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Research on the Construction of Three Level Elderly Care Service System in County, Town and Village

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Abstract

The degree of China's aging population has continued to deepen, and the social problems caused by it have become increasingly prominent. In this paper, through the study of the effectiveness and problems of the construction of the three level old-age service system in the county, town and village, and combined with the field survey in Jianhu County, Yancheng City, Jiangsu Province, countermeasures and suggestions are put forward to accelerate the promotion of the function of the grassroots old-age service system.

Keywords: elderly care, medical services, service system, village clinic

1. The Current Situation of Three Level Elderly Care Service System

(1) Three-level medical service

Three-level medical service system should be built for the health service circle(Marandi, 2022). Through the establishment of three level general hospital, two level medical institutions and one level medical and health institution, the rapid health service circle was built. The three level medical service system includes township (Center) health centers, village (community) clinics and individual clinics, so as to realize the full coverage of the township of the grassroots medical and health institution and the full coverage of the village health room and the village(Barke, 2024). The system will make the number of medical treatments in county-level medical units, town level medical institutions and village level medical institutions tend to be stable, avoiding the number of medical treatments in a single medical unit.

(2) Three-level elderly care service system

Three-level old-age service system should be establish to fuse County Service complex(Muliawati, 2024), Town Service Center, and Village mutual assistance. It is

necessary to build a multi-level and full coverage three level old-age service system including the county level old-age service complex(Nillaor, 2022), the town level comprehensive old-age service center, and the village level mutual pension and good neighborhoods(Aghaji, 2022). Governments at all levels need to introduce relevant evaluation methods for elderly services, comprehensively optimize and adjust the construction and operation evaluation standards and support policies for community home-based elderly care services, center day care centers, comprehensive elderly care service centers, and elderly meal and bath facilities(Dawam, 2021). Through the establishment of the county elderly care service complex, the town level comprehensive elderly care service center, the elderly canteen, and the rural mutual pension and good neighborhoods, a complete elderly care service system is formed.

(3) County level township level elderly care institutions

Public construction and private mode of county level township level pension institutions should be promoted. The welfare centers at all levels need to implement the model of "public construction and private operation". In the construction of county-level old-age institutions, medical and nursing enterprises can be introduced to establish Rehabilitation Hospital, and use the medical and nursing advantages of the enterprise to set up a "concentrated nursing home for the very poor", so as to improve the nursing level of the old-age institutions(Yorulmaz, 2021). In terms of the construction of town level pension institutions, it focuses on promoting the transformation and upgrading of town nursing homes and subdistrict nursing homes to standardized regional pension service centers, attracting high-quality pension service enterprises to operate, giving full play to the role of pocket, inclusive and demonstration, and constantly improving the bed utilization rate of public pension institutions.

(4) Smart home-based elderly care with doorstep services

The rapid development of smart home care home service should be guaranteed. It is necessary to actively explore the development of "Internet +" market + "home based elderly care home service, build a county smart elderly care service platform, improve the county, town and village three level elderly care service network, provide home based home service for the elderly and the elderly through the government purchase of services, actively carry out the family pension bed pilot, complete the family member care skills training, the aging adaptation project for the elderly family and the elderly family, install a key call and smoke alarm device for the elderly living alone, and constantly improve the happiness index of the elderly.

(5) Medical services capacity

The medical service capacity of primary health institutions should be Upgraded(Shakil, 2024). Continuously optimize the allocation of medical resources, complete the construction of emergency sub stations, and achieve the full coverage of the county's pre-hospital medical emergency service network(Intawong, 2021). Two, township health centers improve the quality and efficiency of high-quality services, formulate and implement the action plan for upgrading the service capacity of grassroots medical and health institution, achieve high-

quality service at the grassroots level, and build a community hospital. Around the development goal of "one hospital, one special", the provincial characteristic department, the municipal characteristic department and the grassroots characteristic department were built. Three is to build a distinctive Traditional Chinese Medicine library, including five level Traditional Chinese Medicine libraries, four level Traditional Chinese Medicine libraries and three level Traditional Chinese Medicine libraries, covering a comprehensive range.

(6) Village clinics

The distribution of village clinics. Increase medical investment should be balanced and reasonable(Chokphukiao, 2023). According to the provincial construction standards, new and rebuilt all administrative village clinics, and build provincial-level demonstration village clinics and provincial class a village clinics. Combined with the construction of rural residents concentrated settlements, scientifically adjust the planning and layout of village clinics, and give full play to the bottom role. The township health center will lead the village clinics to ensure the basic medical and health care and service supply.

2. Problems in the Three-Level Elderly Care Service System

(1) Low utilization rate of public elderly care institutions in towns and villages

The traditional "family elderly care" model based on Confucian filial piety culture is still the mainstream, and most elderly people choose to stay at home for elderly care. The proportion of elderly people who personally spend money on elderly care institutions is very low. The main reasons are: firstly, elderly people themselves are unwilling to leave their original living circle; secondly, they are afraid of spending money and increasing their children's financial burden; thirdly, their children are afraid of bearing the stigma of being unfilial to their parents and preventing them from going to private elderly care institutions. At present, the majority of people who spend money on elderly care institutions in county towns are elderly people who cannot take care of themselves. Therefore, there are few private elderly care institutions in Jianhu County, and the utilization rate of public elderly care institutions at the town and village levels is low.

(2) Low coverage of elderly care services

The current home-based elderly care services mainly rely on government purchased services. By purchasing elderly care services through the government, the basic needs of elderly people in urban and rural areas facing difficulties such as disability, disability, and lack of care that are difficult for their families and individuals to cope with can be addressed. However, due to the limited financial resources of the county, the service targets are only limited to elderly people, disadvantaged elderly people, and disabled elderly people, with a low service coverage rate. There are relatively few elderly people who independently consume and purchase elderly care services, and the social expansion service market needs to be improved.

(3) Difficulty in promoting the hierarchical medical system

The outflow of rural population is relatively prominent. With the accelerating pace of urbanization construction in counties, some permanent residents of towns and villages have

been relocated to urban areas, resulting in a continuous shrinkage of the service population of village level primary medical institutions, which restricts the development of village level medical institutions. In addition, due to the weak guiding role of the reporting policy of medical insurance at the county and town levels, coupled with convenient transportation, rural patients tend to seek medical treatment in county towns for serious illnesses, making it difficult to promote the hierarchical medical system.

(4) Shortage of professional talents in village clinics

It is difficult to recruit personnel from grassroots medical and health institutions at the town and village levels, and there is frequent mobility. There are relatively few full-time undergraduate medical students openly recruited by primary healthcare institutions, and the majority of medical students who volunteer to serve at the grassroots level are college graduates, especially in the fields of oral anesthesia, otolaryngology, technology, and psychological counseling, which are difficult to find. The village clinic is facing a severe shortage of professional talents due to low income and lack of attractive job opportunities.

3. Elderly Care Services in Jianhu County of Jiangsu Province in China

At present, Jianhu County has 305 medical institutions, including 1 comprehensive hospital of Grade III and Grade B, 6 secondary medical institutions, 18 primary medical and health institutions, including 16 township (central) health centers, 2 other medical institutions, 234 village (community) health clinics, and 44 individual clinics. The county has actually opened 3495 beds, achieving full coverage of grassroots medical and health institutions in towns and villages, and full coverage of village clinics and residences. The number of diagnosis and treatment visits in county-level medical units, town level medical institutions, and village level medical institutions account for 41%, 26%, and 33% of the total number of diagnosis and treatment visits in the county, respectively. There are 2669 institutional elderly care beds in the county, including 1814 nursing beds, accounting for 67.9%. By the end of 2023, one county elderly care service complex, six town level comprehensive elderly care service centers, 10 elderly canteens, and 16 rural mutual aid elderly care neighbors will be added.

The county has provided free home-based services to over 32000 elderly people in need and elderly people, completed care skills training for 70 family members, and carried out aging friendly renovation projects for nearly 1200 families of elderly people in need and elderly people. It has installed one click call and smoke alarm devices for 2460 elderly people living alone. It has built 64 provincial demonstration village clinics, 6 provincial Grade A village clinics, 2 fifth level traditional Chinese medicine clinics, 2 fourth level traditional Chinese medicine clinics, 13 third level traditional Chinese medicine clinics, 3 provincial characteristic departments, and 18 municipal characteristic departments, with a coverage rate of 70.6% for grassroots characteristic departments.

4. Strategies for Improving the Three-Level Elderly Care Service System

(1) Adhere to the main position of “family elderly care”

The aging population at the town and village levels is large and widespread, and the Confucian filial piety culture that has long been rooted in rural China has formed the

traditional model of "family elderly care". “Filial piety and indulgence of children” is the highest ideal and greatest spiritual sustenance for elderly people in China in their later years. Vigorously promote the traditional Chinese filial piety culture and adhere to the dominant position of “family elderly care”. Elderly people who are nourished by family affection are more likely to gain a sense of belonging and security, which can reduce the cost of elderly care, promote family harmony and intergenerational communication, and vigorously promote the traditional Chinese virtues of respecting the elderly, loving the young, and respecting the elderly for thousands of years. In towns and villages, a good elderly care culture atmosphere is constantly created, where the elderly are physically and mentally happy, the family is harmonious, the neighbors are harmonious, and the community is harmonious.

(2) Persist in providing grassroots elderly care services

Continuously improving the level of family elderly care security, strengthening the expansion of home-based services and content, and significantly increasing the coverage of home-based services for the elderly. Guiding the establishment of family elderly care beds, adhering to the implementation of aging friendly home renovation, exploring the construction of family care beds, and supporting emergency call system services for empty nest elderly living alone.

Accelerate the completion of service facility shortcomings, and build at least one comprehensive elderly service center with functions such as full day care, rehabilitation and health care, and home services in each town and street. Encourage the construction of "hub style" elderly care service complexes with comprehensive functions within the built-up areas of each county, and achieve basic full coverage of meal and bath assistance points for elderly people in urban communities. Complete the transformation and upgrading of rural home-based elderly care service centers, gradually transforming them into mutual aid elderly care and neighborly points.

Promote the transformation and upgrading of institutional services, promote the transformation and upgrading of public nursing homes into standardized rural regional elderly care service centers, and open the remaining beds to disadvantaged elderly people in rural areas. Encourage high-quality elderly care service enterprises to implement branding and chain operation. Improve the medical service capacity of elderly care institutions, encourage the development of integrated medical and elderly care institutions, community embedded elderly care institutions, open up special care areas for disabled and dementia elderly, increase the supply of nursing type elderly care beds, and meet the rigid service needs of long-term care for disabled and dementia elderly.

(3) Innovative model for attracting and training grassroots medical talents

In terms of talent attraction and innovation, according to the actual needs of grassroots medical and health institutions, we entrust the training and targeted training of full-time undergraduate medical students or college medical students urgently needed at the grassroots level to fill the weak personnel of township health centers or village level health clinics. Every year, a certain number of town level and village level doctors are appointed to regularly attend county-level or city level hospitals for further training. At the same time, experienced

retired and retired experts are hired to regularly provide assistance and training to grassroots medical and health service institutions

In terms of incentive policies, we will moderately relax the policy of attracting grassroots medical talents, encourage and guide high-quality and high-level talents to serve in grassroots medical and health institutions, and moderately relax conditions in terms of professional title evaluation and children's education according to service years and performance. At the same time, increase the sharing ratio of primary healthcare institutions in medical insurance reimbursement settlement.

5. Conclusion

Through the study of the county-level elderly care service system and field research, the paper would help achieve high-quality “elderly care and medical care”.

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Authors contributions

Yunqi Li was responsible for study design, data collection and analyse. Jun Sun revised the manuscript. All authors read and approved the final manuscript. In this paragraph, also explain any special agreements concerning authorship, such as if authors contributed equally to the study.

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