China's Rural Integrated Medical and Elderly Care Policies, Supply Systems, and Implementation Challenges

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Abstract. China faces a severe aging crisis in rural areas, with the elderly population reaching 24% by 2024. This demographic shift brings challenges of chronic diseases and disability, creating an urgent need for integrated medical and elderly care services. However, rural areas suffer from insufficient medical and elderly care resources, imbalanced resource allocation, and significant mismatches between supply and demand. Against this backdrop, the state issued the 2024 Guiding Opinions and the 2025 Demonstration Project Work Plan to propel rural medical-elderly care integration into a phase of high-quality development. This paper systematically analyzes the policy evolution, service provision, and implementation challenges of rural integrated medical and elderly care by reviewing relevant research. Findings indicate that rural integrated care has shifted from policy-driven initiatives to multi-stakeholder collaborative governance, forming a development path combining central top-level design with local innovative practices. Notable examples include Tengchong City's governance model and Qihe County's regulatory standards. Nevertheless, systemic challenges persist, such as fragmented governance, shortages of talent and funding, inadequate interdepartmental coordination, and difficulties in digital technology adoption. The study proposes that enhancing the accessibility, equity, and sustainability of rural medical and elderly care services requires establishing multi-stakeholder collaborative governance mechanisms, advancing supply-side reforms, and improving regulatory frameworks. These measures offer valuable insights for addressing rural aging challenges.

Keywords: rural integrated medical and elderly care; policy evolution; supply-side reform; collaborative governance; aging population.

1. Introduction

Population aging has become an important phased feature of China's social development. By the end of 2024, the number of people aged 60 and above in China will reach 310 million, accounting for 22% of the total population. Among them, the proportion of rural elderly people in the rural population is even higher, reaching 24%. The elderly in rural areas are confronted with multiple challenges such as chronic disease and disability and have an urgent need for complex demands in disease prevention and chronic disease management, thus forming a multi-level demand structure of "high medical care - low elderly care" and "high medical care - high elderly care". However, due to the unbalanced development between urban and rural areas, rural medical and elderly care resources have long been insufficient in supply and unbalanced in allocation. The resources of township health centers and nursing homes are scattered and lack coordination. There is a shortage of professional care talents, which makes it difficult to meet the demands of medical and elderly care services. "Precise matching of supply and demand" has become the core to solve the predicament of rural medical and elderly care integration.

Against this backdrop, the state has successively introduced policies to promote institutional innovation in the integration of medical care and elderly care. In December 2024, five departments including the National Health Commission issued the "Guiding Opinions on Promoting High-Quality Development of Medical and Elderly Care Integration Services". In July 2025, the National Health

Commission released the “Work Plan for Demonstration Projects of Medical and Elderly Care Integration (2025 Edition)”, marking that China's medical and elderly care integration has entered a new stage of demonstration promotion and high-quality development from pilot exploration. A systematic review of the logical framework and practical orientation of these two policies, as well as an analysis of their implementation paths and effectiveness in rural areas, is of great significance for improving the rural elderly care service system and implementing the strategy to address population aging.

The research topic is the policy evolution, governance challenges and service problems of the integration of medical and elderly care in rural China. The research objective is to systematically sort out the development process of rural medical and elderly care integration policies and analyze the governance difficulties and service supply shortcomings in practice. The research method combines qualitative and quantitative approaches. Through literature review to sort out policies and theories, in-depth interviews to obtain the viewpoints of stakeholders, and questionnaires to collect data, statistical analysis is conducted to provide a basis for problem-solving.

2. Policy Evolution and Service Supply

2.1. Policy Evolution

The development of integrated medical and elderly care services in rural China is progressing gradually under the national top-level strategic framework, driven by both population aging and healthcare system reform Liu Yana pointed out that China’s integrated medical and elderly care policy network exhibits multi-level coupling characteristics, with the central government responsible for strategic guidance and policy supply, while local governments flexibly adapt based on regional fiscal capacity and population structure [1]. This stage of policy exploration laid the foundation for the subsequent interaction between top-level design and local practice.

Entering a new phase of policy deepening, the National Health Commission has successively issued the “Guiding Opinions on Promoting High-Quality Development of Integrated Medical and Elderly Care Services (No. 40 [2024] of the National Health Commission on Ageing)” and the “Work Plan for Demonstration Projects of Integrated Medical and Elderly Care (2025 Edition)”. By clarifying the overall principle of “departmental collaboration, policy linkage, and resource sharing”, these policies gradually establish a systematic and collaborative governance system for integrated medical and elderly care. The relevant policies aim to break down the institutional barriers separating medical and elderly care resources, promote a “policy coupling” mechanism among health, civil affairs, and medical insurance departments, and achieve resource integration and policy alignment from a top-level design perspective. The 2025 Demonstration Project Plan presents a progressive policy logic, emphasizing mechanism innovation and results orientation, rather than focusing on top-level planning and institutional coordination as the 2024 Guiding Opinions did. This shift signifies that China’s governance logic for integrated medical and elderly care is moving from planning-oriented to demonstration-oriented, and from supply-driven to demand-driven. However, in rural areas, policy diffusion is still constrained by structural factors such as fiscal constraints, difficulties in inter-departmental coordination, and a shortage of professional talent. It is worth noting that although the overall policy effect is positive, the study by Zhou et al. also reveals gender differences [2]. The policy has a more lasting effect on improving the functional dependence of elderly men, while women benefit less, reflecting structural inequalities in service accessibility and social resource allocation. This suggests that when promoting integrated medical and elderly care in rural areas, special attention should be paid to the actual needs of vulnerable groups such as women, the elderly, and those living alone.

From the implementation perspective, the integration of medical and elderly care in rural areas initially relied heavily on administrative promotion, with services largely limited to basic care and simple health management. Problems such as fragmented resources, unclear responsibilities, and insufficient professional expertise were prominent. Although grassroots efforts attempted to

coordinate resources through the construction of integrated medical and elderly care institutions and cooperation with township health centers or third parties, systematic integration remained difficult [3]. As policies continued to advance, the governance logic shifted, with more policy tools moving towards the demand side. The 2025 version of the Demonstration Project Plan which strengthens pilot demonstrations, evaluation feedback, and incentive mechanisms, is seen as a significant attempt to break path dependence, promoting a shift in governance from one-way administration to multi-stakeholder cooperation and mechanism innovation [4].

In local practice, some regions are exploring innovative paths with local characteristics. For example, Tengchong City has incorporated integrated medical and elderly care into its urban planning as a "World Healthy Living Destination," forming a governance model of “Party Committee coordination—Health Commission leadership—Financial support”, which was recognized as a national typical case in 2024 [5]. This shows that local areas have certain room for innovation under the guidance of central policies and can form integrated medical and elderly care models adapted to their own conditions through institutional innovation.

Overall, the development of integrated medical and elderly care policies in rural China has not only restructured the coordination mechanisms between institutions but also injected new institutional impetus and policy paradigms into addressing the pressures of rural aging and health inequalities through multi-level governance interactions. Future research needs to be grounded in empirical evidence, further optimizing policy design and enhancing the accessibility, fairness, and sustainability of services to better address the increasingly severe challenges of population aging.

2.2. Supply Actors and Models

The effective supply of integrated medical and elderly care services in rural areas depends on the collaborative participation of multiple stakeholders and the rational allocation of resources. Studies generally agree that the supply system exhibits a pattern of “government leadership, market participation, and social collaboration,” but in practice, insufficient coordination and resource imbalances still exist [6]. Scholars typically analyze this from three aspects: governance structure, service model, and resource allocation.

At the supply level, the government is generally regarded as the planner, guide, and regulator of the integrated medical and elderly care system [6]. Through top-level design such as the Demonstration Project Plan the state has proposed an overall framework of “Party and government attention and departmental collaboration” to integrate resources from health, civil affairs, and medical insurance departments and promote policy coordination and overall planning. However, the rights and responsibilities of the multiple stakeholders remain unclear, and the collaboration mechanism is not smooth. The long-term separation of the medical and elderly care systems has led to “multiple leadership and unclear responsibilities”, making it difficult for institutions to form genuine collaboration due to different goals [7]. From the perspective of stakeholder theory, the interplay of interests among different stakeholders leads to a fragmented supply system. Families, as core stakeholders, are seeing their caregiving role weaken and their social security burden grow. The government, as a dormant stakeholder, continues to struggle with overlapping functions and siloed departments. Communities and social organizations, as marginal stakeholders, lack both independence and service capacity [8]. To alleviate this imbalance, Dong Ziyue proposed constructing a three-tiered network system of “township elderly care service centers—village-level stations—socialized institutions,” introducing social capital through public-private partnerships or public-private partnerships to achieve resource allocation and service balance [9]. Some regions have already begun implementing this, such as adding elderly care functions to township health centers to enable the elderly to “enjoy medical services without leaving home,” and increasing subsidies for private institutions [10]. These practices demonstrate that fiscal incentives can effectively mobilize social forces, enabling medical and elderly care services to gradually shift from a single administrative-led approach to a multi-faceted collaborative approach.

From the perspective of resources and supply models, rural integrated medical and elderly care is transforming from a single institutional supply to a multi-level, networked system. Studies generally categorize it into three types: institutional, community, and home-based medical and elderly care, to meet the differentiated needs of different elderly groups. This evolution indicates that the supply of integrated medical and elderly care has shifted from facility construction to service matching, with the focus gradually shifting from government leadership to social co-governance. At the resource allocation level, human resources and funding remain key bottlenecks restricting the sustainable development of rural integrated medical and elderly care. Grassroots medical and nursing personnel have long faced the dilemma of insufficient numbers, an aging workforce, and a lack of incentives [7]. In response, the Guiding Opinions proposes "strengthening service capabilities" and "expanding training," emphasizing the cultivation of multi-skilled personnel through multiple channels. However, township health centers suffer from staff shortages and aging equipment, village clinics have limited functions, and facilities such as rural community health centers often face operational difficulties [7]. At the funding level, the supply system still relies excessively on fiscal input and subsidy mechanisms. Private institutions face significant difficulties in financing, tax incentives, and long-term operation [7]. The rural coverage of medical insurance and long-term care insurance is also low, which weakens the sustainability of the service system.

2.3. Digital Technology Application

The introduction of digital technologies has provided a new breakthrough for supply-side optimization. Smart terminals, telemedicine, and digital platforms can improve service efficiency and promote resource sharing in time and space [11]. However, the promotion of these technologies in rural areas is still subject to multiple structural constraints. On the one hand, weak infrastructure and inconsistent data standards make information exchange difficult and hinder cross-institutional collaboration; on the other hand, many elderly people in rural areas neither know how to operate smart devices nor can afford the related service fees. In addition, smart healthcare and elderly care have also exposed problems such as insufficient age-friendliness, a gap in digital literacy, and a lack of data governance in actual operation. For example, the general lack of operational skills among the elderly in rural areas leads to low service delivery efficiency; the lack of data sharing protocols creates "information silos," and even results in duplicate physical examinations by medical institutions [7]. Therefore, digital technologies that should improve convenience have instead excluded some elderly people due to usage barriers and costs, resulting in a rejection effect of technology empowerment. With the expansion of the “Internet+” elderly care model, smart healthcare and elderly care based on the “institution + family” model is gradually extending to rural areas, establishing a more precise matching mechanism between social resources and the needs of home-based elderly care.

In summary, the supply-side reform of rural integrated medical and elderly care services is transforming from structural fragmentation to collaborative governance. Existing research collectively reveals the diverse evolutionary paths of this system driven by policy, and points out the ongoing challenges of supply coordination, resource balancing, and digital transformation. Future policy and academic research should further focus on improving cooperation mechanisms and enhancing resource allocation efficiency to promote the rural integrated medical and elderly care system towards a more efficient, equitable, and sustainable direction.

3. Implementation & Operational Issues

Studies suggest that the integrated elderly care and medical services policies in rural areas generally exhibit characteristics of fragmentation of systems during implementation and operation. The challenges primarily are concentrates on key areas such as governance structures, resource guarantee, departmental coordination, technical support, and supervision mechanisms. These intertwined issues reveal a significant structural disconnect between Top-level design and grass roots implementation.

Though the majority of study offer the concept of multilateral collaborative governance, optimizing the mechanism of integrated elderly care and medical service, but during the actual implementation of the policy, the fragmented governance and institution barriers between elderly care and healthcare sectors constitute fundamental obstacles to policy implementation [7,8]. The basic-level governments often use quantitative indicators such as the number of institutions and the coverage rate of the projects of integrated elderly care and medical service, but ignore the quality of service and the experiment of the old, resulting in the deviation of policy implementation from its original intention [8]. In collaborative decision-making, primary healthcare institutions and elderly care facilities are often influenced by factors such as cost pressures, insufficient incentives, and uneven distribution of benefits. This makes "competition" a more likely strategic choice than "cooperation," thereby hindering the evolution of synergistic governance into a stable equilibrium. Concurrently, studies indicate that the level of government subsidies, regulatory intensity, and adjustments to the structure of cooperative benefits are key variables that propel collaboration toward a convergent and stable state [12]. The difference in management mechanisms, the differentiation of the interests and lack of necessary cooperation between the medical institution and the elderly care institution cause the disruption of the service chain, The conflict between performance-based management and public service reveals the contradiction between the quantitative implementation of polities and actual demand.

Fragmented governance further undermines the implementation of the policy. Rural grassroots generally face problems such as serious brain drain of caregivers and medical staff, low salaries, and limited promotion opportunities. For instance, the elderly in remote mountainous areas of Tengchong city require family doctors to travel over mountains to provide services [5]. This example preliminarily illustrates that current rural elderly care is confronted with a human resource dilemma characterized by insufficient quantity, aging structure, and lack of incentives [13,14]. The urban-rural gap in financial investment and insufficient insurance coverage have exacerbated this imbalance. The narrow scope of medical insurance reimbursement and the limited promotion of long-term care insurance in rural areas make it difficult for the policy to form sustainable support on the "funding side" [13]. Resource constraints not only hinder the implementation of the policy but also invisibly widen the urban-rural gap in integrated elderly care and medical services.

Insufficient departmental collaboration is the core performance of fragmented systems. The integrated elderly care and medical services involve multiple departments, like health and wellness departments, civil affairs department and medical insurance department. However, segmented and fragmented administrative systems with overlapping responsibilities have led to the pervasive phenomena of "multiple agencies overseeing the same issue" and "conflicting policies" [15]. For example, in Jiangxi province, 71.9% of integrated elderly care and medical service institutions have been destinated as medical insurance designated hospital, but challenges such as prolonged assessment cycles and difficulties in integrating township resources persist [10]. Furthermore, the disconnect between medical insurance policies and elderly care service standards has impeded the conversion between "medical beds" and "elderly care beds," thereby undermining the viability of the "one-bed" model [16]. The lack of departmental collaboration has significantly reduced the efficiency of the integrated elderly care and medical services, particularly department between cities and rural areas. Resource for elderly care and medical services as well as urban and rural resources are difficult to be fully integrated. This increases the medical expenses for the elderly population and contradicts the people-centered approach advocated by the National Health Commission, which encourages coordinated planning and adjacent development of primary healthcare institutions and elderly care facilities to essentially meet the health and elderly care needs of rural older adults [17].

The weakness in technology and regulatory systems has resulted in limited sustained support for policy operation. Rural areas generally lack unified information platforms, leaving medical and elderly care data isolated and hindering smart services such as remote diagnosis and shared health records [18]. Meanwhile, regulatory mechanisms remain underdeveloped; some institutions treat

qualification reviews as formalities, adopt vague service standards, and lack regular quality assessment and feedback, making policy implementation difficult to standardize [8,14].

In general, the implementation difficulties of integrated elderly care and medical services in rural areas stem not from a single factor but from systemic issues shaped by fragmented governance, resource constraints, and institutional misalignment. Existing studies reveal a structural tension between policy goals and grassroots capacity, indicating fragility in local institutional integration. They also show that advancing integrated care requires strengthening institutional consolidation, resource coordination, and governance synergy. Enhancing local governments' governance capacity, operational efficiency, and coordination mechanisms is essential for shifting from "fragmented policies" to "an integrated system."

4. Limitaitons

This study integrated the existing research findings of the integrated elderly care and medical services policies in rural areas through systematic classification and organization, and discovered some limitation of the exiting studies. The majority of study concentrates on analysis on policy texts and qualitative analysis, and lack of cross-regional comparisons and verification of causal relationships based on empirical data, which is unable to reflect the differences among various regions. Moreover, the lack of horizontal comparisons has to some extent limited the generalizability and universality of the conclusion. Moreover, some studies that primarily rely on policy documents and interview materials may be constrained by the researchers' geographic focus or the availability of information, potentially leading to issues of sample bias and information asymmetry. During the process of classification and synthesis, this review observes that the majority of the literature focuses on delineating policy logic and institutional structures, while demonstrating a relative lack of attention to the actual experiences of older adults at the grass-root-level. The absence of in-depth field investigations has led to an incomplete representation of the social dimensions of policy effectiveness. In terms of method, although this study attempts to integrate findings along the analytical pathway of "policy impact, supply-side, and implementation problems," the significant differences in analytical frameworks, time scales, and data sources across different studies have limited the depth of comparison and synthesis.

5. Conclusion

This study is a review article focusing on integrated elderly care and medical services in rural China. It aims to classify and synthesize the current landscape and problems regarding policy evolution, service provision, and policy implementation in this field. Ultimately, the study clarifies a fundamental shift in rural integrated care in China—from being primarily policy-driven toward a model characterized by multiple subjects participation and collaborative governance. It identifies and responds to the contradiction between the growing elderly care and medical demands of the aging rural population and the need for precise alignment in the supply and demand of care resources.

This study finds that the field of integrated elderly care and medical services in rural China has gradually developed a policy refinement path characterized by central-level top-level design and local-level innovative practices. Currently, China has over 7,800 integrated elderly care and medical service institutions, with social patricipants participating in more than 70% of them. Local experiences include Qihe County establishing regulatory standards and Tengchong City incorporating the Healthy City initiative into its urban development plan. But integrated elderly care and medical services still face challenges, such as fragmented service providers, shortages of elderly care resources, funding, and professional personnel, and difficulties in the promotion of digital solutions. In policy implementation, insufficient interdepartmental coordination and regulatory mechanisms that require further improvement remain systemic difficulties to be solved. These findings provide

valuable references for shaping the development path and facilitating feedback and improvement in integrated elderly care and medical services in rural China.

The core value of this study lies in providing a clear action roadmap for the high-quality development of integrated elderly care and medical services in rural areas: by establishing a multi-stakeholder collaborative governance mechanism, promoting supply-side service-oriented reforms, integrating digital technologies, and creating a new evaluation and supervision system centered on the well-being of older adults, thereby systematically enhancing the accessibility, quality, and sustainability of rural elderly care services.

Present studies also have certain limitations, which can be addressed through the following three avenues for further research. First, expanding the scope of research samples through cross-regional surveys and data collection would allow for further analysis of the differential development of integrated elderly care and medical services in rural China under varying levels of economic development. Additionally, increasing research focused on the demand side of older adults—by means such as fieldwork to engage with elderly individuals and their families—would help address the current lack of attention to service experience, practical effectiveness, and the specific needs of the elderly. Furthermore, future studies could focus on specific pathways for digital age-friendly reforms and the rural coverage of long-term care insurance, seeking feasible approaches to facilitate integrated elderly care and medical services and strategies for the sustainable development of elderly care resources and services.

Authors Contribution

All the authors contributed equally and their names were listed in alphabetical order.

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