INSTITUTE FOR GLOBAL PROSPERITY

‘The Last One Kilometre’
the Community-Based Eldercare System in Beijing

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Abstract

Ageing China, as one of the most significant and profound social topics, has sparked tremendous discussions in the academic field. Facing the surging and irreversible ageing trend, China is promoting community-based eldercare nationwide, which is widely named 'the last one kilometre'. Beijing has also made its own attempts under national guidance. This dissertation is to evaluate Beijing's practice through a mixed methodology: horizontal comparative review of Italy, the United States and Japan's relatively mature eldercare system from a macro view and focus group interviews of two chosen communities in Beijing from a micro view to generate a comprehensive analysis. As a result, Beijing's design can be concluded as a three-levels eldercare network with public-private partnership (PPP) cooperation as the main pattern under the leadership of the government. Regarding the elderly people's perceptions, although price and family as the most sensitive and valued aspects of elderly people have been satisfied, and most of them expressed positive attitudes towards Beijing's practice, some of their demands present diverse and non-uniform characteristics and are hard-to-meet through unified design. In the end, this dissertation suggests that sustainable eldercare and higher prosperity for elderly people can be achieved through grass-roots empowerment and rent-seeking behavior prevention. The contribution of this dissertation is that it innovatively combines macro theoretical analysis with micro interviews, ensuring the systematic, comprehensive and practical value of the research, filling the academic gap and providing valuable theoretical and methodological references for future research.

Keywords: *Community-Based Eldercare, Beijing's Practice, Comparative Review, Focus Group Interview*

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List of Abbreviations

ADHC - the United States Adult Day Health Center

ASLs - Italian Local Health Authorities

CDRF - the China Development Research Foundation

GDP - Gross Domestic Product

GPs - General Practitioners

LREC - Local Research Ethics Committee

LTC - Italy Long-Term Care

LTCI - Japan Long-term Care Insurance

NDRC - the National Development and Reform Commission

PACE - the United States All-inclusive Care for the Elderly

PPP - the Public-Private Partnership

SDGs - Sustainable Development Goals

SSN - Servizio Sanitario Nazionale (National Health Service)

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1. Introduction

China's rapid population ageing has become one of the most pressing issues during the past decades. The main drivers of demographic change include the "One-Child Policy", a sharp decline in fertility rate, changes in marriage perceptions and family patterns due to rapid economic development and the urban-rural gap. In addition, development of medical technology and cultural changes have further accelerated the ageing trend *(Flaherty et al., 2007)*. By the 2030s, more than 25% of China's population will be over 60 years old. The demographic change will have a profound impact on the economy and public policies. The growing elderly population will bring major challenges to elderly care services, health care, and public welfare distribution. In order to cope with this pressure, the government and institutions must implement more comprehensive, detailed, and sustainable policies. Efforts such as expanding pension and medical insurance coverage, developing infrastructure suitable for the elderly, and innovating the elderly care system urequire careful planning and execution. In addition, the ageing trend will also have a wider impact on areas such as the labor market, consumer behavior, and the real estate industry, although these aspects will not be discussed in depth in this article. Therefore, the issue of China's population ageing is a complex and multifaceted topic that requires the joint efforts of the government, society, and individuals. Facing this trend, the Chinese government is promoting a community-based eldercare system, which is widely named as 'the last one kilometre' by local managers and planners. Specifically, it means the elderly people's common demands and required daily services can be found within one-kilometre ranges.

Urbanization is an important indicator of a country's development level and a focus that Chinese governments at all levels have always attached great importance to. According to *Sun et al. (2016)*, China's urbanization rate is expected to exceed 70.12% by 2030. By then, the urban population will increase by 386 million, and the permanent urban resident population will be over a trillion. This shift will not only promote industrial transformation, but also place higher demands on urban management. Coupled with the ageing trend discussed earlier, solving problems related to the elderly in urban areas has become more critical and urgent. In addition, the high population density in cities makes the elderly care system itself more complex, and it is possible to become a model for wider application across the country.

Therefore, in light of China's ageing population and continued urbanization, this paper will focus on innovative urban elderly care systems. Specifically, the paper will focus on Beijing. Beijing is an ideal location for social research because it is one of the most

populous cities with more than 21 million residents and often serves as a testing ground for new policy implementations.

What is the true prosperity? This is the core question of my IGP research. Prosperity is not limited to economic success or technological progress; it is an abstract and subjective concept that varies from group to group. Therefore, field research is essential to understand the real perspectives of different groups. Although the older generations make up a large part of Chinese society, they often find themselves marginalized in the rapidly evolving technological environment, their voices are rarely heard, and their needs are ignored. Therefore, it is crucial to explore their needs and design a sustainable system that suits their needs, especially in the context of ageing and urbanization, which will face major challenges in the future. Hence, this dissertation aims to answer the following questions: What are the urgent demands of the Chinese elder generation, and how can a sustainable and feasible eldercare system be designed under China's circumstances? This dissertation will not only analyze Beijing's practice through theoretical methodologies but also reveal the true demand and perceptions of elderly people through face-to-face interviews and further offer an innovative research structure for subsequent research.

This dissertation can be divided into seven sections. In section 2, the related literature is presented and illustrated to build a stable basis for further research. This section starts with a background of China's ageing trend and China's specific circumstances. It also briefly introduces some of the mature and representative examples of world elder care and provides explanations of the reasons for choices. Besides, the key elements of a sustainable eldercare system are discussed in China's context. In section 3, the main methodologies are introduced, including the advantages and how to process them in the following analysis. Section 4 and 5 are the main bodies of this dissertation. In section 4, the comparative reviews are used to generate a horizontal comparison among the eldercare systems in Italy, the United States and Japan through several aspects to conclude the positive and negative experiences that are valuable for Beijing's practice. Section 5 introduces the preparation, process, and results of focus group interviews and analyses the characteristics of the elderly people's demands and perceptions. Following the main body, section 6 gives a comprehensive analysis of the comparative review and focus group interview and concludes the pros and cons of Beijing's current practice. Finally, section 7 concludes the whole dissertation and discusses the aspects that can be further improved in future research.

2. Literature Review

2.1 Background

Starts with the demographic background of China's eldercare system. Under the irreversible tide of ageing, population structure transformation has obtained wide social consensus. According to the Seventh Population Census conducted by the *National Bureau of Statistics of China (2021)*, although China still has a large population of over 1400 million, the average annual growth rate sharply reduced to 0.53% in 2020. The sluggish average annual growth rate becomes the most direct culprit of the ageing crisis. The census also shows that the population over 60 years old occupies 18.70% of the whole population, which has increased by 5.44 percentage points compared with the sixth national census in 2010. *Zeng (2001)* describes China's ageing trend as 'two highs and three larges'. 'Two highs' represents the high speed of the increase and the high proportion of the ageing population, whereas 'three larges' represents the large elderly population, large dependency ratio and large regional disparities. This trend is far more than temporary; population transition caused by the birth rate has long-term effects, as the current fierce ageing peak has a strong connection with the baby boom in the 1950s and 1960s *(Chen, 1999)*. The low birth rate nowadays has great inertia over time. *Li. et al. (2009)* make a stochastic forecast for the future trend of China's population. In his forecast, the total population hit the peak in 2024 with 1,372 million people, which is in line with the actual situation and steps into a moderately decreasing period. As for the age structure, he predicts that China will shift to a structure with characteristics similar to Europe's pattern. That is, the largest age group will gradually shift to the population in the 60 to 70 range despite the uncertainty of the young generation and eventually reach a 'regressive age pyramid shape'. Thus, European experiences could provide considerable reference value to this dissertation.

Urbanization, as the only road towards modernization and the realization of the 'China Dream'[1], is another significant long-term trend for China's development. China has made great progress in urbanization after Reform and Opening Up from 1978, reaching 65.22% by 2022. Urbanization is a comprehensive and complex concept that includes aspects from economic structure and social structure to spatial structure *(Guan et al., 2018)*. According to the document published by *the National Development and Reform Commission [NDRC] (2019)*, one of the key tasks of China's urbanization construction is to accelerate the transition of the agricultural transfer population and promote the

[1] 'China Dream': An alternative expression of 'the Great Rejuvenation of the Chinese Nation'. Specifically manifested in the prosperity of the country, the rejuvenation of the nation, and the happiness of the people *(Jin, 2017)*.

settlement of 100 million non-registered people in cities. From the angle of population distribution, urbanization will also have vital impacts on the spatial distribution of China's elderly population. This urbanization trend is also verified in the 2021's census, which shows that 63.89% of the population live in cities, with an increase of 14.21 percentage points compared with 2010's level. Surprisingly, the ageing and urbanization trends seem to have a 'coupling' effect in that the ageing rate is significantly higher in those regions with higher urbanization rates like Liaoning (25.72%), Shanghai (23.38%) and Heilong Jiang (23.22%) *(Li et al., 2009)*. Therefore, cities will become the main field of China's future elder system in practice, which is correspondingly the main focus of this dissertation.

Under the collective effects of overwhelming ageing trends and urbanization, China is facing tremendous social pressures to handle the issues properly. According to *Zhu and Walker (2021)*, the challenge for China is mainly in the following aspects. Firstly, the rapid growth of the elderly population will bring a heavy burden to the social welfare system, which is mainly supported by government finances. Secondly, owing to the absence of a robust market mechanism caused by the unfinished 'social welfare socialization'[2] strategy raised in the 1990s, there exists a huge gap between the elder service supply and the potential demand in the next decades. Also, the decline of the family scale caused by the past 'one-child' policy not only increases the pressure on family eldercare but also aggravates the imbalance between supply and demand. Besides, *Zhu and Walker (2021)* also mention that the expansion of the elder population scale will bring challenges to the sustainability of social pension, which is more like a fiscal rather than an eldercare issue. Meanwhile, the dialectical methodology firmly believes that challenges and opportunities coexist. China's ageing future also contains tremendous opportunities. A comprehensive and sustainable eldercare system design can not only help China cope with the great pressure brought on by the ageing trend but also provide wide opportunities for China's development and the older generation themselves. Therefore, the value of this dissertation is to evaluate the current attempts in Beijing and discover a feasible eldercare structure design that could contribute to China's urgent demand and help the older generation realize their own prosperity.

[2] 'Social welfare socialization' is raised by the Ministry of Civil Affairs in 1983 which proposed the combination of state and social forces to develop social welfare. Specifically, promoting the transformation of social welfare from a single, closed state-run system to running by the state, collectives and individuals *(Chen, 2004)*.

2.2 China's circumstances

To ensure the feasibility and reliability of this dissertation, it is necessary to have a basic understanding of the China's specific circumstances before processing the formal analysis and design. Hence, this part will introduce the eldercare system in the context of China's circumstances from three aspects: history, culture and current status.

The history of China's eldercare practices can be traced early to the Northern and Southern Dynasties (AD 420-589). According to *Mu and Wang (2023)*, the first nursing house was built by Emperor Wu of Liang, which provided food, clothing, and funeral affairs to elders without descendants. This system was developed maturely in the Sui Dynasty (AD 581-618) and Tang Dynasty (AD 618-907), when established large-scale nursing houses with correspondingly institutional support. For example, during the WU Zetian era, a charity institution called 'Beitian Health House' *(悲田养病坊)* was built *(Mu & Wang, 2023)*. In the next thousand years, China's eldercare system gradually developed in the direction of popularization and initially presented the seed of marketization in the Qing Dynasty (AD 1644-1911). Under the context of the absence of government and the weakness of local gentries, the Taiping Heavenly Kingdom built Puji Tang *(普济堂)*, which was organized by the government and the public jointly. However, in ancient China, the function of eldercare had not separated from other social welfare institutions as an independent and professional sector. Known from the introduction above, it is obvious that the eldercare system in ancient China only focused on the groups under extreme difficulties, which is described as the widower, widow and lonely *(鳏寡孤独)*. Thus, it was a preferential rather than a universal system with a relief function. *Wang (2016)* points out that although many attempts at the eldercare system had been made, the majority of eldercare responsibility was taken by families in ancient China; as for how to build the responsibility of family eldercare, the dominant means is via the establishment of social morality, like the thoughts of Confucius and Buddhism, which will be further discussed in the culture section. Besides, the government also had reward and punishment measures to promote eldercare, like commendations and tax reductions *(Wang, 2016)*. However, an interesting point is the concept of 'family' in ancient China is different from its modern explanation. It is similar to the meaning of 'clan', which was greatly eliminated during China's socialist revolution.

From the angle of the culture, 'filial piety' *(孝)*, which originated from the Clan Commune Era, is the theoretical basis for the spirit of respecting and caring for the elderly of China *(Kang, 2000)*. Although the philosophical ideas of ancient China thinkers such as Confucius, Mozi, Zengzi and Guanzi are quietly different, their similar attitudes towards 'filial piety' together form the keynote of respecting and caring for

the elderly of China *(Wang, 2016)*. 'Universal Love' *(兼爱)* is the main proposal of Mozi, and his view of the elderly is also in line with this proposal. Mozi wanted all the elderly to be cared for, including those who are without a spouse or descendants, via universal love. Compared to the 'universal love' of Mozi, Confucius's proposal mainly focuses on the responsibility of families, especially the responsibility of children. He believed that it is the most fundamental responsibility of children to take care of their parents. Zengzi is usually considered the Heir of Confucius's Thought *(Wang, 2016)*. His elderly-related proposal also takes the position that 'filial piety' should be the most basic morality and children should take the main responsibility. Different from the proposals from Mohism and Confucianism, Ganzi put his emphasis on institutional policies. He suggested nine policies that cover the aspects of food, diseases, clothing and social assistance, which could be seen as the ideological basis of the aforementioned eldercare institutions in ancient China. The thought of 'filial piety' played a significant role in the development of Chinese philosophical thought over thousands of years and will provide guidance on values and methodologies for China's eldercare system design in the relatively long term. Therefore, it can be concluded from history and culture background that in the traditional Chinese culture, the responsibility for eldercare should be taken by society and family together. That is, from the view of continuous culture, families will continue to play an important role in China's eldercare system, and the pattern of custodial nursing homes would be difficult to be accepted by China's public.

China's urgent demand for a comprehensive eldercare system originated from its rapid demographic shift, or precisely, the proportion of ageing in the population structure. Several studies have been conducted on the existing elder care designs in urban China. Take Nanjing as an example, *Feng et al. (2011)* analyze the eldercare system construction during the first decade of the 21st century. Their research mainly focuses on industrial growth, ownership, funding, eldercare staff, residential characteristics, and government policy support. In the first decades, the scale of Nanjing's elder institutions realized significant growth, and most of the newly established facilities were invested by private sectors. Regarding the ownership, the government dominated the development before the 1990s, in charge of about 96% of the eldercare industry. However, the private sector gradually took the leading position; about a quarter of the industry in Nanjing was controlled by non-governmental sectors till the 2010s. Correspondingly, the funding sources of elder care facilities follow a private-government cooperation pattern: the government provides bed occupancy subsidies, and over 80% of daily operating costs are afforded by payments and donations from private sources. The staff of current eldercare industries present the characteristics that most of them are rural migrant workers, which provides an ideal employment

channel. However, this also leads to the consequence that most of them are not professional and lack related medical and caring knowledge. Besides, the staff-elder ratio is about 18:100, which can basically ensure the nursing level of eldercare facilities. Regarding the conditions of eldercare facility residents, 18% need eating assistance, 40 need dressing assistance, and 41% need walking assistance, and those proportions are significantly higher in non-governmental facilities, which raises higher requirements for their management and caring levels. As discussed above, the design of the Chinese government's eldercare industry has changed during the past two decades. Specifically, it shifted from the 'government sectors dominating' pattern to the 'government-private sectors cooperating' pattern, which endows private sectors with larger space and freedom to develop. Hence, how to balance the relationships between government and private sectors is an important question that needs to be answered in the future.

Krings et al. (2022) systematically examine China's 'Five-Year' policy plans on the eldercare system construction field. The six main topics in the Chinese government's policies are Infrastructure, Community Involvement, Home-Based Eldercare, Filial Piety, Active Ageing and the Eldercare Industry. In China's official design, community elder care has three main functions: daily care, basic family care support, and promotion of cultural and sports activities. To realize its design and leverage the strength of community involvement, China has introduced a series of relevant policies. For example, the mandatory licensing requirements for community nursing institutions were cancelled in 2018 to lower the market entry barriers and provoke market vitality. Besides, local governments are required to build and improve elder infrastructures for education, leisure and entertainment. From 2015 to 2020, the Chinese central government allocated 5 billion yuan (approximately 743 million US dollars) to encourage countries in 203 cities to build new projects for home-based elderly care services. Overall, these policy incentives aim to enhance the role of communities in elderly care services by reducing market access barriers, providing financial and technological support, promoting social participation, and utilizing technological innovation. Moreover, as we know from the whole picture of China's policies, community involvement is not an independent direction but rather designed to be a vital part of the comprehensive social eldercare system.

2.3 Mature system in other countries

Compared to China's emerging community eldercare system, several countries have faced the same ageing situation for decades and have built relatively mature community-based systems since last century. Thus, it is worthy to learn from their experiences by horizontal comparative review. Before the formal analysis, it is

necessary to discuss which countries and regions have similarity to some extent with China's circumstances so that can provide valuable reference significance for China's design.

Firstly, in Europe, because of the population age structure change caused by World War II, many attempts at elder long-term care (LTC) were made as early as after the war. According to *Theobald & Luppi (2018)*, elder LTC in Europe can roughly be classified into three patterns: the 'Public Financing Cluster' represented by Sweden, the 'Public Financing of Private Care Cluster' represented by Germany and the 'All in the Family Cluster' represented by Italy. Unlike Sweden's and Germany's policies, which separately emphasize publicly financed family care and public services, Italy's LTC strongly emphasizes family care supported by the state. This is combined with the aforementioned discussion about the characteristics of China's circumstances, where families play an important role in the eldercare system. Italy's pattern is much more similar to China's design. Furthermore, Italy's LTC is under a subsidiarity framework, which takes local and regional governments as central execution, and the central government plays the role of cash benefits provider and policy maker *(Albertini & Pavolini, 2015)*. Another characteristic of Italy's LTC is that informal care services have significant dominance in the market; only 10% of the elderly population relies on public care services. This private sector leading pattern could provide precious experiences in the context of China's strong encouragement of private sector development. Therefore, Italy's 'All in the Family Cluster' pattern is more suitable as the analysis example in the formal comparative review part compared to other European countries.

Another classic example of community-based eldercare system is the Program of All-inclusive Care for the Elderly (PACE) of the Uniter States, which was first applied in San Francisco in the 1970s. The birth of PACE was under the urgent ageing trend caused by the baby boomers in 70s, and the population over 65 is estimated to occupy 20% by 2030, which has demographic similarity with China's circumstances *(U. S. Bureau of the Census, 1996)*. PACE serves those who are over 55 years old or sufficiently frail that are needed to be provided comprehensive health services by their states. The main aim of PACE is to enable elders who are qualified for nursing standards to continually live in communities rather than moving into eldercare facilities *(Mui, 2001)*. Hence, PACE set it to emphasize the function of the community, which is similar to China's design. Different from the traditional independent community-based eldercare system, the PACE system consists of many community care centers that provide basic medical, nursing, nutrition, pharmaceuticals, and other daily-life services. However, the financing model of PACE is quite different from Italy and Japan; PACE obtains capitation

payments from state government programs, such as Medicare and Medicaid, rather than obtaining a package of government funding. Despite the differences in the funding pattern, the United States PACE still could provide precious experiences and lessons for China's practice in organizational structure, departmental collaboration, service quality improvement, cost control and other aspects.

Furthermore, because of the similarity of ethnicity, culture, population density, and other aspects of China, Japan's practice is worthy of analysis. For the community-based eldercare in Japan, *Yamada & Arai's (2020)* research illustrates Japan's Long-term Care Insurance (LTCI) system, which was introduced in 2000. Similar to European countries, the population change caused by World War II gave birth to the prototype of Japan's eldercare system. The financing model of LTCI looks like the combination of Italy's LTC and the United States' PACE. LTCI's budget is equally afforded by premiums (50%) and taxes (50%), where all citizens over 40 years old are required to pay premiums, and the tax funding is from the national government (25%), prefecture (12.5%) and municipality (12.5%). Older individuals who are certified by LTCI only need to afford 10% of the services charged. In LTCI's planning, a 'Community-based Integrated Care System' will be established by 2025. In Japan's design, home medical support is the cornerstone of the system; other home-based services are also important, such as caring, nursing, nutrition, etc. Japanese officials also promote extensive participation of social groups to reduce disability incidence and long-term care costs by holding community group activities. From 2013 to 2017, the number of relevant social groups in Japan surged from 43154 to 91059.

Overall, from a global perspective, mature community-based elder systems in Italy, the United States and Japan have own characteristics and are suitable for comparative review. In the comparative review part, this dissertation will conclude the strengths and weaknesses of these three patterns and build references for the further design. However, for China's specific national conditions, neither of them can perfectly fit in. Italy's LTC, in which informal services take dominance in the market, is not applicable in the short term to the Chinese market, which is still dominated by the public sector; the United States' PACE has a different financing pattern from China's design; Japan's LTCI with the highest similarity with China's design but is still in progress, still have uncertainty in practice to some extent. Therefore, the dissertation's design will not simply copy existing designs but give a unique design that is based on the characteristics of China's conditions.

2.4 Key points of eldercare system

About how to assess the quality of care and how to build a high-quality system,

Donabedian's (1997) approach is one of the most significant landmarks in this field. Before assessing the quality, it is necessary to specify what is the standard of the quality. Donabedian proposed that the quality of care can be assessed from four scopes: performance of staff, distribution of services among individuals, consequence of care, and monetary cost. Donabedian divides the performance of staff into two sub-aspects: technical and interpersonal. Technical performance measures the knowledge and judgment of staff in practice and interpersonal performance, which is usually ignored when assessing, affecting the effect of care and feedback from elders. Interpersonal performance is the vehicle of technical implementation and decides its success. The second scope represents the distribution of the service among elders in the community. That is, the experience of each individual might differ because of the limited resources. How to ensure that each elder can have the same services equally is important for system design. The third scope is to measure the service effect. However, who is to value is controversial. Sometimes, effects are hard to be fully felt intuitively by elders, and it is hard to give subjective judgements for those with perceptual disability individuals. Finally, monetary cost is another important part of quality assessment. Donabedian points out that the 'Diminishing Returns Law' is also applicable to the caring field. Thus, balancing the relationship between cots and effectiveness is important for a nationwide system. Donabedian also mentions other aspects, including environmental, privacy, convenience, and family contributions. Although Donabedian's approach gives a valuable reference to system design and is widely used in the caring field, it mainly emphasizes the top-up assessment, which ignores the feelings and opinions of the elders themselves. Therefore, this dissertation will use the structure of Donabedian's approach, but it will use the focus-group interview to explore the true needs of elders in Beijing and build the design based on their voices. Besides, the sustainable development goals (SDGs) could also provide reference values. Since created in 2015, the SDGs plays an important role in the effect of solving global poverty, environment, health, education, gender and other social issues. Taken ‘peace and prosperity’ as ultimate goal, the SDGs emphasizes that its goal represents the common prosperity of human society, that is, covers the different age ranges, genders and regions. Ageing as a universal topic has strong connection with many of the 17 goals of the SDGs. Precisely, the statements in the SDGs about well-being, poverty, gender equality, inequality and sustainable community could be taken as effective criteria for China’s design.

Furthermore, before formally designing China's community-based eldercare system, it is important to discuss the concept of 'community' in China's context. In the Western context, 'community' developed from the German word 'Gemeinschaft', which represents social organizations, including families, neighborhoods, and settlements

that are based on nature, blood or geography *(Ferdinand, 2012)*. 'Community', as an imported word which first appeared in the Chinese context until the 1930s, is translated as '*社区*', which means a space occupied by people *(Li, 2012)*. Compared with its original definition, 'community' is simpler and more inclined to the space concept without spiritual meaning in the Chinese context. As the 'community' concept is constantly being deconstructed and reconstructed, it is gradually becoming not only limited to the academic field but has also started to be widely used by the public since the 1990s in China. According to *Li's (2012)* research, the 'community' concept has the following characteristics in modern China. Firstly, it emphasizes regional division. Introduced by Chicago school scholars in the 1930s, it naturally has a similarity with Chicago's usage. Besides, the 'Hukou' policy and other Chinese ideologies further deepen this path dependence in practice. Secondly, a significant difference in the Chinese context is its emphasis on the material content. In the Western context, 'community' refers more to the people themselves. In China, it also refers to the material contents in space, including air, food, water, the environment, infrastructure, and other resources. Besides, as a socialist country, 'community' has been given a political meaning that it did not originally have, which is the most vital difference from the Western context. After China's state-owned enterprise reform in the 1990s, the original state-owned enterprises-based city governance pattern was no longer applicable. Communities that were generally divided by streets gradually became the most fundamental unit of the city governance system. Corresponding, subdistricts *(街道办事处/街道办)* and residents' committee *(居民委员会/居委会)* became the most fundamental unit that carries the roles of government and Communist Party of China (CPC). In the political context, 'communities' is the widest and most direct department that is related to citizens' daily lives. Just like the Sinicization of Marxism in historical practice, the meaning and role of 'community' also have experienced forty years of Sinicization and has become a part of China's specific national condition. Therefore, the political role of 'community' will still play a vital role in China's future eldercare system. It also decides that the community-based eldercare system in other countries cannot be directly copied into China's practice. Field research on specific situations is necessary for China's design.

China's community-based eldercare system is still in the early stages of exploration, and the mainstream research in academia is mainly focused on simple analysis of existing policies. Although some scholars have analyzed the existing international systems, they have not yet become mainstream. In addition, there is a lack of research from the perspective of the elderly. Therefore, this dissertation will combine the comparative theoretical review and focus group interviews to fill these gaps, evaluate Beijing's practice, and provide an analytical framework for subsequent research.

3. Methodology

Based on the former discussion, this dissertation will combine the horizontal analysis of community-based eldercare systems with field research. Hence, this section will introduce the methodology of this dissertation: comparative review and focus group interviews.

3.1 Comparative review

Firstly, as a scientific methodology, the comparative review aims to generate a comprehensive, unbiased and accurate analysis of certain topics. Compared to the traditional literature review, a comparative review has the superiority of standardized and structured approaches. It is a scientific research approach frequently used in the medical and healthcare field. Therefore, this dissertation will follow the brief introduction of community-based eldercare systems in Italy, the United States and Japan above, analyze the strengths, weaknesses and practical experiences more deeply and comprehensively by using the comparative review and finally provide steady support for further research.

Roughly, the procedure of the comparative review can be divided into five steps. Step 1: Framing the target questions. The first step before proceeding with the formal analysis is to frame the main questions to be discussed in a clear, specific, unambiguous form. By doing this preparation step, the subsequent information collection and analysis would have a clear and obvious direction and range. Step 2: Identifying the relevant literature. Based on the pre-framed questions, it is necessary to collect adequate information from relevant literature to structure a comprehensive foundation. *Khan (2003)* also points out that literature should not have language restrictions, which is applicable to this dissertation and the literature in Italian and Japanese could be valuable for analysis. Step 3: Summarizing the findings. Following the analysis procedure, this step will mainly conclude the findings from literature about the target questions. Step 4: Interpreting the results. In the final step, the former steps including information collection and discussion will be examined to ensure the results are unbiased and reliable. Suggestions will be given in the end to the further research of this dissertation.

As discussed in the literature review, Italy, the United States and Japan have built a relatively mature eldercare system when facing the ageing trend and have decades-long experiences in practice. The aim of comparative review is to discover the answers to: How are the eldercare systems of Italy, the United States and Japan and what lessons can be learnt from their cases? To generate a comprehensive analysis, sub-

topics are necessary to be set. The analysis will be processed through 6 dimensions: geography and sociodemography, Economic context, political circumstance, care system, financing and critiques.

3.2 Focus group interview

Following the comparative review, field research will be processed to step into Beijing's communities to discover the real demand of the elderly there. As a popular social research technique for collecting qualitative data, focus group interviews have proven their feasibility in the field of caring and have also been effective for elder groups *(Heller et al., 1990)*. Regarding the approach of the focus group, this dissertation will use semi-structured interviews. *Longhurst (2003)* provides a mature and comprehensive guideline about how to process a focus group semi-structured interview. He points out that the ideal size of focus groups is between 6 to 12 participants, and a quiet, familiar site could be helpful. Unlike structured and non-structured interviews, questions in semi-structured interviews need to be prepared, but they rely more on the interactions between the interviewee and interviewer. As for the focus group interview with elder groups, *Heller et al. (1990)* especially mention the importance of simplifying language to give a better understanding. It is believed that this dissertation will obtain intuitive and precious information about the perceptions and perspectives of the elderly population in Beijing. However, limitations also exist. Because of the limited sample size, the results of focus groups have no universality and need further quantitative analysis to verify *(Heller et al., 1990)*. Also, the group format might inhibit sharing and affect individual expression, which further influences the results generated from the interview.

Furthermore, before processing the focus group interviews, it is necessary to discuss the choices of focus groups. This dissertation will choose two communities in Beijing, the capital city of China as the example. Firstly, as one of the largest cities in China, Beijing has the second largest population (22 million, slightly lower than Shanghai) and a relatively high ageing proportion (14.2% over 65 years old). Secondly, as the political center of China, Beijing has unparalleled advantages in policy, economic, fiscal, medical, infrastructure and many other aspects compared to most cities in China. Besides, 32 communities have been set as the model communities in Beijing as the national community eldercare construction in the near future. Therefore, Beijing could be an ideal example to test the current attempts, discover the key points and provide precious information for China's design and that ofother Chinese cities.

The first step is to decide the interviewees of the research. Currently, although China is making great effort to promote community-based eldercare and has introduced a

series of relevant policies from the government side, the construction is still in the early stage and has no clear and unified direction. In other words, China's current attempts are in the stage of diversity and uncertainty. In this context, this dissertation chooses two communities separate in two districts in Beijing, which attempt different pathways in practice. One of them focuses on the expansion of traditional community service and is titled as the 'National Model Elder-Friendly Community', which is a national demonstration project that names 999 communities nationwide *(National Health Commission of the People's Republic of China, 2023)*. The other one focuses on the technological innovation of eldercare scenarios such as smart care and is directly endorsed by *the Beijing Municipal Civil Affairs Bureau (2023)*.

In a nutshell, the innovation of this dissertation is to design a community-based elder care system suitable for China by combining the comparative review and focus group interviews, which mainly focus on the perspectives of the elderly themselves.

4. Comparative Review

As a social system that serves one of the largest groups and relates to numerous industries, the eldercare system is not isolated and should be analyzed under the basic social backgrounds. Thus, this section will separately discuss the geography and sociodemography, Economic context, political circumstance, care system, financing and critiques of the eldercare systems of Italy, the United States and Japan.

4.1 Italy: Long-term care

4.1.1 Geography and sociodemography

Firstly, a brief introduction will be given about Italy's basic geographic and sociodemographic conditions. Italy is a parliamentary republic southern European country with 59 million population (2022), which is the sixth most in Europe. The population density of Italy is 198.2 (Persons per square kilometre), which is double the European average level; around 69% of the population is living in urban areas. As for the population structure, from the 1980s, it changed significantly owing to the remarkable declines in fertility rate and life expectancy; ages over 65 occupy 24% of the population till 2023 *(Eurostat, 2023)*.

4.1.2 Economic context

As a traditionally developed country in the European Union zone, Italy is the fifth largest in Europe and the tenth largest in the world ranked by nominal gross domestic

product (GDP). However, nominal GDP is far from reflecting the economic development of a country with depth. Three macroeconomic indices could be helpful to this dissertation: GDP per capita, fiscal deficit-to-GDP ratio and Gini index, which separately represent the overall economic condition, government fiscal ability and wealth gap of a country. Hence, according to the data from the World Bank, the GDP per capita is 34,776.42 USD, the fiscal deficit-to-GDP ratio is 8.6%, and the Gini index is around 0.35 *(World Bank, 2022)*.

Although Italy is the main economy in Europe, the GDP growth rate has not been optimistic since the 1980s and suffered severe depressions during the Wall Street financial crisis (2008) and the Covid-19 pandemic. Hence, tight fiscal policy became the mainstream of Italy government during the past decades, which further resulted in the reduction of social welfare including pension and health-care benefits and the rise of private sectors as the replacement of the role of public responsibility.

4.1.3 Political circumstance

Italy is a parliamentary, democratic republic with a multi-party political system. The Italian territory is divided into 20 regions by the Constitution with significant variety. For example, the ageing rate is higher in the central and northern areas than it is in the southern regions. Compared to the relatively more liberal legislative powers of each region, their financial autonomy is limited. Only 20% of the tax income can be freely arranged and is mostly used in the regional healthcare system. According to the Bassanini Law published in 1997, the responsibility for regulating, planning and organizing the healthcare system has been distributed to regions themselves and the central government only retains the responsibility for establishing basic principles and institutional rules, authorizing the National Health Plan and distributing fiscal budget in the healthcare sector *(Ferré et al., 2014)*.

However, five out of the 20 regions including Valle d'Aosta, Friuli-Venezia Giulia, Province of Trento, Province of Bolzano, and Sicily & Sardinia are given their home rule power on legislation, administration and finance by the Constitution. Meanwhile, these regions need to afford their budget for healthcare, education and infrastructure systems *(Ferré et al., 2014)*.

4.1.4 Care system

In a broad sense, Italy's care system is based on a national system called the National Health Service (Servizio Sanitario Nazionale, SSN), which provides universal services. This system consists of three levels: national, regional and local. Roughly speaking, the national level is in charge of benefit packages, financing and budget distribution, monitoring and other macro and long-term care tasks. The regional level shares the

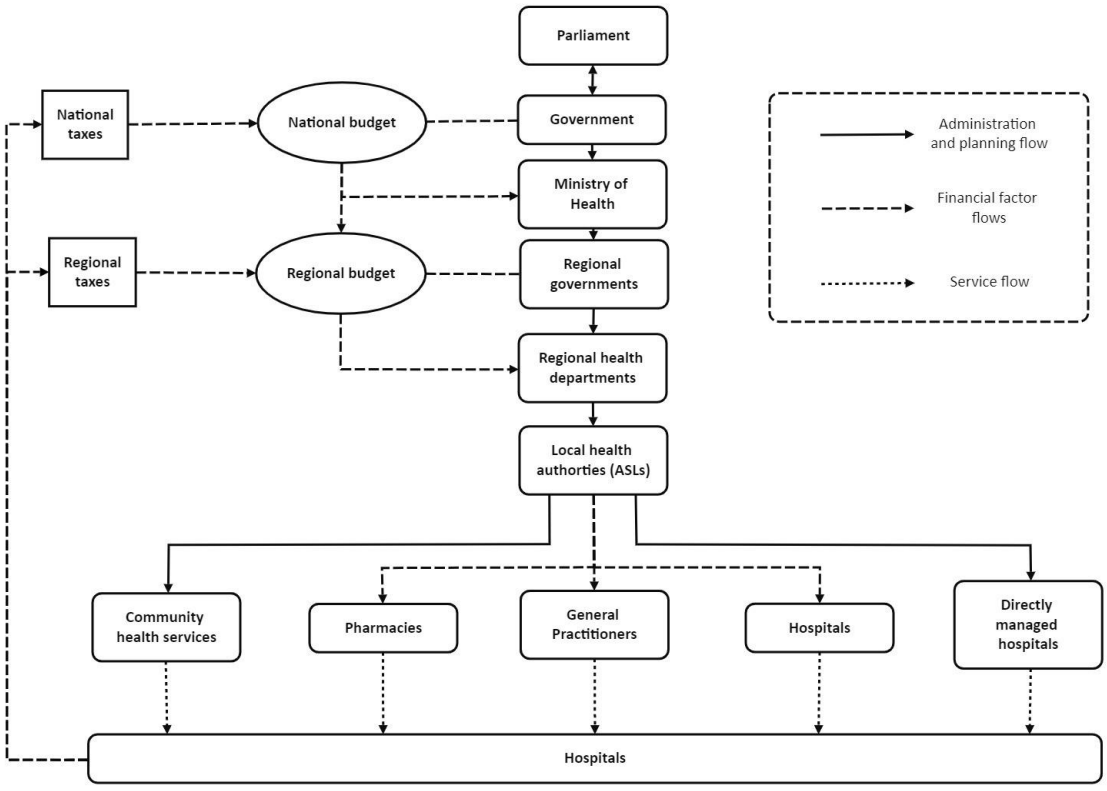
planning and financing responsibilities with national institutions but more like the role of complement, which is mainly in charge of the short-term plan and specific implementation details of the health care plan *(Ferré et al., 2014)*. At the local level, Local Health Authorities (ASLs) play central roles and are directly ruled by regional departments. Different from pharmacies and commercial hospitals, community services, which include medical/nursing care and home/residential care, are administered and funded by ASLs and follow the general plans.

4.1.5 Financing

At the national level, according to *Ferré et al. (2014)*, 78% of Italy's care system budget is from public sources, with tax income being the majority. 17.8% is from out-of-pocket payments, which are generated from diagnostic procedures, pharmaceuticals, and unconventional care. In Italy, only 1% of the care budget is afforded by private health insurance. About the distribution, the annual budget is commonly allocated into three categories in which community health care occupies 50% of the funding.

At the citizen level, SSN covers all citizens and also ordinary European Union residents, who can accept totally free general community care services.

Figure 1. *Structural Overview of Italy Long-Term Care*



4.1.6 Critiques

Facing tremendous pressure from the ageing trend, although Italy has built and practiced its LTC system under the structure of SSN for decades, many critiques toward its current situation still exist. The main critique is about the disorganized LTC system, which is described as 'jungle' by *Ferré et al. (2014)*. Firstly, this disorganization is reflected in the blurred responsibility division. Theoretically, ASLs, as the direct administration institution of community care, should take the major responsibility for LTC services. However, in real practice, the general practitioners (GPs) network, which belongs to the regional system, plays the essential role. This disorganization is also reflected on the larger scale. Because of the aforementioned care system, every region has sufficient autonomy regarding their care plan, including budget plans, which leads to an obvious regional imbalance in care facilities and service qualities *(Ferré et al., 2014)*. Roughly, elderly people in more affluent northern regions could enjoy better services. Furthermore, excessive waiting times is also another maligned problem. The rapid growth of the elderly population and the slow replenishment of medical and community workers lead to the imbalance between supply and demand in LTC services. According to *Signorelli et al. (2020)*, 15% of patients need to wait for more than 60 days in public care facilities. Therefore, while Italy has made undeniable progress in its LTC system in facing the ageing trend, effective practice is still a long way off.

4.2 The United States: All-inclusive care for the elderly

4.2.1 Geography and sociodemography

In a broad geographical sense, the United States is the collective term of mainland, Alaska, Hawaii and several Pacific islands such as Northern Mariana, Virgin and Guam. Because of the inconsistence and complexity between the U.S. mainland and its enclaves, the United States in this section is narrowly defined as the contiguous United States, i.e., 'the Lower 48'.

According to a report published by *USA FACTS (2024)*, in 2023, the population of the United States reached 334.9 million and achieved a positive growth of 1.6 million. As the world's fourth largest country ranked by land mass, slightly lower than China, the population density is 36 (Persons per square kilometre), which is only one-fifth of Italy. However, over 90% of the population lives in urban areas, especially in New York, California and Florida *(World Bank, 2022)*. The United States is also facing severe ageing problems; people over 65 years old will occupy 18% of the population in 2023. Besides, as an immigrant country, the diversity caused by the immigrant influx is worthy of note. For example, immigrants contributed 74% of the population net increase. The most direct consequence of this change is the diversity of ethnic makeup;

the proportion of white people has dropped from 80% to 58.9% in the past decades, and Hispanic people have surpassed black people and become the second-largest race in the United States *(USA FACTS, 2024)*. The ethnic diversity would further lead to the diversity of religion and culture and would bring more challenges for the eldercare system practice.

4.2.2 Economic context

As one of the designers of the post-war global order, the United States has obtained tremendous wealth with overwhelming technological advantages and the strong position of the U.S. dollar. Although the U.S.'s GDP growth rate has maintained a low rate in recent years, its total nominal GDP occupies the top position by 27.36 trillion USD *(World Bank, 2023)*. Like the discussion of Italy, GDP per capita, fiscal deficit-to-GDP ratio and Gini index can reflect the economic situation more comprehensively. As for the United States, the GDP per capita is 81,695.2 USD, the fiscal deficit-to-GDP ratio is 6.3%, and the Gini index is 0.40 in 2023 *(World Bank, 2023)*.

4.2.3 Political circumstance

As a presidential federal republic country, the United States has a relatively complete democratic system like Italy. However, the care system of the United States is widely different from Italy's, which even can be described as 'unique' worldwide. The U.S. was the only developed industrial country that had no uniform care system and universal care coverage until the compulsory coverage – 'The Affordable Care Act' was legislated in 2010 by ex-president Obama.

Regarding the factors that caused this strange phenomenon, *Vladeck (2003)* raised an explanation that money contributions play a vital role in the election system of the U.S., and groups with significant resources oppose universal care. Correspondingly, politicians from both parties prefer to choose a middle ground in order to obtain maximum support. Thus, this natural limitation will continually influence the care practice of the United States in the foreseeable future.

4.2.4 Care system

As mentioned before, the United States has no uniform and universal care system; the major responsibilities are taken by private sectors, and there exist differences among states. Specifically, most regulatory frameworks are designed haphazardly and nearly have no consideration of how to collaborate *(Federal Trade Commission & The Department of Justice, 2004)*. Hence, the All-inclusive Care for the Elderly (PACE) of the United States is not processed under a national framework like Italy.

The PACE itself originated from an attempt made by a community agency in San Francisco which aimed to provide an alternative to frail elderly persons with multiple medical conditions by offering community-based medical and social services. After being widely recognized and promoted in a wider range, PACE gradually evolved into a more mature and universal pattern. Based on the community, PACE provides a one-stop service package, including facility services and long-term community services. Speciality and ancillary medical care, social work and restorative therapy are provided in health care, hospital nursing homes and other PACE facilities. In the community, aside from medical care, other auxiliary services are also available, such as transportation, food, home care, and personal care *(Mui & A. C., 2001)*.

Organizationally, the PACE pattern consists of the adult day health center (ADHC), PACE housing, hospital and home. ADHC is the service-delivery center that mainly provides primary medical services, including assessment, treatment and rehabilitation. 90% of PACE participants are utilizing ADHC services *(Mui & A. C., 2001)*. Housing is the PACE site designed for the elderly who lack of support from family. Hospitals are only for those who are out of the care ability of primary care to cope with urgent and emergency situations. Home services are to provide in-home medical care by skilled medical personnel.

4.2.5 Financing

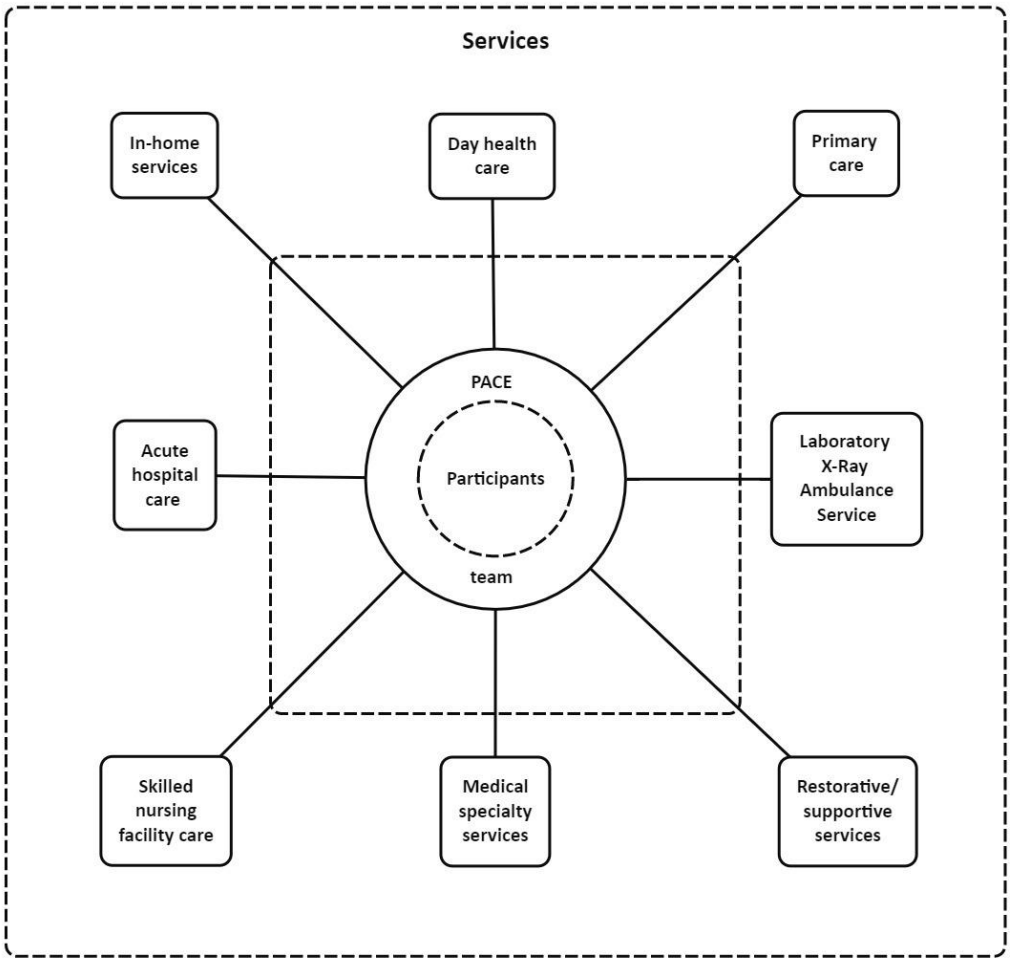
Different from the financing model of Italy's LTC, supported by direct fiscal payment from central and regional governments, PACE is mainly financed by the federal health program Medicare and Medicaid. Specifically, PACE receives monthly payments counted by registered capitation; participants out of Medicaid need to pay monthly fees themselves. However, the specific amount is calculated by Medicare and Medicaid and differs from different states based on geographic data. For example, the monthly capitation fee is $3330 in Alabama *(Polska, 2017)*.

4.2.6 Critiques

Although it has had great success in the United States, limitations still exist in the design of PACE. Firstly, the service range of PACE is limited. Currently, there are 167 PACE organizations in 33 states, but the Mideastern states such as Montana, Wyoming, Nevada, and Arizona are not covered *(PACE, 2023)*. Secondly, the eligibility criteria of PACE are strict. PACE is financed by Medicare and Medicaid, so the enrollment also strictly follows the standard of those federal programs. Specifically, the participants need to meet four conditions: ①Age over 55; ②Live in PACE covered area; ③Certified by the state that needs the nursing home level of care; ④Able to live safely in the community when enrolls *(PACE, 2023)*. Thirdly, from a financial angle, the

all-inclusive pattern of PACE has no caps for service costs and has no opportunity to shift when the costs are unaffordable *(Eng et al., 1997)*.

Figure 2. *Structural Overview of The U.S. All-inclusive Care for the Elderly*



Besides, limitations also exist in practice. Firstly, although home service is designed as a vital component of PACE, the service rate is far away from expectation, only 2.4 hours per month per participant, which is lower than the number of housemakers with 10 to 17 hours. Secondly, PACE provides housing facilities for elderly people without family support. However, the housing resources are limited, and it usually takes 4 months to 2 years to wait for a space. Finally, because PACE is led by private sectors, it leads to the absence of a unified and well-planned management. The community doctors who are originally in charge of the community care services are dissatisfied because PACE takes the clients that should belong to them *(Mui & A. C., 2001; Eng et al., 1997)*.

4.3 Japan: Long-term care insurance

4.3.1 Geography and sociodemography

Consisting of 4 main islands and more than 3000 small islands, Japan has a 377,727 km^2 combined land area. Different from Italy and the United States, Japan is a typical island country with limited land resources. Additionally, three-fourths of Japan's topography is predominantly mountainous. Only 4.4% of the land is used for residential usage with a high population density of 338 (Persons per square kilometre), which is approximately 2 times of Italy and 10 times of the U.S. *(Ministry of Land, Infrastructure, Transport and Tourism, 2024)*.

According to the data published by *the Statistics Bureau of Japan (2024)*, in 2024, the overall population is 123.96 million, where the population over 65 is 36.26 million, occupying about 29.2% of the whole population. It is obvious that Japan's ageing population problem is far more serious than that of Italy and the United States. According to research by *the National Institute of Population and Social Security Research (2023)*, Japan's population has stepped into a decline and is expected to fall below 100 million by the mid-century. However, the ageing population would not follow the declining trend of the overall population. The population over 65 is expected to reach a peak of 39.53 million in 2043. As for the rate, 38.7% of the population would be over 65 in 2070. Thus, although Japan's ageing population problem has reached a high level, it is far away from the most serious moment.

4.3.2 Economic context

As one of the most rapidly developed economies after the World War, Japan has struggled in a liquidity trap for nearly 20 years since the 1990s. Until today, Japan still has no hope of returning to the place once owned in the world economy. In 2023, the GDP per capita is 33,834 USD, the fiscal deficit-to-GDP ratio is 6.4% and the Gini index is 0.31 in 2023 *(World Bank, 2023)*.

Japan's economic difficulties appear to be the consequence of the burst of bubbles in financial markets and real estate markets, but they are closely related to the imbalance of population structure. 1990 was the landmark of economic recession; the Bank of Japan raised the interest to depress inflation and overheated asset markets. Meanwhile, the total fertility rate dropped below 1.57, which is called the '1.57 shock' *(Population Reference Bureau, 2010)*. 'The lost decades' began. *Aoki (2013)* analyzed the relationship between the ageing population and the economic downturn; he believes that Japan's rapidly growing elderly population and financial support for eldercare policy have, in an unwise way, brought heavy burdens to the economy.

4.3.3 Political circumstance

Different from Italy and the United States, Japan has a largely different political system: constitutional monarchy under a dominant-party bicameral parliamentary. The Prime Minister leads the Cabinet and directs the executive institution, the National Diet owns the legislative power, and the Judicial power is vested in the Supreme Court and lower courts. For example, the LTCI of Japan launched in 2000 and experienced a lengthy process: The proposal will be discussed, evaluated, and decided by the Cabinet and ruling party before being submitted to the National Diet.

Although Japan implements an election system, the Liberal Democratic Party has been in power since 1955 nearly continuously. Following the economic context, *Aoki (2013)* also proposes that the ruling party's pursuit of votes made them refuse to make changes to balance the relationship between the financial budget and eldercare cost.

4.3.4 Care system

Implemented in 2000, Japan's LTCI emphasizes the role of community-based care rather than institutional care to relieve the increasing care stress. In Japan, the rate of the number of people using Home/Community care and Institutional care is 1:1. Organizationally, the care services are roughly delivered through community/home services and institutions. Community/home services are mainly divided into 15 categories: primary and short-term care, such as bathing, nursing, rehabilitation and basic medical care. Also, small-scale and multifunctional assistant facilities and group homes are available for specific groups like elderly people with dementia *(Tsutsui & Muramatsu, 2007)*. The majority of institutional responsibilities are taken by general nursing homes, professional medical nursing homes and sanatorium-type nursing homes *(Yong & Saito, 2012)*. Compared to Italy and the United States, Japan's community services are more comprehensive, not only including medical and nursing services but also offering life assistance services.

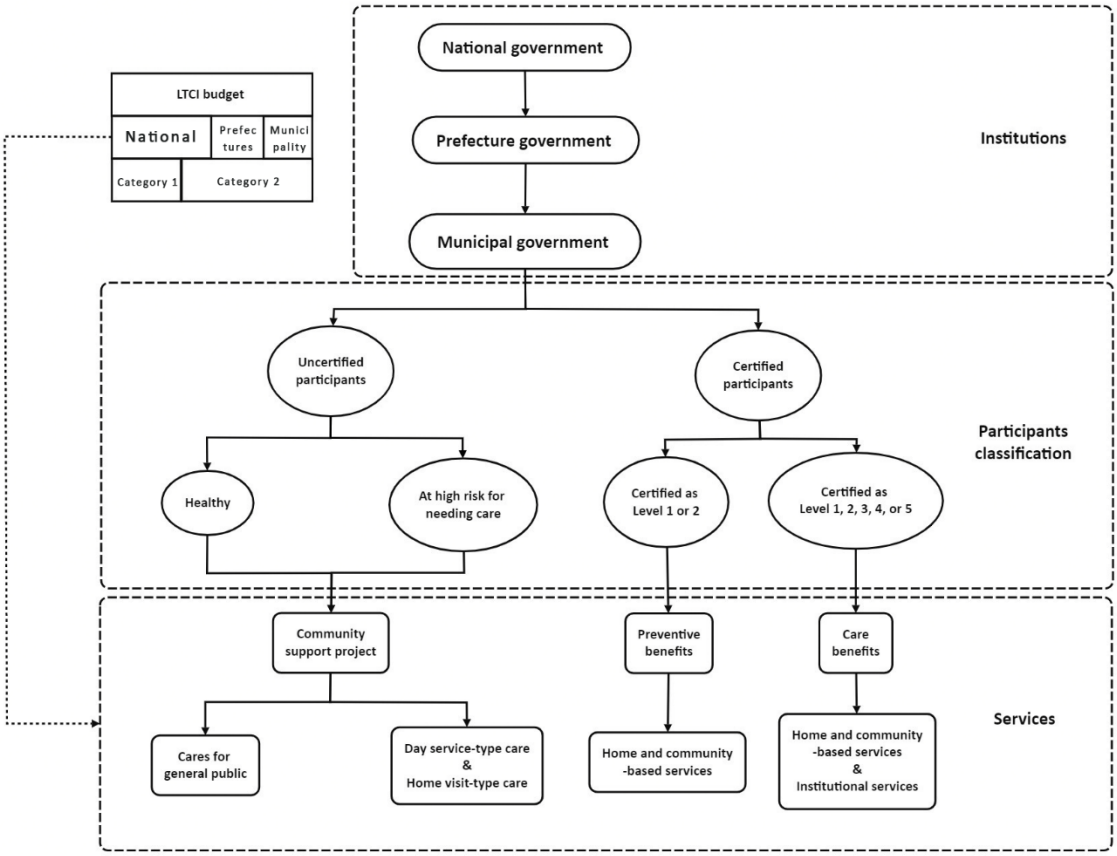
As for the participants, Japan's LTCI divided the elderly people into two categories. Category 1 is those who are over 65 and eligible for services regardless of certification. Category 2 is those who are between 45 and 65 and need to be certificated due to ageing-related diseases *(Tamiya, 2011)*. Category 1 has a larger available services range, but also has differences in expenditure. Generally, insurance premiums are calculated depending on the age, income and residence region.

4.3.5 Financing

Compared to Italy's and the United States' funding patterns, Japan adopts a more sophisticated system. Roughly speaking, the cost of LTCI is afforded by the government

budget and insurance premiums equally. Specifically, half of the budget is shared by the National Treasury as a fixed rate (20%), the National Treasury as a subsidy (5%), Prefectures (12.5%) and Municipality (12.5%). As for the other half, which is afforded by participants, category 1 contributes 22%, and category 2 contributes the last 28% *(Japan Health Policy NOW, 2019)*.

Figure 3. *Structural Overview of Japan Long-term Care Insurance*



4.3.6 Critiques

Although Japan's LTCI system provides a valuable and high-level pattern of eldercare system for other countries under ageing pressure, critiques and challenges also exist.

From a structural perspective, the cost of LTCI continuously increases due to the growing elderly population. Although the total cost is afforded together by citizens and three levels of government, it will still be a heavy burden. The government can solve the funding shortage through tax reform, but the citizens seem helpless. Secondly, LTCI lacks regional flexibility in implementation. The national government determine the policy structure, including age eligibility, assessment standards and care prices, whereas regional gaps are widening. Thus, LTCI cannot adjust rapidly according to

specific circumstances during implementation.

From an individual perspective, inconsistency exists between policy objectives and policy orientations. Excessive subsidies towards institutional services make elderly participants prefer nursing homes rather than community services and cause a long waiting list for beds. To cope with this situation, some regions introduced the policy that participants need to pay for their meals as out-of-pocket expenses, and the situation is alleviated to some extent. Critique also exists among LTCI employees. Employees in communities and institutions are universally facing the problem of heavy workloads and low income, and this problem will be more serious in the foreseeable future *(Yong & Saito, 2012)*.

4.4 Discussion

Combining the discussion above, Italy, the United States and Japan have made own attempts at community-based eldercare when facing the ageing trend, and all have achieved surprising results. To generate a more intuitive comparison of those systems, show the major information below:

Table 1. *Horizontal Comparison among Italy, the U.S. and Japan*

		Italy	**the U.S.**	**Japan**
Geography and socio-demography	Population *(million)*	59	334.9	122.6
	Population density *(persons / km^2)*	198.2	36	338
	Proportion over 65 yrs	24%	18%	29.2%
Economic context	GDP per capita *(USD)*	34,776.4	81,695.2	33,834.0
	fiscal deficit-to-GDP ratio	8.6%	6.3%	6.4%

	Gini index	0.35	0.40	0.31
Political circumstance	Government form	parliamentary republic	presidential federal republic	constitutional monarchy
Care system	Property	public	private	mixed
	Structure	hierarchy	grid	parallel
		national ↓ *regional* ↓ *local*	*ADHC* ↓ *hospital* ↓ *housing* ↓ *home*	*institutions / community & home*
	Services	medical nursing	medical nursing	medical nursing residential
Financing	Fund sources	government budget (78%) **+** participant payment (18%)	federal health program	government budget (50%) **+** insurance premiums (50%)

Although differences exist among those three systems, some common advantages can be recognized:

- Participants diversion: All those eldercare systems design a mechanism that the community only provide primary care and basic services; other chronic diseases and emergency conditions are served by corresponding nursing homes and hospitals. While ensuring efficiency and quality of care, it also reduces the pressure and workload of community workers.

- Systematic planning: Both Italy's LTC and Japan's LTCI are designed by governments and a unified framework for differentiated implementation. Although the United States PACE system is mainly led by the private sector, it also has an independent department to decide the development plan and policies. This ensures the rational utilization of resources and regional and institutional cooperation in the system.
- Mixed funding sources: Italy's LTC and Japan's LTCI are financed by both the government and the public, although the proportions differ. Superficially, PACE is entirely financed by Medicare and Medicaid. Actually, Medicare and Medicaid budgets come from taxes, income, and insurance premiums. On the one hand, this kind of combination broadens funding sources; on the other hand, it also eases government fiscal pressure and reduces the deficit risks.

Besides, there are some aspects that are not common but worthy of mention and learning about the eldercare systems of those three countries. Firstly, in the early stage of the United States PACE system, a scientific data set had already been built. Information, such as patient records, is collected from every PACE site. Based on this mechanism, the advantages and challenges of the system in practice can be collected, analyzed, and shared, which have great positive implications for PACE's adjustment and development *(Mui, 2001)*. Besides, in Japan's LTCI, to ensure the quality of care services, participants can choose their providers. If participants are not satisfied with their care workers, they can apply a change by reporting to their care manager. Generally, most workers serve the participants' interests well out of worrying about potential conflicts *(Tamiya, 2011)*.

Apart from the positive aspects, challenges and difficulties are more valuable to this research. Some critiques have been discussed before. Conclude those lessons as below:

- Ambiguous responsibilities: As discussed on Italy's part, ambiguous care responsibilities lead to the consequence that general practitioners (GPs) play the major role that should be played by local health authorities. In Japan's case, a lack of clarity between different care levels causes the overcrowding of institutions such as nursing homes and hospitals. Hence, ambiguous responsibilities could cause the unreasonable usage of limited resources, affect care efficiency and bring damages to both elderly people and the care system.
- Financing risks: Although the financing patterns of the United States and Japan are different, both face increasingly serious financing risks. For the United States, cost caps are not set in the PACE, and the pattern of being fully funded by Medicare and Medicaid makes it no way to shift the cost burden. For Japan, under the fixed

financial cost share, an individual's burden would continually increase with the increase in the total cost. Hence, facing the growing ageing problem and the increasing elderly population, how to distribute the cost and build a financially sustainable eldercare system is another vital aspect that needs to be considered.

- Regional imbalance: The regional imbalance of care resources and qualities is a common problem In Italy, the United States and Japan. Generally, the services are better in those richer regions. Hence, how to eliminate or minimize the imbalance is another criterion for a high-level eldercare system.

Overall, this section systematically and comprehensively analyses the existing community-based eldercare system in Italy, the United States and Japan. Through those cases, the advantages and disadvantages could both become precious experiences for China's eldercare system. As a famous Chinese saying goes: Crossing the river by feeling the stones.

5. Interview Findings and Analysis

5.1 Interview design

Following the discussion above, this dissertation uses focus group interviews to process the empirical qualitative study. A semi-structured interview format is used to collect the perspectives and attitudes of interviewees to their community-based eldercare services. Before processing the recruitment and formal interviews, the reach ethic form application has been approved by the IGP's Local Research Ethics Committee (LREC). All the interviews are voluntary, all the private information, including name, address, contact numbers and other recognizable features, are not collected, and all collected data is strictly confidential. This dissertation chooses two communities in two districts in Beijing. Because the real names of communities are not permitted by residents and community workers, this dissertation will use Community Alpha and Community Beta to represent them. The interviewees' recruitment procedure is voluntary, and some small gifts are used to attract elderly people. Also, community workers are interviewed on smaller scales to collect their perspectives more comprehensively.

The interviews are designed as about 60 to 90 minutes each and 6-12 people as a group scale. The interview starts with ice-breaking activities. Self-introduction, research background, and research purposes are introduced to help interviewees better understand the interview itself and the benefits they can obtain. Then,

interviewees are invited to introduce themselves to build a comfortable and relaxing atmosphere and let them feel free to express their opinions. The formal interview starts with a basic question about their daily life and gradually induces them to share more in-depth information.

Marinelli, et al. (2023) empirically examine the 3I-8P model and proposes that it is a comprehensive framework to promote sustainable eldercare services. The focus group interview questions will be designed under this framework and to cover topics from community services, facilities, and workers to their families and their perceptions of current situations through 8-10 questions. In addition, interviews with community workers are also processed. In consideration of their work time, the interviews are much shorter and aim to discover the elderly people's lives from another angle and their perceptions of the current community-based eldercare design. The interview questions are at the end of the dissertation (See Appendix).

Table 2. *The 3I-8P Conceptual Framework*

Integration	Health/Life Smart Care	Product
	Residential/Community/Home	Place
	Low/Medium/High	Price
Inclusion	Welfare/Commercial	Promotion
	CareGivers/Receivers	People
Institution	Planning/Marketing	Process
	CareHome/HomeCare	Physical Evidence
	Public/Private	Partnership

Source: Marinelli, et al. (2023)

5.2 Samples

The interviewees are from two communities of two different districts in Beijing. Community Alpha is in Dongcheng district *(东城区)*, and Community Beta is in Chaoyang *(朝阳区),* which are two districts but with huge differences. To present the background of the two communities, compare them through the Beijing Regional Statistical Yearbook published by *the Beijing Municipal Bureau of Statistics (2023)*.

Demographically, the population of Dongcheng is largely smaller than Chaoyang. This numeral relation remains in the external population, where the proportion of the external population in Chaoyang is obviously larger than it is in Dongcheng. However,

in spite of Dongcheng's smaller population, the population density is over two times of Chaoyang. About the ageing population and corresponding rate, Dongcheng is slightly higher than Chaoyang. Economically, Dongcheng's general public budget is nearly half of the budget of Chaoyang, whereas there is a tiny difference between the disposable income per capita of the two districts.

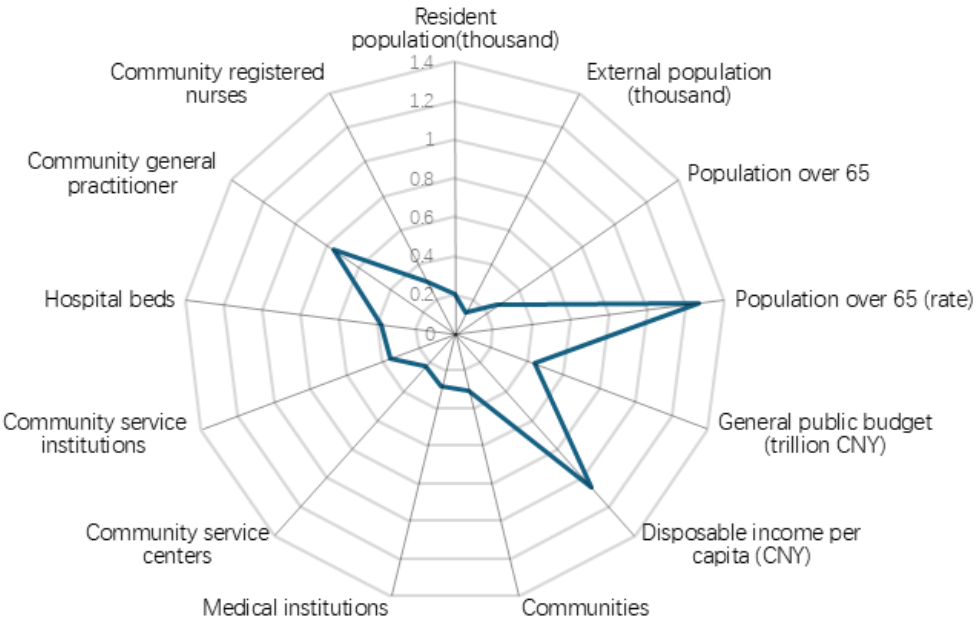
About the smaller scope of the medical and care field, some criteria can comprehensively present the conditions in two districts. The medical institutions criteria contain all categories of medical and care sites including hospitals, community services centers, maternal and child health hospitals, disease control and prevention centers and Clinics. Other criteria present more information at community level. Obviously, Chaoyang has advantages in every criterion because of its population advantage.

Table 3. *The Chosen Districts of Focus Groups*

Community	**Alpha**	**Beta**
Location	Dongcheng	Chaoyang
Resident population(thousand)	704	3442
External population (thousand)	149	1240
Population density (Persons per square kilometre)	16818	7564
Population over 65	129249	492775
Population over 65 (rate)	18.2%	14.3%
General public budget (trillion CNY)	24.99	56.24
Disposable income per capita (CNY)	92040	86981
Communities	168	544
Medical institutions	544	1910
Community service centers	65	280
Community service institutions	327	919
Hospital beds	10027	26401
Community general practitioner	390	516
Community registered nurses	595	1973

To better show the comparison between those two districts, it is vital to eliminate the influence of total numbers (See as Figure 4). The rate is an ideal index with intuitiveness and continuity. Take the population rate of 0.2 as the benchmark; a rate higher than 0.2 means Dongcheng is relatively higher in proportion, and a lower than 0.2 means Chaoyang is relatively higher in proportion. Based on this assumption, the relations are much more obvious. Demographically, the external population occupies more of the population in Chaoyang, but the ageing rate is higher in Dongcheng.

Figure 4. *Adjusted Ratio between Focus Groups Chosen Districts*



Economically, Dongcheng's general public budget is richer. In the medical and care aspects, the situations are entirely opposite to the total numbers; Dongcheng has advantages in every criterion, especially in community-level numbers. Precisely, Dongcheng has relatively more community service institutions, general practitioners and nurses in the proportion scope.

Overall, in the context of focus group interviews, Dongcheng is more densely populated, has a more adequate budget for public spending, and has a more serious ageing problem at the local level. From a community scope, Dongcheng also has richer medical and care resources to cope with its elderly population. Individually, residents in Dongcheng are commonly wealthier, and this could affect their perceptions of life.

5.3 Data collection

The research involves two focus groups designed to explore elderly individuals' perceptions of community-based eldercare services. The sample consists of 22 elderly interviewees from Community Alpha and Community Beta. Focus group Alpha comprises 12 interviewees and focus group Beta comprises 10 interviewees, both of which are carefully selected to ensure a balanced and representative sample. The focus group Alpha is composed of seniors from Community Alpha, while the other group includes residents from Community Beta.

The interviewees range in age from 65 to 87, with a fairly even distribution across this age span. In the focus group Alpha, the interviewees include 5 individuals aged 65-74, 5 aged 75-84, and 2 aged 85 and older. The focus group Beta also mirrors this distribution, with 5 interviewees aged 65-74, 3 aged 75-84, and 2 aged 85 and older. This age range ensures that the study captures a broad spectrum of experiences and perceptions, from those who are relatively young seniors to those who are in advanced old age. Also, both groups include a mix of genders, with each group consisting of relatively even proportions. Focus group A consists of 7 males and 5 females and focus group B consists of 4 males and 6 females. This gender balance allows the study to explore any differences in how men and women perceive and interact with eldercare services.

In terms of health status, the groups include interviewees with varying degrees of mobility and health conditions. In focus group Alpha, 7 interviewees state good health conditions with minimal mobility issues, while the other 5 have chronic conditions that require regular care to varying degrees. In focus group Beta, the split is slightly different, with 5 interviewees in good health, 4 with chronic diseases and the last one dealing with more significant health challenges. This diversity in health status is crucial for understanding how different levels of need impact the use and perception of community-based eldercare services.

The socio-economic backgrounds of the interviewees also vary between the two communities. In line with the discussion in the previous section, Community Alpha is characterized by a wealthier level with interviewees generally more financially stable, while Community Beta includes more interviewees from external residents' households. This contrast helps to explore how financial resources influence access to and satisfaction with eldercare services.

All interviewees were recruited using voluntary sampling, targeting local senior centers, healthcare providers, and community organizations within the two communities. The selection process aimed to reflect the demographic and socio-economic diversity

within each community, ensuring a comprehensive understanding of the factors shaping elderly residents' perceptions of eldercare services.

The focus groups are conducted in familiar community settings to make the interviewees feel comfortable and to encourage open discussion. The relatively small size of each group ensured that every individual had the opportunity to share their experiences while still allowing for a dynamic and interactive exchange of ideas. This approach is expected to generate rich qualitative data, providing deep insights into how elderly urban residents perceive and experience community-based eldercare services within their specific contexts.

Table 4. *The Composition of Focus Groups*

		Community Alpha	**Community Beta**
Focus group size		12	10
Age range	65-74	5	5
	75-84	5	3
	Above 85	2	2
Gender	Male	7	4
	Female	5	6
Health status	Healthy	7	5
	Chronic diseases	5	5

5.4 Findings

5.4.1 Integration findings

Place

The attitudes of interviewees about the place of eldercare are roughly consistent between the two communities and among group interviewees. Among family, community and institutions, the majority expressed a strong preference for home care, valuing the comfort and familiarity of staying in their familiar circumstances. Some interviewees highlighted the importance of maintaining their independence and routine, with home care services allowing them to age in place while receiving the

necessary support. In the interviews, many interviewees mentioned the role of 'family' in their preferences, and home is not just a location concept for them, but rather an emotional and spiritual concept. Hence, the company of family and the sense of being 'in a family' is a significant criterion for eldercare. For example, an interviewee described this demand as:

'I have suffered all the hardships and enjoyed all the happiness in my life. Now, I don't have many requirements for food and clothing. I just want to spend more time with my family.'

Community care was viewed favourably as well, particularly by those who were more socially active or who had little health needs. The interviewee's comments about community care cover roughly three aspects: daily services, medical services, and social activities. Daily services, mainly considered as food supply and home maintenance, are useful for those who live alone. For medical services, the community can only offer basic support. In community Alpha, physical examinations are regularly organized and are highly praised. These interviewees from both communities also appreciated the social interaction and activities available in community centers, which provided a sense of belonging and reduced feelings of isolation.

Institutional care was generally seen as a last resort. Many interviewees directly expressed their dislike or even resistance because of their concerns about losing their independence and being removed from familiar environments. Conversely, those who live alone or with more significant health challenges, especially in community Beta, acknowledged that institutional care might become necessary if their health deteriorates or if they can no longer manage at home. Overall, the interviews indicated a clear preference for home and community-based care, with institutional care considered and accepted only when other options were no longer enough for maintaining their lives.

Product

As discussed above, basic daily services and medical services are commonly applied by two communities and highly praised by interviewees. In addition to the daily food supply and home maintenance, which significantly facilitates interviewees' lives, daily services are essential for those who live alone or have mobility issues. For example, in Community Alpha, an interviewee with relative serve mobility issues who needs assistance expressed his appreciation for community services, which offers him

comprehensive day-time assistance to help him walk and socialize in community.

Healthcare services were also regarded as essential, with interviewees expressing a strong appreciation for regular medical check-ups, medication management, and access to health professionals. Many interviewees with chronic diseases especially emphasized the importance of these services in maintaining their quality of life and managing chronic conditions. For example, an interviewee in Community Beta stated that:

'I have had diabetes for decades. Now I measure my blood pressure and blood sugar regularly in the community. It is very convenient and I don't have to bother my son to worry anymore.'

Besides, interviewees also commented positively on smart care, as the main direction of Community Beta's development. In Community Beta, many of the elderly people's homes have installed 'smart emergency response equipment'. As introduced by community workers, this device is usually set at the regular activity area at home, like the door, bedside, kitchen and bathroom. Once the elderly people press the button under emergency situations, the community workers would arrive in a few minutes. However, some of the interviewees expressed their hesitation about the new technology. Their main concerns are mostly about privacy issues and resistance to new technologies.

Price

Price is the most realistic and one of the most sensitive factors for elderly people. Price is a critical factor that influences their perceptions of health, life and community-based services. Community workers explained the price mechanism of community-based services. As stated by them, the community has no pricing power for the services they are providing in practice. Most of the services are provided by external professional service providers. Communities are more like the bridges between elderly people and service providers. They collect the demands and requirements of elderly people and deliver them to the corresponding companies that have cooperation agreements with the government. Regarding the specific prices, Community Alpha was willing to provide part of the service list, whereas Community Beta was not.

Table 5. *The Patial Community Services List of Community Alpha*

Category	Services	Content	Price (CNY)
In-home 24 hours services packages	'Enjoy' services *(乐享服务)*	For elderly without disability	5000 per month
	'Healthy' services *(颐享服务)*	For elderly with partial disability	6800 per month
	'Sage' services (安享服务)	For elderly with fully disablity	8500 per month
Hospital accompaniment	Local medical accompaniment	For daily checks and minor hospital treatment	240 per time
	Car pick-up accompaniment	For elderly with mobility problem	580 per time
	8-hours professional accompaniment	For complex situations and elderly with disablity	699 per time
Medical services	Respiratory tract cleaning	For elderly with slight breathing disorders	299 per time
	Lung function improvement	For elderly with breathing disorders	499 per time
	Medication custody	Assistance for medication storage and taking	168
Sanitation services	Room cleaning	Bathroom	388 per time
		Kitchen	468 per time
	Personal cleaning	Haircut	30 per time
		Bathing assistance	180 per time
Food services	Breakfast	Porridge	18-22 per person
	Lunch/dinner	Package (rice/noodles/buns+3 dishes + 1 soup) with different flavors	15-55 per person + 4 delivery fee

Observing from the service list above, the services are charged in two forms: package services and separate services. Separate services like food, haircut and room cleaning are commonly lower than the market general prices, whereas the service packages start from 5500 CNY per month, which could be a heavy burden for elderly people. Interviews also reflected this fact. Most of the interviewees were satisfied with the service qualities and pricing levels of separate services. However, for service packages, it is a conflict that those who have no disability problems nearly have demands for this comprehensive care, and 8000 CNY per month is expensive for those elderly people with strong demand.

5.4.2 Inclusion findings

Promotion

In the eldercare evaluation system, promotion level is another vital part which directly influences the elderly people's understanding of their related policies, services and welfare. In focus group interviews, this topic was also recurringly mentioned by interviewees. Interviewees from the two communities both show complex comments towards promotion.

On the one hand, some elderly people are satisfied with the community promotional activities. In Community Alpha and Beta, community service centers, elderly activity centers, and other community facilities are used as information dissemination centers. Community workers also regularly organize street promotions and home visits to help elderly people understand new policies and updated services. Community Beta spends more effects on information visualization, that is, through promotional material that has simplified and enlarged words, images and illustrations to help elderly people better understand.

However, issues still exist. More than half of the interviewees in both communities reported that they were feeling uninformed or confused about the promotion information. Some of them complained that the information they received was scattered, complex, and hard to remember and understand. Take 'Beijing Basic Elderly Care Service List (2022 Edition)' published by *Beijing Municipal Civil Affairs Bureau (2023)* as an example; this government document contains the current eldercare service objects in all categories and corresponding service types, contents, standards and policy basis which is highly significant to elderly people. Nevertheless, the 13-page original document with forms and numerous policy standards is too complicated and cumbersome for elderly people. Even for community workers, those documents need many effects to understand and reorganize. On the other hand, hearing impairment,

concentration impairment, and memory loss problems of elderly people also cause unsuccessful promotion. As a community worker in Community Alpha stated:

'We usually introduce new policies and services to the elderly 3-4 times before they can fully understand and remember them. Even so, some elderly people will easily forget them. Thus, on the one hand, we try to simplify the content, and on the other hand, we also convey the information to their family members.'

People

In addition to the differences between the two focus groups, gaps also exist in age, gender, health condition and external population.

Generally, interviewees of different ages showed different demands for services. Those who are above 70 and often deal with more advanced age-related challenges expressed a stronger need and higher requirement for comprehensive support, including medical care, personal assistance, and mobility aids. Many in this age group reported experiencing increased dependency and a corresponding need for regular, reliable services, and they prefer home services rather than community service centers. In contrast, younger seniors below 70 were more focused on maintaining independence and socializing activities, preferring services which supported their lifestyle rather than those that addressed severe health concerns.

In line with the finding in *Marinelli et al. (2023)* work, gender also plays a role in shaping experiences. The gaps mainly showed in the preferences of eldercare types and content. For eldercare types, male interviewees expressed the importance of independence and commonly preferred community services, which can ensure their independence in their lives. Conversely, female interviewees had fewer objections to more detailed and comprehensive services such as home services. As for service contents, male interviewees preferred activities like chess, table tennis and calligraphy, whereas female interviewees preferred activities like cooking, knitting and gardening. One male interviewee in Community Beta complained that most of the activities are boring. Thus, gender balance in community activities is also important for shaping experiences.

Health conditions were another critical factor in determining the type of eldercare services needed. During interviews, those interviewees with chronic diseases such as diabetes, arthritis, or cardiovascular issues often have higher requirements for more specialized care, including frequent medical appointments and ongoing medication

management. Interviewees with mobility issues also expressed the importance of accessible home care services and assistive devices. In contrast, interviewees with better health conditions were more interested in preventive care and services that helped them maintain their current level of health.

Besides, household registration status could also generate differences in eldercare services. Although there are no differences in service lists and prices for local and external elderly people, there exist invisible obstacles in their lives. On the one hand, household registration increases administrative costs for elderly people. For example, external elderly people need more materials and procedures when applying for the Beijing Pass: Aged and Disability Assistance Card *(北京通—养老助残卡)*, which is a multifunctional and integrated card. On the other hand, differences in accents, habits and social networks also become obstacles that the external elderly people need to overcome in their community lives.

5.4.3 Institution findings

Process

Focus group interviews provided precious insights into elderly people's perceptions of the process of accessing and receiving services. Many of the interviewees in the two communities were roughly satisfied with the service processes. Generally, community workers collect daily service demands through Wechat or phone calls and send them to service providers. 7*24 services are also available to cope with emergency situations. As stated by a worker by Community worker:

'*One of the most important tasks of our community is to simplify the process of elderly people obtaining services. Specifically, it is to simplify the process of finding, investigating, and booking services and to serve as a bridge between the elderly and service providers*.'

Physical Evidence

Physical evidence presents the elderly people's perceptions of the physical environment of community care, such as the environment where the services and activities are delivered. The cleanliness, accessibility and space are mostly mentioned by interviewees.

Interviewees were more satisfied in well-maintained and welcoming environments. In the interviews, interviewees preferred clean, well-lit, sufficient and easy-accessed spaces. For example, interviewees in Community Alpha praised the comfortable sofa, clear signs and accessible facilities like ramps in the community service center. In contrast, some interviewees in Community Beta complained about the narrow rooms and corridors in their community facilities. Another interesting finding was the influence of colour. One interviewee in Community A stated that she preferred rooms in orange rather than blue because warm colours made her feel calmer and safer. This phenomenon was also confirmed by community workers that elderly people are mostly gathered in rooms with decorations in warm colours.

Partnership

As highlighted in the research of *Marinelli et al. (2023)*, 'Partnership' is highly significant to inclusive and sustainable eldercare. As the abbreviation of the public-private partnership (PPP), which is defined as the cooperative relationship between government and private sector out of the development trend and the market demand for private financing, risk-sharing and better goods and services provided, is widely promoted by the Beijing government to fill the huge gap between the demand and supply in eldercare market. In practice, this partnership is specifically shown as the intermediary function of a community service center. That is, community service centers play the role of bridging the gap between older people and service providers.

The advantages of this partnership are obvious. On the one hand, for elderly people, external service providers could provide services with higher diversity and quality, and a relatively open market environment promotes competition among providers. In two communities, most of the interviewees expressed their satisfaction with the diversity of food, and they could find specific medical assistance according to their physical symptoms. For example, there are 7-8 food suppliers in Community Alpha at similar price levels from several cuisine styles for elderly people to choose from. On the other hand, for community workers, this partnership significantly reduced their workload and financial cost. By playing the intermediary role, the community not only realizes the simplification of the work process and reduction of workload but also decreases the tremendous demand for professional doctors. In Community Beta, the community services center is responsible for more than 6 thousand elderly people by having only three full-time workers.

6. Discussion

According to the National 9073 Eldercare Guidelines published by *the China Development Research Foundation [CDRF] (2020)*, China's eldercare design roughly follows the 9073 principle. That is, 90% of the Chinese elderly population is under home care, 7% under community care, and the rest 3% under institutional care. In this research, community-based eldercare refers not only to community care in the narrow sense but also includes home care because home care is also under the support of community services. According to the Beijing Home-based Elderly Care Service Network Construction Work Plan published by *the Beijing Municipal Civil Affairs Bureau (2023)*, Beijing's design can be roughly described as: under the unified planning of the government, a three-levels eldercare network with public-private partnership (PPP) cooperation as main pattern. Combining the information gathered from focus group interviews, the whole picture of this model can be seen in Figure 5 below.

Specifically, the municipal government and departments (finance, civil affairs, medical insurance, etc.) issue various framework documents for guidance, planning and supervision. Three-levels eldercare networks are constructed in each district under the framework. The three-levels are district, street regional and community from high to low level. As discussed in the literature review, the community is not only a simple geographic or settlement concept in the modern Chinese context but also a political-administrative division concept. The district-level service center's responsibility is to generate plans and guidance in the region according to local conditions. In contrast, street and community level focus more on the specific work. The difference is that the street level is responsible for organizational works like supply and demand matching and resource distribution and has advanced facilities for irregular demands from elderly people, whereas the community level is only in charge of simple, basic and repetitive daily work. The PPP pattern is another characteristic of Beijing's practice. That is, elderly people report their demands for service to the community, and the community plays the role of bridge between elderly people and service providers. The income of service providers is roughly from two sources: subsidies from government and eldercare organizations and direct payment from elderly consumers.

Figure 5. *Structural Overview of Beijing's Practice*

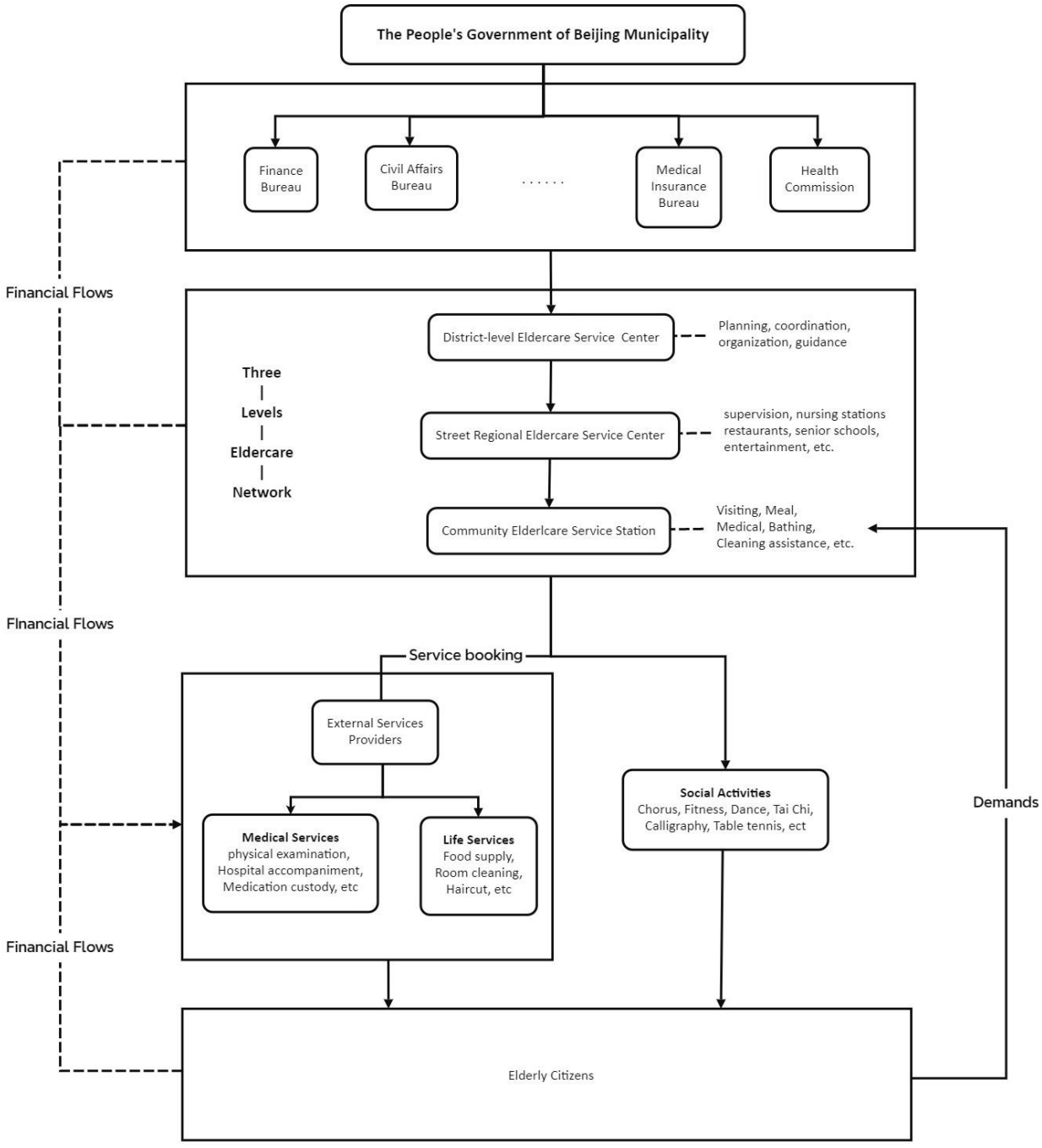


Figure 6-1 and Figure 6-2 show the actual distributions of eldercare service centers in Dongcheng and Chaoyang. The orange point represents the distribution of neighborhood committees[3], which is a common type of spontaneous organization in the community and can illustrate the population distribution. It can be observed that

[3] Neighborhood committee: a type of spontaneous organization in the community but smaller than the community by range. Usually, a community contains several neighborhood committees.

the distribution of service centers is basically consistent with the residential areas. However, although the government has published clear plans for three-levels eldercare network, most of service centers are at the community level in current stage.

Figure 6-1. *Distribution of Eldercare service centers (Dongcheng)*

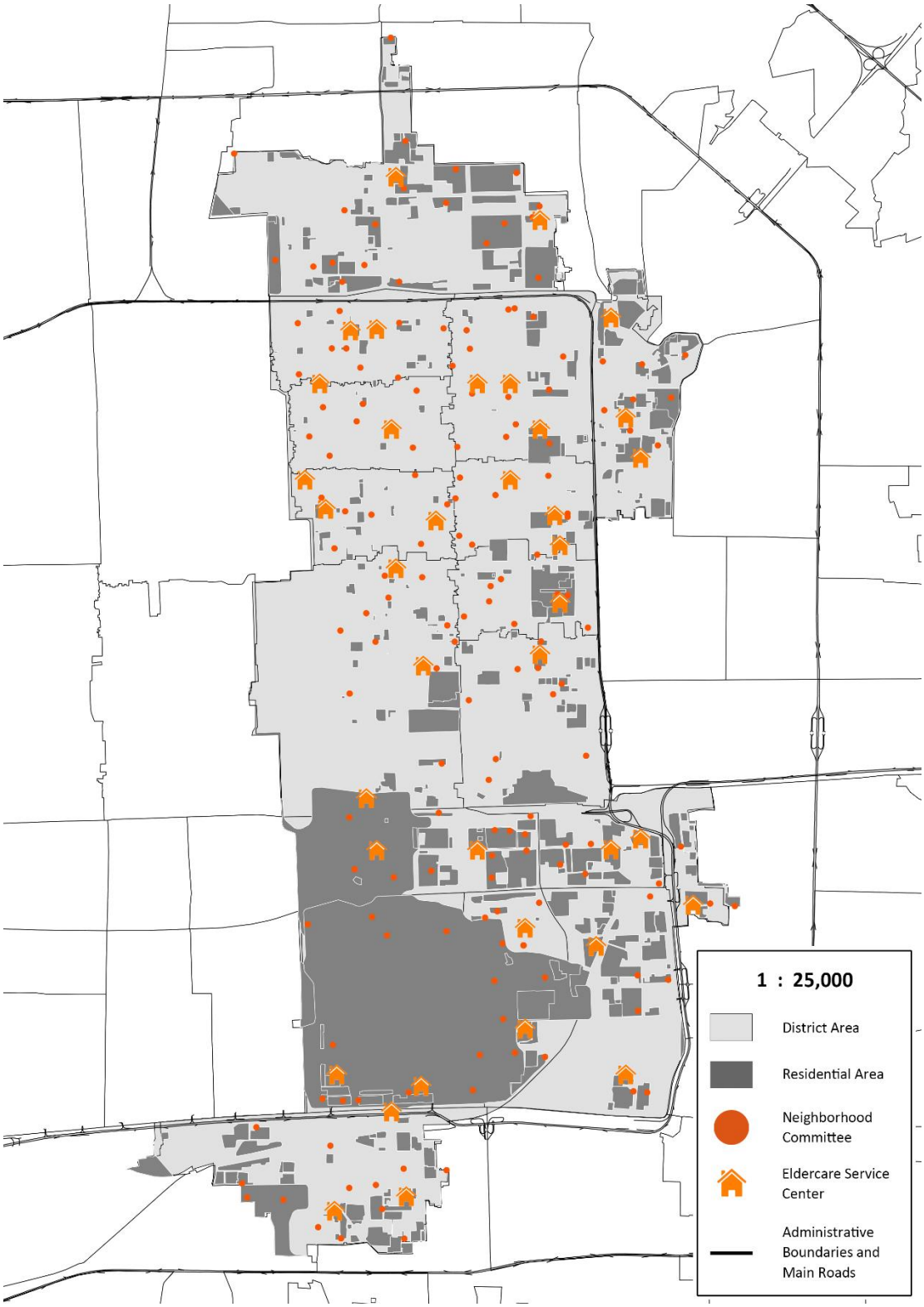
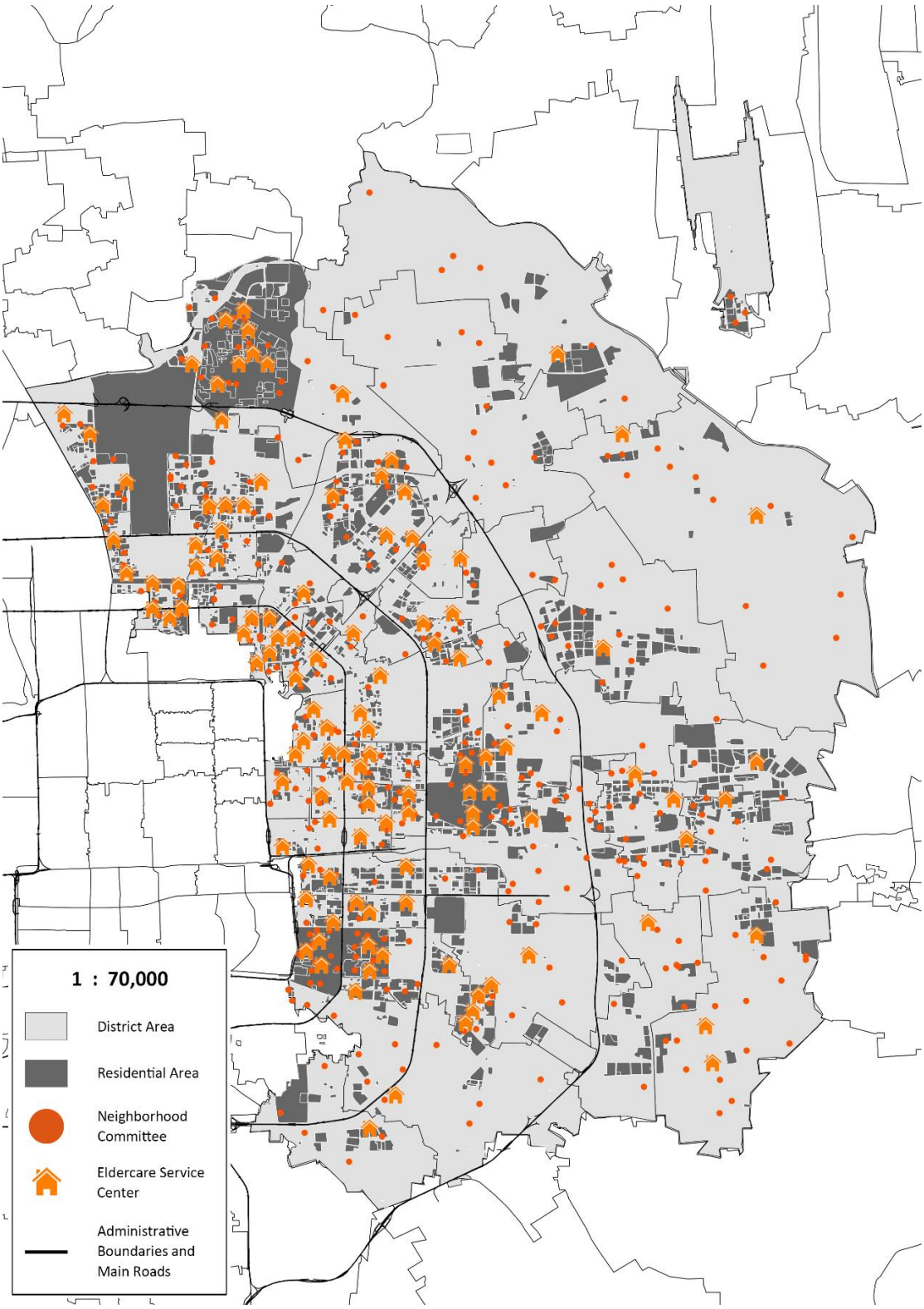


Figure 6-2. *Distribution of Eldercare service centers (Chaoyang)*



Data Source: The People's Government of Beijing Municipality (2023)

From a macro perspective, Beijing's practice is similar to the mature community-based eldercare system in Italy, the United States, and Japan. System planning promises consistency in the direction of eldercare network construction and rationality of resource utilization. Participants diversion reasonably allocate the responsibilities to institutions at different levels, improving work efficiency and reducing the workload of the grass-roots service stations. Moreover, the three-levels eldercare network further clarifies eldercare responsibilities at different levels. While ensuring the unity of overall planning, autonomy and flexibility are given to each region and community to develop in accordance with local conditions. The service system under the PPP pattern reduces institutional costs and ensures the quality of professional services while encouraging the participation of the private sector and releasing market activity. Besides, the PPP pattern also solves some of the limitations that Italy, the United States and Japan have to some extent. For example, external companies as the service providers under the PPP pattern offer homogeneous services, which eliminates the service imbalances among regions, communities and individuals.

From a micro perspective, current eldercare services receive roughly positive reviews from elderly people. Primarily, elderly people's preference for family and familiar circumstances is satisfied, which is also the starting point of China's 9073 principle. Elderly people are practically satisfied with the cost-effectiveness of the services they receive. Under the PPP pattern, they receive professional services with diversity and prices below the market average. Besides, after external service providers release community workers from heavy workloads, communities have more resources to organize and support elderly people's social activities. Known from the focus group interviews, the most frequently mentioned aspects that influence elderly people's perceptions are Pirce and Social Relations. Elderly people are commonly price sensitive and commonly conservative about consumption, even medical expenditures. Social relations include family level and external social level such as neighborhood and community, where various community activities satisfy their demands well. Another point worthy of being mentioning is that although Community Beta is practicing eldercare with new technology, intelligent equipment has not significantly improved the subjective satisfaction of elderly people at this stage.

Although Beijing's practice has solved some of the limitations that Italy, the United States, and Japan have, the probability of new issues has surged. PPP pattern might provide opportunities for rent-seeking. Currently, in spite of the diverse choices offered to elderly people, the companies need to be certificated by the government to be on the list of service providers. Thus, the eldercare service market is a monopolistic competition market with high entry barriers rather than a highly competitive market.

From an economic perspective, it creates space for rent-seeking and brings challenges for supervision. *Koppenjan and Enserink (2009)* analyze that rent-seeking under a PPP partnership comes from two sources: regulatory capture and regulatory rent-seeking. The former refers to the situation in which the government might be based in favor of service providers rather than representing the public interest. The latter refers to regulators transferring interest to service providers by using illegal methods such as corruption. Secondly, while a multi-level eldercare network brings a high degree of work division, it also increases the administrative costs and organizational regulatory barriers. Hence, a direct feedback mechanism for elderly people is necessary to ensure effective operation.

From elderly people's perspective, the limitations show diverse and non-uniform characteristics. Some of the interviewees complained about the narrow space of the community service center; some expressed their difficulties in learning the new technology; some required social activities in their interest; some were unsatisfied with the community's promotion methods, which are not intuitive and easily reading enough. Therefore, it is difficult to design a systematic and structural policy or regulation to satisfy the diverse demands. One effective approach is to fully leverage the autonomy of low-level service centers by empowering and making them able to adjust and meet the demands of their jurisdiction.

7. Conclusions and Limitations

7.1 Conclusions

Under the inevitable and serious ageing trend, China is promoting a community-based elder care system, and Beijing has made its attempts. This research reveals the structure and operational patterns of Beijing's practice and gives a systematic and comprehensive evaluation. In order to realize this aim, analysis is processed from micro and macro scopes. This research first compares the designs and practices of the community-based eldercare service systems in Italy, the United States and Japan over the past few decades, summarizes and analyzes their respective advantages and disadvantages and concludes valuable references for China's practice. After that, this research processes the focus group interviews in two communities in different districts in Beijing to investigate the instinctive perceptions of elderly people towards Beijing's practice and identify the strengths and weaknesses of current attempts.

From a macro perspective, Beijing's practice has obvious latecomer advantages and successfully avoids the limitations in other countries. Beijing's community-based eldercare system mirrors mature systems from foreign countries, with a strong emphasis on systematic planning and participant diversion. Innovatively, the three-level eldercare network in Beijing effectively distributes responsibilities across different institutional levels, enhancing work efficiency and reducing the burden on grass-roots service stations. The use of the PPP pattern further streamlines costs, ensures service quality, and encourages private-sector participation. By standardizing services, the PPP pattern helps eliminate regional disparities, offering consistent care across communities. However, although many advantages are recognized, rent-seeking spaces and increased administrative costs also bring new challenges to China.

At the micro level, elderly individuals generally express satisfaction with the services provided, which prioritizes family-based care. The affordability and diversity of services under the PPP pattern meet their needs while allowing communities to focus more on social activities. Price and social relations, as the most valued by elderly interviewees, can be well balanced in Beijing's practice. However, challenges remain; the diverse and non-uniform demands of elderly residents make it difficult to design a one-size-fits-all policy from the top. To address these issues, empowering street and community service centers to adapt and respond to specific community needs is crucial for improving overall satisfaction and effectiveness.

The contribution of this dissertation is the combination of macro and micro analysis while conducting a systematic theoretical analysis of Beijing's current practices. The subjective perceptions of the elderly people are also incorporated into the evaluation process through the focus group interviews, avoiding unrealistic idle theorizing and providing valuable theoretical and methodological reference value for future research.

7.2 Limitations

Although provides a systematic and comprehensive analysis of Beijing's community-based eldercare system, this dissertation still has several limitations can be improved.

Firstly, because of the contradiction between the long cycle of focus group interviews and limited time and resources, the sample size is not fully adequate to reflect the elderly people's perceptions in a larger range and the gaps among different districts. This research chooses two communities from the Dongcheng and Chaoyang districts, both of which are located in the central area of Beijing and are better developed. Hence, it is necessary to cover more areas with different development levels in future research.

Secondly, this research is influenced by biased data. In the focus group interviews, most of the interviewees were elderly people in relatively healthy conditions, and only a small part of them had serious chronic diseases or were even worse. However, according to community workers, their main service receivers are those senior elderly people with mobility issues. The reason behind this biased data is the recruitment of focus group interviewees. Although focus group interviews can obtain in-depth information, number and face-to-face gathering requirements become obstacles for those who have a physical disability. From a statistical point of view, the samples could not perfectly present the characteristics of the target population. Hence, purely focus group interviews cannot satisfy the research requirements. More efforts are needed to modify and develop a more scientific methodology.

Besides, this research only examines the practice of Beijing. As discussed in the previous section, Beijing has overwhelming advantages in most aspects including economic, financial, infrastructural, political, etc. On a national scale, Beijing's practice is indeed a valuable reference to other provinces, but due to the differences in resources, culture, customs and other aspects, simple imitation is difficult to success. Therefore, future larger-scale research and practice should be adapted and modified according to the local circumstances.

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Appendix

Interview guide

With elderly people

Ice breaking： Self-introduction, research background introduction and invitation to the interviewee to introduce themselves.

1. How would you describe the needs of your life? (can be any aspects including physical/mental/medical/financial/others)
2. What is your preference among home/community/institution eldercare?
3. What services have you received to address these needs? What needs remain unmet?
4. What roles does your community play in your life?
5. How has been your experience in receiving the services you need in the community? (price/time/quality)
6. How has been your experience with community employees?
7. Do you think is there any needs that the community system cannot meet?
8. How has your experience with your family been affected by community care?
9. How has your life been affected by community care?
10. What is the ideal care system that meets your expectations?

With community workers

1. What are the common needs of elderly people in the community?
2. How has been your experience in providing the services in the community?
3. How has your work experience been affected by the change in community care?
4. What aspects could be improved about the current community care?