Institutional Incentives, Resource Synergy, and Team Empowerment: Multi-dimensional Dilemmas and Resolution Strategies for the Construction of Gold-Standard Family Doctor Teams—A Qualitative Study in Tianjin (Postprint)

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Abstract

Background: Family doctor teams serve as critical gatekeepers for resident health; however, their development generally faces bottlenecks such as formalized contracting and the mismatch between capabilities and resources. Tianjin Municipality has listed the construction of "Gold Medal Family Doctor Teams" as a 2025 People' s Livelihood Project, but there is a gap between policy implementation effects and the original design intent, necessitating a systematic diagnosis. Objective: To systematically identify obstacles in the construction of Gold Medal Family Doctor Teams and propose optimization solutions. Methods: From May 2025 to October 2025, an interview outline was developed based on relevant literature and the objectives of this study. Data were collected using purposive sampling, and semi-structured interviews were conducted with 20 experts. Problem identification was performed according to the ROCCIPI framework [Rules, Opportunity, Capacity, Communication, Interest, Process, and Ideology]. Results: The analysis revealed that problems do not exist in isolation but stem from three sets of deep-seated contradictions: at the institutional level, the decoupling of administrative recommendation from incentives leads to insufficient "gold content" of the title; at the operational level, the fixed-pairing support model and fragmented information systems struggle to support actual service demands; at the organizational level, the lack of team autonomy and excessive member workload make it difficult to substantiate services. These intertwined contradictions restrict the benchmarking role that Gold Medal teams should play. To address this: first, establish a growth-oriented incentive mechanism characterized by "dynamic certification and honor linkage" ; second, construct a flexible support system combining a "specialist resource pool and intelligent referral platform" ; third, grant teams greater autonomy

complemented by process-oriented management tools; and fourth, explore pilot programs for paid service packages based on policy norms and public communication. Conclusion: Based on evidence from key informants, this study extracts three sets of transferable contradictory structures—"selection and incentive,""support and synergy," and "organization and empowerment" —and subsequently constructs a matching set of policy tools. This provides an actionable mechanistic explanation and intervention path for benchmarking primary-level team policies to transition from "awarding titles" to "improving quality."

Full Text

Preamble

Institutional Incentives, Resource Synergy, and Team Empowerment: The Multidimensional Dilemmas and Solutions for "Gold Standard"Family Doctor Team Construction —A Qualitative Study in Tianjin

Abstract

Background: As the "gatekeepers" of residents' health, the construction of family doctor teams is a core component of the hierarchical medical system. However, in practice, these teams face multiple challenges, including insufficient motivation, resource fragmentation, and limited professional autonomy.

Objective: This study aims to explore the multidimensional dilemmas faced by "Gold Standard" family doctor teams in Tianjin and propose targeted strategies to improve team effectiveness through institutional incentives, resource synergy, and team empowerment.

Methods: Using a qualitative research design, semi-structured interviews were conducted with primary healthcare providers, administrators, and health bureau officials in Tianjin. Grounded theory was applied to analyze the data, identifying key themes related to institutional barriers and operational challenges.

Results: The study identifies three primary dimensions of the current dilemma: (1) Institutional incentive mechanisms are rigid, failing to adequately reflect the value of complex primary care services; (2) Resource synergy is hindered by fragmented information systems and a lack of effective coordination between primary and secondary care; and (3) Team empowerment is restricted by administrative burdens and a lack of professional development pathways.

Conclusion: To optimize family doctor team construction, it is essential to establish a value-based incentive system, promote deep integration of medical resources through digital health platforms, and enhance team autonomy through professional empowerment.

Figure 1

Figure 1: Figure 1

Introduction

The family doctor system is the cornerstone of a sustainable healthcare system. In China, the transition from a hospital-centric model to a primary care-centered model relies heavily on the capacity and motivation of family doctor teams. Despite significant policy support, the "Gold Standard" (high-performing) family doctor teams still encounter structural bottlenecks that impede their ability to provide comprehensive, continuous, and coordinated care.

1. Theoretical Framework and Research Design

This study adopts a multidimensional analytical framework focusing on three pillars: institutional incentives, resource synergy, and team empowerment.

1.1 Institutional Incentives

Institutional incentives refer to the formal rules and reward structures that govern the behavior of healthcare providers. In the context of family medicine, this includes salary structures, performance evaluations, and career advancement opportunities.

1.2 Resource Synergy

Resource synergy involves the efficient allocation and integration of human, financial, and informational resources across different levels of the

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背景

Institutional Incentives, Resource Coordination, and Team Empowerment: Multidimensional Dilemmas and Strategies for the Construction of the "Gold Family Doctor Team" — A Qualitative Study in Tianjin

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Abstract

Family doctor teams serve as critical gatekeepers for resident health; however, their development generally faces bottlenecks such as formalized (superficial)

contracting and a mismatch between capabilities and resources. Tianjin has designated the construction of "Gold Family Doctor Teams" as a key "People's Livelihood Project" for 2025. Nevertheless, a gap exists between the effects of policy implementation and the original design intent. There is an urgent need to systematically identify obstacles to the construction of these gold-standard teams and propose optimization solutions.

From May 2025 to October 2025, this study developed an interview outline based on relevant literature and research objectives. Using purposive sampling, semi-structured interviews were conducted with 20 experts. Problem identification was performed according to the ROCCIPI framework [Rules, Opportunity, Capacity, Communication, Interest, Process, and Ideology].

The analysis reveals that the identified problems do not exist in isolation but stem from three sets of deep-seated contradictions. At the **institutional level**, the decoupling of administrative recommendation from effective incentives leads to a lack of perceived value in the "Gold" designation. At the **operational level**, the fixed-pairing support model and fragmented information systems struggle to support actual service demands. At the **organizational level**, teams lack autonomy and members are overburdened, making it difficult to provide substantive services. These intertwined contradictions restrict the benchmarking role that Gold Family Doctor Teams are intended to play.

To address these issues, this study proposes: first, establishing a growth-oriented incentive mechanism characterized by "dynamic certification and honor-linked rewards"; second, constructing a flexible support system combining a "specialist resource pool" with an "intelligent referral platform"; third, granting teams greater autonomy supported by process-oriented management tools; and fourth, exploring pilot programs for paid service packages based on policy standardization and public communication. Based on evidence from key informants, this study extracts three sets of transferable contradictory structures— "Selection and Incentives," "Support and Synergy," and "Organization and Empowerment" —and constructs a matching mix of policy tools. This provides an actionable mechanistic explanation and intervention path for transitioning benchmarking primary care team policies from mere "branding" to "quality enhancement."

Keywords: General Practitioners; Gold Family Doctor Team; Primary Health Care; Policy Implementation; ROCCIPI

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Introduction

Family doctor teams are the backbone of primary healthcare, yet the transition from quantitative expansion to qualitative improvement remains a significant challenge. While the "Gold Family Doctor Team" initiative in Tianjin represents a high-level policy commitment to excellence, the practical execution often

encounters structural barriers. This study utilizes the ROCCIPI framework to deconstruct these barriers and provide a strategic roadmap for policy optimization.

Methods

Data Collection

Between May and October 2025, the research team employed purposive sampling to select 20 experts for semi-structured interviews. Participants included primary care administrators, clinical leads of family doctor teams, and academic experts in health policy. The interview guide focused on the implementation challenges of the Gold Family Doctor Team initiative.

Analytical Framework

The study adopted the ROCCIPI framework to systematically categorize the factors influencing policy implementation: - **Rules:** Regulatory frameworks and standards. - **Opportunity:** External circumstances facilitating or hindering action. - **Capacity:** Resources, skills, and infrastructure. - **Communication:** Information flow between stakeholders. - **Interest:** Incentives and motivations for actors. - **Process:** Procedural workflows and administrative steps. - **Ideology:** Values and beliefs of the participants.

Results and Discussion

The analysis identified three core dimensions of contradictions that impede the effectiveness of the Gold Family Doctor Teams.

1. Institutional Level: Selection vs. Incentives

A primary finding is the "decoupling" of administrative recognition from tangible rewards. When the "Gold" designation is treated as a one-time administrative honor rather than a dynamic status linked to ongoing performance and career progression, its motivational power diminishes. This results in a "Gold" brand that lacks substantive value (the "gold content" problem).

2. Operational Level: Support vs. Coordination

The current support model often relies on rigid, fixed pairings between primary care teams and secondary/tertiary hospitals. This rigidity, combined with fragmented information systems that do not allow for seamless data sharing or intelligent referrals, creates a bottleneck. The "Capacity" and "Process" dimensions are hindered by these technological and structural silos.

3. Organizational Level: Autonomy vs. Burden

At the grassroots level, teams are often micro-managed with little clinical or administrative autonomy, yet they are burdened with extensive non-clinical documentation and administrative tasks. This "Process" and "Capacity" imbalance prevents teams from focusing on high-quality, personalized resident care.

Policy Recommendations

To transition from "branding" to "quality," the following strategies are proposed:

1. **Dynamic Incentive Mechanisms:** Implement a system where the "Gold" status is periodically reviewed and directly linked to financial bonuses, professional promotion tracks, and public recognition.
2. **Flexible Support Systems:** Replace rigid pairings with a "specialist resource pool" and utilize AI-driven intelligent referral platforms to ensure that family doctors can access specialist expertise when and where it is needed.
3. **Empowerment and Tools:** Grant team leaders greater control over internal resource allocation and provide digital tools that automate administrative tasks, thereby reducing the "burden" and allowing for substantive service delivery.
4. **Value-Based Service Packages:** Develop and pilot paid service packages that offer enhanced value to residents, supported by clear communication strategies to align public expectations with service capabilities.

Conclusion

The construction of Gold Family Doctor Teams requires more than just a change in nomenclature. By addressing the underlying contradictions in incentives, coordination, and empowerment, policymakers can transform these teams into true benchmarks for primary healthcare. The proposed policy tool combination offers a scalable model for other regions seeking to enhance the efficacy of their family doctor systems.

Background

Family doctor teams are key gatekeepers of residents health; however, their development commonly faces bottlenecks such as formalistic contracting and mismatches between capacity and resources. Tianjin has designated the development of "Gold Medal Family Doctor Teams" as a 2025 people-centered initiative, yet gaps remain between policy implementation outcomes and the original design intent, warranting a systematic diagnosis.

Objective To systematically identify barriers to the development of Gold Medal Family Doctor Teams and propose optimization strategies.

Methods

From May FU J R, LI M H, DU Y, et al. Institutional incentives, resource coordination and team empowerment: multidimensional dilemma and strategies for the construction of the gold family doctor team: a qualitative study in Tianjin[J]. Chinese General Practice, 2026. [Epub ahead of print] Editorial Office of Chinese General Practice. This is an open access article under the CC BY-NC-ND 4.0 license.

Chinese General Practice https 2025 to October 2025, an interview guide was developed based on relevant literature and the study objectives. Using purposive sampling, data were collected through semi-structured interviews with 20 experts, and problems were identified using the ROCCIPI framework (Rules, Opportunity, Capacity, Communication, Interest, Process, Ideology) .

Results

The issues were not isolated; rather, they stemmed from three sets of underlying contradictions. At the institutional level, the decoupling of administrative recommendation from incentives undermined the credibility and value of the "gold medal" designation. At the operational level, a fixed pairing support model and fragmented information systems failed to meet real-world service needs. At the organizational level, limited team autonomy and excessive workload among members hindered substantive service delivery. These intertwined contradictions constrained the intended benchmarking role of Gold Medal teams. Accordingly, four strategies are proposed: (1) establish a developmental incentive mechanism featuring "dynamic accreditation linked to honorary recognition"; (2) build a flexible support system integrating a "specialty resource pool" with an intelligent referral platform; (3) grant teams greater autonomy supplemented with process-oriented management tools; and (4) on the basis of policy standardization and public communication, explore pilot programs for paid service packages.

Conclusion

Based on the key informant evidence, this study extracts three sets of transferable contradictory structures: "Selection and Incentive" , "Support and Synergy" , and "Organization and Empowerment" , and then constructs corresponding policy tool combinations, providing operational mechanism explanations and intervention paths for the benchmarking policy of grassroots teams from "plaque" to "quality improvement" .

Introduction

Family doctor team services represent a people-centered primary health care model characterized by primary diagnosis as the entry point and continuous, comprehensive care as its core feature. The essence of this model emphasizes

providing stratified, categorized, proactive, and continuous integrated medical and public health care for key populations and patients with chronic diseases throughout the entire life-cycle health management chain. Against the backdrop of an aging population, the rising burden of chronic diseases, and the increasing health demands of residents, family doctor teams have become a critical force in primary diagnosis, and their role in the supply of community health services has become increasingly prominent.

In response to the public' s demand for high-quality health services, national policies have been issued to promote the high-quality development of family doctor services. In 2022, the state issued the *Guiding Opinions on Promoting the High-Quality Development of Family Doctor Contracted Services*, which explicitly proposed optimizing family doctor teams. In 2025, six departments, including the National Health Commission, released *Several Measures to Enhance the Perception of Family Doctor Contracted Services*, setting clear requirements and plans for improving the service quality of these teams. However, in practice, family doctor teams still face widespread issues such as formalized (superficial) contracting, talent shortages, and imperfect team collaboration mechanisms. Significant obstacles remain in the process of translating policy momentum into actual service quality and a sense of health gain for residents [**?**].

The "Gold Medal Family Doctor Team" service is a specialized diagnostic and treatment service characterized by its "benchmarking"and "experimental"nature. It features strong professional capabilities and high comprehensive quality, with an emphasis on service quality and patient experience. Its construction aims to break through the bottlenecks of the current family doctor system and explore paths for high-quality development through resource focus and institutional innovation. In 2025, Tianjin included "Building Gold Medal Family Doctor Teams" in its "People' s Heart Project," planning to establish one gold medal team in each of the 176 primary health care institutions in agricultural-related districts to drive overall improvement through a benchmarking effect. The policy design emphasizes a "General Practice + Specialized Disease" capability orientation, a mentor-based teaching system, and the goal of continuously optimizing the structure of family doctor teams.

Nevertheless, in practice, a "gap" remains between the institutional design and the execution of Gold Medal Family Doctor Teams in Tianjin, necessitating a systematic response from the perspectives of policy design and institutional innovation. In view of this, this paper focuses on "how to identify and accurately respond to problems in the construction of Gold Medal Family Doctor Teams." By combining the ROCCIPI analysis framework—encompassing Rules, Opportunity, Capacity, Communication, Interest, Process, and Ideology—with thematic analysis of semi-structured interviews, this study performs a systematic diagnosis of persistent problems and dynamically captures emerging issues. The objective is to reveal the dimensional affiliations of problems in the construction of Gold Medal Family Doctor Teams and the mechanisms of mutual influence between these problems, thereby exploring systematic solutions and

providing actionable new ideas for improving construction quality and efficiency.

1.1 研究对象与资料

The study was conducted from May 2025 to October 2025. This research employed a purposive sampling method, taking into account factors such as age, gender, cultural differences, and professional titles. The inclusion criteria were: (1) individuals who have been directly involved in or responsible for the construction and management of family doctor teams or "Gold Medal" teams within the past two years; (2) frontline management positions closely related to contracted services; and (3) voluntary participation in this study after being informed of the research objectives. Exclusion criteria were: (1) those who were inconvenienced by audio recording or data use authorization; and (2) those with less than six months of tenure or a significant lack of understanding regarding relevant processes. This study was approved by the Ethics Committee of Tianjin Fourth Center Hospital (Ethics Approval No.: SZXLL-2025-K022), and all participants signed informed consent forms. The sample size followed the principle of "information saturation," ultimately resulting in interviews with 20 experts. Participants were coded using a combination of their professional title abbreviations and numbers. General information for the research subjects is presented in . Each interview lasted approximately 30–60 minutes. A total of 20 interviews were conducted, accumulating approximately 800 minutes of interview time and resulting in over 140,000 words of transcribed text.

This study utilized semi-structured interviews for data collection. The investigation was conducted by two uniformly trained investigators who performed either face-to-face or online interviews.

The interview moderator made appropriate adjustments to the order and wording of questions based on the actual circumstances of the interviewees and the interview environment to ensure suitability for the current session.

Interviews were conducted according to a pre-designed semi-structured interview outline. With the consent of the interviewees, the entire process was recorded and transcribed. The interview content was subsequently converted into text and summarized with reference to the ROCCIPI analytical framework.

Development of the Interview Outline: The content of the interview outline was derived from relevant literature and the objectives of this study. Prior to the formal interviews, a pilot interview was conducted in May 2025 with subjects including primary-level managers and individuals knowledgeable about "Gold Medal" team construction. The pilot interview was primarily used to test question comprehension, sensitivity, and narrative flow. Adjustments focused on three areas: (1) reducing excessive questioning regarding the interest dimension; (2) increasing follow-up questions on the details of "resource synergy" ; and (3) merging repetitive questions and optimizing the sequence to reduce leading prompts. Data from the pilot interviews were not included in the formal analysis. The final interview outline included: (1) value positioning and goal recognition

of the Gold Medal family doctor team; (2) the governance structure of the Gold Medal family doctor team; (3) service and synergy models of the Gold Medal family doctor team; (4) capacity building and talent guarantee mechanisms for the Gold Medal family doctor team; and (5) internal and external resource allocation for the Gold Medal family doctor team.

ROCCIPI: This study introduced the ROCCIPI technical analysis framework, which consists of seven dimensions: Rules, Opportunity, Capacity, Communication, Interest, Process, and Ideology. This framework allows for a systematic analysis of the influencing factors of policy issues and their interaction mechanisms. The study performed dimensional coding and co-occurrence identification on the interview texts, tracking how each dimension couples through mechanisms such as incentive transmission, resource flow, risk imputation, and organizational identity. This approach examines the institutional environment and action logic of family doctor team construction from the perspective of holistic governance, as shown in .

The sum of institutional arrangements including laws, regulations, policy documents, technical standards, and supporting details related to the construction of Gold Medal family doctor teams; the favorable conditions and opportunities faced during the construction of Gold Medal family doctor teams; the supply of resource elements and the configuration of capacity support conditions for Gold Medal family doctor teams and their affiliated institutions; (Com) internal and external cooperation, learning, and communication of Gold Medal family doctor teams; (Int) the interest mechanisms among stakeholders related to the construction of Gold Medal family doctor teams; the full-cycle operation and governance of Gold Medal family doctor teams; and the perceptions of core stakeholders regarding Gold Medal family doctor teams.

2 金牌家庭医生团队建设的核心矛盾识别

Based on the ROCCIPI framework, this study systematically analyzes deep interview data from 20 key informants. Building upon dimensional co-occurrence, we further extract underlying mechanisms to identify three dominant interaction paths, which subsequently form three distinct clusters of contradictions:

First, the establishment of selection and certification rules (R) proactively shapes the expectations of relevant stakeholders regarding benefits and fairness (I). This, in turn, influences the actual investment and implementation levels in team building and service provision (P). Whether the implementation process can consistently yield visible and verifiable service outcomes conversely reinforces or erodes the credibility and sustainability of the institutional rules (R).

Second, the modality and quality of cross-institutional synergy are constrained by institutional rules and responsibility boundaries (R), while also being driven by the collaborative opportunities and pressures provided by external reform processes and policy windows (O). The effectiveness of implementation depends

on the level of support from resources and information technology (C). On this basis, the smoothness of collaborative communication mechanisms (Com) determines the efficiency and predictability of key processes such as referrals, consultations, and guidance (P). Furthermore, whether risk attribution is clear and benefits are visible further shapes the willingness and intensity of continued participation among all parties (I).

Third, the perceptions and attitudes of managers and teams toward the positioning of "Gold Medal Teams" (Int) dictate the institutional choices regarding authorization methods and process governance (R). This subsequently affects the availability of team resources and the actual workload of members (C). Through changes in the quality of team collaboration and the accumulation of resident trust (Com), these factors continuously provide feedback that solidifies organizational mindsets and behavioral inertia (Int).

Contradiction Cluster I: Distortion of selection mechanisms and rupture of the incentive loop, leading to the dilution of the "Gold Medal" value and insufficient endogenous motivation.

The core of this contradiction lies in the fact that the designation of "Gold Medal" family doctor teams has failed to establish a virtuous cycle that stimulates fair competition and continuous growth.

2.1.1 评选的行政化与"去竞争化"

The current selection mechanism for "Gold Medal Teams"is essentially an administratively driven "internal recommendation" model rather than a "competency-based recruitment" model grounded in objective performance and public evaluation. This model typically relies on internal nominations within an institution and final approval by superior departments. Consequently, the selection criteria are often vague and the process lacks transparency, causing the "Gold Medal" designation to devolve into a mere distribution of administrative resources. As one interviewee noted: "In a broad sense, a Gold Medal family doctor team should be selected based on capability, but current practice has narrowed it into a recommendation-and-cultivation model" (Interview GL1).

This shift has led to multiple drawbacks. First, it undermines the fairness and credibility of the selection process, making the results difficult for the public and peers to accept; this triggers widespread questioning, such as "Why were you recommended and not me?" (Interview GX2). Second, it stifles the motivation of grassroots teams to gain recognition through hard work and fair competition. Ultimately, this dilutes the benchmarking significance and demonstrative value of the "Gold Medal" at its source. Without a solid foundation of legitimacy for these team honors, it is difficult to inspire broad identification with the program or a "catch-up" effect among other teams.

2.1.2 激励的短期化与偶然性

The "Gold Medal" title currently functions primarily as a spiritual honor and a potential source of short-term performance rewards, failing to be deeply integrated into the long-term professional development systems for medical personnel. Specifically, there is a lack of rigid, actionable linkage mechanisms between this honor and the key institutional frameworks that govern a physician' s core professional interests—such as professional title promotion, research project applications, high-level talent selection, and opportunities for long-term domestic or international fellowships. Consequently, its incentive utility remains superficial, characterized by significant short-termism and contingency.

As noted in interview JY3, "honor is not a rigid necessity." For team members, while receiving the "Gold Medal" title provides temporary validation, its attractiveness diminishes rapidly over time because it cannot be converted into developmental capital or sustainable capacity building. This situation results in a lack of sustained endogenous motivation for the construction of Gold Medal teams. Members may perceive the initiative merely as a periodic task rather than a professional platform worthy of long-term investment that yields career growth. This fundamentally constrains the long-term commitment of teams to pursue excellence and continuous improvement.

2.1.3 分配失衡与内部张力

Under the long-standing cultural tendency toward "egalitarianism" within primary healthcare institutions, there is a lack of publicly recognized, transparent evaluation standards and accounting bases for allocating resources toward "Gold Medal Teams." Consequently, additional investment objectively disrupts the pre-existing relative balance based on seniority or professional titles, easily triggering disputes over fairness and psychological imbalances both between and within teams. As noted in one interview: "If one team performs exceptionally well and earns more money and performance bonuses, it actually creates competition and tension with other teams" (Interview GX3). This dissatisfaction is rooted in the inertia of the "big pot" (equalitarian) mindset: "Because everyone has had enough of the 'big pot' or has grown accustomed to it, any tilt in incentives leads to resentment" (Interview GL4).

The consequence of this dynamic is that "benchmarks," which are intended to serve as role models for learning, may instead become focal points for internal conflict and mutual alienation. Non-gold medal teams may develop resistance, becoming unwilling to cooperate with or even isolating the gold medal teams. Conversely, members of the gold medal teams may suffer a loss of motivation due to the criticism and pressure they face. such internal friction seriously undermines organizational synergy, running counter to the original policy intent of driving overall improvement by establishing benchmarks.

Contradiction Cluster II: Static Resource Misallocation and the Absence of Collaborative Systems, Leading to Support System Failure. The core of this con-

tradiction lies in the fact that the supporting framework of the policy design is too rigid in practice. Due to a lack of detailed implementation rules, the system is unable to respond flexibly to dynamic demands.

2.2.1 专科支援的固定配对与需求多样性矛盾

Rigidity at the policy level is manifested in two primary aspects. First, specialist support is subject to rigid quantitative caps (for instance, a fixed limit on the number of teams a single specialist can support), which artificially restricts the radiation and sharing of high-quality specialist resources across a broader scope. Second, the professional supply remains singular; by permanently binding a specific specialist to a particular team, the system fails to respond flexibly to the complex reality of "multimorbidity" among contracted residents. As noted in one interview, "The help this team needs isn' t just for cardiovascular issues; they might also have gastrointestinal diseases or tumors" (Interview JY5).

This static configuration model of "one-to-one" or "one-to-limited" support leads to significant resource mismatch and waste. On one hand, some teams may face idle specialist support or a misalignment between the available expertise and resident needs. On the other hand, a larger number of teams are unable to obtain timely multi-specialty support when required. Consequently, the "capacity amplifier" effect that specialist support was intended to provide is severely weakened. In practice, the "addition" intended by the institutional design may devolve into formalism, failing to establish a flexible specialist support system characterized by demand-driven mobility and dynamic response.

2.2.2 信息系统的割裂与转诊流程阻滞

Information technology is intended to be the core technical engine for implementing hierarchical medical systems and enhancing collaborative efficiency. However, information systems across various levels of medical institutions currently remain in a state of "data silos," failing to achieve the interconnection of business processes and data. This fragmentation directly leads to blockages in the service chain. As revealed in the interviews: "The degree of interconnection between information systems in lower-level hospitals is insufficient"(Interview JY3). When a patient needs to be transferred downward, primary care physicians face the fundamental communication dilemma of being unable to contact the relevant grassroots doctors. Consequently, the referral process relies on personal acquaintances or even requires patients to transmit information themselves.

Although the medical consortium framework theoretically establishes a contractual relationship for two-way referrals, information barriers render this relationship fragile. Because doctors in superior hospitals cannot conveniently and comprehensively access a patient' s complete diagnostic and treatment records from the primary level, they often develop uncertain expectations regarding the reliability of primary-level diagnoses and treatments. This uncertainty, in turn,

reduces the level of trust and the willingness to cooperate in downward referrals and collaborative care.

2.2.3 协同责任的“风险悬空”与关系网络依赖

In the absence of clear, rigid definitions of responsibility and risk-sharing mechanisms, the act of referral—which should inherently be a standard form of medical collaboration—carries uncontrollable professional and legal risks for the primary care physicians who initiate it. The core of this risk lies in the ambiguity of accountability and the unidirectional burden of consequences. As one participant noted, “For patients who are referred out, if the treatment outcome is good, they might come back to thank me; but if the outcome is poor, they might still blame me” (Interview JY4-2). Consequently, formal, condition-based institutional referral channels have been largely replaced by informal networks.

These informal networks are based on private relationships and trust. This operational model makes the quality of collaboration highly dependent on personal connections between individuals, resulting in significant instability and inequity. This led one interviewee to lament, “The general collaboration I see is far too superficial” (Interview JY4-1). When “relationships” rather than “rules” become the key to smooth coordination, it not only exacerbates the “Matthew Effect” in resource acquisition but also deeply erodes the foundation of the Medical Consortium system. This makes it difficult for cross-institutional collaboration to achieve standardization, scalability, and sustainability.

Contradiction Cluster 3: The hollowization of organizational forms and the lack of team empowerment, leading to “idling” operations. The core of this contradiction is that the teams have only achieved a “physical integration” of their organizational structures, without realizing a “chemical fusion” of their service functions.

2.3.1 管理认知滞后与任务化执行

The construction of “Gold Medal” family doctor teams has not yet been elevated to the strategic height of driving service model transformation and sustainable development in the minds of some primary healthcare institution managers. Instead, it is often oversimplified as a mere “administrative task” that must be completed. This cognitive bias directly leads to the formalization of actions, where compliance is prioritized over substance. As one interview pointedly noted: “During the operation process, both institutional leaders and members of the family doctor teams first need to ‘change their brains’ ” (Interview GL5).

The core of this “changing of brains” requires managers to transcend traditional operational mindsets centered on disease treatment and outpatient volume. Instead, they must establish a new service paradigm centered on resident health that emphasizes continuity and coordination. If managers cannot lead the way in transitioning their professional identity from “clinical directors” to “orga-

nizers of health gatekeeping," the construction of Gold Medal teams is likely to become a superficial gesture—deemed "important during meetings, secondary after meetings, and dispensable when busy." Without this cognitive shift, even the most advanced institutional designs face the risk of being neutralized by traditional inertia at the point of execution.

2.3.2 团队自主权缺失与科室化运作

Despite the nominal formation of interdisciplinary "Gold Medal Teams," the internal power structures and operational models within these institutions have not undergone fundamental changes. As primary service units, these teams lack critical authority over personnel scheduling, financial management, and performance-based distribution; instead, their actions remain entirely subject to unified directives at the hospital level. As noted in interview JY7: "The team's power is held by the hospital's decision-making level; everyone simply works together to execute the tasks assigned by the hospital." This "centralized command, decentralized execution" model prevents teams from flexibly allocating members' time and energy based on the specific health profiles of contracted residents, and hinders their ability to implement targeted prevention, follow-up, or health management projects.

The result is a "new wine in old bottles" scenario: the team structure exists only as a list of names, while actual operations continue to follow deeply entrenched departmental silos. Team members have failed to develop an identity as a "team symbiotic entity" in either thought or action; collaboration relies on ad hoc coordination between departments rather than a normalized division of labor and integration based on shared goals. This "departmentalized" operation causes the Gold Medal Teams to lose their core functional advantage of "integrated care," rendering them unable to function as a flexible, mobile whole that can provide agile and continuous responses to the health needs of residents.

2.3.3 人员角色超载与碎片化投入

The construction of "Gold Medal Teams" has failed to effectively integrate resources or alleviate the burden on staff. Instead, it has imposed new responsibilities on top of an already heavy existing workload, leading to a pervasive state of role overload and emotional exhaustion among team members.

Many proactive tasks within family doctor contract services—such as health management, home follow-ups, and data entry—frequently encroach upon the personal rest time of medical personnel. As noted by one interviewee, "it's all completed by utilizing rest time" (Interview JY2). A more fundamental conflict lies in the fact that team members must simultaneously operate across two vastly different task streams: first, individual-oriented, diagnosis-driven clinical work; and second, population-oriented, prevention-driven public health services.

"There is an inherent conflict in the allocation of time and energy between

Figure 1

Figure 2: Figure 1

public health work and routine clinical diagnosis and treatment"(Interview JY5). Consequently, residents experience rushed outpatient visits, formulaic follow-ups, and management that lacks personal warmth, making it difficult to establish a sense of benefit or trust. This creates a vicious cycle that is hard to break: residents remain "dissatisfied and distrustful" due to poor experiences, while the teams lose the intrinsic motivation to improve services because of negligible results, negative feedback, and their own profound exhaustion.

3 金牌家庭医生团队建设的综合对策分析

Based on the aforementioned analysis and the requirements set forth by relevant authorities regarding the development of "Gold Standard" family doctor teams, this study proposes recommendations in the following key areas. These suggestions aim to provide a practical reference for the construction and optimization of these teams, as illustrated in Figure 1

.

Strategy One: Constructing an "Dynamic Certification-Integrated Development" Incentive and Evaluation Mechanism

To effectively enhance the professional capabilities and service quality of family doctor teams, it is essential to establish a robust incentive and evaluation framework. This strategy focuses on the implementation of a "Dynamic Certification-Integrated Development" model, which aligns individual career progression with the overall goals of primary healthcare delivery.

1.1 Implementation of Dynamic Certification

The core of this strategy lies in the transition from static, one-time qualifications to a dynamic certification process. Family doctors and their team members should undergo periodic evaluations that assess not only their clinical knowledge but also their practical performance, patient satisfaction, and contribution to community health outcomes.

By implementing a tiered certification system—ranging from basic practitioners to "Gold-Medal" family doctors—the healthcare system can create a clear professional ladder. This dynamic approach ensures that team members remain motivated to update their skills and adapt to evolving medical standards. Certification should be linked to specific competencies, such as chronic disease management, geriatric care, and mental health support, ensuring a comprehensive service offering for the community.

1.2 Integrated Development and Career Pathways

Integrated development refers to the harmonization of clinical practice, continuous education, and performance-based rewards. The strategy aims to break down the silos between different levels of medical institutions by fostering collaborative networks.

- **Professional Training:** Establishing a standardized training curriculum that emphasizes both clinical excellence and soft skills, such as communication and patient empathy.
- **Resource Sharing:** Facilitating the flow of expertise from secondary and tertiary hospitals to primary care centers through mentorship programs and joint consultations.
- **Incentive Alignment:** Developing a compensation structure that moves beyond basic salary to include performance bonuses tied to the quality of contracted services, health management outcomes, and patient retention rates.

1.3 Target Analysis and Expected Outcomes

The primary objective of this strategy is to cultivate a high-quality, stable, and motivated family doctor workforce. The target analysis focuses on three key dimensions:

1. **Service Quality:** By linking certification to performance, the system ensures that residents receive evidence-based and personalized care. The target is to significantly improve the management rates of chronic diseases such as hypertension and diabetes within the community.
2. **Professional Identity:** Providing a clear path for career advancement enhances the social status and job satisfaction of family doctors. This is crucial for reducing turnover rates and attracting high-caliber medical graduates to primary care.
3.

To address the distortions in selection mechanisms and the breakdown of incentive loops revealed by the first cluster of contradictions, we propose a systemic shift in incentive structures from static "status conferral" to dynamic "growth empowerment." The core of this transition involves replacing the current administrative recommendation system with an open, standard-based competitive recruitment system. This requires establishing a set of quantified, transparent, and traceable certification standards where core performance metrics—such as resident satisfaction, contracted service coverage, and health management outcomes—serve as the primary "entry tickets." Furthermore, third-party evaluations and hearings involving resident representatives should be introduced to ensure the credibility of the selection process. Crucially, the "once-and-for-all" evaluation model must be dismantled in favor of annual reviews and "bottom-ranking warnings." By ensuring that honors can be both granted and revoked, the system will exert the necessary pressure and motivation for teams to pursue

continuous improvement.

Building upon these reforms, it is essential to dismantle the barriers between "Gold Medal" honors and professional career advancement. Through joint policy directives issued by provincial or municipal health and human resources departments, the experience and performance of core members in Gold Medal teams should be explicitly recognized. These achievements should serve as criteria for exceptional promotion to senior professional titles, preferential consideration for graduate supervisor selection, and priority support for municipal-level or higher scientific research projects.

Simultaneously, regarding performance distribution, a "basic guarantee + incremental sharing" team performance contracting system should be explored. Under the premise of clear rules and controllable risks—particularly if pilot programs for differentiated value-added services are implemented (see Section 3.4)—a portion of incremental income should be included in the team' s internal secondary distribution. This approach aims to create an incentive intensity that is commensurate with service quality, thereby deeply aligning team interests with service excellence. Such a mechanism will stimulate endogenous creativity and service enthusiasm, ultimately constructing a closed loop for healthy professional growth.

Strategy 2: Establishing an Empowerment Support System via a "Specialist Resource Pool + Intelligent Referral Platform"

To resolve the second cluster of contradictions—namely, the static misallocation of resources and the absence of collaborative institutional frameworks—it is necessary to restructure the family doctor service model and the collaborative processes within Medical Alliances.

First, the rigid "fixed pairing" model must be replaced by a "flexible specialist resource pool" established at either the municipal or Medical Alliance level. This pool should incorporate specialists with associate senior titles or higher from secondary and tertiary hospitals. Based on the specific disease profiles of their contracted residents, primary care "Gold Medal Teams" can utilize a regional collaborative platform to request specialists for remote consultations, joint outpatient clinics, technical training, or case guidance on an as-needed basis, similar to "booking a specialist appointment."

The resource pool will be managed through a "points-based system," where the participation of specialists is directly linked to the performance evaluations of their respective departments. This approach aims to revitalize and efficiently allocate scarce specialist resources across the healthcare system.

Secondly, technical empowerment and institutional safeguards must be leveraged to clear existing barriers to patient referrals. The government should lead the construction of a city-wide, standardized "Intelligent Referral Collaboration

Platform." This platform must mandate integration with the Hospital Information Systems (HIS) of medical institutions at all levels to achieve full-process, closed-loop management. This includes one-click synchronization of electronic medical records, online approval of referral applications, real-time viewing of bed availability, and the automatic transmission of diagnostic and treatment results.

Furthermore, the platform should embed a legally vetted "Referral Responsibility Sharing Agreement." This agreement must explicitly stipulate that primary care physicians shall not bear primary responsibility for subsequent treatment in cases where referral behavior conforms to clinical indications and follows standardized platform procedures. By providing an institutional basis for "non-liability referrals," the system can provide primary care physicians with the necessary confidence and eliminate the psychological root cause of their reluctance to refer patients.

Strategy 3: Promoting the "Team Autonomy and Process Quantization" Management Model

To resolve the issues of organizational formalization and insufficient team empowerment revealed by the third cluster of contradictions, it is critical to drive a paradigm shift in the management of primary healthcare institutions. This involves transitioning from the traditional "departmental control" model to a modern "team empowerment" model.

The primary initiative is to substantially decentralize management authority by implementing a "Team Objective Management Responsibility System." Institutions should sign annual objective responsibility agreements with gold-standard teams, clearly defining core indicators such as resident health management standards and service satisfaction levels. Simultaneously, team leaders should be granted critical autonomy regarding the internal allocation of personnel tasks, the distribution of monthly performance bonuses, and the approval of operational expenses within specified limits. This empowerment ensures that team leaders become truly accountable for the team' s overall performance, enabling them to flexibly mobilize resources to meet the dynamic needs of residents.

Secondly, it is essential to upgrade the management tools for "Gold Medal" teams, transitioning from vague outcome-based management to precise, quantitative process management. Leveraging municipal information platforms, digital monitoring tools should be developed specifically for the operation of these teams. While ensuring data integration, interface simplification, permission security, and ease of use at the grassroots level—thereby avoiding any additional administrative burden—these tools should provide real-time visualization of key process data. This includes contract dynamics, follow-up completion rates, the volume and efficiency of two-way referrals, and online resident interactions and evaluations. Based on these data, management agencies can conduct routine quality monitoring and provide feedback, ensuring that management interventions are more precise and timely.

Strategy 4: Exploring a "Policy Opening and Public Sentiment Safeguarding" Service Package

To address the overlapping conflicts identified in Clusters 1 and 2—which span the dimensions of interest, process, and communication—a dual approach is required. On one hand, it is necessary to identify incremental incentive pathways that do not exacerbate existing conflicts over the distribution of internal stock resources. On the other hand, a transparent communication and risk-management mechanism must be established to align with resident expectations. This prevents the reform from falling into a structural trap where "benefits are invisible while controversies are highly visible."

In light of these contradictions, and considering the fiscal constraints of grassroots governments alongside the long-term sustainability of incentive policies, an approach characterized by "soft investment and strong orientation" should be explored. This strategy aims to enhance residents' sense of gain and organizational identity through non-capital-intensive means.

For instance, primary healthcare institutions should standardize the establishment of "Gold Medal Family Doctor Team Studios." By designating these service units within a relatively independent and identifiable physical space, institutions can create a fixed environment for the teams. These studios serve as a platform to display visual markers of success, such as team honors, patient appreciation letters, and service achievements, thereby strengthening the team' s professional identity and cultural cohesion.

At the same time, paid service packages have been proven in domestic research and practice to be an effective means of addressing insufficient incentives for family doctor teams and providing differentiated health services within the national context. Under the premise of policy compliance, the Tianjin "Gold Medal Family Doctor" teams can adopt a "small steps, fast run" approach to pilot and promote value-added services through these paid contracting packages. By charging appropriate fees for services that exceed the scope of the basic service package—such as home nursing, extended outpatient hours, and personalized health management—residents can voluntarily choose to purchase these options. This approach not only satisfies diverse health demands but also creates additional revenue streams for the medical teams.

Furthermore, it is essential to simultaneously implement an active and professional "public opinion safeguarding" project. To prevent potential public outcry regarding "arbitrary charges" that might arise from a lack of oversight, the publicity and health departments should collaborate to plan a promotional series titled "Discovering the Value of Gold Medal Services." Through in-depth reports in mainstream media, the professional value, time costs, and positive outcomes of the additional services provided by Gold Medal teams should be highlighted. These narratives should emphasize the positive message that "high-quality service deserves reasonable compensation" and that "moderate payment can be exchanged for health and convenience," while widely disseminating the genuine

sense of gain experienced by contracted residents. By proactively setting the agenda, the public can be guided toward a rational understanding and expectation of value-added family doctor services, thereby fostering a rational and supportive social environment for these reforms.

Abstract

To foster a supportive social atmosphere, it is essential to achieve a positive interaction between the "implementation of policies" and "public recognition." This synergy ensures that healthcare reforms are not only executed effectively at the administrative level but are also embraced and supported by the general populace, thereby creating a sustainable environment for the development of general practice and primary care in China.

4 小结

Based on expert interviews, this study finds that the construction of "Gold Medal Family Doctor Teams" in Tianjin still faces several challenges. These include a disconnect between honorary incentives and substantive rewards, insufficient coordination regarding specialist support, referral collaboration, and information connectivity between upper and lower-level medical institutions, as well as heavy workloads and a lack of autonomy among team members. Therefore, it is recommended that continuous optimization focus on improving dynamic incentive mechanisms, strengthening specialist support and referral synergy, and enhancing the autonomous operational capabilities of teams. Furthermore, while maintaining standardized practices, the supply of differentiated services should be moderately expanded to facilitate a transition in the development of Gold Medal Family Doctor Teams from "award-based management" to "quality and efficiency enhancement."

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参考文献

Liu R, Yang DH, Wu HY, et al. A comparative study of family doctor contracting service models toward a Healthy China [J]. Chinese General Practice, 2020, 23(25): 3139-3145.

Sun CX, Liu TF, Jiang F, et al. Research on the development process and implementation of family doctor policies in China [J]. Chinese General Practice, 2021,

24(7): 765-774. DOI: 10.12114/j.issn.1007-9572.2021.00.091. Guiding opinions on promoting the high-quality development of family doctor contracting services (Guo Wei Ji Ceng Fa [2022] No. 10) [J]. Gazette of the National Health Commission of the People' s Republic of China, 2022(3): 5-8.

Department of Primary Health, National Health Commission. Notice on printing and distributing several measures to improve the perception of family doctor contracting services [A/OL]. (2025-08-19). Sun CX, Si SJ, Jiang F, et al. Construction of a performance evaluation index system for family doctor contracting services in China [J]. Chinese General Practice, 2021, 24(34): 4378-4385.

Zhao LL, Shao S, Luo Q, et al. Research on practical strategies for the integration of medical and preventive services in domestic family doctor teams [J]. Chinese General Practice, 2023, 26(22): 2715-2719. DOI: 10.12114/j.issn.1007-9572.2023.0039. Gong C, Yang SQ, Liu CY, et al. Research on the equity of resource allocation for family doctor contracting services in Tianjin [J]. Chinese Journal of Health Policy, 2022, 15(12): 60-66.

Li Y, Fu SX, Chen HY, et al. Problem identification and analysis of public health talent cultivation in the new era based on the ROCCIPI framework [J]. Chinese Health Service Management, 2024, 41(3): 307-309, 333.

Huang MH. Chongqing: Breaking the "Matthew Effect" in talent distribution [J]. China Health, 2020(1): 96-97. Yin D, Zhang JR, Wang Z, et al. Current status and research progress of family doctor contracting services in China [J]. Chinese General Practice, 2018, 21(7): 753-760.

GNEPP J, KLAYMAN J, WILLIAMSON I O, et al. The future of feedback: Motivating performance improvement through future- focused feedback [J] . PLoS One, 2020, 15(6): e0234444.

Development Status and Optimization Recommendations for Family Doctor Contract Services in Beijing Under a Policy Framework

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Abstract

Family doctor contract services serve as a vital foundation for the hierarchical medical system. This study analyzes the current development status of these services in Beijing by examining the existing policy framework. By identifying key challenges in service delivery, resource allocation, and policy implementation, this paper proposes targeted optimization strategies. The goal is to enhance the quality of primary healthcare and provide a reference for the sustainable development of family doctor services in urban settings.

1. Introduction

The implementation of family doctor contract services is a core component of China' s healthcare reform, aimed at shifting the focus of medical resources toward primary care. As the national capital, Beijing has been at the forefront of exploring innovative models for these services. However, despite significant progress, discrepancies remain between policy objectives and actual implementation. This study evaluates the current landscape of family doctor services in Beijing to identify bottlenecks and suggest improvements.

2. Current Status of Family Doctor Contract Services in Beijing

2.1 Policy Framework and Implementation

Beijing has established a comprehensive policy framework to support family doctor services, focusing on "contracting, fulfilling, and managing." The policies emphasize the integration of medical treatment and prevention, with a particular focus on elderly populations, patients with chronic diseases, and other vulnerable groups.

2.2 Service Coverage and Quality

Recent data indicates a steady increase in the number of residents signing contracts with family doctors. However, the "fulfillment rate" —the actual delivery of promised services—varies significantly across different districts. While basic public health services are well-covered, specialized clinical services and personalized health management remain areas for improvement.

2.3 Resource Allocation and Team Composition

Family doctor teams in Beijing typically consist of general practitioners (GPs), community nurses, and public health physicians. Despite efforts to strengthen the primary care workforce, there is still a shortage of high-quality GP talent, and the workload per team remains high, potentially impacting the depth of patient-doctor relationships.

3. Challenges in the Development of Contract Services

3.1 Imbalance Between Supply and Demand

There is a notable gap between the diverse health needs of residents and the standardized service packages currently offered. Many residents perceive family doctor services as limited

AGGARWAL M, HUTCHISON B, KOKORELIAS K M, et al. The impact of remuneration, extrinsic and intrinsic incentives on interprofessional primary care

teams: results from a rapid scoping review [J] . BMC Prim Care, 2025, 26(1): 25. DOI:10.1186/ s12875-024-02653-5.

GANGA R N, SANTA K, ALI M, et al. The impact of a digital referral platform to improve access to child and adolescent mental health services: a prospective observational study with real-world data [J] .

Int J Environ Res Public Health, 2024, 21(10): 1318. DOI:10.3390/ ijerph21101318.

TORIUS T, CLAUSEN T, DYREBORG LARSEN A, et al. Impact of decentralized management on sickness absence in hospitals: a two-wave cohort study of frontline managers in Danish hospital wards [J] . BMC Health Serv Res, 2024, 24(1): 816.

VAN DORSSEN-BOOG P, VAN VUUREN T, DE JONG J, et al.

Healthcare workers autonomy: testing the reciprocal relationship between job autonomy and self-leadership and moderating role of need for job autonomy [J] . J Health Organ Manag, 2022, 36(9): 212-231. DOI:10.1108/jhom-04-2022-0106.

MEIER F L, JÄGER L, SENN O, et al. Effectiveness of interactive dashboards as audit and feedback tools in primary care: a systematic review [J]. PLoS One, 2025, 20(6): e0327350. DOI: 10.1371/journal.pone.0327350.

ZHANG Xiaoyan, YANG Shiyu, WANG Yuxuan. A study on the feasibility of "paid services" from the perspective of supply and demand: A case study of family doctor contract services in Community X [J]. Chinese Rural Health Service Administration.

ZHANG Y L, YANG Y C. A survey on the implementation of family doctor contract services in China from the perspective of resident demand [J]. Fam Pract, 2025, 42(1): cmae075. DOI: 10.1093/fampra/cmae075.

[20] SUN D, LI Y P. Influence of strategic crisis communication on public

perceptions during public health crises: insights from YouTube Chinese media [J] . Behav Sci, 2024, 14(2): 91. DOI:10.3390/ bs14020091.

Zhang Rudong, Huang Zhao, Guo Keshu, et al. Social Media Health Communication from a Global Health Perspective: A Social Network Analysis Based on USAID' s Twitter Account [J]. Contemporary Communication, 2022(4): 72-77.
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Abstract

In the context of global health, social media has become a critical platform for international organizations to disseminate health information and engage with global audiences. This study employs social network analysis to examine the health communication strategies and network characteristics of the United

States Agency for International Development (USAID) on Twitter. By analyzing interaction patterns, node centrality, and community structures, the research reveals how USAID leverages its digital presence to influence global health discourse. The findings suggest that while USAID maintains a dominant position in the information flow, the effectiveness of its health communication is contingent upon the collaborative dynamics of a multi-stakeholder network. This study provides theoretical insights and practical implications for enhancing the impact of global health communication in the digital age.

1. Introduction

The rapid evolution of digital technology has fundamentally transformed the landscape of global health communication. As traditional boundaries of information dissemination blur, international development agencies are increasingly turning to social media platforms to manage public health crises, promote health literacy, and coordinate international aid. Among these platforms, Twitter (now X) serves as a primary hub for real-time interaction and policy advocacy.

The United States Agency for International Development (USAID), as a leading entity in international development and humanitarian assistance, plays a pivotal role in global health governance. Understanding its communication patterns is essential for deciphering how institutional power and health information are distributed across global networks. This paper adopts a social network analysis (SNA) perspective to investigate the structural properties of USAID' s communication network, identifying key actors and the mechanisms of information diffusion.

2. Methodology

2.1 Data Collection and Preprocessing

The data for this study were retrieved from the official Twitter account of USAID. We focused on tweets related to global health initiatives, including maternal and child health, infectious disease control (such as COVID-19, malaria, and HIV/AIDS), and nutrition. The dataset encompasses original tweets, retweets, mentions, and replies over a specified period to capture the longitudinal dynamics of interaction.

To ensure data quality, we performed several preprocessing