

Evaluation of the Effectiveness of Initial Consultation at Primary Level for Rural Residents under the Context of Hierarchical Medical System – An Empirical Study Based on Five Mountainous Counties in Wenzhou City

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Abstract: Objective: This study aims to evaluate the effectiveness of first consultation at the primary care level for rural residents under the hierarchical medical system, explore key factors influencing primary care first visits, and provide a scientific basis for further improving the hierarchical medical system and enhancing the accessibility of rural primary healthcare services. Methods: A stratified random sampling method was adopted to select rural residents from five mountainous counties in Wenzhou City (Cangnan, Pingyang, Taishun, Wencheng, Yongjia) as research subjects. A self-designed questionnaire, the "Evaluation of the Effectiveness of First Consultation at Primary Care Level for Rural Residents under the Hierarchical Medical System," was used for the survey, yielding 369 valid responses. Data analysis was performed using SPSS25.0 statistical software, employing descriptive statistics, chi-square tests, and one-way ANOVA. Results: The willingness of rural residents to choose primary care for their first visit was 42.0%; Significant regional differences existed in the geographical accessibility of medical services, with 39.6% of residents living ≤ 1 km from the nearest healthcare facility, but the standard deviation was large; 70.5% of residents had not experienced insufficient medical resources, but 23.8% had encountered service shortages 1-2 times; Overall satisfaction with medical services was relatively high, but about 30% of residents held neutral or negative evaluations; 18.4% of residents had delayed or forgone treatment due to cost issues. Conclusion: The overall effectiveness of first consultation at the primary care level for rural residents in the five mountainous counties of Wenzhou City is generally good. However, issues such as uneven service radii, imbalanced resource distribution, variable service quality, and economic burden persist. It is recommended to comprehensively improve the effectiveness of primary care first visits by optimizing service radii, improving resource chains, enhancing service capacity, and strengthening the safety net.

Keywords: Hierarchical medical system; First consultation at primary care level; Rural residents; Accessibility of medical services.

1. Urban Measures to Promote Free Trade

In 2015, the General Office of the State Council issued the "Guiding Opinions on Promoting the Construction of a Hierarchical Medical System", clearly proposing the establishment of a hierarchical

medical model characterized by "first consultation at primary care level, two-way referral, separation of acute and chronic care, and upper-lower linkage" [1]. To thoroughly implement national decisions and deployments, in 2016, the Zhejiang Provincial Government, considering the province's economic, social, and medical health development realities, issued the "Implementation Opinions on Promoting the Construction of a Hierarchical Medical System". Focusing on the hierarchical diagnosis and treatment of common, frequent, and chronic diseases, it aimed to improve service networks, operational mechanisms, and incentive mechanisms, Promote the allocation of high-quality medical resources to lower-level areas, gradually establish a scientific and rational medical treatment order, and promote more equitable and accessible basic medical and health services [2]. The Report to the 20th National Congress of the Communist Party of China further pointed out that first consultation at the primary care level, as the foundation and key to hierarchical medical system, is of great significance for achieving the medical reform goals of "guaranteeing basics, strengthening grassroots, and establishing mechanisms" [3]. Through field research on the implementation of the hierarchical medical system construction in primary healthcare institutions in Wenzhou City, Zhejiang Province, this paper aims to deeply analyze the prominent problems faced by primary hospitals during the implementation of hierarchical diagnosis and treatment and explore corresponding countermeasures.

2. Study Design

2.1 Research Subjects

The research group conducted a questionnaire survey on the effectiveness of first consultation at the primary care level among rural residents in five mountainous counties of Wenzhou City (Cangnan, Pingyang, Taishun, Wencheng, Yongjia). A total of 386 questionnaires were distributed, and 369 valid questionnaires were recovered, with an effective recovery rate of 95.6%. The basic characteristics of the sample are as follows: 166 males (44.9%), 203 females (55.1%); average age 48.85 ± 15.32 years; 357 Han Chinese (96.7%), 12 ethnic minorities (3.3%); occupational distribution included 67 social production and life service personnel (18.2%), 66 unemployed individuals (17.9%), 45 agriculture, forestry, animal husbandry, and fishery production and auxiliary personnel (12.2%), 35 professional and technical personnel (9.5%), 34 retirees (9.2%), 33 production and manufacturing personnel (8.9%), 21 heads of Party and government organs, state organizations, mass organizations, social organizations, enterprises and institutions (5.7%), 19 clerical and related personnel (5.1%), 1 military personnel (0.3%), and 48 other practitioners not conveniently classified (13.0%); Regarding education level, 94 had junior high school education (25.5%), 82 had primary school education (22.2%), 57 had bachelor's degree or above (15.4%), 46 had high school education (12.5%), 38 had junior college education (10.3%), 35 had no education (9.5%), and 17 had technical/vocational school education (4.6%); Marital status: 306 married (83.0%), 41 unmarried (11.1%), 13 widowed (3.5%), 9 divorced (2.4%); Main source of income: 303 self or spouse (82.1%), 26 children (7.0%), 17 parents (4.7%), 15 relatives/friends (4.1%), 6 government assistance (1.6%), 2 others (0.5%); Average total household income in the previous year was $159,040.84 \pm 511,045.69$ yuan; 126 considered themselves healthy (34.1%), 243 considered themselves unhealthy (65.9%); 235 had chronic diseases (63.7%), 106 had no chronic diseases (36.3%). See Table 1.

2.2 Research Methods

The questionnaire used in this study was designed based on a comprehensive review of relevant domestic and international literature, combined with the theoretical framework of hierarchical medical system and medical service accessibility, and was revised through expert interviews and a pilot survey. The questionnaire consists of two parts: Part 1 collects basic resident information, including gender, age, ethnicity, occupation, education level, marital status, source of income, family income, health status,

etc.; Part 2 is the evaluation survey on the effectiveness of first consultation at the primary care level for rural residents, covering four dimensions: geographical accessibility of medical services, availability of medical resources, acceptability of medical services, and economic accessibility of medical services, comprising a total of 18 items. Items were measured using a five-point Likert scale (1=strongly disagree/very dissatisfied, 5=strongly agree/very satisfied) or categorical options. The Cronbach's α coefficient for the total scale was 0.894, the KMO value was 0.894, and Bartlett's test of sphericity was $P < 0.001$, indicating good reliability and validity of the questionnaire. Additionally, the research group used literature research to systematically review relevant domestic and international studies and conducted in-depth interviews in selected typical township health centers to gain deeper insights into residents' genuine feelings and suggestions regarding primary care services.

2.3 Questionnaire Testing Method

The research group first selected Cangnan County and Wencheng County based on their economic development level and distribution of medical and health resources to conduct a pilot survey, gathering residents' opinions and revising the questionnaire multiple times, adjusting question order, and refining language to ensure easy comprehension. The formal survey employed a stratified random sampling method, selecting rural residents from the five mountainous counties of Wenzhou (Cangnan, Pingyang, Taishun, Wencheng, Yongjia) as survey respondents. Investigators were students familiar with the local dialect, who underwent uniform training before conducting household questionnaire surveys. Throughout the investigation, the research team provided full guidance throughout via an online platform during the research process. Concurrently, the research group selected representative township health centers for on-site visits to supplement qualitative data.

2.4 Statistical Processing Methods

Data analysis was performed using SPSS 25.0 statistical software. Measurement data were expressed as mean \pm standard deviation ($\bar{x} \pm s$), and count data were expressed as frequencies and percentages. Comparisons between two groups were conducted using independent samples t-tests or chi-square tests; comparisons among multiple groups were conducted using one-way ANOVA. $P < 0.05$ was considered statistically significant.

Table 1: Basic Characteristics of the Sample (n=369)

Variable	N (%)	
Gender [n (%)]	man	166(44.9)
	woman	203(55.1)
Age (years)	48.85 \pm 15.32	
Ethnicity [n (%)]	Han	357(96.7)
	Ethnic Minority	12(3.3)
Occupation [n (%)]	Responsible Person in Party/Government/Social Organizations/Enterprises	21(5.7)
	Professional and Technical Personnel	35(9.5)
	Clerical and Related Personnel	19(5.1)
	Social Production and Life Service Personnel	67(18.2)
	Agriculture, Forestry, Animal Husbandry, Fishery Production Personnel	45(12.2)
	Production and Manufacturing Personnel	33(8.9)
	Military Personnel	1(0.3)
	Other Practitioners Not Easily Classified	48(13.0)
	Retired	34(9.2)
	Unemployed	66(17.9)
Education Level [n (%)]	No Education	35(9.5)
	Primary School	82(22.2)
	Junior High School	94(25.5)
	Secondary/Vocational School	17(4.6)

	High School	46(12.5)
	Junior College (Associate Degree)	38(10.3)
	Bachelor's Degree or Above	57(15.4)
Marital Status [n (%)]	Unmarried	41(11.1)
	Married	306(83.0)
	Divorced	9(2.4)
	Widowed	13(3.5)
	Self or Spouse	303(82.1)
Main Source of Income [n (%)]	Children	26(7.0)
	Parents	17(4.7)
	Relatives/Friends	15(4.1)
	Government Assistance	6(1.6)
Total Household Income (Previous Year)	Others	2(0.5)
	159040.84±511045.69	
Self-rated Health [n (%)]	Healthy	126(34.1)
	Unhealthy	243(65.9)
Suffer from Chronic Disease [n (%)]	Yes	235(63.7)
	No	106(36.3)

3. Research Results

Table 2: Willingness for First Contact at Primary Level

First Contact Location	N (%)
Primary Healthcare Institution	155(42.0)
County/District Level Hospital	172(46.6)
Municipal Level Hospital or Above	42(11.4)

Table 2 shows that 42.0% of respondents preferred primary healthcare institutions for first contact, 46.6% chose county/district level hospitals, and 11.4% chose municipal level hospitals or above.

3.1 Current Status of Geographical Accessibility of Medical Services

Table 3: Current Status of Geographical Accessibility of Medical Services

Geographical Accessibility Item	1	2	3	4	5	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Q1	146(39.6)	85(23.0)	53(14.4)	12(3.2)	73(19.8)	2.40	1.511
Q2	128(34.7)	139(37.7)	44(11.9)	33(8.9)	25(6.8)	2.16	1.194
Q3	102(27.7)	66(17.9)	54(14.6)	21(5.7)	126(34.1)	3.01	1.641
Q4	47(12.7)	98(26.6)	50(13.6)	46(12.5)	128(34.7)	3.30	1.477

The highest proportion (39.6%) of respondents lived within ≤ 1 km of the nearest healthcare facility, while the smallest proportion (3.2%) lived within ≤ 4 km. Most people lived relatively close to the nearest primary healthcare institution, but the large standard deviation indicates that some households might be very far from these institutions.

On average, travel time to the nearest primary healthcare institution was relatively short, with the highest proportion (37.7%) taking ≤ 10 minutes, and the smallest proportion (6.8%) taking > 20 minutes, but significant variation also existed.

The largest proportion (34.1%) of respondents lived > 8 km from the county/district hospital, and the smallest proportion (5.7%) lived ≤ 8 km, with a large standard deviation.

The average travel time to the county/district hospital was mainly >20 minutes, accounting for 34.7%, while the smallest proportion (12.7%) took ≤1 minute.

3.2 Current Status of Availability of Medical Resources

Table 4: Current Status of Availability of Medical Resources

Availability Item	1	2	3	4	5	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Q1	3(0.8)	19(5.2)	99(26.8)	177(48.0)	71(19.2)	3.79	0.845
Q2	8(2.2)	13(3.5)	88(23.8)	260(70.5)	-	3.62	0.665

From Table 4, it can be seen that 67.2% of respondents perceived local medical resources as "relatively sufficient" or "sufficient," but 32.8% rated them as "average" or below.

The vast majority of respondents (70.5%) indicated that they had never failed to obtain needed medical services due to insufficient local medical resources in the past year. However, nearly 23.8% of respondents had experienced insufficient medical services 1-2 times, and notably, 2.2% of respondents reported experiencing service shortages more than 5 times.

3.3 Current Status of Acceptability of Medical Services

Table 5: Current Status of Acceptability of Medical Services

Acceptability Item	1	2	3	4	5	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Q1	2(0.5)	13(3.5)	107(29.0)	175(47.5)	72(19.5)	3.79	0.845
Q2	2(0.5)	12(3.3)	91(24.7)	191(51.8)	73(19.7)	3.87	0.786
Q3	1(0.3)	11(3)	106(28.7)	174(47.2)	77(20.8)	3.85	0.789
Q4	2(0.5)	15(4.1)	120(32.5)	162(43.9)	70(19.0)	3.76	0.827
Q5	8(2.2)	8(2.2)	84(22.8)	269(72.8)	-	3.66	0.647

Overall, respondents were relatively satisfied with local medical services. However, 29.0% rated their satisfaction as "average," and 4.0% (3.5% and 0.5%) were dissatisfied or very dissatisfied.

In the survey on satisfaction with the environment and hygiene conditions of local medical institutions, the combined proportion of satisfied and very satisfied reached 71.5%. However, 24.7% of respondents still rated it as average, and 3.8% (3.3% and 0.5%) chose dissatisfied or very dissatisfied.

Regarding satisfaction with the convenience of the appointment and consultation process at local medical institutions, the overall response was relatively positive. However, 28.7% of respondents chose "average," and 3.3% expressed dissatisfaction or very dissatisfaction.

Most respondents were relatively satisfied with the competence of medical staff at local institutions. However, 32.3% of respondents chose "average," and the combined proportion of dissatisfaction and very dissatisfaction was 4.9%.

72.8% of respondents had never delayed or given up seeking medical care due to dissatisfaction with local medical services in the past year. However, 22.8% of respondents had delayed or given up care 1-2 times in the past year due to dissatisfaction, and notably, 4.4% of respondents had experienced multiple instances of delay (including 3-5 times and more than 5 times) due to dissatisfaction.

3.4 Current Status of Economic Accessibility of Medical Services

Table 6: Current Status of Economic Accessibility of Medical Services

Economic Accessibility Item	1	2	3	4	5	Mean	Std. Dev.
	N(%)	N(%)	N(%)	N(%)	N(%)		
Q1	29(7.9)	133(36.1)	189(51.2)	17(4.6)	1(0.2)	2.53	0.724
Q2	168(45.5)	144(39.0)	36(9.8)	12(3.3)	9(2.4)	1.79	0.932
Q3	9(2.4)	6(1.6)	53(14.4)	301(81.6)	-	3.75	0.616
Q4	4(1.1)	24(6.5)	116(31.4)	159(43.1)	66(17.9)	3.70	0.879

Feedback on the level of medical service costs was mainly concentrated in the "acceptable" category, accounting for 51.2%. However, combined with the proportions for "very expensive" and "relatively expensive" (totaling 44%), this indicates that nearly half of the respondents perceived medical costs as high.

In terms of the distribution of medical expenditures, the vast majority of people (84.5%) had medical expenses below 5,000 yuan. However, 2.4% of respondents had medical expenses exceeding 10,000 yuan.

The vast majority of respondents (81.6%) stated that they had never delayed or given up treatment due to medical cost issues in the past year. Nevertheless, 18.4% of respondents (the sum of 1-2 times, 3-5 times, and more than 5 times) had delayed or given up treatment due to cost in the past year, with the proportion for 1-2 times being relatively high.

Satisfaction with medical insurance reimbursement was generally leaning towards satisfied. However, 31.4% of people still chose "average," and 6.5% and 1.1% chose "dissatisfied" and "very dissatisfied," respectively.

4. Discussion and Recommendations

4.1 Optimize the Service Radius to Overcome the "Spatial Barrier"

The accessibility of primary healthcare services in Zhejiang Province exhibits structural contradictions. Survey data show that although 39.6% of residents live within 1 km of the nearest healthcare facility, the large standard deviation reflects significant regional heterogeneity in the service radius. This spatial imbalance stems from three factors: First, significant gradients in geographical environment; Second, the "center-periphery" polarization effect in resource allocation, with high-quality medical resources concentrating in county cores, leading to generally low numbers of health technicians per thousand population in remote administrative villages; Third, a spatial-temporal mismatch between service supply and population mobility, where "hollow villages" formed during new urbanization reduce healthcare resource utilization, while peri-urban areas experience service overload.

Therefore, addressing the significant regional heterogeneity in primary care service radii, local governments can continue, under the guidance of the "Thousand Villages Demonstration, Ten Thousand Villages Renovation" project, to base planning on the requirement of a 20-minute medical service circle in rural areas [4]. Using this as the basic unit, a radial system of "1 county medical center + N mobile service stations" can be constructed in mountainous areas like Southwest Zhejiang. Regarding transportation support, efforts could include launching medical shuttle buses for administrative villages with a permanent population >1000, In areas with a population of 500 to 1,000, an appointment-based mobile medical vehicle service will be implemented., and configuring AI smart

medicine cabinets + drone delivery systems in areas with <500 people. Simultaneously, further implement and refine the hierarchical medical system by establishing "medical shuttle" buses to open up life channels and improve patient referral convenience. Additionally, promoting the "County Medical Community 2.0" reform and implementing a "one policy per institution" development path: township health centers can develop specialized departments integrating general practice with specialties, while village clinics can develop "micro-specialties" like traditional Chinese medicine pavilions and rehabilitation stations, thereby increasing residents' willingness for primary care first visits. These recommendations aim to promote the reconfiguration of medical institutions and improvement of transportation networks, thereby narrowing the gap in geographical accessibility of medical services.

4.2 Optimize the Resource Chain to Bridge the "Supply-Demand Gap"

The accessibility of primary healthcare services in Zhejiang Province exhibits characteristics of "overall improvement, localized shortcomings." Survey data show that while 70.5% of respondents never encountered insufficient medical resources, 23.8% experienced service shortages 1-2 times, and 2.2% encountered shortages five times or more, indicating significant regional imbalance in the distribution of high-quality medical resources. Furthermore, regarding first consultation willingness, up to 58% of respondents still chose county-level hospitals or above for their first visit.

To address these issues, implementing a three-dimensional quality and efficiency improvement plan is recommended. In the resource supply dimension, Build a resource sharing mechanism of "gradient sinking + intelligent empowerment": strengthen the hub function of county hospitals within the medical community, Establish a "1+N" expert consultation system, improve resource utilization efficiency through teleconsultation and equipment sharing; accelerate the construction of "Internet + smart mobile hospitals" to achieve on-demand delivery of medical services in mountainous areas; improve the drug supply guarantee system by establishing a dynamic adjustment mechanism for the "list of essential drugs needed at the grassroots level" [5]. In the talent development dimension, implement a talent revitalization plan focusing on "simultaneous cultivation and introduction + incentive guarantees": Optimize the training policies for primary-level medical students with targeted training, implement "county management, township employment" staffing management; establish a long-term mechanism for "team-based" paired assistance [6], cultivate core primary care physicians through a "mentorship system"; improve preferential policies for professional title evaluation, linking grassroots service years to title promotion, and establish special post allowances for grassroots positions. In the service capacity dimension, create a development model of "capacity enhancement + service transformation": rely on the medical community to establish a two-way rotation system between primary care physicians and specialists, strengthening practical skills training; promote the transformation of primary care institutions from "disease treatment" to "health management," focusing on developing specialized services like chronic disease management, rehabilitation nursing; establish an "Internet + continuing education" platform to enhance the professional competence of primary care staff through online and offline methods. Through systematic reforms, primary care services can leap from "guaranteeing basics" to "optimizing quality," providing a solid health guarantee for the construction of a demonstration zone for common prosperity.

4.3 Enhance Service Capacity to Warm the "Last Meter"

Survey data indicate that while respondents are generally satisfied with current medical services, facility environment, consultation convenience, and medical staff competence, about 30% hold neutral or negative evaluations. This suggests dissatisfaction persists in areas like the convenience of

appointment and consultation processes, medical staff competence, and facility environment/hygiene. Notably, 22.8% of respondents reported delaying or forgoing care 1-2 times in the past year due to dissatisfaction, and 4.4% frequently did so (including 3-5 times and ≥ 5 times). As residents' health needs upgrade from "guaranteeing basics" to "optimizing experience," shortcomings in service convenience, comfort, and transparency have become key bottlenecks restricting the credibility of primary care.

Therefore, primary care institutions, as the gatekeepers of residents' health, should first optimize consultation processes and establish comprehensive appointment systems. Residents should be able to book appointments in advance through multiple channels such as phone, internet, and mobile apps, reducing on-site waiting times. For the middle-aged and elderly, implement a "Silver Age Care Plan," equipping them with smart wristbands for indoor navigation and activating dialect-based AI voice guidance. Secondly, medical institutions at all levels can establish a "three-tier training system" (pre-job standardized training + annual skills assessment + specialized rotation training), incorporating doctor-patient communication skills into compulsory courses. Simultaneously, implement a "dual random, one public" supervision model (random case inspections, random patient interviews, public rectification results) and establish a "Medical Service Warmth Index" included in performance assessments. Encourage cultural immersion projects in medical institutions nationwide, conducting a "five ones" humanistic construction initiative (one smiling greeting per day, one health lecture per week, one patient consultation per month, one skills competition per quarter, one service star selection per year). Finally, regarding supervision, implement multi-stakeholder governance: at the societal level, form a "medical quality observer" team (including People's Congress deputies, community leaders, patient representatives), granting rights to access medical records and propose rectifications; institutions can mutually supervise and conduct self-assessments; also, establish a "Grassroots Service Contribution Award," providing special financial subsidies to institutions ranking in the top 10% of satisfaction for three consecutive years. This promotes the transformation of primary care services from "functional supply" to "quality service," injecting new momentum for health governance into the construction of a common prosperity demonstration zone.

4.4 Strengthen the Safety Net to Alleviate "Economic Burden"

A survey on the current status of primary healthcare service accessibility in Zhejiang Province shows that 81.6% of respondents did not delay or forgo treatment due to cost in the past year, reflecting that most residents have a good capacity to bear medical expenses. However, 18.4% still face pressure from medical costs, highlighting certain shortcomings in the current medical security system. Combined with data from the seventh national census, where the population aged 60 and above in China has reached 18.70%, accelerating aging is leading to a continuously expanding population of chronic disease patients, placing higher demands on the medical security system. Currently, the medical insurance reimbursement rate has become a focal point for residents, especially concerning long-term medication for chronic diseases and major illness treatment. Existing protection levels still lag behind the actual needs of the public. Furthermore, despite the national implementation of policies for volume-based drug procurement, some drug prices remain high. Coupled with inadequate drug supply systems in primary care institutions, residents face a heavy burden for medication. These factors collectively constrain the accessibility and equity of primary healthcare services.

Therefore, it is recommended that medical insurance departments appropriately increase the reimbursement rate for outpatient coordination in urban and rural resident insurance based on the affordability of local medical insurance funds and residents' medical needs[7]. More common and frequent disease outpatient expenses should be included in the medical insurance reimbursement scope, especially long-term medication costs for chronic disease patients, which could be granted higher

reimbursement rates. For major diseases, it is recommended to include them in the coverage of critical illness insurance, providing special protection for rare diseases and high-cost treatment items. For low-income families and special populations, the medical insurance deductible can be appropriately lowered to ease the economic burden. Secondly, strengthen drug supply guarantees, promote the construction of provincial or cross-regional centralized drug procurement platforms, expand procurement scale, and reduce drug costs; simultaneously improve drug inventory management in primary care institutions to ensure timely and sufficient drug supply. Finally, relevant national regulatory authorities can accelerate the evaluation of generic drug consistency, strengthen the promotion of generic drugs, improve their quality and public recognition, further reduce drug production costs, and help reduce residents' medical expenses. Through multiple measures, effectively reduce the medical burden on residents and enhance the accessibility of medical services.

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