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From Family Doctor Contract Services to the Implementation and Optimization of the Tiered Diagnosis and Treatment System: A Case Study of Harbin

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Abstract: Family doctor contract services are an important lever for implementing the tiered diagnosis and treatment system and for promoting first contact at the primary level and health management. Taking Harbin as a case, and adopting a dual perspective that coordinates the supply of medical services with the medical security system, this paper draws on policy text analysis and official statistical data to examine the positioning, progress, and obstacles of family doctor contract services in tiered diagnosis and treatment. The findings are as follows. First, the coverage of contract services in Harbin has continued to expand, and measurable progress has been achieved in the health management of key populations; in addition, a reimbursement gradient favoring the primary level has taken shape in medical insurance benefits. Second, owing to such factors as an inadequate supply of primary-level health workforce, low levels of residents' trust in and participation in the services, weak linkage between contract services and medical insurance benefits, and the lack of any constraint on "signing without engaging," the leveraging effect of contract services on tiered diagnosis and treatment remains limited. Accordingly, this paper proposes optimization pathways that include enhancing primary-level service capacity, strengthening residents' awareness and participation, deepening the reform of medical insurance payment methods and benefit-based guidance, and promoting the articulation between long-term care insurance and contract services.

Keywords: Family doctor contract services; tiered diagnosis and treatment; primary health care; first contact; medical insurance; long-term care insurance

1. Introduction

1.1. Research Background

The tiered diagnosis and treatment system is an important component of China's deepening reform of the pharmaceutical and healthcare system. Its purpose is to resolve the structural contradiction of medical resources being over-concentrated in large hospitals while primary-level service capacity remains inadequate: by having primary-level medical institutions deliver initial care and health management, patients are guided to seek care in an orderly manner, thereby easing the consultation pressure on large hospitals. Working within the institutional framework of "first contact at the primary level, two-way referral, separate pathways for acute and chronic diseases, and vertical linkage between higher- and lower-level institutions," the National Health Commission (NHC) has taken the development of medical consortia as the vehicle and the tiered management of common, frequently occurring, and chronic diseases as the breakthrough point, continuously refining top-level design so as to build a more scientific pattern of tiered diagnosis and treatment [1]. Family doctor contract services constitute the micro-foundation of this pattern: through health management, chronic disease management, and disease prevention, family doctors provide residents with continuous, personalized, long-term health services, and they serve as the key vehicle for achieving first contact at the primary level and for health "gatekeeping."

Received: 18 August 2026

Revised: 23 September 2026

Accepted: 06 October 2026

Published: 09 October 2026



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As the capital of Heilongjiang Province, Harbin has a high concentration of medical resources, yet it also faces unbalanced allocation of medical resources, inadequate primary-level service capacity, and severe overcrowding of large hospitals; moreover, most primary-level medical institutions suffer from a shortage of general practitioners and limited technical competence. Against this background, family doctor contract services have become an important instrument for Harbin to implement tiered diagnosis and treatment. Their actual effectiveness, and the crux of the problems they face, merit dedicated investigation.

1.2. Research Purpose and Significance

This paper aims to review the current state of implementation of family doctor contract services in Harbin, to analyze—from the perspective of coordination between the supply of medical services and the medical security system—the mechanisms through which these services promote the implementation of tiered diagnosis and treatment and the real obstacles involved, and to propose targeted optimization strategies. The significance is twofold. On the one hand, the paper contributes to an understanding of the concrete forms of practice and the institutional constraints of family doctor contract services in a central city of Northeast China. On the other hand, by incorporating medical insurance payment and benefit-based guidance into the analytical framework, it may serve as a reference for cities of a similar type in improving the three-medical linkage and in making tiered diagnosis and treatment substantive.

2. Theoretical Framework and Literature Review

2.1. Theoretical Foundation of Tiered Diagnosis and Treatment

Tiered diagnosis and treatment means that diseases are graded according to their severity and urgency and the difficulty of treatment, and that medical institutions of different levels undertake the treatment of diseases of the corresponding grades, so as to progressively realize a care process moving from general practice toward specialization. Its purpose is to promote the division of labor and collaboration among medical institutions, to make rational use of medical resources, and to establish a scientific and orderly order of diagnosis and treatment that ensures patients receive appropriate care [2]. The effective operation of tiered diagnosis and treatment hinges on forming a rational patient-flow mechanism, strengthening capacity building in primary-level medical institutions, raising the capacity of the primary level to undertake first contact and health management, and enabling smooth information exchange and referral between institutions at different levels.

2.2. Theoretical Foundation of Family Doctor Contract Services

Under China's current family doctor contract services, general practitioners serve as core members and, through the formation of family doctor service teams, provide residents within designated service areas with medical, health, and health management services across the full life course [3]. The significance of contracting lies in binding family doctors and residents through a contractual relationship, thereby establishing a long-term, stable, and continuous doctor–patient relationship and providing residents with a dependable provider of health services. Such services not only meet residents' everyday needs for health consultation and basic medical care but also sustain efforts in disease prevention, chronic disease management, and health promotion, thereby improving residents' health status and quality of life [4].

Mechanistically, through health assessment and initial diagnosis, family doctors screen and triage patients, provide primary care, manage chronic diseases, and conduct regular health screening, and they make referral recommendations when necessary, thereby reducing residents' disorderly dependence on large hospitals. It should be stressed that this guiding role can function only on the premise that the contracted relationship is genuinely established and genuinely honored, that medicines and diagnostic tests are accessible at the primary level, and that referral pathways are smooth.

Unlike the United Kingdom's gatekeeping system, which mandates first contact with a designated doctor, residents in China are not compulsorily bound by the contracted relationship in choosing where to seek care; the triage function of family doctors is instead realized mainly through "soft constraints" such as service stickiness and economic incentives. This institutional difference is the key to understanding the problem of "signing without engaging" discussed below.

2.3. The Coordinating Mechanism between the Medical Security System and Family Doctor Contract Services

The coordination between the medical security system and family doctor contract services can be understood through two mechanisms: supply-side payment and demand-side guidance. On the supply side, medical insurance funds are not merely compensators of the costs incurred after illness; they are also "third-party purchasers" of medical services. In 2016, the Guiding Opinions on Promoting Family Doctor Contract Services (Guoyigaibanfa [2016] No. 1), issued by the State Council Medical Reform Office together with six other departments, established the arrangement whereby contract service fees are jointly financed by funds for basic public health services, medical insurance funds, and out-of-pocket payments by contracting residents [5]. This marked the entry of medical insurance funds into family doctor contracting as purchasers of primary-level health management services. In 2022, the Guiding Opinions on Promoting the High-Quality Development of Family Doctor Contract Services (Guoweijicengfa [2022] No. 10) further required improving the interface between contract service fees and medical insurance payment policies and exploring payment methods such as capitation based on the number of contracting residents, so as to channel medical insurance funds toward the primary level [6]. On the demand side, the tiered design of medical insurance reimbursement ratios, deductibles, and maximum payment limits constitutes the economic incentive shaping patients' care-seeking behavior. In the absence of a mandatory first-contact requirement, whether residents choose first contact at the primary level depends to a large extent on the strength of the "soft constraint" created by differential medical insurance benefits. Whether family doctors can genuinely play a triage role therefore depends largely on whether the leverage of medical insurance benefits converges with contract services—and this is precisely the entry point from which this paper examines Harbin's practice from the medical security perspective.

2.4. Review of Relevant Studies at Home and Abroad

Research on family doctor contracting began earlier in Europe and the United States. The British general practitioner (GP) system, the core of the United Kingdom's National Health Service (NHS), has performed the principal functions of primary care since the 1950s. The UK operates mandatory first contact: any health problem must first be diagnosed and treated by the family doctor with whom the resident has contracted, and any genuinely necessary referral must likewise be proposed and arranged by that doctor, who thereby plays a strict "gatekeeper" role [7]. The United States, by contrast, has adopted the health maintenance organization (HMO) model, in which HMOs act as a bridge linking medical institutions and physicians: residents must first be insured with an insurer affiliated with an HMO, which then assigns and contracts a family doctor for them; even with commercial insurance mechanisms in place, first contact must still be completed at the contracted family doctor's practice, and referrals are likewise determined by that doctor [8]. Both the British and American models are thus underpinned by gatekeeping mechanisms that are either mandatory or strongly incentivized, together with corresponding payment systems—in sharp contrast with China's institutional arrangement, in which contracting is not tied to mandatory first contact.

On the domestic front, the 2009 Opinions on Deepening the Reform of the Pharmaceutical and Healthcare System proposed a system of "first contact at the primary level, tiered medical care, and two-way referral." In 2011, the State Council issued the Guiding Opinions on Establishing a General Practitioner System (Guofa [2011] No. 23), which laid the institutional foundation for building the general practitioner workforce

and for contract services [9]. In 2015, the General Office of the State Council issued the Guiding Opinions on Promoting the Construction of the Tiered Diagnosis and Treatment System (Guobanfa [2015] No. 70), elevating tiered diagnosis and treatment into a systematic institutional arrangement [1]. Thereafter, policies on family doctor contract services were issued intensively: in 2016, Guoyigaibanfa [2016] No. 1 rolled out contract services nationwide [5]; in 2022, Guoweijicengfa [2022] No. 10 shifted the policy orientation of contract services from "emphasis on coverage" to "improving quality and efficiency," setting the targets that by 2035 the whole-population contracting coverage rate should exceed 75%, the rate among key populations should exceed 85%, and the satisfaction rate should reach approximately 85% [6]. In 2025, two central-level documents were issued in succession: the List of Basic Service Packages for Family Doctor Contracting (for Trial Implementation) (Guoweiban Jiceng Han [2025] No. 133) [10], which unified and standardized the basic service packages, and the Several Measures for Improving Residents' Perceived Benefits of Family Doctor Contract Services (Guoweiban Jiceng Fa [2025] No. 21), which deployed ten measures, including making appointment-based referral substantive, issuing long-term prescriptions for chronic diseases, conducting home follow-up visits for residents aged 80 and above, and providing personalized service packages [11].

Even so, China has yet to form a nationally unified model of contract services, and localities have explored different paths in light of their own conditions, such as Shanghai's "1+1+1" combined contracting model [12] and Hangzhou's "integrated medical, nursing, and care" model [13]. Turning to existing research, studies of family doctor contract services in Harbin are limited in number and are largely confined to policy reviews of the early pilot stage; research on the "improving quality and efficiency" phase since 2022—in particular, on the coordinating role of medical insurance payment and benefit policies—remains insufficient. This constitutes the gap that this paper seeks to fill.

3. Current Status of Tiered Diagnosis and Treatment and Family Doctor Contract Services in Harbin

3.1. Overview of Harbin's Medical System

High-quality medical resources in Harbin are relatively concentrated: large hospitals far surpass primary-level medical institutions in the number of beds, the stock of medical equipment, and the number of physicians. Residents' care-seeking therefore tends to concentrate in large hospitals, whose outpatient departments are overcrowded while primary-level hospitals remain relatively idle, resulting in a mismatch and waste of medical resources. At the same time, the service capacity of primary-level medical institutions is relatively limited and can hardly meet residents' growing demand for medical services. With deepening population aging and a rising number of chronic disease patients, aggregate medical demand in Harbin has continued to grow, and the needs of older adults for chronic disease management and health monitoring are especially acute, which objectively requires the primary level to assume a larger share of first-contact and health management functions.

3.2. The Launch and Development of Family Doctor Contract Services in Harbin

Heilongjiang Province launched pilot family doctor contracting at an early stage. From 2013 onward, community health service centers across the province successively piloted contracting by general practitioners (teams). In 2016, according to Liu Yuan's research, Heilongjiang Province issued implementation opinions on standardizing family doctor contract services, which clarified the adoption of a packaged contracting model delivered through general practitioner teams [14]. In August 2017, the Heilongjiang Provincial Health and Family Planning Commission and other departments issued a notice on advancing pilots of tiered diagnosis and treatment, requiring further enhancement of primary-level service capacity and the substantive implementation of family doctor contract services. In the course of this process, each district developed its own local features. Xiangfang District issued the Work Plan for Family Doctor Contract

Services in Xiangfang District, the Work Plan for the "Six Unifications" of Family Doctor Contract Services in Xiangfang District, and the supporting Agreement on Family Doctor Contract Services in Xiangfang District, thereby standardizing the organizational forms of contract services [15]. Nangang District, building on the regional integration of medical care and elderly care, explored a "home-based contracting" model, relying on family doctor teams to provide key populations with integrated services such as circuit diagnosis and treatment and health consultation.

From 2018 onward, family doctor contract services in Harbin entered a stage of comprehensive rollout. In connection with grassroots medical reform, the municipal government gradually expanded contracting coverage with a view to reaching every community and township as well as parts of rural areas, while giving priority to key populations such as older adults, chronic disease patients, and pregnant and postpartum women so as to enhance the precision of health management. After 2021, acting on provincial policies on "Internet + healthcare" and on the construction of an intelligent platform for family doctors, Harbin has continued to promote the informatization of family doctor contract services, popularizing intelligent service tools such as intelligent voice follow-up and online health consultation in primary-level medical and health institutions, and relying on information systems to aggregate and manage residents' health record data so as to improve the efficiency of health data management [16–17].

After more than a decade of policy promotion, contract services in Harbin have moved from localized pilots to full-scale rollout. What level of coverage, then, has actually been achieved? And what differences exist across regions?

3.3. The Coverage Scale and Regional Progress of Family Doctor Contract Services in Harbin

The contracting coverage rate is a basic indicator of the progress of family doctor contract services, and the scale of contracting in Harbin has expanded continuously in recent years. According to data released by the Harbin Municipal Health Commission, as of May 2026 the city had formed 4,528 family doctor teams, providing full-lifecycle health protection to 6.127 million urban and rural residents, with the resident contracting coverage rate reaching 62.14% [18]. Looking back to the beginning of full-scale rollout, by the end of 2017, 2.5219 million permanent residents—29.12% of the total—had signed contracts, of whom 1.2599 million (55.80%) were drawn from key populations such as older adults and chronic disease patients, and the city had organized about 971 family doctor teams [19]. A comparison of these two points in time shows that over eight years the coverage of contract services in Harbin has increased dramatically, moving from the stage of "pilot coverage" to the stage of "broad coverage."

Alongside the expansion of aggregate scale, the organizational forms and regional practices of contract services display differentiated characteristics. Taking the entry of family doctor teams into the community grid as its lever, Xiangfang District has embedded contract services into the basic units of community governance: as of 2023, 174 family doctor teams had entered the grid, enabling precise alignment between family doctors and residents' "doorstep" health needs [20]. Supported by the expansion of the primary-level service system, Harbin New District has kept the contracting rate among key populations stably above 90%, raised the physical examination rate of residents aged 65 and above by more than 50% year on year, and markedly enhanced the diagnosis and treatment capacity of primary-level institutions [21]. These cases indicate that, in urban districts with concentrated resource input and a sound primary-level foundation, contract services are already in a position to transition from "coverage in quantity" to "effective fulfillment of contracts."

It should be pointed out that a relatively high contracting coverage rate does not automatically translate into effective use of primary-level services or health management. The contracting rate reflects the establishment of a contractual relationship; after signing, residents may still "sign without engaging, and engage without using." Moreover, the citywide contracting rate of 62.14% still falls short of the national target of a whole-population coverage rate above 75% by 2035 [6], and progress is uneven across regions

and between urban and rural areas. Assessing the actual role of contract services in tiered diagnosis and treatment therefore cannot stop at the single indicator of coverage; it must be judged comprehensively in conjunction with such dimensions as the use of primary-level services, referral, and the quality of health management. For residents, whether to choose first contact at the primary level and whether to "keep the contract" by remaining there depend to a large extent on the economic guidance provided by medical insurance benefits—which is precisely the question addressed in the next section.

3.4. The Current Articulation between Medical Insurance Benefits and Contract Services in Harbin

The expansion of contracting coverage does not automatically translate into effective use of primary-level services and health management. Whether the tiered design of medical insurance benefits can provide residents with sufficient economic guidance to remain at the primary level is a key link in judging whether family doctors can genuinely play a triage role. This question is examined below from two aspects: the structure of benefits and its articulation with contract services.

As regards the structure of medical security benefits, Harbin's medical insurance policies have already formed a reimbursement gradient in which benefits are higher at the primary level and lower at large hospitals. Taking inpatient benefits under the basic medical insurance for urban and rural residents as an example, under the benefit standards implemented in Harbin from January 1, 2026, the deductible decreases with the level of the medical institution: it is lowest at community health institutions, township health centers, and grade-I hospitals, intermediate at grade-II hospitals, and highest at grade-III hospitals. The reimbursement ratio for expenses within the policy scope likewise follows a pattern in which the primary level ranks highest and grade-III hospitals lowest, with grade-I and below (90%) [22] exceeding grade-III hospitals (65%) [23] by roughly 25 percentage points. On the outpatient side, the general outpatient pooling scheme sets differentiated payment ratios according to the grade of the medical institution (grade-I and ungraded institutions higher than grade-II institutions, and grade-II institutions higher than grade-III), although the annual maximum payment limit is relatively modest; for chronic conditions such as hypertension and diabetes, the reimbursement ratio for outpatient medication at primary-level institutions below grade II is likewise higher than at grade-II institutions. In addition, out-of-area benefits are directly tied to referral behavior: where patients seek care outside the city after standardized referral and filing procedures, the ratio is correspondingly reduced relative to that for institutions of the same grade within the city, and the reduction is even greater where patients leave the city without referral on their own initiative. This design in itself embodies the institutional intent to guide "orderly referral and first contact at the primary level."

On the whole, Harbin's medical insurance benefits have, in their institutional design, already reserved economic room for first contact at the primary level and have created positive incentives for standardized referral. Yet the actual effect of this guidance remains subject to multiple constraints. First, the roughly 25-percentage-point gap in reimbursement between primary-level institutions and grade-III hospitals is not sufficient to offset residents' concerns about the quality of primary-level diagnosis and treatment and the availability of medicines, and the benefit differential may not effectively translate into use of primary-level services. Second, no marked difference has yet been established between contracting and non-contracting residents in terms of outpatient pooling quotas, reimbursement ratios, or appointment-based referral; the "economic substance" of the contracted relationship is limited, and residents can hardly perceive any difference between "contracting and not contracting" at the benefit level. Third, supporting deficiencies—such as the limited level of outpatient pooling protection and the incomplete medicine formulary at the primary level—objectively weaken the appeal of seeking care at the primary level. The failure of the leverage of medical insurance benefits and contract services to converge is precisely a key constraint on the transition of Harbin's family doctor contract services from "expanding coverage" to "effective fulfillment."

At this point, the surface appearance of "broad coverage and large scale" in Harbin's contract services coexists with the underlying concern of "limited medical insurance guidance and incomplete supporting mechanisms." To what extent, then, have contract services actually promoted tiered diagnosis and treatment, and by which real-world factors is their role constrained? Section 4 explains the mechanisms of action, and Section 5 focuses on the problems and challenges encountered in operation.

4. The Mechanism of Action of Family Doctor Contract Services in Tiered Diagnosis and Treatment

This section sets out the mechanisms through which family doctor contract services promote tiered diagnosis and treatment. It should be noted that the following analysis addresses the normative question of how such services ought to function; their actual effects in Harbin will be judged in conjunction with the real-world constraints examined in Section 5.

First, family doctor contract services help strengthen the comprehensive service capacity of primary-level medical institutions. Under the traditional model, primary-level institutions mostly provide fragmented basic diagnosis and treatment and are unable to manage residents' health systematically or to track it over the long term. By establishing long-term and stable doctor–patient relationships, contract services enable family doctors to grasp the health status of contracting residents comprehensively and to provide personalized health management, chronic disease prevention and control, and regular follow-up, thereby enhancing the responsiveness of primary-level institutions to residents' health needs and creating the conditions for the primary level to undertake first contact.

Second, family doctor contract services help guide orderly care-seeking and reduce disorderly concentration. Family doctors assume the functions of initial diagnosis, screening, and the management of common and frequently occurring diseases for contracting residents, and they can identify and refer cases beyond the capacity of the primary level, thereby preventing patients from flooding directly into large hospitals without screening. If this mechanism operates effectively, it will compress the space for disorderly care-seeking and excessive medical treatment and promote the formation of an order of care in which "minor ailments are treated at the primary level and major illnesses at hospitals."

Third, family doctor contract services play a positive role in chronic disease management and in the health maintenance of older adults. Through regular follow-up, health guidance, and medication management, family doctors help control the progression of chronic diseases and delay the onset of complications, thereby easing the pressure on large hospitals caused by acute exacerbations of chronic conditions. For older adults, contract services can also be extended to health assessment, home-based care, and psychological support, thereby improving their quality of life. It should be noted that all of the above functions presuppose that the contracted relationship is genuinely established and genuinely honored, that medicines and equipment are accessible at the primary level, and that referral pathways are smooth—precisely the real-world constraints examined in Section 5.

5. Problems and Challenges in Family Doctor Contract Services in Harbin

5.1. Insufficient Supply of Primary-Level Health Workforce, Including General Practitioners

Although contracting coverage has expanded year by year, the overall shortage of general practitioners remains the foremost constraint. At the primary level in Harbin, particularly in remote areas and townships, both general practitioner capacity and specialist strength are inadequate; family doctor teams are difficult to assemble, and there are gaps in service delivery. In recent years, although the municipal level has introduced incentive measures such as raising primary-level remuneration and increasing training, the situation in which talent "cannot be recruited and cannot be retained" has not been

fundamentally reversed, and the growth of supply finds it difficult to keep pace with the expansion of contracting scale.

5.2. Insufficient Awareness and Participation among Residents

Low willingness to contract and low participation among residents are prominent obstacles to the promotion of contract services, and they are especially evident in rural areas and among older adults. A considerable proportion of residents harbor doubts about the service content, professional competence, and practical utility of family doctors, are accustomed to "going straight to large hospitals when ill," and place limited trust in primary-level institutions. Some residents regard contracting as a mere formality, and the service content is hardly perceptible, giving rise to a gap between the contracting rate and the rate of genuinely fulfilled contracting. How to raise residents' awareness and increase their willingness to participate is a problem that urgently needs to be solved.

5.3. Failure of the Economic Leverage of Medical Insurance and Contract Services to Converge

First, the guiding force of the benefit gradient is limited. The roughly 25-percentage-point gap in reimbursement between primary-level institutions and grade-III hospitals is not enough to overturn residents' concerns about the quality of primary-level diagnosis and treatment; a considerable proportion of residents would rather pay more to "get it done in one step" at a large hospital, and the benefit differential has not effectively translated into primary-level consultation rates. Second, "breaching the contract" is costless. Tiered diagnosis and treatment in China operates under soft constraints: after signing, residents can still bypass the primary level and seek care at higher-level institutions freely without any restriction on reimbursement, so the contracted relationship lacks binding force over care-seeking behavior. Third, contracting lacks "economic substance." Contracting and non-contracting residents differ little in outpatient pooling quotas, reimbursement ratios, and appointment-based referral, so residents can hardly perceive any substantive difference between "contracting and not contracting," which naturally dampens their incentive to contract. Fourth, incomplete supporting mechanisms weaken the appeal of the primary level. The incomplete medicine formulary at the primary level, the limited level of outpatient pooling protection, and the inadequate implementation of the long-term prescription policy mean that even chronic disease patients who are willing to remain at the primary level may turn to large hospitals because of the inconvenience of obtaining medication. Taken together, these problems give rise to "signing without engaging, and engaging without using," making it difficult for contract services to genuinely leverage tiered diagnosis and treatment.

5.4. Excessive Workload on Family Doctors

Contract services require family doctors to perform simultaneously multiple tasks, including diagnosis and treatment, follow-up, health education, and the management of health records. In some areas, the per-doctor number of contracted residents far exceeds the doctor's service capacity. An excessive number of service recipients directly squeezes the time available for personalized health management; sustained high-intensity work readily induces burnout and impairs service quality, forming a vicious circle of "signing many contracts but managing them poorly."

5.5. Imperfect Incentive and Assessment Mechanisms for Contract Services

Although Harbin has introduced some incentive measures for contracting doctors, the incentive mechanisms remain limited: remuneration does not match work intensity, career advancement channels are unclear, and the motivation of primary-level doctors is thereby affected. Moreover, the performance evaluation system is still imperfect: assessment indicators are weighted heavily toward the number of contracts while underweighting service quality and residents' satisfaction, which objectively induces a behavioral orientation of "emphasizing signing while slighting fulfillment." This is not conducive to the continued quality improvement of contract services.

6. Optimization Pathways for Tiered Diagnosis and Treatment and Family Doctor Contract Services

6.1. Strengthening Capacity Building for Primary-Level Medical Services

Primary-level institutions are the foundation of tiered diagnosis and treatment and contract services. Harbin should increase investment in community health service centers and township health centers, improve infrastructure, and update medical equipment. At the same time, it should strengthen the training and recruitment of general practitioners, improve remuneration and professional-title policies for primary-level personnel, and encourage high-quality medical resources to sink to the primary level for mentoring and teaching, so as to genuinely enhance the capacity of the primary level to undertake first contact and health management and to make "resolving minor ailments in the community" a realistic prospect.

6.2. Strengthening Residents' Awareness and Participation

In view of residents' inadequate understanding of, and insufficient trust in, the functional positioning of contract services, knowledge about family doctors and tiered diagnosis and treatment should be popularized through multiple channels, including media publicity, community activities, and health lectures, so as to improve residents' health literacy. At the same time, contracting procedures should be simplified, flexible forms of delivery—such as home visits, appointment-based diagnosis and treatment, and contracting on a household basis—should be developed, and residents' trust should be won through tangible service outcomes, so that contracting shifts from "administrative push" to "demand pull."

6.3. Improving Incentive Mechanisms with Reform of Medical Insurance Payment and Benefit-Based Guidance at the Core

The key to incentivizing family doctors lies not in simply raising salaries but in reforming payment methods at the primary level, so that the income of primary-level institutions is linked to residents' health outcomes rather than to the volume of services. In advancing the reform of medical insurance payment methods, Heilongjiang Province has already established an incentive and risk-sharing mechanism of "retaining the surplus and sharing the reasonable overspending" [24]. Within contract services, Harbin could explore packaged capitation payment based on the number of contracting residents, guiding primary-level institutions to shift from "more consultations, more income" to "managing health well, controlling costs, and retaining the surplus," so that family doctors have an intrinsic incentive to deliver substantive health management and chronic disease prevention rather than to pursue the number of contracts. On the demand side, the gap in reimbursement ratios between the primary level and higher-level hospitals should be appropriately widened, deductibles should be calculated cumulatively across institutions for patients following standardized referral procedures, and convenience measures—such as outpatient pooling quotas, long-term prescriptions for chronic diseases, and appointment-based referral—should be tilted toward contracting residents, so that "contracting" carries genuine economic value and residents are thereby retained at the primary level.

6.4. Promoting the Articulation between Long-Term Care Insurance and Family Doctor Contract Services

Older adults with disability or cognitive impairment are both the key population for home follow-up visits by family doctors and the principal beneficiaries of long-term care insurance. Heilongjiang Province has issued the Implementation Plan for Establishing the Long-Term Care Insurance System in Heilongjiang Province, which provides that Harbin and Mudanjiang will take the lead in establishing the system in 2027 and that it will be extended to the whole province by the end of 2028 [25]. Harbin should seize this opportunity to realize the articulation between disability assessment and contract services: family doctors should participate in preliminary disability screening and the management of health records, so as to provide continuous health information for applications for long-

term care insurance benefits; the incorporation of contract services into the care-delivery chain of long-term care insurance should be explored so as to alleviate the shortage of primary-level nursing manpower; and information sharing between the contract service platform and the long-term care insurance administrative system should be promoted to reduce duplicate assessments. This articulation can open up a stable and sustainable channel through which contract services are paid for, and it can also improve the accessibility of home-based care for older adults with disabilities. It is therefore a feasible breakthrough point for Harbin to advance the coordination of tiered diagnosis and treatment with the multi-tiered medical security system.

6.5. Strengthening Multi-Departmental Coordination and Supporting Safeguards

The optimization of tiered diagnosis and treatment and contract services involves multiple departments—health, medical insurance, finance, civil affairs, and drug administration—and calls for a routine coordination mechanism. At the government level, fiscal investment and policy coordination should be increased to guarantee funding and the allocation of resources. Health departments should unify service norms and referral procedures across medical institutions at all levels. Medical insurance departments should coordinate the advancement of payment method reform and the interface of benefit policies. Community institutions should substantively fulfill their service functions and enhance residents' sense of benefit. At the same time, supporting safeguards—including medicine supply and the construction of information platforms—should be coordinated to ensure that the tiered diagnosis and treatment system operates efficiently as a whole.

7. Conclusion and Recommendations

Drawing comprehensively on policy texts and statistical data, and from the perspective of coordination between the supply of medical services and medical security, this paper has examined the mechanisms, progress, and obstacles of family doctor contract services in Harbin in promoting tiered diagnosis and treatment. Three main conclusions emerge. First, the coverage of contract services in Harbin has continued to expand, measurable progress has been made in the health management of key populations and in the prevention and control of chronic diseases, and a reimbursement gradient favoring the primary level has taken shape in medical insurance benefits, all of which provide a necessary foundation for tiered diagnosis and treatment. Second, the leveraging effect of contract services on tiered diagnosis and treatment remains limited, and the core of the problem lies not in "signing" but in "use": the inadequate supply of primary-level health workforce, insufficient residents' trust and participation, the failure of the leverage of medical insurance benefits and contract services to converge, and incentive and assessment mechanisms that "emphasize quantity over quality" jointly give rise to "signing without engaging, and engaging without using." Third, the way out lies in simultaneous efforts on both the supply side and the security side: not only should primary-level service capacity be enhanced and residents' awareness and participation be strengthened, but supply-side incentives should be reshaped through reform of medical insurance payment methods such as capitation, demand-side behavior should be reshaped through differentiated benefit-based guidance, and the value space of contract services should be expanded through articulation with long-term care insurance and other institutional arrangements. Only in this way can family doctor contract services move from "expanding coverage" to "effective fulfillment" and genuinely underpin the deepening implementation of the tiered diagnosis and treatment system.

Research Limitations and Outlook: This study relies mainly on policy texts and publicly available statistical data; it does not conduct field surveys or quantitative tests, and its causal judgments concerning the "contracting–care-seeking" relationship remain to be strengthened. Subsequent research could obtain first-hand data from residents and family doctors through questionnaire surveys and interviews, and could empirically test the actual effects of contract services in promoting tiered diagnosis and treatment by using

indicators such as the share of diagnosis and treatment volume handled at the primary level, referral rates, and the standardized management rate of chronic diseases. It could further compare institutional differences between Harbin and other cities so as to distill replicable experience.

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