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Equitization of Basic Public Health Services in China: An Experiment in Public Service Equity for a "Super-Large Nation"

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Abstract

The equalization of basic public health services represents a core institutional experiment undertaken by China to advance public service equity within the context of its vast-scale national governance framework. Based on data spanning the period 2009–2025, this paper systematically examines the evolutionary trajectory, regional practices, and institutional innovations associated with the equalization of basic public health services. The study finds that the per capita funding subsidy standard increased from RMB 15 to RMB 99, representing a 560% growth, yet this funding equalization did not automatically translate into service equalization; the number of general practitioners per 10,000 population rose from 2.90 in 2020 to 4.91 in 2025, a 69.3% increase, yet interprovincial disparities remain significant; the maternal mortality rate declined to 13.4 per 100,000 live births, and the infant mortality rate fell to 3.8‰—indicating continuous improvement in health indicators—yet urban-rural and regional disparities persist. By 2025, the policy direction underwent a significant shift: additional funding was directed toward supporting the "elderly and young populations" as well as patients with chronic diseases; for the first time, health check-ups for the elderly now included chest DR imaging and glycated hemoglobin testing. In May 2026, the State Council of China issued the "Implementation Opinions on Providing Basic Public Services Based on Permanent Residence," which promotes the decoupling of public services from household registration systems, thereby establishing an institutional safeguard for ensuring that the 358 million migrant population can equally access basic public health services. Through an in-depth analysis of more than a dozen typical cases, including Longhua District in Shenzhen, Wuhu City in Anhui Province, Baicheng County in Xinjiang, Zhongguan Town in Yuexi County, Anhui Province, Zhouzhi County in Shaanxi Province, Zhuhai City in Guangdong Province, and Zhuji County in Zhejiang Province, this paper argues that China's equalization of basic public health services has moved beyond the "institutional coverage equalization" phase and is now facing a critical challenge in transitioning from "formal equality" to "substantive equality."

Keywords

Basic Public Health Services; Equity; Health Equity; Primary Healthcare; Floating Population; Public Services at Place of Permanent Residence

I. Introduction: An Institutional Experiment in a "Super-Large Nation"

In 2009, China launched a new round of healthcare system reform, designating "promoting the gradual equalization of basic public health services" as one of five key reform areas. In that year, the per capita subsidy standard for basic public health services was set at 15 yuan, and there were only nine categories of service items. By 2025, this pilot program had entered its 16th year. In June, the National Health Commission and three other departments issued the "Notice on Carrying Out Basic Public Health Service Work for 2025" (Guo Wei Ji Chu Fa [2025] No. 7), which raised the per capita subsidy standard to 99 yuan, a cumulative increase of 560%, and expanded the range of service items to more than 14 categories.[1]

Over the past 16 years, this policy has evolved from being merely on paper into a reality, extending from urban to rural areas and from the registered population to the mobile population, becoming the public health intervention program with the largest global coverage. By 2025, approximately 145,725,000 individuals aged 65 and above received health management services at primary healthcare institutions, while the total number of patient visits at these institutions nationwide reached 5.65 billion. However, a fundamental question remains unresolved: what does "equitization" actually mean in a "megacity" with a population of 1.4 billion, an area of 9.6 million square kilometers, vast urban-rural disparities, and highly uneven regional development? To what extent has this concept moved from theory into practice?

The year 2025 is particularly significant. According to the "Bulletín of Key Data from the 2025 National Sample Survey of the Population (1% Sample Method)," the total national population stood at 1,405,450,000[7], with the population aged 65 and above reaching 223,090,000, which accounted for 15.87% of the total population, indicating a continued deepening of the aging trend; the number of births for the year was merely 7,920,000, and the birth rate fell to 5.63‰. Meanwhile, the size of China's migrant population reached 358 million. In May 2026, the State Council issued the "Implementation Opinions on Promoting the Provision of Basic Public Services Based on Permanent Residence" (State Council Document No. 11 [2026]), marking the first time that a systematic effort to decouple public services from household registration (hukou) was undertaken at the national level.[2]

This article focuses on three progressive questions: First, after 16 years of effort, what level of equity has been achieved in China's basic public health services? Second, what innovative practices have been developed by various regions in the

process of advancing equity? Third, what direction of institutional transformation does the new policy landscape for 2025 reveal?

The data in this article are sourced from the Annual Statistical Bulletin of the National Health Commission (2009–2025), financial funding documents issued by the Ministry of Finance and the National Health Commission, the 2025 1% Population Sample Survey data from the National Bureau of Statistics, as well as practical case studies and performance data made publicly available by the health commissions of various provinces and municipalities. As of 2025, the total national health expenditure is preliminarily estimated at RMB 9,336.72 billion, accounting for 6.7% of GDP; the total number of healthcare professionals nationwide stands at 16,121,000, including 13,455,000 healthcare technical personnel; and the number of people enrolled in the national basic medical insurance scheme amounts to 1,330,690,000, with the enrollment rate remaining stable at 95%.[6][7]

II. The Evolutionary Path of Equalization: From Funding Allocation to Health Outcomes

2.1. Funding Allocation: Sustainable Growth and Convergence of Disparities

Since the launch of the new healthcare reform in 2009, the per capita subsidy standard for national basic public health services has experienced continuous growth, rising from RMB 15 to RMB 99 over the past 16 years without interruption, with an average annual compound growth rate of approximately 11.8%.

Table 1. Funding Allocation for Basic Public Health Services in China

The particular year	Per capita subsidy (RMB)	Annual increase (RMB)	Cumulative growth rate	Number of service items
2009	15	—	—	9 categories
2011	25	+5	+66.7%	10 categories
2013	30	+2.5	+100%	11 categories
2015	40	+5	+166.7%	12 categories
2017	50	+5	+233.3%	14 categories
2019	69	+9	+360%	14 categories
2021	79	+5	+426.7%	14 categories
2023	84	+2.5	+460%	14 categories
2024	94	+5	+526.7%	14 categories
2025	99	+5	+560%	14 categories +

From the perspective of growth trajectory, the period can be divided into three distinct phases: the 2009–2013 period represents the "Fast Growth Phase," characterized by an average annual growth rate of approximately 3.75%, reflecting a relatively rapid expansion against a low baseline; the 2014–2019 period constitutes the "Accelerated Growth Phase," during which the year-on-year increase reached 9%, marking the highest growth rate ever recorded; and the 2020–2025 period corresponds to the "Stable Growth Phase," during which the growth rate has remained steady at 5% per year.[3]

Based on a population of 1.4 billion, the total funding allocated for national basic

public health services in 2025 is approximately RMB 138.6 billion. This funding is disbursed to primary healthcare institutions through a four-tier fiscal distribution system spanning the central, provincial, municipal, and county levels. In this framework, the central government plays a stabilizing role by providing subsidies at rates as high as 80% for western regions, 60% for central regions, and varying subsidy rates for eastern regions depending on their fiscal capacity.

The shift in the allocation of additional funding for 2025 holds significant symbolic meaning. Over the past 16 years, the additional funding was distributed equally per capita, ensuring that every individual received a share. However, the situation changes in 2025: the additional RMB 5 billion will be explicitly directed toward supporting elderly and young populations, as well as patients with chronic conditions such as hypertension, type 2 diabetes mellitus, and chronic obstructive pulmonary disease, in alignment with key annual initiatives such as the "Pediatric and Mental Health Services Year" and the "Weight Management Year." This signifies a shift in policy logic, from a "scattergun" approach to a "targeted focus" where the funds remain the same, but their allocation method has changed.

From the perspective of interprovincial fiscal resource allocation, the disparity between the highest and lowest-performing provinces has continued to narrow. The ratio of the highest-performing province to the lowest-performing province fell from 2.8 times in 2009 to 1.7 times by 2025, indicating a significant reduction in the funding gap among the eastern, central, and western regions. This trend is primarily attributable to the strong targeted fiscal support provided by the central government to the central and western regions.

However, there are two noteworthy details. First, the pace at which the gap is narrowing has slowed down. Between 2009 and 2017, the ratio of the highest to the lowest level decreased from 2.8 to 2.0, a decline of 0.8; between 2017 and 2025, this ratio fell from 2.0 to 1.7, which means the rate of decline narrowed to 0.3. Second, the practice of local governments in developed regions providing excess funding has given rise to a new source of disparity. By 2025, the actual per capita subsidy rate in Zhuji City, Zhejiang Province, reached 112 yuan, which is 13 yuan above the national benchmark of 99 yuan; in Longhua District, Shenzhen, leveraging its robust district-level fiscal capacity, the actual per capita public health expenditure far exceeded the national average. This "excess funding" indicates that economically developed regions have the capacity to provide higher-quality services, thereby effectively widening the gap with less developed regions.[4]

It is noteworthy that an analysis of the sources of interprovincial disparities reveals that the uneven distribution of public fiscal investment primarily stems from intra-regional differences rather than interregional disparities. Intra-regional disparities are particularly pronounced among the eastern provinces; the gap between developed provinces and municipalities such as Beijing, Shanghai, and Zhejiang and less-developed provinces like Hebei and Hainan even exceeds the

average gap between the eastern and western regions. This implies that equalization policies should not be examined solely through the lens of the "east–central–west" triad of regions, but should also take into account the "highland" and "lowland" areas within each region.

2.2. Human Resources: Total Capacity Meeting Targets vs. Uneven Distribution

General practitioners represent the core human capital within basic public health services. According to the 2025 Statistical Bulletin on the Development of China's Health Care System, the number of general practitioners per 10,000 people was expected to reach 4.91 by 2025, significantly exceeding the target set in the 14th Five-Year Plan (3.93) and representing a 69.3% increase compared to the 2.90 practitioners recorded in 2020[8].

Table 2. Analysis of the Number of General Practitioners in China

The particular year	Number of general practitioners per 10,000 inhabitants	Increase over the previous year	Remarks
2020	2.90	—	By the end of the 13th Five-Year Plan period
2021	3.08	+0.18	—
2022	3.28	+0.20	—
2023	3.66	+0.38	accelerated growth
2024	4.35	+0.69	The year with the fastest growth
2025	4.91	+0.56	Exceeds the "14th Five-Year Plan" target by 24.9%

Over the past five years, the number of general practitioners per 10,000 people has increased by 2.01. When measured against a total population of 1.4 billion, this represents an increase of approximately 280,000 general practitioners nationwide. The year 2024 saw the fastest growth rate, with an annual increase of 0.69 practitioners; this trend is closely linked to the accelerated development of the general practitioner training system in recent years, which includes the full implementation of diversified training models such as the "5+3" standardized training program, assistant general practitioner training programs, and general practitioner career transition training programs.

The total number of healthcare professionals across China has been steadily increasing. By the end of 2025, the total number of healthcare personnel nationwide stood at 16,121,000, including 13,455,000 healthcare technical staff, an increase of 435,000 compared to the previous year, representing a growth rate of 3.3%. The number of licensed (or assistant) physicians per 1,000 people was 3.78, while the number of registered nurses per 1,000 people was 4.32. Compared to 2015, over the past decade, the number of physicians per 1,000 people has increased by 1.56, and the number of nurses per 1,000 people has increased by 1.96, indicating that the healthcare workforce density has nearly doubled.

However, the inter-provincial distribution is highly uneven. In the developed eastern

provinces and municipalities (Shanghai, Zhejiang, Jiangsu, and Beijing), the number of general practitioners per 10,000 people ranges from 6.5 to 7.2, which is 32% to 47% higher than the national average; in the central provinces, this figure is approximately 3.2 to 3.8 per 10,000 people, which is 22% to 35% below the national average; in the western provinces, it ranges from 2.5 to 3.2 per 10,000 people, which is 35% to 49% below the national average; in remote areas such as Xizang and Qinghai, the number is less than 2 per 10,000 people, representing a gap of more than three times compared to the developed eastern regions.

Equitable distribution of human capital is far more challenging than achieving equitable allocation of fiscal resources. Funds can be rapidly allocated through transfer payments, being transferred from the central treasury to county-level finance within just a few days. However, it takes a general practitioner 5 to 8 years to progress from entering medical school to practicing independently. More critically, market forces continuously draw high-quality human capital toward large cities and developed regions; factors such as compensation packages, career advancement opportunities, children's education, and lifestyle convenience create an invisible "talent siphoning" pipeline. This gap cannot be bridged simply by increasing the annual subsidy by just RMB 5.

From the perspective of the primary healthcare network, by the end of 2025, there was a trend characterized by a "reduced number of facilities coupled with an increase in personnel." The total number of healthcare institutions nationwide reached 1,108,335, an increase of 14,784 compared to the previous year. Among these, the number of hospitals increased by 1,656, while the number of primary healthcare institutions increased by 12,057—the growth rate of primary healthcare institutions was more than seven times that of hospitals, indicating that medical resource allocation is increasingly favoring the primary care level.

Table 3. Analysis of the Number of Primary Healthcare Facilities in China

Institution Type	2025 Quantity	Year-on-year change	Health officer	Personnel changes
Health clinics in towns and townships	33,126	-208	1,698,000 people	+15,000 people
Community Health Service Center (Station)	37,580	—	856,000 people	+29,000 people
Village Health Clinic	560,000	—11,000	1,135,000 people	—
This includes licensed (assistant) physicians and individuals holding a rural doctor's certificate.	—	—	965,000 people	—

The decline in the number of township health centers and village clinics is primarily attributable to mergers resulting from administrative boundary adjustments, where multiple "small, fragmented, and under-resourced" village clinics were consolidated into a single "large and robust" central village health clinic. Meanwhile, the number of healthcare personnel has increased. By 2025, the total number of patient visits served by primary healthcare institutions reached 5.65 billion; among these, township health centers, community health service centers (stations), and village clinics collectively handled 4.19 billion patient visits, representing an increase of 210

million visits over the previous year. The number of healthcare facility beds per 1,000 people stood at 7.38, marking another year-on-year increase.

2.3. Service Coverage: Urban-Rural Disparities and Project Differentiation

In 2025, the core performance targets for national basic public health services encompass 13 major projects. When comparing urban and rural areas, there are significant differences in the coverage rates of these services.

Table 4. Analysis of the Core Performance Objectives for China's National Basic Public Health Services

Service item	2025 National Objective	Urban coverage rate (estimate)	Rural coverage rate (estimate)	Urban-rural gap
Resident Electronic Health Record Establishment Rate	≥65%	90.2%	84.5%	5.7pp
Vaccination coverage rate for children aged 0–6 years	≥90%	97.0%	94.5%	2.5pp
Maternal Systemic Management Rate	≥90%	92.5%	86.8%	5.7pp
Hypertension patients' standardized management rate	≥65%	73.8%	67.2%	6.6pp
Standardized management rate among patients with type 2 diabetes mellitus	≥65%	72.1%	64.8%	7.3pp
Elderly population health management rate	≥65%	76.5%	68.8%	7.7pp

The data reveal a clear pattern: the urban-rural disparity in service provision is positively correlated with the "complexity" of the service project. For projects characterized by "short duration, single-session, and high mobilization," such as vaccination programs, the urban-rural disparity is the smallest, at just 2.5 percentage points. For maternal system management, which involves multiple follow-up visits from pregnancy through postpartum, the urban-rural disparity expands to 5.7 percentage points. For projects that are "long-term, continuous, and rely on patient compliance," such as hypertension and diabetes management, the urban-rural disparity further widens to between 6.6 and 7.3 percentage points. The urban-rural disparity in elderly health management coverage is the largest, reaching 7.7 percentage points; this is closely related to the "triple overlay" phenomenon, namely, the more profound aging of the rural population (the proportion of the rural population aged 65 and above is approximately 3 percentage points higher than in urban areas), lower health literacy, and weaker primary healthcare service capacity.

By 2025, the service offerings will see two major breakthroughs. First, an upgraded elderly health check-up program, for the first time including a chest DR anteroposterior radiography examination and a glycated hemoglobin (HbA1c) test. The DR examination can effectively screen for common age-related conditions such as lung cancer, tuberculosis, and chronic obstructive pulmonary disease (COPD); in China, approximately 820,000 new cases of lung cancer are diagnosed annually, with over 60% of these cases occurring in individuals aged 65 or older. The HbA1c test reflects the average blood glucose level over the past 2–3 months, providing a more

accurate assessment of glycemic control than a single fasting blood glucose measurement. Previously, primary healthcare facilities relied solely on fasting blood glucose screening, leading to a diabetes misdiagnosis rate as high as 30%–50%. Second, an expanded chronic disease management service which, building upon the existing programs for hypertension and type 2 diabetes, the 2024 initiative now includes health management for patients with chronic obstructive pulmonary disease (COPD). In China, the prevalence of COPD among individuals aged 40 and older is as high as 13.7%, affecting approximately 100 million people; this new addition holds significant public health implications.

At the national level, by 2025, the number of elderly individuals aged 65 and above receiving health management services at primary healthcare institutions reached 145,725,000. Based on a total population of approximately 223,090,000 individuals aged 65 and above, the national health management rate for the elderly stood at approximately 65.3%, precisely meeting the national baseline target. However, when examining the data by province, significant disparities exist: in the developed eastern provinces and municipalities, the management rate ranged from 75% to 80%, whereas in some regions of the central and western parts of the country, it ranged only between 55% and 60%.

2.4. Health outcomes: Continuous improvement with significant internal disparities

According to the 2025 Statistical Bulletin on the Development of China's Health and Wellness Sector, the three major core health indicators continue to show positive trends.[8]

Table 5. Analysis of Core Health Indicators for China's Health System

Metric	2020	2025	Change	Amplitude of variation
Life expectancy per capita	77.93 years old	79.25 years old	+1.32 years old	+1.7%
Maternal mortality rate	16.9 per 100,000	13.4 per 100,000	-3.5 per 100,000	-20.7%
Infant mortality rate	5.4‰	3.8‰	-1.6‰	-29.6%
Mortality rate among children under 5 years of age	7.5‰	5.4‰	-2.1‰	-28.0%

The average life expectancy has increased from 76.34 years in 2015 to 79.25 years in 2025, representing an increase of 2.91 years over the decade, which is equivalent to an average annual increase of approximately 0.29 years. Following this trend, the average life expectancy is expected to exceed the 80-year mark during the 15th Five-Year Plan period. The maternal mortality rate has declined from 20.1 per 100,000 live births in 2015 to 13.4 per 100,000 live births in 2025, marking a 33.3% reduction over the decade, nearly reaching the target set by the "Healthy China 2030" initiative (12 per 100,000 live births). The infant mortality rate has fallen from 8.1 per 1,000 live births in 2015 to 3.8 per 1,000 live births in 2025, representing a 53.1% reduction over the decade, making China one of the countries with the fastest decline

in infant mortality rates globally.

However, when compared to the levels observed in more developed regions, the disparity remains significant. In Shanghai, the infant mortality rate in 2025 is merely 2.34‰, and the maternal mortality rate is only 1.85 per 100,000; in Beijing, the maternal mortality rate stands at 1.64 per 100,000, and the infant mortality rate is 1.30‰. These figures represent among the highest globally and are comparable to those of Nordic countries. In contrast, the health indicators in the less developed western regions lag far behind those of the eastern regions by several times: in some western provinces, the maternal mortality rate remains as high as 20–30 per 100,000, while the infant mortality rate ranges between 5–8‰. The overall improvement in the national average does not mean that every individual or every region is experiencing simultaneous progress.

In terms of total health expenditure, the national total health expenditure in 2025 amounted to RMB 9,336.72 billion, accounting for 6.7% of GDP. Of this total, government health expenditure accounted for 25.2%, social health expenditure accounted for 47.7%, and out-of-pocket health expenditure accounted for 27.1%. The per capita total health expenditure was RMB 6,637.9.

Table 6. Analysis of Health Sector Investment in China

Metric	2015	2020	2025	Ten-year transformation
Total health expenditure (RMB million)	40974.6	72175.0	93367.2	+127.9%
Proportion of GDP	6.0%	7.1%	6.7%	+0.7pp
Per capita total health expenditure (RMB)	2980.8	5146.4	6637.9	+122.7%
Proportion of personal hygiene expenditure	29.3%	27.7%	27.1%	-2.2pp

The share of personal health expenditure decreased from 29.3% in 2015 to 27.1% in 2025, representing a reduction of 2.2 percentage points, yet it still falls significantly below the 15%–20% range recommended by the World Health Organization. This indicates that the out-of-pocket healthcare cost burden for households remains relatively high, and the risks of "falling into poverty due to illness" or "returning to poverty due to illness" have not been fully eliminated. The equalization of basic public health services can serve as a "safety net" in alleviating individual financial burdens: effective prevention leads to fewer severe illnesses, and fewer severe illnesses result in lower personal healthcare expenditures.

In terms of healthcare service utilization, the total number of patient visits to medical and health institutions nationwide reached 10.65 billion in 2025, representing an increase of 510 million visits over the previous year, or a growth rate of 5.0%. Among these, hospital visits increased by 220 million, while visits to primary healthcare institutions increased by 250 million. The national hospital bed utilization rate stood at 74.7%, with the rate for public hospitals at 76.8%. The average length of stay for discharged patients was 8.7 days, down by 0.9 days compared to 9.6 days in 2015, reflecting improved healthcare efficiency. The average outpatient cost per visit was RMB 357.7, a year-on-year decrease of 0.9%; the average inpatient cost per visit was

RMB 9,768.9, a year-on-year decrease of 1.0%, highlighting the cost-control effects of the centralized drug procurement initiative and the reform of payment mechanisms.

III. National Typical Cases for 2025: Evolving from "Formal Equality" to "Substantive Equality"

The year 2025 marks a "turning point" for the equalization of basic public health services in China. On November 12, the Population Culture and Primary Health Care Center of the National Health Commission hosted the "15-Year Anniversary Thematic Conference on Basic Public Health Services" in Beijing, reviewing the achievements made over the 15-year implementation of this initiative and unveiling outstanding exemplary cases nationwide. The following cases illustrate diverse pathways toward transitioning from "formal equality" to "substantive equality" from multiple perspectives.[9]

3.1. Digital Empowerment: Longhua, Shenzhen vs. Wuhu, Anhui

The project titled "Dual-Driven Approach of 'Business + Information' Under Demand-Oriented Strategy – Innovative Practices in Digital Empowerment of Basic Public Health Services," submitted by Longhua District, Shenzhen, was selected as a national-level exemplary case and is one of three cases selected from Guangdong Province. Longhua District is a major industrial and demographic hub in Shenzhen, with an actual administrative population exceeding 3 million, of which the migrant population accounts for more than 70%, resulting in a highly complex demographic structure.

As early as 2017, Longhua District issued the city's first comprehensive master plan for healthcare informatization, establishing the "Five Unifications" principle (unified network, unified platform, unified data, unified standards, and unified operation and maintenance). Subsequently, the district built a "1+1+N" digital health system: one overarching plan precisely defines the development direction; one "Healthcare Big Data Infrastructure" breaks down information barriers to enable the aggregation and sharing of healthcare data across the entire district; and N intelligent tools—such as smart follow-up services, AI-assisted diagnosis, and resident health profiling—bring healthcare services directly to the public. Residents' medical records, physical examination reports, and chronic disease follow-up data from various healthcare institutions are all consolidated on a single platform, transforming the follow-up approach for chronic disease patients from "passive waiting" to "proactive outreach."

The Longhua District's digital health system has yielded quantifiable outcomes: the standardized coverage rate for residents' electronic health records exceeds 92%, significantly surpassing the national baseline target of 65% and outpacing the national urban average (approximately 90%); the standardized management rate for hypertensive patients exceeds 80%, and that for diabetic patients exceeds 78%—both figures are substantially higher than the national averages

(approximately 74% and 72% for urban areas, respectively); resident satisfaction has risen from 76.3% in 2019 to 91.5% in 2025, an increase of 15.2 percentage points over a six-year period. The key takeaway from the Longhua District case is that digital transformation is not merely about "technological upgrading" but rather about "institutional reshaping." Traditional primary-level public health services often face the challenge of "information silos," where residents' health data cannot be seamlessly shared when they register at one community health center and seek medical care at another hospital; however, Longhua District has overcome this challenge through a "unified platform" that enables "single-time registration, district-wide accessibility, and lifelong data updates."[5]

Wuhu City, Anhui Province, was also selected as one of the top 15 exemplary cases nationwide, sharing its innovative approach of "Strengthening Foundations + Empowering Intelligent Governance." Wuhu has integrated regional medical resources by incorporating specialists from municipal and district-level hospitals into family doctor teams, forming a "1+1+1" care model (1 general practitioner + 1 specialist + 1 health management specialist); it has also established an intelligent health management platform that provides automatic early warnings for abnormal fluctuations in blood pressure or blood glucose levels; furthermore, it utilizes mobile devices to enable real-time updating of contracted residents' health records and remote follow-up care. This initiative has been recognized by the National Health Commission as "a typical example of leveraging digital transformation to enhance the quality and efficiency of primary-level public health services."

Both Longhua and Wuhu are exemplary cases of digital transformation, yet their approaches differ: Longhua focuses on the comprehensive development of a "data infrastructure" and the widespread adoption of intelligent tools, representing a "high-investment, high-return" model; in contrast, Wuhu places greater emphasis on "integrating existing resources" and "optimizing current processes," embodying an "existing-asset optimization" model. For most cities, Wuhu's approach may offer greater reference value.

3.2. Integration of Medical Care and Disease Prevention with Performance Evaluation: Baicheng County, Xinjiang; Donggang District, Rizhao City, Shandong Province

In 2025, Baicheng County, Xinjiang, formulated the "Baicheng County National Basic Public Health Service Project Implementation Plan." Its most innovative approach involves integrating the County Center for Disease Control and Prevention (CDC) into the county-level healthcare consortium. Traditionally, the CDC and medical institutions operated under a "two-track" system: the CDC was responsible for public health services, while hospitals managed clinical care, operating independently with conflicting interests between "medical care" and "disease prevention," as hospitals generated revenue from "treating illnesses," whereas public health institutions were evaluated based on their "disease prevention" performance. Baicheng County broke

down this barrier by establishing a supervision model characterized by "monthly guidance, periodic assessment, and problem resolution." The CDC took the lead in overseeing major public health decisions and providing technical guidance, and established a chronic disease management and integrated medical-preventive service team structured as follows: "CDC-led guidance → Public Health Management Center overseeing implementation → County, township, and village public health physicians conducting standardized services." Within the healthcare consortium, unified assessment and allocation mechanisms were implemented; the CDC no longer "focuses solely on prevention without providing treatment," and the hospitals no longer "focus solely on treatment without providing prevention," as both operate within the same system to serve a common objective.

The case study titled "Precision and Detailed Evaluation to Promote Standardized Fund Utilization and Support Comprehensive, Continuous Project Implementation" from Donggang District, Rizhao City, Shandong Province, has been included in the Performance Evaluation section of the 'Collection of Innovative Practice Cases in Basic Public Health Services (2025)'[10], jointly compiled by the Department of Primary Health Care of the National Health Commission and the National Health Commission's Health Development Research Center. Donggang District focuses on key populations, including individuals with hypertension or diabetes, pregnant women, and children aged 0–6 years, by optimizing service delivery in a demand-driven manner. Leveraging a comprehensive family doctor grid-based service coverage system, the district implements precise screening, tailored interventions, and full-cycle follow-up. Its core innovation lies in upgrading "performance evaluation" from a "post-event assessment" approach to a "whole-process management" approach—focusing not only on "how much money was spent" but also on "whether that money was well spent." For example, when evaluating the management of hypertensive patients, the focus is not merely on "whether four follow-up visits were completed" but also on "whether the blood pressure control rate has actually increased." This "result-oriented" evaluation methodology effectively curbs the tendency toward formalism in "formalistic public health practices."

3.3. Frontier Practice: Korla, Xinjiang, and Yunnan

Korla City in Xinjiang has utilized the "15-minute health service circle" as a platform to promote the decentralization of basic public health service resources; this initiative was included in the 10th issue of the 2025 Primary Healthcare Work Exchange Materials issued by the Health Commission of the Xinjiang Uygur Autonomous Region. Korla's approach comprises three tiers: First, scientifically planning service delivery points to ensure that residents can reach at least one service point within a 15-minute walk. In densely populated old urban areas, this is achieved through community health service stations providing "500-meter coverage";

in sparsely populated suburban areas, mobile service vehicles are deployed for regular weekly outreach visits. Second, integrating basic public health services into the community-based grid management system, with community grid members also serving as "health liaisons." Third, in ethnic minority residential areas, bilingual health management professionals are appointed to eliminate language barriers. Korla's practice demonstrates that in multi-ethnic regions along the western frontier, equitable access is not merely a matter of "finance," but also involves issues of "spatial accessibility" and "cultural acceptability."

Since 2023, Yunnan Province has included chest X-ray examinations in its free health check-up program for elderly citizens, two years ahead of the national policy rollout. Following the official introduction of the national policy in 2025, the Yunnan Provincial Bureau of Disease Prevention and Control issued a dedicated public science outreach document explaining the safety of DR imaging: "The radiation dose from a single DR chest X-ray is only 1%–2% of the safe threshold, which is roughly equivalent to the natural radiation exposure received during a few hours of air travel at high altitudes." Yunnan's pioneering experience provides an important reference for nationwide adoption of this initiative, showing that the western regions are not "unable to implement" such measures; the key lies in policy determination and effective resource coordination.

3.4. Enhanced Elderly Health Management Program: Zhongguan Town, Yuexi County, Anhui Province – in collaboration with Guangming District, Shenzhen

In October 2025, the Zhongguan Town Health Center in Yuexi County, Anhui Province, which is located deep within the Dabie Mountains, officially launched an upgraded elderly health check-up program. The town is home to approximately 2,800 residents aged 65 and over, who live across nine administrative villages and more than 160 natural settlements; however, transportation in these mountainous areas is extremely challenging.

Zhongguancun's approach represents a "textbook-level" example of effective grassroots implementation. First, targeted screening: the township health center collaborated with village doctors to conduct an in-depth survey of all elderly residents within their jurisdiction in advance. Second, centralized mobilization: extensive public awareness campaigns were launched through village broadcast systems, WeChat groups, and other channels, clearly announcing that the period from October 9 to October 31 would be designated as the centralized health check-up period. Third, transportation support: village doctors provided dedicated transportation services; some made multiple round trips using electric tricycles, while other village officials used their private vehicles to transport the elderly along their regular routes. Fourth, human-centered care: after the health check-ups were completed, the township health center prepared warm breakfasts for the elderly, allowing them to rest and recover their energy before continuing their journey.

The implementation outcomes are encouraging: during the centralized health check-up period, DR imaging and glycated hemoglobin (HbA1c) testing were performed on 1,120 individuals; 23 new cases of pulmonary abnormal opacities were identified (two of which were confirmed as early-stage lung cancer by higher-level hospitals); and 186 individuals exhibited abnormal HbA1c levels, among whom 72 were previously undiagnosed diabetic patients. These "hidden" conditions could not be detected during routine health check-ups in previous years, when screening relied solely on stethoscopes and fasting blood glucose measurements; the detection of lung cancer or latent diabetes at the primary care level was virtually impossible. The case study from Zhongguan Town illustrates the meaning of the "last mile" concept: no matter how robust the national policies or how ample the funding may be, equity in healthcare remains an empty promise unless the challenge of limited access to healthcare services for elderly residents in mountainous areas is resolved.

In contrast, Guangming District in Shenzhen leverages its existing network of community health service centers to integrate DR examinations into the two-way referral system connecting these centers with district-level hospitals; for elderly individuals with mobility limitations, mobile medical examination vehicles are deployed within communities to conduct DR examinations "right at their doorstep"; these vehicles can serve between 80 and 100 patients per day; glycated hemoglobin testing is now performed in the laboratory facilities of community health service centers, enabling a "same-day blood sampling, same-day result delivery, and same-day feedback" process. While Guangming District and Zhongguancun in Yuexi County are one situated in a megacity and the other in a mountainous township, which face vastly different challenges, their overarching goal is the same: to ensure that every individual aged 65 or older, regardless of their location, can access standardized health examination services.

3.5. Family Doctor Contracting and Maternal and Child Health: Zhouzhi, Shaanxi; Zhuhai, Guangdong

In 2025, Zhouzhi County, Shaanxi Province, will vigorously advance the implementation of family doctor contract-based healthcare services. A set of data illustrates the scale of this initiative: 379 specialized contract-based service teams have been established, covering 483,362 individuals across the county, representing a contract signing rate of 86.5%; 267,048 individuals from key populations have been enrolled in these services, achieving a signing rate of 96.1%; health check-ups have been conducted for 40,360 elderly individuals aged 65 and above; and a total of 1,558 health education lectures have been organized across the county, township, and village levels, with more than 390,000 copies of promotional materials distributed. Focusing on key health conditions such as hypertension and diabetes, Zhouzhi County conducts quarterly follow-up visits and provides free blood pressure and blood glucose testing, while developing personalized health intervention plans. The

96.1% signing rate for key populations means that nearly every elderly person, pregnant or postpartum woman, child, and individual with a chronic condition in the county has a designated "family doctor." However, the real challenge lies in the quality of service provided after enrollment. Zhouzhi County is striving to transform "paper-based contract signing" into "substantive, in-person care" through quarterly follow-up visits and personalized interventions.

Zhuhai City, Guangdong Province, demonstrated the critical "lifeline" role of maternal health management through a real-life case. Two days after a mother was discharged from the hospital, a community doctor identified generalized jaundice during a postpartum follow-up visit, noting that the skin appeared "orange-colored." Based on this professional assessment, the community doctor immediately took photographs and reported the finding to the lead specialist for high-risk pregnant and postpartum women at the Maternal and Child Health Hospital, while also contacting the Xiangzhou District Health Bureau. Through coordinated efforts by multiple stakeholders, the mother was promptly transported back to the hospital, where she was diagnosed with acute cholecystitis and underwent emergency cholecystectomy. Had it been just one or two days later, the consequences would have been dire. In 2025, Zhuhai City launched the "Early Pregnancy Care Initiative," which aims to advance the establishment of maternal health records earlier in the pregnancy journey and leverage a mobile app to streamline data management, thereby reducing the need for patients to make multiple trips. This case vividly illustrates the value of the postpartum follow-up system. Among all basic public health service programs, postpartum follow-up may represent the most cost-effective approach: a single home visit and a single observation can potentially save a life.

3.6. "Excess supporting facilities" in developed regions: Zhuji, Zhejiang Province

In October 2025, Zhuji City, Zhejiang Province, issued the "Zhuji City 2025 National Basic Public Health Service Project Implementation Plan." Based on a resident population of 1,229,200, the plan implements a per capita funding standard of RMB 112, which is RMB 13 higher than the national baseline of RMB 99. Adhering to the principle of "steady growth with priority given to quality," Zhuji City has enhanced the management capacity of the leading hospital within its medical consortium for basic public health services and has refined and implemented targeted health management initiatives for key population groups. Zhuji's approach of "excessively allocated funding" not only reflects the fiscal capacity of more developed regions but also reveals an inherent tension in the process of achieving equitable healthcare access: while the national baseline serves as the "bottom line," developed regions are permitted to "add extra funding," which may give rise to new forms of inequity. How to strike a balance between encouraging local initiative and safeguarding basic fairness is a question that must be addressed in the next phase.

IV. Floating Population: An Equalization "Pressure Test" and Institutional Breakthroughs by 2025

4.1. Basic pattern of the floating population

According to the 2025 National Sample Survey of the Population (covering 1% of the total population), China's migrant population stood at 357.88 million, approximately 18 million fewer than the 375.8 million recorded in the Seventh National Population Census conducted in 2020. Inter-provincial migration has declined, while intra-provincial migration has increased; among migrant workers residing outside their place of origin, those moving within their own province accounted for 61.7% of the total, indicating that non-inter-provincial migration has become the predominant pattern. The number of people with separated household registration and actual residence nationwide is approximately 520 million; the urbanization rate of the permanent resident population is 67.74%. However, there is a gap of approximately 18 percentage points between this urbanization rate and that of the registered population—this means that more than 250 million people live in urban areas over the long term without having obtained urban household registration; among them, approximately 170 million are migrant workers who have moved to cities and their accompanying family members.

Table 7. The distribution pattern of China's floating population in 2020 and 2025

Metric	2020 (Seventh National Population Census)	2025 (1% sample)	Change
National population	1.412 billion	1.405 billion	-6,740,000
National floating population	375.8 million	358 million	-17,940,000
Population with separation of household registration and actual residence	493 million	Approximately 520 million	≈27 million
Urbanization rate	63.89%	67.74%	+3.85pp
Cross-provincial migration share	33.4%	Show a downward trend	Primarily interprovincial mobility

The coverage rate of various public health services among the migrant population is significantly lower than that among the registered resident population. The resident health record establishment rate stands at approximately 87.5% for the registered resident population, compared to only about 62% for the migrant population, a gap of approximately 25 percentage points. The systematic maternal care management rate is approximately 90% for the registered resident population versus about 65% for the migrant population, also representing a gap of approximately 25 percentage points. The largest disparity is observed in chronic disease management; specifically, the standardized management rate for hypertensive patients: it is approximately 70% for the registered resident population, compared to merely about 35% for the migrant population, a gap of 35 percentage points; thus, the standardized management rate for hypertensive patients among the migrant population is roughly half that of the registered resident population. This disparity stems from multiple

barriers: the migrant population often has high workloads and limited leisure time, making it difficult for them to adhere to regular follow-up visits; their high mobility leads to "discontinuities" in their health records across different cities; and they generally have low awareness of local policies, not realizing that they are entitled to receive free healthcare services.

4.2. 2025 Institutional Breakthrough: Decoupling of Public Services from Household Registration System

On May 22, 2026, the State Council issued the "Implementation Opinions on Promoting the Provision of Basic Public Services Based on Permanent Residence" (State Council Document No. 11 [2026])[2], marking the first specialized policy document issued at the national level focusing on the provision of basic public services based on permanent residence. This document represents a landmark institutional reform in the process of achieving equal access to basic public services.

The document explicitly states: "Basic public services should be provided based on individuals' place of permanent residence; the link between basic public services and household registration should be gradually eliminated, ensuring that the non-housed permanent population enjoys the same access to basic public services as the household-registered population." Among the six key tasks, those directly related to basic public health services include: fully removing household registration restrictions on participating in employee social insurance schemes at the place of employment; strengthening the social security systems for migrant workers and flexibly employed individuals; and establishing a "funds follow the people" fiscal support mechanism—where central government transfer payments are linked to the size of the permanent population, enabling regions with population inflows to secure more resources. Effective July 1, 2026, this policy will be implemented first in the four major sectors—education, healthcare, social security, and public administration. According to the plan, by 2030, a comprehensive system for providing basic public services based on individuals' place of permanent residence will be fully established.

4.3. Early Practical Case Study: Maternal and Child Health Services for the Floating Population in Nanchang

Before the new policy was introduced, some cities had already taken the lead in piloting similar measures. Liu Yulin, who hails from Yichun, Jiangxi Province, had been working in Nanchang for an extended period. When she gave birth to her first child in 2021, she found that to access prenatal care services and receive cost reductions, she needed to return to her registered residence in Yichun, which involved a journey of hundreds of kilometers each time, which not only consumed significant time and money but also increased the risks associated with pregnancy due to delayed screening. When she gave birth to her second child in 2025, she underwent her prenatal check-ups at the Nanchang Reproductive Health Hospital,

where she received not only meticulous and attentive care but also the same cost reductions available to local residents. This change reflects Nanchang's efforts to extend the coverage of basic urban public services to all permanent residents. Liu Yulin's experience serves as a micro-level example of the institutional benefits offered by the principle of "providing basic public services at the place of permanent residence."

4.4. Policy Implementation Challenges

By the end of 2025, approximately three-quarters of the 81 service items specified in the current national basic public service standards will have been made available at the place of permanent residence. However, the remaining one-quarter often involves significant fiscal investment and resource reallocation, which remains a particularly challenging aspect of the reform. In the field of basic public health services, the primary challenges lie in: the funding settlement mechanism (how to implement cross-provincial settlement under the principle of "funds following the individuals"); information interoperability (the nationwide unified resident health record platform has not yet been established, making it difficult to facilitate the cross-provincial transfer of health information for the mobile population); and incentive compatibility (the motivation of primary healthcare institutions in receiving areas to provide services to the mobile population requires institutional safeguards). Currently, a reverse incentive system, where more service provision is associated with greater accountability, and less service provision is associated with lesser accountability, is widely prevalent.

V. Discussion: The Transformational Challenges from "Formal Equality" to "Substantive Equality"

5.1. The triple meaning of "equitization" and the tensions it entails

The preceding analysis reveals a core contradiction: the equalization of input allocation, output allocation, and outcomes does not occur simultaneously. The degree of equalization in public funding allocation has already reached a relatively high level; the interprovincial disparity has narrowed from 2.8 times to 1.7 times; but disparities in human capital and service output remain significant, while improvements in health outcome equity lag further behind. This "gradient lag" phenomenon exposes the profound limitations of equalization policies:

First, equal funding does not equate to equal access to services. Even when per capita funding is identical, disparities in "conversion factors," such as human capital quality, institutional management efficiency, and residents' health literacy, can still lead to unequal service delivery outcomes. For instance, the same amount of 99 yuan may enable targeted follow-up care through digital platforms in Longhua District, Shenzhen, whereas in remote mountainous areas, it might not even cover the travel expenses for a village doctor to visit the patient.

Second, equal access to services does not equate to equal health outcomes. Health outcomes are influenced by a wide range of non-health system factors, such as genetics, environment, income, education, and lifestyle. The equalization of basic public health services can only address the "accessibility to health services" component of health inequality; it cannot address the "social determinants" component.

5.2. The Equalization "Ceiling Effect"

The current process of equalization is approaching its "institutional ceiling."

Fiscal ceiling: The per capita subsidy has increased from RMB 15 to RMB 99—a 560% rise in 2016—though this growth rate has since stabilized at an annual increase of RMB 5. Against the backdrop of slowing economic growth and rising local government debt levels, the potential to drive further equalization through "sustained raising of subsidy levels" is diminishing. With a per capita subsidy of RMB 99, the total amount allocated to a population of 1.4 billion has reached RMB 138.6 billion; further substantial increases in this subsidy would place significant fiscal pressure on the government.

Human resource ceiling: It takes 5 to 8 years to train a qualified general practitioner, yet market forces continue to draw high-quality human capital toward urban and developed regions. By 2025, there will be 4.91 general practitioners per 10,000 people—a figure that already exceeds the planned target—yet in remote areas such as Xizang and Qinghai, the number may fall below two. If the challenges of "attracting, retaining, and effectively utilizing primary care practitioners" are not resolved, the human resource gap will persist for the long term.

Governance ceiling: Current efforts to achieve equity primarily rely on an administrative command-and-control model characterized by "centralized benchmarking – local implementation – performance evaluation and accountability." While this model is effective in achieving "institutional coverage," it faces diminishing marginal utility when it comes to promoting "substantive equity," a phenomenon clearly illustrated by formalistic approaches such as "form-filling-based public health practices" or "digital compliance checks." As assessment indicators evolve from the "record-keeping rate" to the "standardized management rate" and then to the "blood pressure control rate"—the corresponding response strategies at the grassroots level also shift—from "creating patient records" to "maintaining follow-up records" and then to "generating blood pressure data"—these changes in assessment indicators do not automatically lead to improvements in actual healthcare delivery.

5.3. Overall insights from the 2025 case study

A comprehensive analysis of policy practices across China in 2025 yields four key insights:

First, digital transformation is a "balancer," not a "panacea." The cases of Longhua

District in Shenzhen and Wuhu City in Anhui Province demonstrate that digitalization can play a significant role in reducing geographical barriers and enhancing service efficiency. However, the prerequisite for digital transformation is infrastructure investment—a factor itself marked by inequality. At the same time, the "digital divide" must be taken into account: groups such as the elderly, who are less familiar with smart devices, may be "excluded" by digitalization rather than being "empowered" by it.

Second, the integration of medical care and disease prevention requires institutional innovation rather than mere appeals. The practice of incorporating the Center for Disease Control and Prevention into the medical consortium in Baicheng County, Xinjiang, represents a beneficial attempt to dismantle the "separation of medical care and disease prevention" at the institutional level. Only by binding the interests of "medical care" and "disease prevention" institutionally—through unified assessment and unified allocation within the medical consortium—can true "integration of medical care and disease prevention" be achieved.

Third, the upgraded elderly health management initiatives have exposed gaps in primary-level healthcare capacity. The nationwide rollout of DR and glycated hemoglobin testing has not only enhanced service quality but has also revealed shortcomings at the primary care level regarding equipment availability, personnel resources, and the ability to utilize test results. For example, Zhongguan Town in Yuexi County, Anhui Province, addressed the "last-mile" challenge through a model combining "village doctors' transportation services with centralized health check-ups," while Guangming District in Shenzhen tackled the issue of "deploying medical equipment to grassroots levels" using a "mobile health examination vehicle." However, whether these successful practices can be replicated on a broader scale still depends on adequate financial and human resource support.

Fourth, the pathway for the floating population to transition from being "suspended" to being "integrated" has become clear; however, actual implementation will still require time. The issuance of the State Council's Opinions on Providing Basic Public Services Based on Permanent Residence has established an institutional framework. Nevertheless, as demonstrated by the Nanchang case, the pace of implementation varies across different regions, and there remains a gap between the mere issuance of "policy documents" and the actual experience of the people. The key task moving forward is to translate principled requirements—such as "funding should follow the people" and "linking people, land, and funding"—into actionable, measurable, and detailed implementation rules.

VI. Conclusion and Policy Recommendations

6.1. Main Conclusions

First, China has achieved remarkable success in ensuring the equity of basic public health services; however, it is now facing the transformational challenge of shifting

from "formal equity" to "substantive equity." While the degree of equity in funding allocation has reached a relatively high level, disparities in human capital and service delivery remain significant, and progress in improving health outcomes equity lags further behind. Practices across different regions—ranging from Zhongguan Town in Yuexi County, Anhui Province, to Longhua District in Shenzhen, and from Baicheng in Xinjiang to Zhuji in Zhejiang Province— demonstrate that the implementation effectiveness of the same policies varies dramatically across different localities; the "last mile" of achieving equity remains the most challenging segment to overcome.

Second, the primary sources of inequality are shifting from "inter-regional" to "within-regional" and "urban-rural" dimensions. Approximately two-thirds of the funding inequality stems from within the East, Central, and West regions rather than between them; in contrast, disparities in service delivery and health outcomes are primarily manifested as urban–rural gaps. This implies that the next phase of equalization policies will require greater precision and sophistication.

Third, 2025 marks the "Year of Transformation" for the equalization of basic public health services in China. Three landmark changes are evident: funding shifts from "increasing per capita funding" to "targeted focus"; service content evolves from "basic coverage" to "quality enhancement" (including the addition of DR and glycated hemoglobin testing); and the institutional framework moves from "household registration-based provision" to "provision based on place of permanent residence." These three transformations collectively point toward a single direction: shifting from merely ensuring "whether services are available" to focusing on ensuring "the quality of those services."

Fourth, the mobile population represents the weakest link in the equalization pilot program, yet the institutional breakthrough has already been initiated. The coverage rate of core public health services among the 358 million mobile population is 7–36 percentage points lower than that among the registered resident population; however, the State Council's 2025 policy of "providing basic public services at the place of permanent residence" offers an institutional framework for addressing this issue systematically. The case study of pregnant and postpartum women in Nanchang demonstrates that the shift from "returning to one's hometown" to "receiving services at one's place of permanent residence" represents not only an improvement in convenience but also a substantive enhancement of health protection.

Fifth, while overall health indicators continue to improve, significant disparities remain within the "super-large country" context. By 2025, the national maternal mortality rate stood at 13.4 per 100,000 live births, and the infant mortality rate was 3.8 per 1,000 live births; however, a gap of several times exists between Shanghai (1.85 per 100,000 live births and 2.34 per 1,000 live births) and the less developed regions in western China. The average life expectancy is 79.25 years; nonetheless, "living longer" does not equate to "living healthier"; the disparity in healthy life expectancy across different regions and income groups could exceed 10 years.

6.2. Policy Recommendations

First, promote the transition of fiscal transfer payments from a "per capita equalization" approach to a "cost-based equalization" approach. Taking into account factors such as geographic accessibility costs, population density costs, and health risk costs, establish differentiated funding allocation coefficients. The per capita service cost in the Ngari Prefecture of Xizang may be 5 to 8 times that of Shanghai; therefore, per capita funding should reflect this disparity.

Second, implement the "Special Project for Equitable Allocation of Primary Healthcare Workforce." Expand the scale of targeted training programs for general practitioners, establish a "Service Period Scholarship" system for primary healthcare professionals, and institutionalize the "Urban Doctors Deployment to Primary Care Settings" initiative. Additionally, address the shortage of primary healthcare personnel through technological solutions such as telemedicine and AI-assisted diagnosis.

Third, address digital spatial inequality while preventing the "digital divide." Promote the digitalization experiences of Longhua and Wuhu; establish a nationally unified resident health record platform; develop AI-assisted diagnosis and intelligent follow-up systems; and simultaneously maintain offline service channels for digitally disadvantaged groups, such as the elderly.

Fourth, accelerate the implementation of the "Nationwide Access" initiative for public health services targeting the migrant population. Put into practice the State Council's Opinions on Providing Basic Public Services Based on Permanent Residency; take the lead in achieving cross-provincial fund settlement under the "funds follow the people" model in the field of basic public health services; and include the service coverage rate for the migrant population as a core indicator in the national performance evaluation system.

Fifth, moderately expand the scope of the "Basic" Service Package. In response to the challenges posed by an increasingly aging population and evolving disease profiles, include cognitive impairment screening, osteoporosis prevention and management, and mental health services within the Basic Public Health Service Package; simultaneously, encourage local authorities to offer "Value-Added Service Packages" based on their disease burden and fiscal capacity.

Sixth, shift from "assessment coverage rate" to "health improvement through assessment." Address the incentive distortions inherent in the "form-filling-based public health" approach by gradually shifting the focus of performance evaluation from process-based indicators—such as "record-keeping rate" and "management rate"—to health outcome-based indicators, such as "blood pressure control rate" and "blood glucose target attainment rate." Drawing on the "whole-process management" experience of Donggang District, Rizhao City, Shandong Province, ensure that performance evaluation truly serves health improvement, rather than merely serving the pursuit of "numerical compliance."

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