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Evolution, geographical expansion, interorganizational co-issuance, and substantive development of palliative care policies in China, 2016–2025: a longitudinal policy document analysis

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Research Article

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Abstract

Background

Population ageing, the increasing burden of chronic disease, and growing demand for end-of-life care have accelerated the development of palliative care policy in China. China has progressively developed a national policy framework for palliative care since its inclusion in the Healthy China 2030 strategy in 2016. However, the temporal, geographical, organizational, and substantive development of this policy system has not been examined comprehensively.

Methods

We conducted a retrospective longitudinal analysis of palliative care policy documents issued in China between January 2016 and December 2025. Documents were retrieved from the Peking University Law Database, the Chinese Government website, the National Health Commission website, provincial government and health commission websites, and the official websites of sampled municipal, county, and district governments. National- and provincial-level documents were systematically searched. Subprovincial jurisdictions were selected using a province-stratified random sampling strategy.

After eligibility assessment, deduplication, and official-source verification, 538 documents were included: 39 national-level documents, 439 provincial-level documents, and 60 documents from sampled subprovincial jurisdictions. Analyses included descriptive temporal analysis, geographical analysis of three national pilot rounds, descriptive analysis of the national co-issuance network, and framework-guided interpretive analysis of policy content.

Results

The annual number of policy documents increased after 2016, peaked in 2022, and declined thereafter. Three broad periods were identified: institutional establishment and pilot exploration during 2016–2019, accelerated expansion during 2020–2022, and consolidation and quality-oriented development during 2023–2025. The national pilot notices designated five city- or district-level jurisdictions in the first round, 71 in the second round, and 61 in the third round. The notices also designated Shanghai as a provincial-level pilot in the second round and Beijing, Zhejiang, and Hunan as provincial-level pilot units in the third round. The map represents formal pilot designation, not complete provincial coverage or actual service availability.

The national co-issuance network included 31 organizations and was visually centred on the National Health Commission and its predecessor. Policy content developed across seven domains, encompassing strategic positioning, service-system organization, standards and clinical practice, workforce, financing, quality management, and psychosocial and family support.

Conclusions

Between 2016 and 2025, China's palliative care policy system expanded in formal coverage and substantive scope. Policy development shifted from strategic recognition, pilot designation, and institutional establishment towards service integration, implementation support, m

ultidisciplinary development, and quality-oriented governance. Persistent gaps included home-based and rural services, sustainable financing, workforce development, psychosocial support, and outcome evaluation.
Keywords: palliative care; hospice care; policy documents; policy development; policy diffusion; policy analysis; China

1 Background

Population ageing and changes in the disease profile have increased the need for palliative care in China. At the end of 2024, approximately 310.31 million people in China were aged 60 years or older, accounting for 22.0% of the population [1].In 2022, an estimated 4.82 million new cancer cases and 2.57 million cancer deaths occurred in China [2]. The World Health Organization (WHO) has emphasized that population ageing and the burden of noncommunicable diseases are increasing the global need for palliative care [3].

Palliative care aims to improve the quality of life of patients and families facing life-limiting illness by preventing and alleviating physical, psychological, social, and spiritual suffering [3,4]. Its development requires more than the establishment of specialist wards or designated institutions. A functioning service system also depends on service standards, workforce development, referral pathways, financing, access to essential medicines, psychosocial support, public education, and coordination between health and social care.

In China, 2016 marked an important policy milestone. The Healthy China 2030 Planning Outline called for integrated health and elderly-care services that included palliative care [5]. In 2017, the former National Health and Family Planning Commission issued national guidance on palliative care practice, institutional standards, and management, and launched the first national pilot programme in five cities or districts [6-8]. The second national pilot round, launched in 2019, designated 71 cities or districts and Shanghai as a provincial-level pilot [9]. The third round, launched in 2023, designated 61 cities or districts and Beijing, Zhejiang, and Hunan as provincial-level pilot units [10]. Palliative care was also included in Article 36 of the Basic Medical and Health Care and Health Promotion Law of the People's Republic of China, which was adopted in 2019 [11].

Previous studies have examined the historical development of palliative care policy in China, policy diffusion in Shanghai, the development of the national service system, and the use of policy instruments [12-17]. A recent national policy analysis also examined a longer historical period using network analysis, text mining, and policy-instrument classification [18] These studies provide important evidence, but their document selection, time frames, administrative coverage, and analytical aims differ. Further analysis can clarify how national and provincial policy issuance changed over the 2016–2025 period, how national pilot designation was distributed geographically, and how policy content developed across administrative levels.

Policy diffusion theory offers a framework for considering how policies are adopted, transmitted, and adapted across jurisdictions and organizations [19,20].

However, similar policy language across locations does not establish a particular diffusion mechanism. Formal policy documents can show the sequence and distribution of adoption, but claims about learning, imitation, competition, coercion, or demonstration effects require evidence beyond policy texts.

This study examined palliative care policy documents issued in China from 2016 to 2025. It addressed four questions:

1.How did the number and administrative distribution of palliative care policies change over time?

2.How did national palliative care pilot designation develop geographically?

3.Which national organizations participated in policy issuance, and how were they connected through joint policy documents?

4.How did the substantive content of palliative care policies develop across periods and administrative levels?

The study aimed to provide an empirically grounded account of policy development and identify priorities for future implementation.

2 Methods

2.1 Study design

This study used a retrospective longitudinal policy document analysis. A database of Chinese palliative care policies issued between January 2016 and December 2025 was constructed through multi-source retrieval, eligibility assessment, deduplication, official-source verification, and standardized metadata extraction.

The study combined four analytical components:

1.Descriptive analysis of policy issuance over time;

2.Geographical analysis of national palliative care pilot programmes;

3.Descriptive social network analysis of national policy co-issuance;

4.Framework-guided interpretive analysis of substantive policy content.

The unit of analysis was a formally issued government policy document. The study examined policy development and formal policy coverage; it did not evaluate actual service utilization, clinical outcomes, patient experiences, or implementation effectiveness.

2.2 Data sources

Policy documents were retrieved from:

1.Peking University Law Database;

2.the Chinese Government website;

3.the National Health Commission website;

4.official websites of provincial-level governments;

5.official websites of provincial health commissions;

6.official websites of sampled municipal, county, and district governments and their health authorities.

The core Chinese search terms corresponded to “安宁疗护”(palliative care), “舒缓疗护”(soothing treatment), and “临终关怀”(hospice care). Searches were conducted during March 2025, and the final search was completed on April 2026.

Where the same document appeared in both a legal database and an official government website, the version published by the original issuing authority was treated as the primary source.

2.3 Selection of subprovincial jurisdictions

National- and provincial-level policy documents were systematically searched across the available official sources. Because a complete search of every municipal, county, and district

government website in China was not feasible, a province-stratified random sampling strategy was used for the subprovincial component.

Several jurisdictions were randomly selected from each provincial-level unit, after which the official websites of their governments and health authorities were searched using the same keywords.

The 60 sampled municipalities, counties, and districts documents refer to the number of eligible policy documents identified from sampled jurisdictions, rather than the number of sampled jurisdictions. Accordingly, these documents constitute a probability-based local sample and not a census of all municipal, county, and district policies in China.

2.4 Eligibility criteria

Documents were eligible when they:

1.were formally issued by a government, health authority, or another governmental organization;

2.were issued between January 2016 and December 2025;

3.directly concerned palliative care, hospice care, or end-of-life care;

4.contained policy objectives, responsibilities, implementation measures, service standards, technical requirements, or supporting arrangements;

5.had an identifiable title, issuing organization, publication date, and complete or substantially complete text.

Eligible document types included laws, regulations, plans, opinions, notices, implementation programmes, administrative measures, standards, specifications, and technical guidelines.

Documents were excluded when they:

1.mentioned palliative care only incidentally;

2.were news reports, policy interpretations, meeting reports, speeches, academic articles, or public-information summaries;

3.lacked a verifiable issuing authority or official source;

4.duplicated another record;

5.merely reproduced a superior-level policy without adding substantive local implementation requirements.

A forwarded superior-level policy was treated as a separate local document only when the forwarding authority added identifiable local responsibilities, implementation arrangements, resource commitments, or service requirements. A policy document and its attachments were treated as one analytical record unless the attachment had an independent document number and policy function.

2.5 Document screening and verification

Retrieved records were manually reviewed against the eligibility criteria. A total of 12,015 records were identified through keyword searches. After 345 duplicate records were removed, 11,670 records remained for title and abstract screening. At this stage, 11,098 records were excluded, including news reports, non-policy materials, and records irrelevant to the study topic. Full-text retrieval was sought for the remaining 572 records; 34 full texts could not be retrieved. The remaining 538 documents were assessed for eligibility through full-text review, and all met the inclusion criteria.

Duplicates were identified using policy title, document number, issuing authority, date, a nd textual comparison. Information inconsistencies were resolved by checking the website of the original issuing authority. One researcher conducted the initial eligibility assessment and data extraction. A second researcher verified the included records, duplicate decisions, administrative classification, and official-source information. Disagreements were resolved t hrough discussion and review of the original government document. The screening process is shown in Fig. 1.

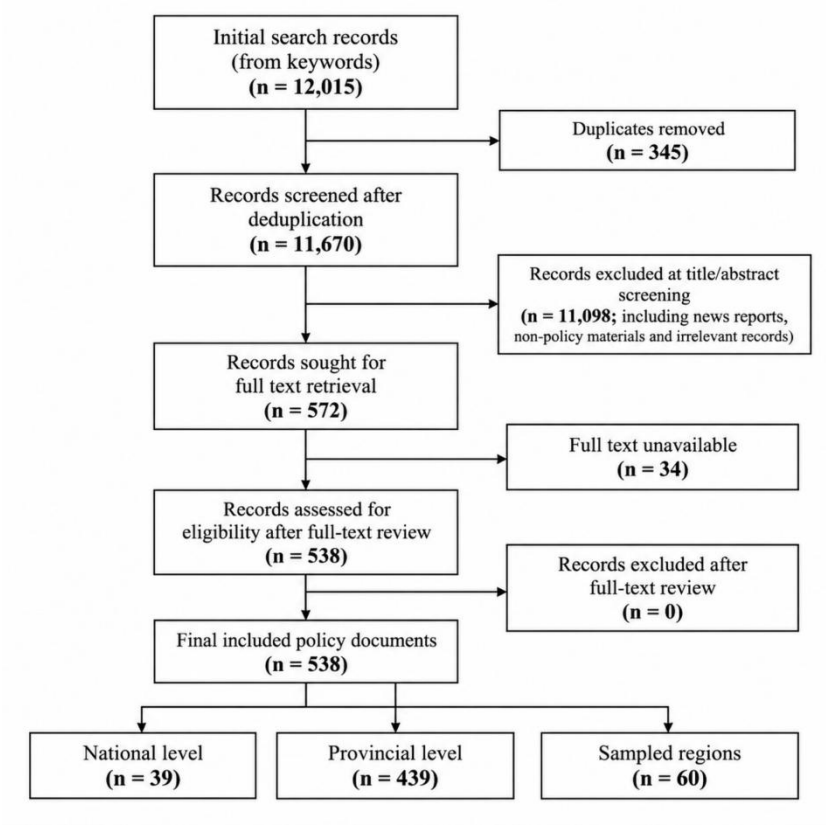


Figure. 1. Flow diagram of policy document retrieval, screening, and inclusion.

2.6 Database construction and data extraction

A standardized data-extraction table was used to construct the policy database. Extracted fi elds included:unique policy identifier;official policy title;document number;publication date and year;primary issuing organization;co-issuing organizations;administrative level;geographic al jurisdiction;document type;source platform;official source address;date of access;duplicate or forwarding status;inclusion decision and, where relevant, exclusion reason.

Administrative level was classified as national, provincial-level, or subprovincial. Provi ncial-level documents included those issued by provinces, autonomous regions, and centrall y administered municipalities. Subprovincial documents included those issued by sampled p refecture-level cities, counties, county-level cities, and urban districts.

2.7 Temporal analysis

Annual policy counts were calculated by publication year and administrative level. Periods of development were identified by combining observed changes in annual policy issuance with major national policy milestones.

The periodization was used as an interpretive device and was not generated through stat

istical change-point analysis. A decline in the number of newly issued documents was ther efore not treated as direct evidence of improved implementation or policy maturity.

2.8 Spatial analysis

The geographical analysis examined the official lists of the three national rounds of pall iative care pilot programmes [8-10]. The first round included five city- or district-level jur isdictions. The second round designated 71 cities or districts and Shanghai as a provincial-level pilot. The third round designated 61 cities or districts and Beijing, Zhejiang, and Hu nan as provincial-level pilot units.

Each officially designated pilot jurisdiction was assigned to its corresponding provincial-l evel administrative division for cartographic presentation. The map therefore represents the presence of officially designated pilot jurisdictions within an administrative division, and separately the provincial-level units expressly designated as pilots. It does not indicate that a province containing a city- or district-level pilot was wholly designated as a pilot area.

The spatial analysis measured formal pilot designation. It did not assess the number of participating institutions, service capacity, actual service availability, utilization, implementat ion intensity, quality, continuity, or equity.

2.9 Organizational network analysis

The organizational analysis was based on the 39 national-level policy documents. A co-iss uance network was constructed in which each node represented a national issuing organiza tion. A connection was established when two organizations jointly issued at least one docu ment. Connection weight represented the number of documents jointly issued by the corres ponding organizations.

UCINET was used to visualize the network and examine patterns of departmental partici pation. Where centrality or density measures are reported in the final paper, their definitio ns and numerical results should be included. In the absence of complete network statistics, interpretations were limited to the observed structure and relative pattern of connections.

Changes in institutional names were harmonized where appropriate. The former National Health and Family Planning Commission and the National Health Commission were inter preted as institutionally continuous but retained as separate labels where required by the or iginal policy records.

Organization abbreviations were used as node labels to improve figure readability. Full English names, Chinese names, and institutional notes are provided in abbreviations.

2.10 Framework-guided policy content analysis

A framework-guided interpretive approach was adopted to examine substantive policy devel opment without presenting the analysis as a formal coded qualitative study.

Policy documents were read comparatively across three developmental periods and three administrative levels. The analysis focused on seven domains:1.strategic positioning and ins titutional legitimacy;

2.service-system organization and care settings;

3.institutional access, technical standards, and clinical practice;

4.workforce development and multidisciplinary collaboration;

5.financing, reimbursement, and resource support;
6.quality management, monitoring, and evaluation;
7.psychosocial, family, bereavement, and public support.

The analysis examined how these domains were expressed in national framework documents, provincial implementation policies, and sampled subprovincial policies. Representative policies were used to illustrate substantive developments.

2.11 Data analysis

Frequencies and percentages were used to describe the database. Temporal results were presented as annual counts. Geographical results were presented through pilot-distribution maps, and organizational relationships were presented through a co-issuance network.

No statistical inference from the sampled subprovincial documents to all municipalities, counties, or districts in China was undertaken.

2.12 Ethical considerations

The study used publicly available government policy documents and did not involve human participants, personal information, or identifiable clinical data. Ethical approval and informed consent were therefore not applicable.

3 Results

3.1 Characteristics of the policy database

A total of 538 policy documents were included in the analysis. The screening process is shown in Fig. 1. Of the 12,015 records identified through keyword searches, 345 duplicates were removed, leaving 11,670 records for title and abstract screening. At this stage, 11,098 records were excluded, including news reports, non-policy materials, and records irrelevant to the study topic. Of the 572 records for which full-text retrieval was sought, 34 full texts could not be retrieved. The remaining 538 documents were assessed for eligibility through full-text review, and none was excluded.

Of the 538 included documents, 39 were national-level documents (7.2%), 439 were provincial-level documents (81.6%), and 60 were identified from sampled municipal, county, and district jurisdictions (11.2%). The administrative distribution of the included policy documents is presented in Table 1. The large proportion of provincial documents reflects the prominent role of provincial governments in translating national policy direction into implementation arrangements. However, the distribution should not be interpreted as evidence that provincial governments were intrinsically more active than all local governments. National and provincial documents were systematically searched, whereas subprovincial documents came from sampled jurisdictions.

Table 1. Administrative distribution of included policy documents

Administrative level	Number	Percentage
National	39	7.2%
Provincial-level administrative units	439	81.6%
Sampled municipalities, counties, and districts	60	11.2%

Total	538	100.0%

3.2 Temporal development

The annual number of policy documents increased after 2016, reached a peak of 127 in 2022, declined to 96 in 2023, and further declined to 51 in 2025. Based on this pattern and major national policy milestones, policy development was divided into three periods.

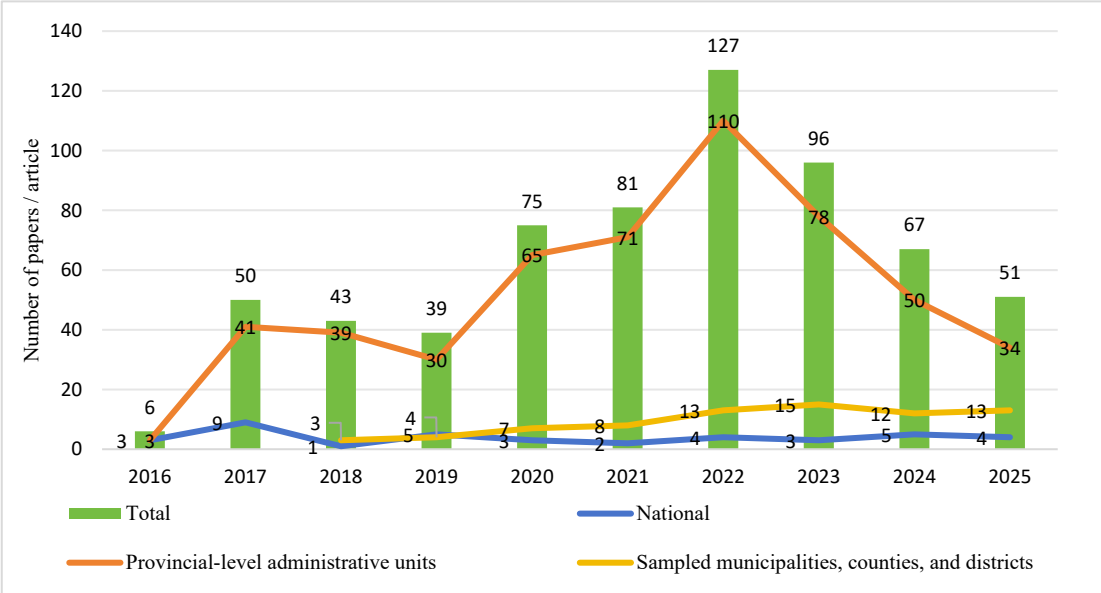


Figure 2. Annual issuance of palliative care policy documents by administrative level, 2016–2025.

3.2.1 Institutional establishment and pilot exploration, 2016–2019

During this period, policy issuance remained comparatively limited. The Healthy China 2030 Planning Outline established strategic recognition of palliative care as part of integrated health and elderly-care services [5]. National practice guidance and institutional standards issued in 2017 clarified initial requirements for palliative care practice, centres, and management [6,7].

The first and second national pilot rounds further established a model combining central standards with local experimentation. Provincial policies during this period largely focused on pilot designation, identification of participating institutions, and translation of national requirements into preliminary local arrangements.

3.2.2 Accelerated expansion, 2020–2022

Policy issuance increased substantially during 2020–2022, reaching its highest level in 2022. Provincial-level policies constituted the majority of the increase.

During this period, policy development moved beyond pilot designation towards service-system construction. Provincial authorities issued implementation plans, institutional standards, training arrangements, service specifications, and, in some jurisdictions, medical insurance or payment policies. Sampled local policies provided more operational requirements concerning designated institutions, community services, home-based care, and local service management.

The increase in policy documents demonstrates accelerated formal policy adoption. It does not, by itself, establish that services expanded at an equivalent pace.

3.2.3 Consolidation and quality-oriented development, 2023–2025

After 2022, the number of newly issued documents declined. During the same period, nati onal and provincial policies increasingly addressed service standards, quality management, t echnical guidance, and multidisciplinary collaboration.This pattern is consistent with a possi ble transition from rapid formal expansion towards policy refinement. However, because i mplementation outcomes were not examined, the decline in document counts should not be interpreted as evidence of policy maturity or improved service performance.

3.3 Geographical expansion of national pilot programmes

National palliative care pilot designation developed through three successive rounds. The fi rst round included five city- or district-level jurisdictions. The second round designated 71 cities or districts and Shanghai as a provincial-level pilot. The third round designated 61 cities or districts and Beijing, Zhejiang, and Hunan as provincial-level pilot units

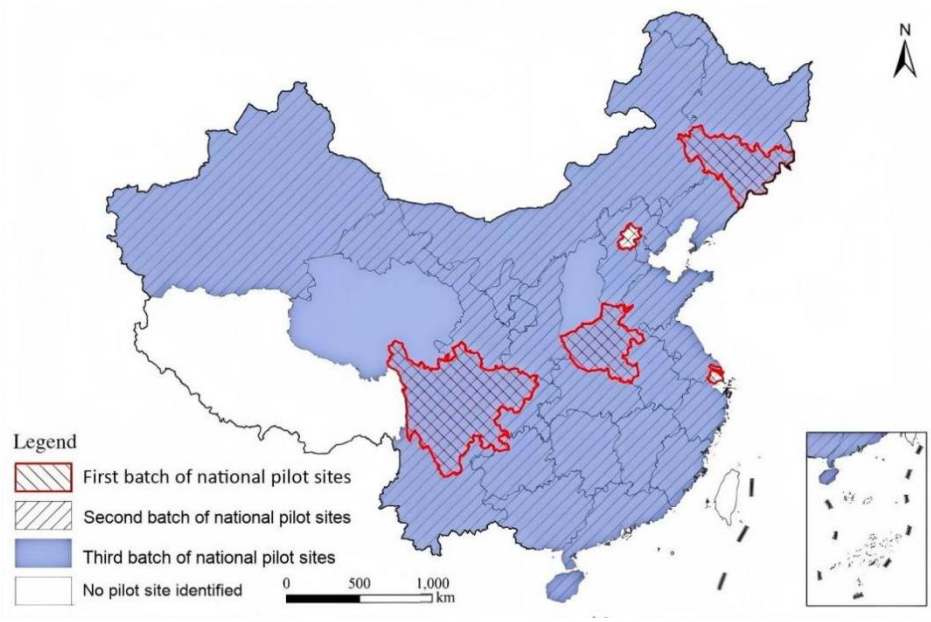


Figure 3. Geographical distribution of China's national palliative care pilot programmes across three rounds.

Figure 3 presents the distribution of these pilot jurisdictions at the provincial-level admi nistrative division scale. Each pilot city or district was assigned to its corresponding provi ncial-level administrative division for cartographic presentation. Thus, a coloured or pattern ed area indicates that at least one pilot jurisdiction within that administrative division was included in the corresponding national round; it does not indicate that the entire province or autonomous region was designated as a pilot area.

The first round involved a small number of geographically dispersed sites and represente d an initial stage of centrally coordinated policy experimentation. The second round marke d the largest increase in the number of designated jurisdictions and extended the pilot pro gramme across a broader range of regions. The third round further added formally designa ted jurisdictions in several western and northern areas, while some provincial-level adminis trative divisions still had no pilot jurisdiction identified in the official lists examined.

This pattern is consistent with a centrally initiated and administratively mediated mode o

f policy expansion. National authorities established the pilot framework and identified or a pproved participating jurisdictions, whereas provincial and local authorities were responsible for translating national requirements into local implementation arrangements. However, the spatial analysis captures formal pilot designation rather than actual service availability, im plementation intensity, service quality, or equity. The presence of a pilot jurisdiction should therefore not be interpreted as evidence of uniform palliative care provision within the co rresponding provincial-level administrative division.

3.4 Interorganizational participation

The national co-issuance network was constructed from the 39 national-level policy docum ents. Each node represented a national issuing organization. An edge was established when two organizations jointly issued at least one policy document, and edge weight represente d the number of documents jointly issued by the corresponding organizations. The network included 31 issuing organizations.

Organization names were displayed using abbreviations to improve figure readability; the corresponding full English names, Chinese names, and institutional notes are provided in abbreviations. The resulting network is shown in Fig. 4.

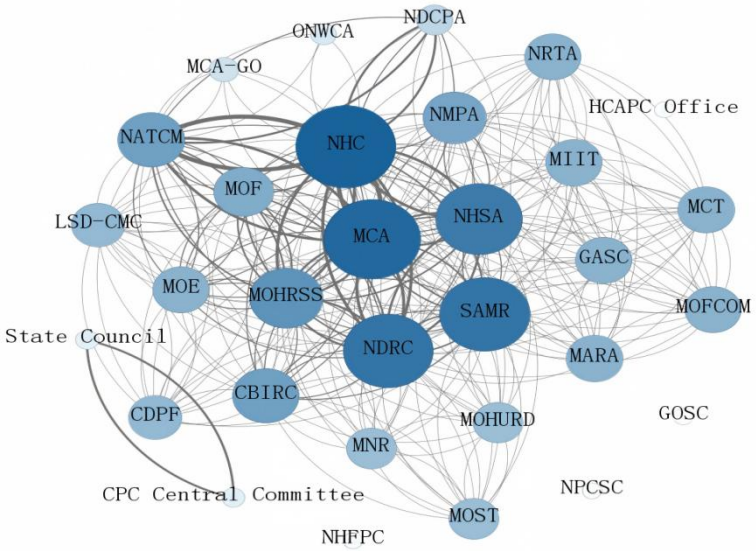


Figure 4. Interorganizational co-issuance network of national-level palliative care policy documents in China, 2016–202 5.Nodes represent national issuing organizations, and edges represent joint issuance of policy documents.

The National Health Commission (NHC) and its predecessor, the National Health and F amily Planning Commission (NHFPC), occupied prominent positions in the national palliati ve care policy network. The Ministry of Civil Affairs (MCA), National Healthcare Securit y Administration (NHSA), National Development and Reform Commission (NDRC), and St ate Administration for Market Regulation (SAMR) were also connected to multiple organiz ations.

Other participating organizations included departments responsible for civil affairs, develo pment and reform, health insurance, finance, human resources and social security, market r egulation, and traditional Chinese medicine. Their participation indicates that palliative care policy intersects with elderly care, social services, financial protection, workforce develop

ment, regulation, and health-system planning.

Organizations concerned with education, science and technology, rural affairs, public communication, culture, and disability affairs appeared less frequently in joint policy issuance. Their more limited participation may indicate that palliative care remained predominantly governed through the health sector, although the co-issuance network cannot directly measure the quality, intensity, or effectiveness of interdepartmental collaboration.

The network provides evidence of formal co-issuance relationships. It does not establish the quality of collaboration, the allocation of decision-making power, informal coordination, or the effectiveness of interdepartmental implementation.

3.5 Development of substantive policy content

The framework-guided interpretive analysis identified seven interconnected domains of palliative care policy content: strategic positioning and institutional legitimacy; service-system organization and care settings; institutional access, technical standards, and clinical practice; workforce development and multidisciplinary collaboration; financing, reimbursement, and resource support; quality management, monitoring, and evaluation; and psychosocial, family, bereavement, and public support. Across the three developmental periods, policy content expanded from strategic recognition and institutional establishment to service-system construction, implementation support, and quality-oriented governance (Table 2).

Across the three developmental periods, policy content expanded from strategic recognition and institutional establishment to service-system construction, implementation support, and quality-oriented governance. National standards and guidance provided an increasingly specific formal basis for service organization and practice.

Table 2. Evolution of palliative care policy content across development periods and administrative levels

Policy domain	**2016–2019: Institutional establishment and pilot exploration**	**2020–2022: Accelerated expansion and system development**	**2023–2025: Consolidation and quality-oriented development**
Strategic positioning	Recognition of palliative care in national health and ageing-related strategies; establishment of legal and institutional legitimacy	Translation of national strategic objectives into provincial implementation plans and pilot arrangements	Emphasis on sustained institutionalization, standardization, and integration into routine health and elderly-care services
Service-system organization	Focus on palliative care centres, wards, and designated pilot institutions	Expansion towards hospital–community–home coordination and integration with primary care and elderly care	Greater emphasis on service continuity, community and home-based care, and coordination across care settings
Standards and clinical practice	Basic institutional standards, management requirements, and practice guidelines	More detailed service procedures, symptom management, comfort care, and multidisciplinary processes	Technical guidance, quality assurance, standardized care pathways, and refinement of service requirements

Policy domain	2016–2019: Institutional establishment and pilot exploration	2020–2022: Accelerated expansion and system development	2023–2025: Consolidation and quality-oriented development
Workforce and multidisciplinary collaboration	Initial recognition of personnel and institutional responsibilities	Expansion of professional training and multidisciplinary team arrangements	Greater attention to competency development, technical guidance, and multidisciplinary quality improvement
Financing and reimbursement	Limited and preliminary support arrangements	Exploration of medical insurance reimbursement, fiscal support, and payment mechanisms	Refinement of financing and payment arrangements, although considerable regional variation remained
Quality management and evaluation	Focus on institutional access and pilot implementation	Introduction of service supervision, management requirements, and preliminary quality control	Stronger emphasis on quality assessment, monitoring, technical guidance, and service improvement
Psychosocial and family support	Mentioned within general principles or clinical service requirements	Increasing attention to psychological support, family communication, social work, and bereavement-related needs	Greater emphasis on person-centred care, family support, social work, public education, and continuity of care

3.5.1 Strategic positioning and institutional legitimacy

Early policy development focused on establishing the legitimacy of palliative care within the national health system. Its inclusion in the Healthy China 2030 Planning Outline positioned palliative care within the national health strategy and integrated health and elderly-care services [5]

The 2019 Basic Medical and Health Care and Health Promotion Law further strengthened its formal institutional status by including palliative care among the services to be provided by health institutions [11]. At the provincial level, strategic recognition was translated into implementation plans and pilot arrangements. Sampled local governments connected palliative care with elderly health, integrated medical and elderly care, community health, and hospital service development.

3.5.2 Service-system organization and care settings

Policy content gradually expanded from specialist institutions to a broader service network. Early documents concentrated on palliative care centres, wards, and designated pilot institutions. Later policies increasingly referred to coordination among hospitals, primary healthcare institutions, communities, elderly-care institutions, and households. The third national pilot notice also called for service development across medical institutions, community health settings, and home-based care [10].

This change reflected a movement from an institution-centred model towards a more continuous service pathway. Some provincial and local policies explored links between palliat

ive care, family doctor services, home medical beds, community care, and integrated medi cal and elderly care.

However, policy arrangements for home-based and rural palliative care remained less sta ndardized than institution-based services. Eligibility, referral, emergency response, caregiver support, medication access, and quality assurance for home services were not consistently specified.

3.5.3 Institutional standards and clinical practice

The 2017 national standards and practice guidance addressed institutional conditions, servic e processes, management requirements, and clinical practice [6,7]. Subsequent policies incre asingly specified symptom assessment, pain management, comfort care, communication, mu ltidisciplinary consultation, and service procedures. Later policies placed greater emphasis o n ward construction, quality management, technical guidance, and standardized service deli very, as reflected in the national 2024 health-industry standard and revised 2025 practice g uideline [21,22].

These documents reduced uncertainty concerning how palliative care should be organized. Nevertheless, the existence of standards did not demonstrate consistent compliance across institutions or regions.

3.5.4 Workforce and multidisciplinary collaboration

Workforce development became more visible as the policy system expanded. Policies incre asingly recognized the participation of physicians, nurses, social workers, psychologists, reh abilitation professionals, pharmacists, and other personnel. National and provincial documen ts addressed professional training and multidisciplinary service teams.

However, policies did not consistently define professional competency requirements, train ing duration, certification pathways, staffing ratios, or sustainable career structures. Chinese research has similarly identified workforce and education as continuing challenges in com munity-based palliative care [23,24]. The policy system therefore recognized multidisciplina ry care more clearly than it resolved the workforce conditions required for implementation.

3.5.5 Financing and medical insurance

Financing emerged as an important implementation issue during the expansion period. Som e provincial and local governments explored medical insurance reimbursement, fiscal suppo rt, per-bed-day payment, and other payment arrangements. Policy analyses of social medica l insurance in pilot regions have identified coverage, financing, payment, and regulation as key areas requiring further development [25].

These developments represented a shift from reliance on administrative designation towards the use of economic and financial instruments. However, financing provisions varied acro ss jurisdictions. Community- and home-based services, psychosocial interventions, family su pport, and bereavement care were not consistently incorporated into payment systems. Exis ting policy-instrument research has also reported an imbalance between the use of environ mental, supply-side, and demand-side tools [16,17].

3.5.6 Quality management and evaluation

Early policies primarily addressed whether institutions and services should be established. Later policies increasingly addressed how services should be standardized, supervised, and

improved.

Quality-oriented provisions included technical guidance, service-process standards, quality control, performance assessment, and capacity improvement. This change suggests a gradual transition from coverage-oriented policy development towards greater concern with service quality.

Nevertheless, many policies continued to rely on structural or activity indicators, such as the number of institutions, wards, beds, or trained personnel. Patient-reported outcomes, caregiver experience, symptom relief, continuity of care, equity, and place-of-death preferences were less consistently reflected in the available policy texts.

3.5.7 Psychosocial, family, bereavement, and public support

The policy definition of palliative care broadened over time. Later documents increasingly referred to psychological support, social work, spiritual comfort, family communication, grief support, and public education in addition to physical symptom management. The WHO framework also emphasizes psychosocial and spiritual distress, family needs, and access to palliative care across levels of the health system [3,4].

However, psychosocial and bereavement services were often expressed as general requirements rather than supported by detailed staffing, financing, referral, or evaluation arrangements. Chinese policy and community-service studies have also discussed public education and cultural acceptance as ongoing concerns [23,24].

3.6 Overall transformation of policy content

Across the seven domains, the substantive development of China's palliative care policy can be summarized as three overlapping transitions.

First, policy moved from strategic recognition to operational organization. Early documents established legitimacy and basic institutional arrangements, while later documents addressed service networks, financing, workforce, and implementation.

Second, policy moved from institution-centred provision to multi-setting care. Hospitals and specialist wards remained important, but community, home, primary-care, and elderly-care settings became more visible.

Third, policy moved from formal service coverage to quality-oriented governance. Later documents gave greater attention to standardization, multidisciplinary care, quality control, and technical guidance.

These transitions were not uniform across all jurisdictions. National policies generally established broad direction and minimum standards; provincial policies translated them into regional programmes and support mechanisms; sampled local policies provided more context-specific operational arrangements. At the same time, some local policies remained largely derivative of higher-level documents, indicating uneven capacity for local policy development.

4 Discussion

4.1 Principal findings

This study constructed a database of 538 Chinese palliative care policy documents and examined their development across temporal, geographical, organizational, and substantive dimensions.

The findings show that policy issuance accelerated after palliative care entered the national strategic agenda, peaked in 2022, and subsequently declined. National pilot programmes expanded geographically, and provincial governments became the principal administrative level for translating national direction into implementation policies.

The organizational network was centred on the national health authority but included organizations responsible for civil affairs, medical insurance, finance, development planning, workforce, and regulation. This pattern reflects the multidimensional nature of palliative care while also showing that participation outside the health sector remained uneven.

The policy content analysis showed that China's policy system did not simply produce more documents. Its substantive scope expanded from institutional legitimacy, pilot designation, and basic standards towards service integration, financing, workforce development, multidisciplinary collaboration, psychosocial support, and quality management. These findings are broadly consistent with earlier Chinese policy-history and policy-instrument analyses, while adding a separate examination of the three national pilot rounds and sampled subprovincial policies [12-18].

4.2 Interpreting policy diffusion

The findings are consistent with a centrally initiated and administratively mediated pathway of policy expansion. National strategic recognition and pilot programmes created an institutional basis for provincial and local policy adoption.

Policy diffusion research distinguishes mechanisms such as learning, imitation, competition, and coercion, and cautions that observed similarity or temporal sequence alone cannot identify which mechanism is operating [19,20]. The geographical distribution of pilot jurisdictions is therefore consistent with centrally coordinated expansion but cannot distinguish administrative compliance from local learning, demonstration effects, or other forms of policy transfer.

Earlier analysis of Shanghai policy documents described diffusion across temporal, spatial, content, and organizational dimensions [13]. More recent national policy analyses have examined long-term policy evolution, intersectoral networks, policy tools, or regional differences [15-18]. The present study complements this work by examining a 2016–2025 policy corpus across national, provincial, and sampled subprovincial levels and by mapping formal pilot designations. It does not provide a causal test of diffusion mechanisms.

Future research could combine policy documents with interviews, implementation data, and event-history analysis to examine why jurisdictions adopted policies at different times and how policy designs were transferred.

4.3 From formal policy coverage to implementation capacity

The expansion of formal policy coverage represents institutional progress, but policy documents are not equivalent to functioning services. Provincial frameworks need to be translated into municipal, county, community, and institutional procedures.

This translation requires stable financing, trained professionals, referral pathways, access to essential medicines, information systems, and measurable quality standards. Chinese studies have identified challenges in financing arrangements and community-level workforce capacity [24,25]. The sampled local policies illustrate operational experimentation but cannot represent all subprovincial jurisdictions. A national assessment of local implementation wou

ld require a more extensive jurisdiction-level sampling design and service-delivery data.

4.4 Policy priorities

Several priorities emerge from the substantive policy analysis.

First, community- and home-based palliative care require clearer national and provincial guidance, particularly regarding eligibility, referral, home visits, access to medicines, emergency response, caregiver support, and quality management. Community-based service research has identified workforce, medication, education, and policy-support constraints [24].

Second, financing arrangements should reflect the characteristics of palliative care. Payment systems should support appropriate symptom management and coordinated care without creating incentives for unnecessary hospitalization or intervention. Policy analyses of social medical insurance in pilot regions provide a relevant basis for further work on coverage, financing, payment, and regulation [25].

Third, workforce policies should move beyond general calls for training and establish competency standards, tiered education pathways, staffing expectations, and professional development mechanisms. Existing Chinese research has identified workforce development and professional education as important system priorities [14,23,24].

Fourth, quality evaluation should include patient- and family-centred outcomes, continuity of care, symptom control, service accessibility, and equity rather than relying primarily on the number of institutions, wards, beds, or trained personnel.

Finally, psychosocial support, bereavement care, advance care planning, public communication, and family participation require stronger operational and financial support. Cultural and policy analyses in China have also emphasized public education and the need for broader social support [23].

4.5 Strengths and limitations

A major strength of this study is the construction of a multi-level policy database covering a ten-year period. The integration of temporal, geographical, organizational, and substantive perspectives provides a broader understanding than analyses limited to individual documents or policy counts.

The study also distinguishes systematically searched national and provincial policies from sampled subprovincial policies, reducing the risk of treating an incomplete local sample as a national census.

Several limitations should be acknowledged. First, government website structures and archival practices vary, and some older or withdrawn documents may not have been retrievable. Second, the subprovincial sample was not designed to enumerate all local policies. Although jurisdictions were selected within provinces, the 60 local documents cannot be used to estimate the total number or exact distribution of local policies nationwide.Third, the substantive policy analysis was interpretive and framework-guided rather than based on formal line-by-line coding. It identifies major policy directions and changes but does not estimate the frequency of policy themes or test inter-coder reliability.Fourth, the co-issuance network reflects formal joint publication and cannot measure informal collaboration or implementation effectiveness. Fifth, the geographical analysis measures formal pilot inclusion rather than actual service availability, utilization, quality, or equity. Finally, the study analyses policy texts and cannot determine whether stated policy objectives were implemented in

practice.

5 Conclusions

Between 2016 and 2025, China developed a more extensive and structured palliative care policy system through national strategic recognition, pilot programmes, provincial implementation, and interdepartmental participation.

The evolution of this policy system involved both quantitative expansion and substantive development. Policy content moved from institutional legitimacy, pilot designation, and basic service standards towards coordinated service networks, financing and workforce support, multidisciplinary collaboration, psychosocial care, and quality management.

Nevertheless, formal policy expansion has not eliminated implementation challenges. Future policy should place greater emphasis on municipal and county implementation capacity, rural and home-based services, sustainable financing, workforce development, measurable quality indicators, and patient- and family-centred outcomes.

The transition from policy coverage to equitable and high-quality service delivery will require stronger connections between national standards, provincial support, local implementation, and empirical evaluation of service outcomes.

Abbreviations

CNKI: China National Knowledge Infrastructure
MCA: Ministry of Civil Affairs
NDRC: National Development and Reform Commission
NHFPC: National Health and Family Planning Commission
NHSA: National Healthcare Security Administration
NHC: National Health Commission
PLAD: provincial-level administrative division
SAMR: State Administration for Market Regulation
WHO: World Health Organization

Declarations

Ethics approval and consent to participate

Not applicable. This study analysed publicly available government policy documents and did not involve human participants or personal data.

Consent for publication

Not applicable.

Availability of data and materials

Full policy texts are available from the official government sources recorded in the database.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

X.L.: Data collection, study design, manuscript drafting.

L.Y.Z:Data checking, manuscript polishing

L.W.H:Data checking, manuscript polishing

A.X.T.: Study supervision, manuscript revision.

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