

Postprint: The Transformation of the Medical Paradigm from Disease Treatment to Life-Cycle Health Management

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Abstract

With the advent of population aging and the longevity era, healthcare systems are facing unprecedented challenges. This paper analyzes the limitations of current healthcare models in addressing the health needs of a longevity society, including service fragmentation, maldistribution of resources, and the sustainability crisis of medical insurance. Based on value-based healthcare and integrated care theories, we propose a paradigm of life-cycle health management, emphasizing three key transformation pathways: prevention-first, integrated collaboration, and diversified support. In this paradigm, general practitioners serve as crucial health “gatekeepers” by shifting health interventions upstream, providing comprehensive health screening, and enhancing community health services to promote comprehensive chronic disease management and integrated medical and elderly care services, while achieving systematic support through multi-tiered medical security, health information interoperability, and collaborative governance mechanisms. This transformation of the healthcare paradigm represents an important pathway toward achieving the goals of “Healthy China 2030,” requiring joint advancement through theoretical innovation, practical exploration, and policy synergy.

Full Text

The Transformation of the Medical Paradigm from Disease Treatment to Whole-Life-Cycle Health Management

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Abstract

With population aging and the advent of the longevity era, healthcare systems face unprecedented challenges. This paper analyzes the limitations of current medical models in addressing the health needs of a longevity society, including service fragmentation, unbalanced resource allocation, and healthcare sustainability crises. Based on value-based healthcare and integrated care theories, we propose a whole-life-cycle health management paradigm emphasizing three transformation pathways: preventive priority, integrated coordination, and multi-dimensional support. In this paradigm, general practitioners serve as crucial health “gatekeepers” by advancing health intervention points, providing comprehensive health screening, and strengthening community health services to promote chronic disease management and integrated medical-elderly care services. Systemic support is achieved through multi-level medical security, health information interconnectivity, and collaborative governance mechanisms. This medical paradigm transformation represents an important pathway to achieving the “Healthy China 2030” goals, requiring joint advancement through theoretical innovation, practical exploration, and policy coordination.

Keywords: Medical paradigm transformation; Whole-life-cycle health management; Longevity era; General practice; Integrated care

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Human society is entering an era of longevity. The life expectancy of Chinese residents has reached 78.6 years, and the proportion of elderly population continues to rise [1]. The core characteristic of a longevity society is that “everyone lives with disease for an extended period,” with a gap of approximately 9 years between healthy life expectancy and total life expectancy, leading to a sharply increasing burden of chronic non-communicable diseases [2]. Traditional healthcare systems, focused primarily on acute disease treatment, struggle to effectively address the health needs of a longevity society. Problems such as fragmented medical services, uneven resource allocation, and continuously rising healthcare costs have become increasingly prominent [3-4]. The report of the 20th National Congress of the Communist Party of China explicitly states that “ensuring people’s health should be given strategic priority,” emphasizing coordinated development and governance of medical insurance, medical services, and pharmaceuticals [5].

Against this backdrop, the medical paradigm must shift from “disease-centered” to “health-centered,” moving from a singular focus on disease treatment to comprehensive life-cycle health management. General practice, with its holistic, continuous, and coordinated characteristics, possesses unique advantages and plays a key role in this transformation. This paper analyzes the theoretical foundations, core connotations, and practical pathways of medical paradigm transformation in the longevity era, exploring the construction of a new medical service model adapted to this era.

1.1 Profound Changes in Health Needs

Health needs in the longevity era exhibit three major characteristics. First, multimorbidity is widespread, with elderly individuals averaging 2-3 chronic diseases, and the disease spectrum shifting from single acute infectious diseases to clusters of chronic non-communicable diseases [6]. Second, suboptimal health status persists continuously, posing severe challenges to healthy aging. Third, demands for health services have diversified, extending from pure treatment needs to comprehensive needs including preventive care, chronic disease management, and quality of life improvement [7].

These changes have created a mismatch between traditional medical services and emerging health needs. When people require continuous, integrated health management services, the healthcare system remains fragmented and decentralized. When chronic disease prevention requires advancing intervention points, medical resources remain concentrated in late-stage disease treatment.

1.2 Fragmented Medical Services and Resource Imbalance

The current healthcare system faces systemic dilemmas. Service fragmentation manifests as vertical disconnection and horizontal separation: prevention, treatment, rehabilitation, and long-term care lack effective coordination, while specialization becomes increasingly refined but inter-specialty collaboration remains insufficient [8]. Chronic disease patients often face multiple comorbidities but must shuttle between different specialties, resulting in uncoordinated treatment plans and even therapeutic conflicts [9].

Uneven medical resource allocation is equally prominent: resources are excessively concentrated in large hospitals and high-end equipment, while investment in preventive care and rehabilitation is insufficient, with significant gaps between urban and rural areas and across regions [10]. The mismatch between changing disease patterns and resource allocation exacerbates this dilemma, creating a situation where large hospitals face “bed shortages” while primary care institutions remain “deserted” [11].

1.3 Healthcare System Sustainability Crisis

Traditional medical models face severe challenges from continuously rising costs and sustainability concerns. The economic burden of chronic diseases already

accounts for nearly 70% of total disease burden and continues to rise rapidly [12]. Medical insurance fund balance has become increasingly difficult, with some regions already experiencing current-period deficits [13].

Under existing incentive mechanisms, healthcare providers' income primarily comes from medical service volume rather than health outcomes, leading to insufficient investment in prevention [14]. This treatment-centered payment model not only struggles to control healthcare cost growth but also fails to achieve long-term health benefits of "early intervention and risk reduction." Medical paradigm transformation has become an inevitable choice to address health challenges in the longevity era, with general medicine playing an irreplaceable role in this transition.

2.1 Value-Based Healthcare: Redefining Core Value of Medical Services

The value-based healthcare concept provides an important theoretical foundation for medical paradigm transformation. Porter [15] defined healthcare value as "health outcomes achieved per unit of cost," emphasizing that improving patient health status is the fundamental goal of medical services. Under this framework, evaluation criteria shift from "service volume" and "revenue" to "health outcomes/cost," posing three challenges to the healthcare system: value measurement shifts from "what was done" to "what was achieved"; institutional competition shifts from "expanding market share" to "enhancing value creation capability"; and payment methods shift from "fee-for-service" to "value-based payment" [16]. China's medical insurance payment reform, transitioning from fee-for-service to DRG/DIP payment, and the establishment of high-quality development evaluation indicators for public hospitals, all reflect practical exploration of value-based healthcare concepts [17].

2.2 Integrated Care: Building a Continuous and Coordinated Health Service System

Integrated care theory is another important foundation for medical paradigm transformation. The World Health Organization defines integrated care as a management and service system that provides "whole-process, all-round" health services for specific populations through coherent, coordinated, and continuous services [18]. Integrated care promotes a shift from fragmented to holistic service models [19-20], including three levels: vertical integration, connecting different stages of health services into a continuum; horizontal integration, breaking down specialty barriers to provide comprehensive services through multidisciplinary collaboration; and functional integration, including information, financial, and management integration to provide institutional and technical support for clinical integration.

Internationally, the United States' Accountable Care Organizations (ACOs) and the United Kingdom's Integrated Care Systems (ICS) all embody integrated care

concepts [21]. China's medical consortium and medical community construction represent localized practices of integrated care, building a tiered diagnosis and treatment system with vertical linkage through organizational integration and service coordination [22].

2.3 Whole-Life-Cycle Health Management: The Implementation Path of Medical Paradigm Transformation

Whole-life-cycle health management integrates value-based healthcare and integrated care concepts, emphasizing health management throughout the entire life cycle. Its core connotations include: shifting focus from “disease” to “person” ; expanding service scope from pure “treatment” to the entire process of “prevention-screening-diagnosis-treatment-rehabilitation-care” ; and shifting management goals from “symptom control” to “improving quality of life and healthy life expectancy” [23].

The implementation pathway follows a “three-all integration” model: all-population coverage, providing differentiated health services for different groups; whole-process management, offering continuous health management from fetal period to old age; all-round services, integrating medical, public health, and health promotion services; and integrated coordination, ensuring seamless connection of health services across all segments and levels [24]. In this paradigm, general practitioners, as health “gatekeepers” for residents, play a central role in medical paradigm transformation through continuous, coordinated, and comprehensive health management services. As Liu Tingjun [25] stated: “The most distinctive feature of a longevity society is that everyone lives with disease for an extended period. Medical services must shift from treatment-centered to health-centered, enabling people to get sick less often and later in life.”

3. Prevention Priority: Practical Innovation in Advancing Health Intervention Points

3.1 Shifting from Passive Disease Response to Proactive Health Management

The primary link in whole-life-cycle health management is advancing health intervention points. This shift is based on two core understandings: most chronic diseases are preventable, and early intervention costs are far lower than late-stage disease treatment [26]. Advancing health intervention points requires building a closed loop of “risk monitoring-warning intervention-behavior guidance.” Through scientific assessment and stratified management of individual health risks, targeted health management programs can be provided for different risk populations. Digital technology enables real-time health status monitoring, timely detection of abnormalities, and early intervention initiation. Through health literacy improvement and behavioral intervention, healthy lifestyles can be promoted.

To better understand the internal logic of medical paradigm transformation, Figure 1 [Figure 1: see original paper] presents the complete framework for medical paradigm transformation in the longevity era. Based on value-based healthcare and integrated care theories, this framework achieves a fundamental shift from “disease-centered” to “health-centered” medical services through the whole-life-cycle health management paradigm. It advances practice through three major transformation pathways—prevention priority, integrated coordination, and multi-dimensional support—and builds a support system relying on multi-level medical security, health information interconnectivity, and three-medical-linkage to ultimately achieve the “Healthy China 2030” strategic goal. In this systematic transformation, general practitioners as health “gatekeepers” play a core role across all levels and segments.

The Guangzhou Zhongcun Street Community Health Service Center has developed personalized health management programs for key populations through an intelligent medical-prevention integration platform, effectively reducing chronic disease prevalence and complication rates [27]. These explorations demonstrate that systematic health risk management and proactive intervention can effectively delay chronic disease onset and reduce medical costs. General practitioners can play the role of health “gatekeepers” in this process, achieving a shift from passive treatment to proactive health management.

3.2 Building a Health Screening and Monitoring System Covering All Populations

An effective health screening and monitoring system forms the foundation for early intervention. Building such a system requires integrating preventive medicine resources to form a multi-level, comprehensive health monitoring network. Resource integration should focus on three aspects: horizontal integration to break down barriers between public health institutions, medical institutions, and health examination centers; vertical integration to establish a five-level health monitoring system linking national, provincial, municipal, district/county, and community levels; and functional integration to closely combine preventive medicine services with clinical medical services, forming a prevention-treatment integration model.

The health screening and monitoring system should provide differentiated and precise services tailored to different population characteristics while establishing a multi-level screening service guarantee mechanism to ensure universal accessibility. Zhejiang’s “Healthy Zhejiang” model has established a hierarchical health risk assessment and screening system, achieving comprehensive screening coverage for key populations and major diseases while effectively linking screening results with health management and medical services [29].

3.3 Strengthening Community Health Services and Primary Care Capacity Building

Primary care institutions are crucial pivot points for implementing prevention-first strategies. International experience demonstrates that robust primary care significantly improves population health levels and reduces medical costs [30]. Strengthening community health services requires addressing three aspects: resource allocation, capacity building, and incentive mechanisms.

In resource allocation, increased investment in primary care institutions should support health risk assessment, lifestyle intervention, and chronic disease management services. In capacity building, urban hospitals should provide targeted assistance to primary care institutions through remote education and training to enhance preventive care service capabilities. In incentive mechanisms, innovative payment methods for preventive care services should be developed by including them in medical insurance coverage, thereby motivating primary care institutions to actively engage in preventive care. Concurrently, new models of family doctor contract services should be explored to clarify health management responsibilities and construct a tiered diagnosis and treatment system.

Shanghai's family doctor team system, through the formation of "1+1+1" teams (general practitioner + public health physician + nurse), provides integrated health management services for contracted residents and achieves data sharing and service coordination with higher-level hospitals through information systems [31].

4. Integrated Coordination: Reconstructing Chronic Disease Management and Medical-Elderly Care Integration Services

4.1 Whole-Process Chronic Disease Management: Breaking the Fragmentation Dilemma

Whole-process chronic disease management aims to break the fragmentation dilemma in medical services and build a patient-centered continuous medical service system, achieving a closed loop of "prevention-diagnosis-treatment-rehabilitation-long-term management" [32]. The system construction should advance along three dimensions: vertical integration of service chains to ensure patients receive continuous and coordinated medical services; horizontal integration of professional teams to establish multidisciplinary collaborative teams providing integrated services for patients' multidimensional needs; and tiered management mechanisms that stratify patients according to disease risk and complexity [33].

Shenzhen's "Three-Physician Co-management" chronic disease management model integrates general practitioners, specialists, and health managers through electronic health records and chronic disease management information systems to provide whole-process services for chronic disease patients [34]. Its success

lies in addressing three core challenges of integrated care. At the mechanism design level, clear division of labor achieves professional integration: general practitioners handle basic diagnosis and treatment, specialists provide technical support, and health managers conduct follow-up interventions. This design avoids the responsibility ambiguity and coordination difficulties of traditional models. At the incentive mechanism level, a results-oriented performance system links team income to health indicators such as patient blood glucose control rates and complication control rates rather than pure service volume, reflecting the core requirement of value-based healthcare theory of “paying for health outcomes.” At the technical support level, a unified information platform enables data sharing, allowing all three physicians to view complete patient information in real time, with the system automatically assigning tasks based on risk ratings. This model has effectively improved standardized chronic disease management rates and control rates, reduced complication incidence and medical costs.

Weifang pioneered the concept of “single-disease group management” in China, treating patients with the same disease as a whole population and providing full-chain health management services from disease screening, assessment, treatment, referral to follow-up, initially establishing a new model of full-chain, whole-life-cycle health management [35]. These measures not only improve overall healthcare quality and efficiency but also provide more considerate and precise services to citizens.

4.2 Medical-Elderly Care Integration: Service Innovation for an Aging Society

Medical-elderly care integration meets the complex needs of elderly individuals for both health and daily care by integrating medical services with elderly care services. As population aging intensifies, the demand for both medical and elderly care services among older adults shows a “dual-high” trend, yet traditional models operate these services separately, creating service gaps [36]. The medical-elderly care integration model constructs a continuum of elderly health services including “preventive care-medical treatment-rehabilitation care-long-term care-palliative care,” achieving seamless connection between health and daily care needs for older adults [37]. Its value lies in reducing unnecessary hospitalizations and readmissions, alleviating healthcare system burdens, improving quality of life for older adults, and reducing family caregiving pressure.

Taikang Insurance Group’s medical-elderly care integration practice establishes “medical-elderly care integrated communities” focusing on chronic disease management, emergency care, rehabilitation, long-term care, and palliative care for older adults, achieving deep integration of medical and elderly care services [38]. This model effectively reduces health risks and medical costs for older adults through prevention-first and early intervention health management concepts.

As the world’s most aged country, Japan introduced the Long-Term Care Insurance (LTCI) system in 2000 to meet the needs of disabled older adults based

on a community-based population strategy, establishing a community that provides seamless prevention, medical care, long-term care, welfare, and housing services for all [39]. At the institutional integration level, LTCI breaks down departmental divisions between medical and social security: a unified insurance system covers medical services, care services, and life support, avoiding fragmented management and buck-passing. Insured individuals only need to pass a unified assessment to receive corresponding comprehensive services. At the service integration level, a “care manager” system achieves case management: care managers, as service coordinators, develop personalized care plans based on older adults’ needs, integrating various service forms such as home care, day care, and institutional care to ensure service continuity. At the financial integration level, a multi-party financing mechanism ensures institutional sustainability: the funding structure comprising insurance premiums, national subsidies, and local government subsidies reflects social solidarity principles while avoiding excessive single fiscal burdens. Over 25 years of implementation, LTCI has effectively controlled medical cost growth, significantly reduced hospitalization rates for older adults, and maintained the proportion of home-based elderly care above 90%. This system’ s inspiration lies in achieving cross-departmental resource integration through institutional design, providing a feasible path for medical-elderly care integration in the longevity era.

Medical-elderly care integration models are extending from institutional pilots to community and home-based services. The “14th Five-Year Plan” proposes promoting integrated development of medical and elderly care services and expanding the coverage of home and community-based elderly care services provided by medical consortia [40]. General practitioners will play an even more critical role in community medical-elderly care integration services.

5.1 Multi-Level Medical Security: From Single Payment to Multi-Party Coordination

Whole-life-cycle health management requires a multi-level medical security system for financial support. Constructing a matching multi-level medical security system requires addressing three aspects: security structure, payment methods, and coordination mechanisms. In security structure, a “five-in-one” multi-level medical security system should be built: basic medical insurance and critical illness insurance as the main body; supplementary medical insurance and commercial health insurance as extensions covering preventive care, rehabilitation, and nursing services; and medical assistance as the safety net [41]. In payment methods, innovative value-oriented payment mechanisms should shift from “fee-for-service” to “payment for health.” On one hand, expand medical insurance coverage to include preventive care and health management services; on the other hand, explore innovative payment methods of “bundled payment + value incentives” that link payment to health outcomes [42]. In coordination mechanisms, effective connection between basic medical insurance and commercial health insurance should be promoted by clarifying the positioning of commer-

cial health insurance in the multi-level security system and exploring a “basic insurance + commercial insurance” collaborative operation mechanism [43].

5.2 Health Information Interconnectivity: Building a Whole-Life-Cycle Health Data Platform

Information interconnectivity is the key technical support for whole-life-cycle health management. Building a whole-life-cycle health data platform requires achieving data standardization, information interconnectivity, and deep value mining. In data standardization, unified standards for health data collection, storage, and exchange should be established to ensure compatibility and comparability of data from different sources [44]. In information interconnectivity, administrative barriers and institutional boundaries should be broken to build regional health information exchange platforms enabling secure sharing and effective circulation of multi-party data [45]. In value mining, big data and artificial intelligence technologies should be applied for deep mining and intelligent analysis of health data to support health risk prediction, early disease warning, and treatment plan optimization [46]. Meanwhile, health data platforms should fully ensure data security and personal privacy.

Zhejiang’s “Healthy Brain” project integrates multi-source provincial data to build a three-level health information platform linking province, city, and county, supporting whole-process health management of “pre-disease prediction, early disease warning, intelligent diagnosis for confirmed diseases, and rehabilitation tracking” [47]. This project provides an innovative model of technical integration for whole-life-cycle health management. At the data integration level, a unified provincial health data warehouse has been established, integrating multi-source heterogeneous data from hospital information systems, public health systems, and medical insurance data, aggregating massive data resources including over 55 million electronic health records, 62 million electronic medical records, and 300 million medical examination reports [48]. Through data standardization and cleaning, “one file per person, holographic files” data integration has been achieved. At the business integration level, an intelligent service system with “four pre-functions” has been constructed: pre-disease prediction identifies high-risk populations through AI algorithms, early disease warning enables early disease detection, intelligent diagnosis provides clinical decision support, and rehabilitation tracking ensures treatment continuity. This design integrates originally fragmented health management segments into an organic whole. At the management integration level, a three-level collaborative governance structure has been established across province, city, and county: the provincial level is responsible for overall planning and standard setting, the municipal level for regional coordination and quality supervision, and the county level for specific implementation and service provision. This multi-level governance avoids traditional pitfalls of fragmentation. Two years after implementation, the project has improved early detection rates of chronic diseases, reduced duplicate examination rates, and significantly enhanced medical resource allocation efficiency. The

project's value lies in achieving systematic reconstruction of health management through technical means, providing a practical sample for digital empowerment of whole-life-cycle health management.

5.3 Collaborative Governance: Three-Medical Linkage of Insurance, Healthcare, and Pharmaceuticals

Whole-life-cycle health management requires institutional guarantees through the “three-medical linkage” of medical insurance, medical services, and pharmaceuticals. The core of three-medical linkage is establishing a collaborative mechanism of “value co-creation and risk sharing.” Medical insurance departments should transform from “purchasers” of medical services to “strategic purchasers” of health value; medical institutions should shift from “disease-centered” to “health-centered,” building a medical service system adapted to whole-life-cycle health needs; and the pharmaceutical supply chain should ensure drug accessibility and rational use [49]. The three-medical linkage reform establishes a collaborative governance mechanism involving health, medical insurance, and drug supervision departments, while exploring a health value assessment and payment model with participation from medical insurance, hospitals, and patients [50]. General practitioners play an important role in this collaborative mechanism, coordinating resources from all parties to provide whole-life-cycle health management services for residents.

6. Conclusion and Recommendations: Development Trends and Practice of Medical Paradigm Transformation

The arrival of the longevity era is driving a transformation of the medical paradigm from “disease-centered” to “health-centered,” shifting from a singular focus on treatment to whole-life-cycle health management. This transformation is not merely a technical model adjustment but a profound reform of healthcare system concepts, organization, and institutions. Value-based healthcare and integrated care concepts guide the healthcare system to shift from focusing on “service volume” to “health value,” and from institutional fragmentation to system integration, providing a solid theoretical foundation for medical paradigm transformation.

From a practical pathway perspective, the core of whole-life-cycle health management lies in building a new health service model of “prevention priority, integrated coordination, and multi-dimensional support.” This involves advancing health intervention points through precise risk management and early intervention to reduce disease risk; breaking the fragmentation dilemma of medical services to build a continuous service system covering the entire chain; and establishing multi-level medical security, health information interconnectivity, and collaborative governance mechanisms to provide solid institutional and technical support [51]. This practical pathway emphasizes systematic thinking and holistic layout, maximizing health value through organic connection of all seg-

ments.

Promoting medical paradigm transformation requires building a policy support system with multi-party collaboration and clear division of labor. Government departments should establish cross-departmental coordination mechanisms: health departments lead the formulation of whole-life-cycle health management standards, medical insurance departments reform medical service payment methods from “service purchasing” to “health purchasing” [52], and finance departments increase investment in primary care and public health. Medical institutions, disease control agencies, commercial insurance companies, technology enterprises, and community organizations should perform their respective functions and collaborate, forming a health governance pattern of “government leadership, departmental collaboration, social participation, and universal co-construction.” Specific implementation recommendations adopt a phased strategy: piloting in 100 counties from 2025-2027, nationwide promotion from 2028-2030, and establishing a complete system after 2030 to ensure steady and orderly reform.

Looking ahead, medical paradigm transformation will present four major trends: shifting from hospital-centered to community and home-based care, from professional-dominated to professional-person collaboration, from standardized services to personalized precision intervention, and from single medical care to integrated medical-elderly care-rehabilitation-nursing services. These trends reflect profound changes on both supply and demand sides of health services, pointing toward more humanized, personalized, and comprehensive health service models. Emerging technologies such as digital technology and artificial intelligence will provide strong technical support for these transformations, driving health management toward intelligent and precise directions.

General practitioners, as health “gatekeepers” for residents, play a central role in medical paradigm transformation. Systematically promoting the shift from “treatment-centered” to “health-centered” medical paradigm [49] and building a medical service system adapted to whole-life-cycle health needs will become the key pathway to achieving the Healthy China 2030 strategic goal. This transformation is both an inevitable choice to address health challenges in the longevity era and an important measure to improve population health and build a healthy China, requiring continuous joint efforts from all sectors of society.

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