Exploration of the Construction Path for Family Doctor Team Service Capacity

Yue Zou

General Outpatient Clinic of Zhelin Town Community Health Service Center in Fengxian District, Shanghai, China

Abstract: With the development of the social economy and the intensification of population aging, residents' demand for health services is increasing, particularly for chronic disease management and personalized medical services. Family doctor contract services, as a primary healthcare service model, aim to provide residents with continuous and comprehensive health management services. Family doctors are already quite common in foreign countries, but in China, this system is still in its initial stage. Although some achievements have been made, there is still a significant gap compared with developed countries. This paper focuses on the theme of family doctor team service capacity building, conducting extensive investigation and in-depth analysis of the main dilemmas and problems currently faced in this process, such as insufficient core team competencies, inadequate support mechanisms, low coordination efficiency with higher-level hospitals, and insufficient resource support. Targeted countermeasures and suggestions are proposed accordingly. The purpose is to provide theoretical reference and practical guidance for further improving the service capacity of family doctor teams, enhancing the attractiveness of contract services, and strengthening the foundation of primary healthcare service networks.

***Keywords*:** family doctor team; service capacity; dilemmas and problems; construction path

1. Introduction

Family doctor contract services, as an important measure to implement tiered diagnosis and treatment, play a significant role in optimizing medical resource allocation, alleviating the problems of "difficult and expensive medical treatment," and improving residents' health service levels. Building a family doctor team with strong service capacity and high resident trust is not only the "gatekeeper" of residents' health but also an effective means to achieve efficient contracting, effective services, cost control, and improvement of national health levels. The Guiding Opinions on Promoting the High-Quality Development of Family Doctor Contract Services clearly states that by 2035, the coverage rate of contract services should reach over 75%, basically achieving full household coverage, with key population contract service coverage reaching over 85%, and satisfaction rate reaching about 85%. As a demonstration zone for family doctor contract services, Shanghai has achieved a contract coverage rate of over 90% for key populations and a satisfaction rate of over 90%. However, in many regions, service coverage and satisfaction rates remain below standards. Strengthening the service capacity of family doctor teams and improving service levels is the key to promoting resident contracts and enhancing satisfaction. In the new era, further research on family doctor team service capacity building, analyzing the dilemmas and problems faced, and scientifically planning construction paths has important practical urgency and far-reaching strategic significance.

2. Overview of Family Doctor Team Service Capacity

2.1 Family Doctor Team Services

Family doctor teams are responsible for undertaking the tasks of family doctor contract services, which specifically include 11 items: basic medical care, public health, health management, health education and consultation, priority appointment, priority referral, home visit services, drug delivery, and medication guidance services, among others. Each family doctor team is staffed with at least one family doctor and one nursing staff, with the family doctor generally serving as the team leader. Based on residents' health needs and contract contents, the family doctor team may expand its members to include public health doctors, specialists, pharmacists, health managers, traditional Chinese medicine health practitioners, rehabilitation therapists, and social workers or volunteers.

2.2 Family Doctor Team Service Capacity

The service capacity of family doctor teams is a comprehensive capability system that includes four aspects: team configuration, core services, operational management, and sustainable development. It aims to provide residents with comprehensive, life-cycle, diversified, and personalized healthcare services.

(1) Team Configuration.

Team configuration refers to the composition of personnel, qualification matching, and appropriate scale. It includes whether the team can provide suitable general practitioners, specialists, nurses, and rehabilitation therapists according to residents' needs while maintaining a reasonable ratio; whether team members hold corresponding professional qualifications and competencies; and whether the number of contracted residents per team remains within a reasonable scope.

(2) Core Services.

Core service capacity is the most crucial element of family doctor team service capacity, mainly including clinical diagnosis and treatment ability, health management ability, communication and humanistic care ability, as well as coordination and collaboration ability. For family doctor teams, the standardized diagnosis and treatment of common and frequently occurring diseases, along with the standardized management of chronic diseases, are undoubtedly important. However, communication and humanistic care abilities are equally vital—how to communicate effectively, build trust, and strengthen humanistic care is increasingly becoming a core competitiveness of family doctor teams. In addition, internal team coordination, information sharing, and efficient collaboration with higher-level hospitals and community resources should not be overlooked.

(3) Operational Management.

Operational management capacity mainly involves internal division of labor, communication, resource integration and utilization, and service quality improvement. A family doctor team, depending on its scale, often needs to contract with 1,500–2,000 residents. Thus, clarifying the division of work, streamlining workflows, and strengthening internal coordination are essential capabilities. Information technology application, equipment and material support, and service quality control also fall under the scope of operational management capacity.

(4) Sustainable Development Capacity.

Sustainable development capacity includes team learning and innovation ability, cohesion and centripetal force, as well as resilience and adaptability. Specifically, it covers the team's ability to learn new knowledge and skills, innovate services based on residents' health needs and conditions; team culture, members' sense of belonging and identity, and member stability; the team's ability to handle intensive workloads, and its adaptability to changes in residents' needs or policy adjustments.

3. Major Dilemmas and Problems in the Construction of Family Doctor Team Service Capacity

3.1 Suboptimal Team Structure and Configuration

As of now, more than 430,000 family doctor teams have been established nationwide, but the overall number is still insufficient. The structural composition of team members is suboptimal, with obvious shortcomings in configuration. Many residents have reported that family doctor teams are unable to provide corresponding medical services, with low visibility and practical effectiveness. The main reason lies in the insufficient number of general practitioners within teams, the lack of specialist support, and the difficulty in ensuring service depth and breadth. The knowledge and skills of team members also need improvement, with gaps between existing abilities and job requirements. Moreover, excessive administrative tasks such as forms and records occupy a large portion of the team's time and energy. Team structures are relatively homogeneous, mostly composed of doctors and nurses, lacking pharmacists, rehabilitation therapists, psychological counselors, and social worker/volunteer support. As a result, they struggle to provide high-quality integrated services and cannot effectively meet residents' diverse healthcare needs. This issue is even more pronounced in underdeveloped counties and rural areas.

3.2 Weak Core Service Capacity

Weak core service capacity is a major factor restricting the signing of contracts with family doctor teams, as well as an important barrier to implementing the hierarchical diagnosis and treatment policy. Residents lack trust in family doctor teams; when facing illness or health problems, they often bypass family doctors and directly seek care at tertiary hospitals. The insufficiency of core capacity is reflected in several aspects: some doctors lack the ability to handle complex cases and make differential diagnoses, undermining residents' trust in initial consultations; experience is lacking in health risk assessment and the development of personalized intervention plans, resulting in suboptimal solutions; communication skills are weak, making it difficult to establish trust and humanistic care, leaving residents psychologically unsatisfied; coordination with higher-level hospitals is inadequate, with unclear referral standards and costs. All of these factors affect residents' perceptions of family doctor teams and hinder the effective implementation of hierarchical diagnosis and treatment.

3.3 Weaknesses in Operational Management

Each family doctor team is responsible for the health management of 1,500–2,000 residents, a heavy workload in addition to their own duties. Therefore, effective coordination and strengthened internal management are crucial capacities. However, many family doctor teams nationwide still face problems such as unclear responsibilities, poor communication, and even information asymmetry. Workflows are not standardized, and processes such as contracting, follow-up visits, health management, and referrals lack unified standards. In terms of team evaluation, assessments are usually based on dimensions such as service volume, service quality, service effectiveness, and resident satisfaction. Yet, in practice, effective quantitative indicators and methods are often lacking, with insufficient public participation, making it difficult to reflect the true outcomes.

3.4 Insufficient Incentive Mechanisms and Professional Attractiveness

The reality of family doctor team work can be described as "much work, little pay, constant running around." Most team members are grassroots doctors who not only bear the heavy burden of family doctor tasks but also need to fulfill duties within their own institutions. The workload is high, the pressure is heavy, and the income is low. In particular, salaries are relatively low, performance distribution mechanisms are imperfect, and income competitiveness is lacking, easily leading to professional burnout. Career development paths are unclear, title promotion is difficult, social recognition is low, and development prospects are limited. These reasons have resulted in a severe shortage of family doctors in China. Team members are "hard to attract" and "hard to retain." Statistics show that the number of general practitioners per 10,000 residents in China is only one-third to one-half of that in developed countries, and many specialists only hold nominal positions with little involvement in actual diagnosis and treatment.

3.5 Incomplete External Support System

Higher-level hospitals show limited attention to family doctor teams, providing very little substantive support in technical guidance, talent training, and resource sharing. On the contrary, they often create a "siphon effect," attracting highly qualified and younger family doctor team members to transfer to higher-level medical institutions. In the current policy framework, incentive mechanisms for family doctor service models are inadequate, failing to effectively motivate grassroots participation. As a result, primary consultation and hierarchical diagnosis and treatment cannot be effectively implemented. In addition, restrictions on grassroots drug formularies and insufficient testing and inspection items significantly affect service delivery capacity. For some routine examinations and medications, family doctors still have limited diagnostic and treatment options, making it difficult to meet residents' deeper and more personalized healthcare needs.

4. Exploring the Paths for Constructing Family Doctor Team Service Capacity

4.1 Strengthening the Internal Construction of Family Doctor Teams

Localities should, based on their actual conditions, further strengthen the construction of family doctor teams. Municipal and county medical and health institutions should adopt approaches such as counterpart assistance, joint department building, and talent allocation to grassroots medical institutions to jointly improve contract services of family doctors, continuously expanding and strengthening the capacity of family doctor teams. According to the population structure and health needs of their jurisdictions, responsibilities of county-level and above hospitals should be reinforced. Flexible employment mechanisms such as "county-level employment, township-level use," "township-level employment, village-level use," and regional shared expert pools should be explored. A "1+1+X" composite team model can be established, that is, one specialist physician from a county-level or above hospital and one grassroots general practitioner, with "X" consisting of several nurses, pharmacists, rehabilitation therapists, traditional Chinese medicine practitioners, village doctors, social workers, and volunteers. Community Party members, volunteers, and grid managers may also be absorbed into family doctor teams to strengthen their capacity. Based on residents' health needs, specialized family doctor teams should be established, such as family doctor teams for hypertension or diabetes. These teams would consist of specialist doctors from secondary and above medical institutions and doctors from local grassroots medical institutions, thereby enhancing the specificity and targeting of services. For example, Shanghai has formulated the Shanghai Family Doctor Contract Service Specifications, which are regularly updated. It has also introduced innovative practices such as establishing family doctor studios named after doctors and promoting the "1+1+1" medical institution combination model, providing policy guidance for strengthening family doctor teams.

4.2 Continuously Enhancing Core Service Capacity of Teams

Localities should, according to their own circumstances and around the core service capacity of family doctor teams,

further intensify education and training efforts, continuously improving service ability and service levels. Training should focus on the "six competencies" (effective treatment of minor illnesses, accurate recognition of major illnesses, timely rescue of emergencies, proper referral of severe illnesses, refined management of chronic diseases, and prevention of diseases before onset). Key areas include diagnosis and treatment of common diseases, refined management of chronic diseases, complication prevention, comprehensive geriatric assessment and care, community rehabilitation and elderly care, as well as resident communication. Both online and offline training should be widely carried out, ensuring full coverage and effective learning outcomes. Training should combine theory with practice and integrate education with assessment, conducting theoretical examinations, skill operations, and team scenario drills to enhance the flexible application of knowledge. The role of regional medical consortia and medical alliances should be fully leveraged to establish clinical practice bases for family doctors in cooperation with higher-level hospitals, providing more opportunities for practical training and further study, thereby improving team members' competencies.The service concept of "patient-centered" should be further deepened. Each team must strictly adhere to the maximum limit on contracted resident numbers to ensure accessibility of services. Teams should improve communication and interaction with residents by regularly organizing health promotion activities, establishing and improving mechanisms for collecting and responding to resident feedback, and exploring personalized health management and treatment approaches to improve service quality and strengthen residents' trust. Based on local realities and citizen needs, diversified and personalized service programs should be explored to meet residents' healthcare demands. For example, Shanghai has actively innovated service models by creating WeChat groups specifically for residents with chronic diseases such as hypertension and diabetes, through which health knowledge and information on specialists' visits are shared. Residents can book appointments in advance and receive door-to-door medical services, enabling them to enjoy professional healthcare without leaving their communities and effectively addressing the problem of difficult access to medical care.

4.3 Strengthening Internal Coordination and Management within Teams

At the grassroots level, family doctor teams are the "needle at the bottom of a thousand threads," facing complex and multifaceted tasks. Strengthening internal coordination and management is therefore of paramount importance. Family doctor teams should, based on the number of contracted residents and their health needs, formulate work plans and improve standardized service processes such as appointment, assessment, consultation, and referral, thereby enhancing work efficiency. Regular internal coordination meetings should be held to discuss typical cases, share experiences, and coordinate work tasks. A sound mechanism should be established to ensure information sharing and collaborative operations between family doctor teams and public health institutions such as disease control centers and maternal and child health institutions, strengthening the management of key populations and infectious disease prevention and control.A four-in-one evaluation system should be developed, consisting of internal evaluation, supervision by higher authorities, third-party professional evaluation, and resident satisfaction surveys. Reliance on a single indicator of contract quantity should be reduced, while strengthening assessments in areas such as service quality, health outcomes, and resident trust. Indicators could include health management plan completion rates and residents' blood pressure and blood glucose control rates, thereby enriching the evaluation system. Evaluation results should be linked to team performance distribution, recognition and awards, and resource allocation, strengthening the use of evaluation outcomes to create positive incentives.

4.4 Strengthening Institutional Safeguards and Policy Incentives

Policy incentives and institutional safeguards should be enhanced. Secondary and above medical institutions should tilt performance-based salary distribution in favor of physicians participating in family doctor contract services. Position allowances should be provided for registered general practitioners and assistant general practitioners at the grassroots level, with financial subsidies granted by government. In principle, the income level of grassroots registered general practitioners should not be lower than the average income of clinical physicians with comparable qualifications at local county-level general hospitals. The "two allowances" policy should be implemented, steadily advancing salary reform in public health institutions—allowing medical institutions to break through existing wage control levels of public institutions, and allowing medical service income, after deducting costs and making required fund contributions, to be primarily used for staff incentives.The "targeted evaluation and targeted use" policy for professional title review of grassroots healthcare workers should be implemented, with an increased proportion of senior positions to encourage professionals to remain in grassroots institutions. Career development plans should be established for family doctor team members, broadening career pathways for grassroots personnel and retaining talent at the primary level. Through these measures, the attractiveness of grassroots posts can be substantially enhanced, mitigating the "siphon effect" of higher-level hospitals.

4.5 Improving the Support System for Family Doctor Services

Efforts should be made to explore unified bundled payments of medical insurance funds to medical institutions implementing tiered diagnosis and treatment. This allows both higher-level and lower-level medical institutions to jointly allocate medical insurance funds, forming a community of shared interests, thereby incentivizing higher-level hospitals to place greater emphasis on family doctor contract services. The guiding role of medical insurance should be fully utilized to promote capitation payment for outpatient visits at grassroots medical institutions. For patients referred through the tiered diagnosis and treatment system, grassroots medical institutions or family doctors should pay part of the referral costs. Standards, procedures, and information system support for two-way referrals should be improved. Higher-level hospitals should reserve appointment slots, open green channels for tests and examinations, and implement systems for expert outreach, ward rounds, and remote consultations. Grassroots drug supply and equipment provision should be strengthened. Based on actual needs, grassroots drug formularies should be dynamically adjusted, and necessary portable diagnostic and testing equipment should be provided to enhance the diagnostic and service capacity of grassroots institutions.

5. Conclusion

In the future, as population aging in China intensifies and residents' demand for health and care services continues to grow, the role of family doctor teams will become increasingly important. Localities should adhere to policy guidance, coordinate and tilt various medical resources toward the grassroots level, and strengthen the construction of medical consortia and medical communities to provide more accessible healthcare services at the primary level. Efforts should be continuously made to enhance education and training for grassroots teams, optimize personnel and compensation systems, comprehensively strengthen the service capacity of family doctor teams, and continuously improve the public's satisfaction and sense of gain, thereby safeguarding the health of grassroots residents.

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