrained by financing and revenue structures, hospitals can only afford providing medical services to those who can afford to consume. Whether a patient is qualified as a consumer and treated as "God" in a hospital is determined by his or her ability to pay [71]. Such a discrimination on grounds of patients' financial ability is a huge distance from the fundamental principle of serving the people equally and indiscriminately. The disparity accentuates the clash between the political agenda advanced by the promotion of patient-centredness as a national policy and the commercial goals that hospitals intend to achieve in implementing the approach.

4.3. Patient-Centredness as Perceived by Medical Professionals and Patients

The clashes are not limited to those between the national agenda and organisational goals. In medical encounters, doctors' and patients' views are likely to disagree with each other, and with that denoted in national policies and organisational goals. There has been a long and unsettled debate about whether pa-

tients are consumers. While patient advocates, lawyers, and hospital managers tend to champion that patients are consumers, the MOH and ordinary professionals have resisted the idea. Within a hospital, what the management wants to achieve through patient-centred medicine usually contradicts with its professional employees' perception of patients and the nature of the relationship between them. Evidence indicates that medical professionals are not well-disposed towards viewing patients as consumers. The medical education and training they received in universities oblige them to serve the people wholeheartedly and treat patients as families [72]. On the job, the ethical quality of their interactions with patients is assessed by how they materialise the fundamental principle of serving the people wholeheartedly, as dictated in MOH/NHFPC decrees [73] [74] [75]. By education and by professionalism, doctors are not socialised to embrace a commercial relationship with patients. But as salaried employees, they are pressured to align their conducts with the administrative goals of hospitals. The contradiction constitutes a source of huge tension that may have impeded the exercise of professionalism in reality. Some doctors have publicly expressed their discontent over treating patients as god-like consumers, claiming that only hospitals benefit from consumer-centred medicine, while both the state, the patient, and the doctor are victims of the approach [71] [76].

Surveys also confirm that medical employees are not enthusiastic about viewing patients as consumers. They tend to regard the nature of their relationship with patients as pure therapeutic, namely, they advise on patients' health issues, and provide diagnosis and treatment. Considerably less doctors consider the relationship as one of commercial. This tendency is illustrated in **Table 4**, which is adapted from a survey conducted in 2008 ([23], p. 34).

The figures presented in **Table 4** indicate that over 60 per cent of doctors perceive patients as patients per se, that is, people who come to them for professional advice and treatment of their health problems for the purpose of recovery. Over 50 per cent of patients perceive their actions of seeking doctors' professional help in hospitals as a process of resolving or addressing their health problems. Doctors and patients holding this view are likely to consider their relationship as illness-centred.

What is concerning here, however, are the figures of those who believe the relationship is a commercial one. As the table shows, one in ten of doctors believe they sell their services as a consumerist product to medical consumers for a profit, while more than two in ten of patients hold that seeking medical services is an action of consumption. The number of patients who perceive doctors as business people or sales persons doubles that of doctors. Available surveys of various scales reveal that it is almost unanimous that far more patients embrace the idea of medical consumerism than doctors [77] [78] [79] [80].

The disparity suggests that more patients tend to believe that if they pay, the outcome of medical treatment must meet their expectations and their illnesses must be cured. Otherwise they could sue the provider for malpractice or negligence of duty [81]. Meanwhile, considerably less doctors would agree that they

Table 4. Patients' and doctors' perceptions of the nature of doctor-patient relationship.

	Medical %	Clash of interests %	Consumeristic %	Contractual %
Patients	50.6	7.7	21.2	20.5
Doctors	60.4	5.6	10.0	23.9

should be held accountable as so. The difference inevitably results into more patients than doctors measuring health outcomes by criteria that may not be professionally appropriate and scientifically reasonable. The disagreement is widely noted as a major contributing factor to the increasing number of medical litigations and strained relationship between doctors and patients [78] [79] [80] [82].

Apparently, doctors and patients have different perceptions of the nature of their relationship, and these perceptions are different from those of the health authorities and hospitals. Doctors tend to approve a non-commercial relationship with their patients, while patients are more inclined to engage with doctors as consumers.

5. Conclusions

When patient-centred care is practiced as a clinical approach, the mode involves only two actors—the professional and the patient, and its materialisation is relatively straightforward, with the medical professional usually taking initiative to show respect for patients and share power with them. Once the approach is adopted as a national policy, patient-centred health care inevitably involves more actors at national, organisational, and individual levels who pursue different agendas and purposes that may conflict with each other. The conflicts could well subvert the efforts of health authorities and significantly compromise the outcome of the practice, as what has happened in the Chinese health care system.

By analyzing how actors at different levels define a patient, this research reveals considerable discrepancies between the agenda of national policy, organisational goals, and individual perceptions in the Chinese health care system. As a national program, patient-centred health care is intended as an inclusive, people-centred approach for the entirety of the population. But the economic reform to the health care system has significantly commercialised medical services. Public hospitals rely largely on user fees and thus offer patient-centred medicine as privileged services exclusive to those who can afford. Medical professionals and patients also perceive patient-centredness differently. Only a small per cent of doctors tend to perceive patients as consumers and their relationship with the latter a commercial one, while significantly more patients see themselves as consumers. These discrepancies constitute a major source of confusion in the implementation of patient-centred health care which has failed to harmonise doctor-patient relationship in China.

Patient-centred health care has many facets. What is examined here is only one, albeit fundamental, facet, namely, how major actors involved in the pa-

tient-centred policy framework define a patient. A lesson that can be drawn from the research is that even if there is ample clinical evidence to prove the benefit of patient-centred care, implementing the approach as a national policy may not produce the same outcome due to discordant perceptions of what a patient is.

Patient-centred health care is likely to continue as a major national program to improve doctor-patient relationship in the Chinese health care system, but if the major actors continue to possess differing perceptions of what makes a patient, chaos will continue and hospitals will remain a battle field. To achieve the policy goals of patient-centred health care as a national level reform in China, as well as in other developed and developing countries, coordination of political agenda, organisational goals, and individual perceptions and objectives throughout the entire health care system is essential.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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