

Research on Systemic Challenges in the Grassroots Implementation of National Basic Public Health Service Programmes and Pathways for Mechanism Innovation

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Abstract

Since its implementation in 2009, the National Basic Public Health Service Programme (hereinafter referred to as NBPHSP) has expanded its service scope from the initial nine categories to encompass diverse domains including chronic disease management, health services for key populations, and major disease prevention and control. It now covers 94.9% of healthcare institutions nationwide. Consequently, China has witnessed a sustained decline in maternal mortality and premature mortality from major chronic diseases, alongside a marked improvement in residents' health literacy and ongoing progress in urban-rural health equity. Nevertheless, primary healthcare institutions—the core implementers of the NBPHSP—still grapple with multiple challenges: role deviation among public health personnel, misaligned performance evaluation metrics, inadequate data utilisation capabilities, and unclear pathways for integrating medical and preventive services. This paper employs policy text analysis, case dissection, and systematic review methodologies to systematically trace the development trajectory and implementation outcomes of the NBPHSP. It conducts an in-depth analysis of existing challenges and proposes breakthrough pathways including health-outcome oriented performance evaluation, empowering public health practitioners with clear responsibilities, data-driven decision-making, innovative mechanisms for integrating medical and preventive services, and building proactive public health capabilities. These recommendations provide policy guidance for advancing the programme's high-quality development and facilitating a shift from "emphasising scale coverage" to "prioritising quality outcomes".

Keywords National Basic Public Health Service Programme; primary healthcare institutions; service capacity; implementation challenges; innovative pathways

1 Introduction

Since its inception in 2009, the National Basic Public Health Service Programme (NBPHSP) has become a pivotal initiative in China for promoting equitable access to basic public health services and strengthening

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the foundational layer of the public health system. In 2019, the programme underwent significant restructuring, integrating 19 services from the former Major Public Health and Family Planning Programme into the NBPHSP. This created a new framework comprising "the original 12 services plus the newly incorporated 19 services," with explicit provisions allowing certain services to be delivered beyond primary healthcare institutions[1]. However, as the "Healthy China" strategy advances and public health demands diversify, primary healthcare institutions—the primary delivery vehicles for NBPHSP—continue to grapple with systemic and structural challenges. This paper employs policy text analysis, case dissection, and systematic review methodologies to identify practical implementation constraints at the grassroots level. It proposes innovative and actionable pathways for overcoming these obstacles, offering insights to advance the programme's high-quality development.

2 Project Progress

2.1 Development History

When the NBPHSP commenced in 2009, primary healthcare institutions provided nine categories of basic services to residents[2]. In 2011, services expanded to include infectious disease and public health emergency reporting and handling, alongside health supervision coordination[3]. By 2013, traditional Chinese medicine health management (for the elderly and children aged 0–6) was incorporated[4]. Tuberculosis patient health management was added in 2015[5]. The 2017 National Basic Public Health Service Standards (Third Edition) established 12 categories comprising 46 service items[6]. That same year, contraceptive provision and health literacy promotion programmes were integrated, expanding the service package to 14 categories and 55 items[7]. Following the consolidation of major public health projects in 2019, service content continued to expand. The addition of chronic obstructive pulmonary disease (COPD) patient management in 2024 and further optimisation of health examinations for the elderly in 2025 signify the NBPHSP's transition from single-disease management to multi-disease co-management, and from basic interventions to full-cycle health services. By 2023, the NBPHSP had covered 94.9% of healthcare institutions nationwide, including 1.016 million primary-level facilities. The total number of primary healthcare personnel reached 4.953 million, accounting for 32.5% of the national healthcare workforce. That same year, primary-level outpatient visits totalled 4.94 billion, representing 51.8% of the national total[8].

2.2 Implementation Outcomes

The infrastructure of primary healthcare institutions has undergone systematic improvement. By the end of 2022, 98.34% of primary healthcare facilities nationwide met the required standards for operational premises. The number of pieces of equipment valued at over ¥10,000 per unit increased by an average of 12.4% annually between 2015 and 2022, with an average annual addition of 106,000 units. Equipment such as digital radiography (DR) systems and fully automated biochemical analysers has become widely available, significantly enhancing primary-level diagnostic and treatment capabilities[9, 10]. Under policy guidance, primary healthcare human resources have seen simultaneous growth in both quantity and quality. By 2023, the total number of healthcare professionals reached 3.877 million, representing a 71.72% increase from 2015. The number of general practitioners rose to 463,000, with the ratio of GPs per 10,000 population increasing to 3.99 – achieving the 14th Five-Year Plan target ahead of schedule[8, 9]. The proportion of personnel holding bachelor's degrees or higher rose from 30.6% in 2015 to 45.4% in 2022, with personnel structure continuously optimised[9–11]. Health disparities between urban and rural areas have steadily narrowed. The maternal mortality rate fell from 88.8 per 100,000 in 1990 to 15.1 per 100,000 in 2023, with the urban–rural disparity ratio decreasing from 1:2.2 to 1:1.4, reflecting continuous improvements in health equity[12]. In 2024, infant mortality and under-five mortality rates fell to 4.0‰ and

5.6‰ respectively, both reaching historically optimal levels[13]. Regarding preventive services, national immunisation programme coverage for eligible children remained consistently above 90%, while measles incidence declined to 0.04 per 100,000[10]. Premature mortality from major chronic diseases decreased from 16.5% in 2019 to 15% in 2023, while residents' health literacy rose from 19.17% in 2019 to 31.87% in 2024, indicating enhanced chronic disease prevention and public health awareness[14].

3 Implementation Challenges

Despite the NBPHSP's notable achievements, its implementation at the grassroots level continues to face multiple deep-seated challenges, constraining its sustainable development and the realisation of anticipated health outcomes.

3.1 Role Distortion Among Public Health Personnel: "Form-Filling Over Service Delivery"

Primary-level public health practitioners should primarily focus on population prevention, health management, and epidemiological interventions. However, they are currently trapped in the awkward role of "form-fillers" and "statisticians". Substantial working hours are consumed by tasks such as organising records, completing follow-up documentation, and submitting data reports. In some regions, performance evaluations place excessive emphasis on formalistic details—such as the standardisation of residential address entries or the presence of omissions in follow-up forms—while neglecting assessments of the actual effectiveness of health interventions for residents. In 2023, a health centre in Changzhou City discovered multiple instances of highly consistent data between 2020 and 2021 reports for basic public health services, indicating clear anomalies. Upon investigation, the centre's public health director admitted to falsifying current service volumes by referencing previous years' data to meet performance metrics and fulfil targets, thereby attempting to fraudulently obtain labour fees[15]. Such issues are not isolated incidents. According to a bulletin from the Qiannan Prefecture Commission for Discipline Inspection and Supervision, 197 cases of misconduct in basic public health services were investigated across the prefecture in 2023. Serious violations, including "fictitious medical examinations" and "fund embezzlement", were even uncovered in certain localities[16]. These phenomena reflect the systemic predicament currently facing grassroots public health systems under administrative pressure and flawed assessment mechanisms. Public health personnel are compelled to deviate from their core professional duties, with some even engaging in misconduct. This not only squanders public resources but also severely undermines the credibility and effectiveness of programme implementation.

3.2 Misguided Performance Evaluation "Command Stick" Orientation

The current performance evaluation system for the National Basic Public Health Service Programme exhibits pronounced formalistic tendencies, failing to effectively channel resources towards genuinely enhancing public health service quality. Certain assessment frameworks place excessive emphasis on procedural documentation, such as over-focusing on quantitative metrics like record completion rates and follow-up visit frequencies, while relatively neglecting core dimensions reflecting actual service outcomes—such as health improvement effects and resident satisfaction. Taking the assessment of Hainan Provincial Health Education Centre as an example, approximately 70% of indicators require submission of graphic materials and archival records. Specifications even extend to the exact dimensions, hanging height, and presentation style of publicity boards, rather than genuinely focusing on health knowledge dissemination rates and improvements in residents' health literacy[17]. This approach, which prioritises form over substance, coupled with high-frequency ranking and reporting systems implemented in some regions (such as monthly assessments with public rankings), forces grassroots units to divert limited human resources

towards administrative tasks like preparing for inspections and compiling documentation. For instance, during its health and civility campaign, Qiongzong County in Hainan Province conducted monthly simulated satisfaction surveys, publicly criticising and summoning units scoring below 95%. While this formally strengthened oversight, it compelled grassroots units to prioritise questionnaire completion and documentation preparation over addressing actual public concerns. Consequently, tangible improvements remained limited, creating a significant gap between outcomes and genuine community needs[17]. Moreover, under the pressure-driven system, assessment targets are frequently escalated through multiple layers, with process-oriented indicators becoming excessively inflated. This further induces reactive formalistic strategies, creating a vicious cycle where "the more assessments, the more formalism"[18]. Such distorted assessment orientations not only fail to establish a performance perspective focused on health outcomes but also exacerbate the misallocation of public health resources and medical services. As highlighted by the Central Working Mechanism for Addressing Formalism and Reducing Burdens at the Grassroots Level, unscientific assessment mechanisms have become a prominent challenge in grassroots operations[19], necessitating systematic reform and optimisation.

3.3 Ambiguous Responsibilities of Public Health Physicians

Research by scholars including Long Chengxu indicates that under new circumstances, public health physicians should undertake three fundamental functions: disease prevention, health maintenance, and health promotion[20]. However, for a long time, the role positioning of public health physicians in grassroots practice in China has been significantly ambiguous, lacking clear definitions of responsibilities and competency standards. This has led to frequent confusion in their work regarding "what they should do and what they can do". Most practitioners fail to fully grasp that the core of "health management" lies in population-level risk factor control and comprehensive interventions, rather than individualised clinical treatment. Research indicates that China's public health physician workforce faces widespread identity crises, primarily manifesting as dual structural dilemmas: firstly, the weakening of their medical practitioner identity, hindering the full application of their combined clinical and preventive medicine expertise in practice; secondly, insufficiently defined functional positioning, with core practice domains lacking clear professional boundaries, exposing them to systemic substitution risks by personnel from other specialisations[21]. Since 2024, pilot schemes granting partial prescribing authority to public health physicians have been implemented in Zhongshan City, Guangdong Province, and Duanzhou District, Zhaoqing City, permitting them to prescribe medications for 18 common conditions including hypertension and diabetes within primary healthcare settings[22]. This policy aims to enhance public health physicians' collaborative service capabilities within the integrated medical-preventive framework, particularly improving medication continuity and intervention effectiveness in chronic disease management. However, in practice, some primary units have simplistically interpreted this reform as merely "permitting public health physicians to administer drug therapy," overlooking their core function as community health managers. This has failed to fully leverage their professional expertise in community diagnosis, health risk assessment, and comprehensive intervention planning, reflecting a misinterpretation of their responsibilities and implementation errors.

3.4 Insufficient Data Utilisation Capabilities

Despite years of NBPHSP implementation and significant increases in electronic health record coverage, substantial data barriers persist between medical, public health, and medical insurance systems. This has resulted in a critical lack of analysis linking health behaviours, disease patterns, and healthcare expenditures. Research indicates that only 31.3% of primary healthcare institutions in Jiangsu Province provide residents with access to electronic health records, while cross-regional medical information sharing rates

remain below 30%. This highlights significant deficiencies in primary-level data accessibility, utilisation, and interoperability[23]. Furthermore, analysis of public health physician concentration indicates that primary healthcare institutions in eastern China demonstrate markedly superior data collection and utilisation capabilities compared to central and western regions. In 2021, the HRAD-PAD gap in eastern China stood at 0.47, whereas central and western regions recorded values of -0.23 and -0.02 respectively, revealing pronounced regional disparities in resource allocation and data support capacity[24]. Additionally, primary-level personnel generally lack proficiency in data analysis tools and epidemiological methodologies. Taking the practice of cultivating research capabilities during standardised training for public health physicians in Shanghai as an example, trainees from district-level disease prevention and control institutions scored significantly lower in research design and application course assessments compared to those from municipal-level institutions ($P < 0.05$). This highlights the lack of systematic research training and data application capability development among grassroots public health physicians, resulting in weaker competencies in data collection, organisation, analysis, and translational application[25]. A deeper predicament lies in the failure of collected data to effectively drive resource allocation optimisation and policy adjustments, creating a phenomenon of "high-input collection with low-efficiency application" that severely constrains the precision and timeliness of proactive health interventions.

3.5 Inadequate Integration Mechanisms Between Medical and Preventive Services

At present, the so-called "integration of medical and preventive services" often exhibits a singular tendency towards "preventive services aligning with clinical practice" in its implementation. This manifests as an undue emphasis on public health practitioners obtaining prescribing rights and participating in clinical diagnostic activities, while failing to effectively guide clinicians in assuming responsibilities for health promotion and disease prevention. To a certain extent, this deviates from the policy's original intent of "health-centred care". Surveys indicate uneven cross-service ratios between clinical and public health personnel in primary healthcare institutions (74.5% clinical vs. 30.5% public health), with qualified public health practitioners constituting less than 15% of staff. This significant mismatch in professional backgrounds reflects substantial systemic barriers in personnel structure, service coordination, and professional integration within current medical-preventive integration efforts[26]. True medical-preventive integration should prioritise prevention over treatment. However, existing healthcare payment systems (such as DRG/DIP) continue to incentivise medical services over preventive care. Coupled with primary healthcare institutions' revenue structures heavily reliant on clinical services, this perpetuates a fundamental imbalance where treatment is prioritised over prevention. As noted by the Xinjiang Health Commission: "The more effective prevention efforts are, the fewer patients there are, and the lower the hospital's income becomes"[27], fully revealing the inherent contradiction in economic incentives between prevention and treatment under the current system. Furthermore, taking the case study of integrated cancer prevention and treatment in Nantong City as an example, although hospitals identified a large number of precancerous lesions and early-stage tumour patients through screening, the lack of interoperability between hospital information systems (HIS), resident health records (EHR) in primary public health systems, and tumour registration systems in disease control departments data transmission still relies on manual export and input. This severely delays the timeliness of community follow-ups, health interventions, and comprehensive management for high-risk populations, resulting in a disconnect between prevention and treatment at critical junctures[28]. Without top-level redesign to restructure medical insurance payment methods that compensate the value of preventive services, and without breaking down information barriers between medical and preventive sectors to achieve data sharing and operational integration, technological enhancements or administrative directives alone will struggle to reverse the entrenched tendency to prioritise treatment over prevention.

4 Breakthrough Pathways

To propel NBPHSP from "scale coverage" to "quality outcomes" in the new development phase, systemic and institutional breakthrough pathways must address current challenges, strengthening effective supply and health outcomes in primary public health services.

4.1 Establishing a New Health Outcomes-Oriented Performance Evaluation System

Reform the existing assessment mechanism by establishing a composite evaluation model integrating process and outcome indicators. Implement "health benefit assessment" by prioritising core health outcome metrics such as chronic disease incidence rates, health improvement rates among key populations, and reductions in regional premature mortality rates, while progressively reducing the weighting of non-core process indicators like record-keeping standards. Drawing on performance assessment experiences from Zhejiang, Shanghai and other regions, pilot the "Primary Public Health Effectiveness Star Rating System" and substantively link evaluation outcomes to fiscal subsidies and personnel performance. Encourage the use of third-party assessments, resident satisfaction surveys and random verification of health records to enhance the credibility and effectiveness of evaluations.

4.2 Implementing the Empowerment and Accountability Plan for Public Health Physicians

Clarify the core responsibilities of public health physicians in health management, population interventions, and community diagnostics. Accelerate the refinement of policy frameworks and practical guidelines for prescribing authority, emphasising their role in issuing health management prescriptions rather than therapeutic ones. Prioritise granting them "agreement prescriptions" or "extended prescribing" rights for chronic disease maintenance medication, vaccinations, nutritional interventions, and rehabilitation guidance, thereby establishing them as genuine "gatekeepers" and "planners" for residents' health. Promote the establishment of "Chief Public Health Specialist" positions within primary healthcare institutions, responsible for spearheading community health diagnostics and designing group intervention programmes, thereby enhancing the professionalism and authority of public health services.

4.3 Strengthening Data-Driven Public Health Decision-Making Mechanisms

Led by the National Centre for Disease Control and Prevention, establish a national data platform for basic public health services, formulating unified standards for data collection, quality control, sharing, and analysis. Vigorously break down data barriers between primary care, hospitals, and disease control centres, promoting deep integration between Electronic Health Records (EHR) and Electronic Medical Records (EMR). Enhance data analysis training for primary-level public health personnel and promote the use of simplified, visualised data analysis tools. This will enable them to independently conduct disease distribution mapping, identify health risk hotspots, and simulate intervention outcomes, thereby advancing public health services from "experience-driven" to "evidence-driven".

4.4 Deepening Institutional Incentives and Payment Reforms for Medical-Preventive Integration

Restructure the investment and incentive framework for preventive services within medical insurance and fiscal funding. Pilot a "regional health budget cap combined with health outcome incentives" system, where surplus funds can be allocated to grassroots institution development and personnel incentives, making "preventive cost savings" a tangible institutional driver. Advance the design of integrated medical-preventive service packages, clarifying collaboration protocols and responsibility allocation between clin-

icians and public health practitioners in chronic disease management, health screening, and rehabilitation care. Strictly limit public health physicians from undertaking excessive clinical duties, encouraging them to lead health management services within family doctor teams. This will genuinely realise an integrated service model where "medical care extends prevention, and prevention precedes medical care".

4.5 Implementing the "Proactive Public Health" Capacity Enhancement Initiative

Implement a certification and training system for primary-level public health personnel in "population health intervention capabilities". Conduct practical training in community diagnosis, epidemiological investigation, health education, and project evaluation through provincial disease control centres or public health schools at universities. Encourage primary institutions to undertake 1–2 "micro-diagnosis" and "micro-intervention" projects annually based on community health needs, such as elderly fall prevention and occupational health risk control. Provide technical support and funding guarantees from higher levels to gradually cultivate primary institutions' capacity for proactively identifying and resolving public health issues.

5 Conclusion

After over a decade of implementation, the National Basic Public Health Service Programme (NBPHSP) has significantly expanded the breadth and depth of primary healthcare coverage. Tangible achievements have been made in reducing maternal and infant mortality rates, narrowing urban-rural health disparities, and enhancing public health literacy. However, as the Health China 2030 strategy advances, the grass-roots implementation of the programme has exposed deep-seated systemic and structural contradictions. These include the alienation of public health personnel (burdened by administrative tasks at the expense of population health interventions), imbalanced performance evaluation mechanisms (overemphasising documentation over health outcomes), a loss of focus in integrating medical and preventive care pathways (where institutional incentives lead to an overemphasis on treatment over prevention), the dormant value of health data (due to data fragmentation and lack of analytical capabilities), and regional disparities in resource allocation (with marked disparities in service capacity between eastern and western regions). These challenges collectively reflect the core bottlenecks in transitioning the programme from "scale coverage" to "quality and effectiveness".

To achieve high-quality development, the National Basic Public Health Service Programme must urgently advance through three innovation pathways: First, reconstructing the value-oriented system: Establishing a performance evaluation mechanism centred on health outcomes, incorporating core indicators such as chronic disease control rates, reductions in premature mortality rates, and residents' sense of fulfilment into the assessment framework to drive resource allocation towards prevention effectiveness; Second, deepen institutional coordination reforms: Address the misallocation of medical and preventive resources through a "regional health budget plus health outcome incentives" payment system. Clarify the primary responsibility of public health physicians in health management and establish standardised service protocols for clinical-public health collaboration. Thirdly, building a resilient enabling ecosystem: creating a centralised data hub platform linking central and local authorities to break down barriers between medical and disease control data, empowering grassroots precision decision-making through visualisation tools; simultaneously implementing region-specific strategies where eastern regions strengthen data-driven innovation and proactive health interventions, while western regions prioritise infrastructure upgrades and human resource optimisation.

The innovation lies in transforming problem-based governance into systemic governance. By optimising performance metrics, redefining public health functions, unlocking data productivity, and restructuring medical insurance incentives, the service model shifts from reactive response to proactive prevention.

Only by achieving synergistic gains in health benefits, economic efficiency, and institutional effectiveness can the National Basic Public Health Service Programme truly overcome the "last-mile bottleneck," fortify the foundation of the public health system, and provide a sustainable grassroots model and institutional support for achieving universal health coverage.

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