The Problems and Countermeasures of Family Doctor Service in China

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Abstract: In response to the persistent problems of "difficult and expensive medical treatment" in China, family doctor contract based services and related policies have become important content in deepening medical reform and promoting graded diagnosis and treatment in recent years. Existing research is mostly based on developed large cities, mainly analyzing the static and dynamic aspects of policy implementation subjectively and objectively, However, there is less attention paid to the problems of collaborative cooperation between grassroots governments and other governance entities in third tier cities with lower levels of development. This study indicates that there are still problems with the management model of family doctors, such as "signing but not signing", poor funding and referral between superiors and subordinates. It is necessary to further strengthen the vertical and horizontal linkage mechanism, expand the number of family doctors and enhance their professional attractiveness, and strengthen publicity to create a good social environment for the implementation of the family doctor service model, so as to further promote and sustainably develop the system.

Keywords: Family doctor service; The issues and countermeasures; Community health service

Introduction

In order to implement the Party's policy on health and wellness work in the new era, establish and improve the contract guarantee system for family doctors, and form a work mechanism led by the government, coordinated by departments, with grassroots medical and health institutions as platforms, and various social resources participating. The service management model adopts a family service team, consisting of a "2+X" model consisting of a general practitioner or practicing (assistant) physician at a community health service center (community health service station), a practicing nurse, a public health physician, and experts from a higher-level contracted hospital. They accept outpatient appointments from patients and come to the contracted residents and key populations for treatment.[3]

Literature Review

The family doctor system plays a crucial role in promoting the construction of a graded diagnosis and treatment system, deepening the reform of payment methods, optimizing the allocation of medical and health resources, and promoting convenient access to basic medical services.[4]The research on family doctor signing services can be mainly divided into two levels: Firstly, the implementation of family doctor services has important practical significance for improving the quality and level of medical services for residents and improving the quality of building a healthy China. The signing of community family doctor contracts significantly reduces the medical expenses of the elderly, promotes graded diagnosis and treatment, optimizes the allocation of data resources, and has a significant impact on improving the health level and accessibility of medical services for the elderly (Li Lele, Li Yixuan, Chen Xiangyu, Gao Jianzhe, Wei Donghao, 2022). Based on the empirical analysis of mobile recognition test data in Guangzhou, Taiyuan, and Chongqing in 2018, it was found that family doctors are conducive to promoting the equalization of basic public services and the realization of urbanization (Liang Tukun, 2022).The second is the problems and mechanism construction faced by the family doctor policy. Due to the ambiguity and conflict in the current family doctor policy, there has been a long-standing dilemma of "signing but not agreeing" in the implementation of family doctor policies. Scholars have explored the reasons why family doctor signing service policies are hindered from the perspectives of the structure and context of policy implementation (Gao and Rong, 2018), as well as issues such as human resource gaps, insufficient incentives for family doctors, and the lack of corresponding supporting facilities (Lu and Wu Zhong, 2015).In summary, existing research has not focused on the impact of collaborative governance among local government departments and community organizations on policy implementation. Thus, collaborative cooperation among various departments and organizations of local grassroots governments is necessary, especially in cities with lower levels of develop-

ment. This article intends to take J City, a third tier city, as an example to explore the problems in the combination of collaborative governance with the implementation of the family doctor model.

Research methods

The method of case analysis is adopted, which is based on literature research and interviews. Firstly, conduct a preliminary analysis of the internal project plan and policies, as well as relevant government documents; secondly, the interview method used is a semi-structured interview, with the main interviewees being government staff who hold key positions in the family doctor signing service project, including frontline staff or department heads from departments such as the Municipal Health Commission. The questions involved the contradictions and conflicts that arise between the collaboration of various governance entities that the interviewees face when implementing policies. 5 interviewees from different departments were interviewed. In addition, interviews were conducted with some family doctors and residents who had signed with family doctors. Based on the above information collection channels, this paper has obtained 14 pieces of effective information, including relevant Report on the Work of the Government, community implementation plan and family doctor work report, involving 10 subjects.

Results

According to a survey, there are a total of 21 family doctor signing institutions in J city, with 482 family doctors, responsible for approximately 2000 people per family doctor. The total population of H community is 13420, with 2840 signed family doctors. There are a total of 3 family doctors in the community. And according to relevant documents issued by the provincial government, in principle, each family doctor service team is responsible for 600 households, with a maximum of 800 households; the number of people is around 2000. Each family doctor serves no more than 200 households, with a population of approximately 600 people.

Discussion

The contract management model for family doctors requires the establishment of effective mechanisms with departments such as medical insurance and pricing. The health and family planning administrative department needs to develop admission standards, service processes, and division of labor guidance for family doctor teams with grassroots medical and health institutions based on actual situations, In addition, collaborative governance needs to be carried out by government departments such as the Municipal Health Commission, some public hospitals, and community health service centers or health centers in pilot streets. Collaborative governance refers to the process of government, economic organizations, social organizations, and the public, within a predetermined scope, with the goal of maintaining and promoting public interests, and with existing laws and regulations as common norms, under the leadership of the government, through extensive participation, equal consultation, cooperation, and joint action, jointly managing social and public affairs, as well as the sum of various methods used in this process.[5]

1. Existing problems

1.1 There is a phenomenon of ‘signing without signing’

1.1.1 Insufficient number of family doctors

According to relevant documents issued by the provincial government, in principle, each family doctor service team is responsible for 600 households, with a maximum of 800 households; The number of people is around 2000. Each family doctor serves no more than 200 households, with a population of approximately 600 people. The relevant departments are also facing problems when trying to increase the number of family doctors. J City does not offer higher salaries and benefits to family doctors compared to other cities with higher economic development levels, so they are unwilling to work here.

1.1.2 Residents still hold a reserved attitude towards the “family doctor service model” for new students

According to the interview results, even though most residents have already signed a family doctor, they still choose to go to the hospital first when facing health problems. In order to complete the tasks of residents signing contracts and establishing health records, many com-

munities have begun to gather acquaintances to sign contracts to increase the signing rate. For residents who are more actively participating in signing contracts, the psychological gap of not enjoying the policy benefits after signing contracts has led to a lack of trust in the executors, and has also exacerbated the difficulty of carrying out family doctor signing work on a larger scale.

1.2 There are financial issues

Each department of the grassroots government needs corresponding houses as office locations when participating in community collaborative governance. According to staff from relevant government departments, the community did not provide government related preferential policies, including water and electricity fees, when renting houses to the government. The Municipal Health Bureau divides financial allocation according to the proportion of signing contracts, leading to blind increase in the signing rate in the community. In this situation, each responsible party responsible for signing the contract will try to achieve or even exceed the signing rate target set by the superior institution.[3]

2. Countermeasures

2.1 Strengthen vertical and horizontal linkage between departments

Firstly, strengthen vertical communication and collaboration among medical institutions, and optimize two-way referral. Secondly, strengthen horizontal linkage between departments. The Health and Family Planning Bureau should strengthen its organizational leadership and coordination capabilities, establish a government led collaborative mechanism with relevant departments, clarify the responsibilities of various governance entities, and achieve collaborative governance. Therefore, medical institutions at all levels need to clarify their own positioning and responsibilities, build good collaborative relationships, improve referral standards and processes, and increase regulatory efforts to ensure the implementation of relevant systems and policies.[2]

2.2Expanding the number of family doctors and enhancing professional attractiveness

Reform and innovate the employment, promotion, continuing in-service education, and training systems for family doctors. The standardized training of general practitioners is currently a top priority in strengthening and enhancing the construction of grassroots medical teams. However, top-level design and strong promotion are also needed.

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