ORIGINAL RESEARCH ARTICLE

Understanding Urban and Rural healthcare services: Structural dilemmas and solutions paths for China

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Keywords: Medical and healthcare integration; structural dilemma; institutional barriers; resource misapplication; digital governance

ABSTRACT

Introduction: China is facing a rapid and profound aging process, and the comprehensive demand of the older adults population for medical care, healthcare and living care will continue to rise. This trend not only has an impact on the family's old-age function, but also poses a serious challenge to the social security system and the allocation of medical resources. By exploring the difficulties faced by China's urban-rural integrated medical and care service system, this paper explores the impact of the dual structural dilemma of system and resources on the integrated development of medical and care.

Methods: Compared to standard systematic reviews, rapid literature reviews are a kind of evidence synthesis that can provide timely information for decision-making and evidence-based practice. This review uses Web of Science and CNKI (China National Knowledge Infrastructure) as the database source. The search keywords include "medical and healthcare integration", "structural dilemma", "institutional barriers", "resource misapplication" and "digital governance." The search scope is restricted to articles published between January 2024 and December 2024 in order to identify the most up-to-date literature.

Results: The development speed of the combination of urban and rural medical care is different. The dual structure of urban and rural areas leads to the uneven distribution of medical resources, and it is difficult for the rural older adults to obtain long-term healthcare and chronic disease management services that are the same as urban ones.

Conclusion: The key to solving the structural dilemma is to build an elastic governance framework with Chinese characteristics. The future institutional design needs to enhance adaptability, pay more attention to the complementary relationship between the informal care system and the formal system, and learn from the global experience of aging social governance.

Main Contribution to Evidence-Based Practice: This paper shows the dilemma of China's urban and rural medical and rural integrated service system, and mainly analyzes the structural contradictions caused by the system and resources. Therefore, it can provide a reference for the government's medical policy.

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What do we already know about this topic?
There are structural difficulties in the medical and healthcare integration service system between urban and rural areas in China.

What is the main contribution to Evidence-Based Practice from this article?
To analyze the problems existing in the current medical and healthcare integration service system, and provide reference for the government's medical and healthcare integration policies.

What are this research's implications towards health policy?
The article identified the need for further research on the structural dilemma of the medical and healthcare integration service system.

Authors' Contributions Statement:
Li conceptualized and designed the study. Zhang reviewed and revised the paper. All authors read and approved the final version of the

Introduction

The aging process in China exhibits the characteristic of "aging before becoming wealthy" (Li Guangyao and Yan Bo, 2024), with significant differences in demand between urban and rural areas, as well as among regions. Urban older adult populations have an urgent need for specialized medical-care, while rural areas, due to the outflow of young adults, require more basic restorative services combined with daily care for their remaining older adults. By the end of 2024, China's population aged 60 and over exceeded 310 million, with 78% suffering from chronic diseases, and 44 million disabled or semi-disabled older adults urgently needing integrated medical and care services (Chen Jihua and Wen Jingxian, 2024).

The concept of the "medical and healthcare integration" model is a significant advancement in geriatric care, emphasizing an integrated, interdisciplinary, and patient-centered approach (Yun Zhao Lin et al., 2024). The implementation of policies for medical and healthcare integration has dramatically improved the health status of older patients with chronic diseases (Penghao Fan et al., 2024). However, the existing service system struggles to meet tiered needs: there is just an oversupply of high-end institutions in cities and a shortage of inclusive services, while rural areas face the dual pressures of scarce medical resources and a lack of older adults care facilities. Despite the nationwide push for medical and healthcare integration policies since 2011, departmental fragmentation and path dependence have made policy implementation challenging. The integration involves multiple departments such as healthcare, older adults care, and social security, but lacks a collaborative mechanism. The multi-headed management by the National Health Commission, Ministry of Civil Affairs, and National Healthcare Security Administration leads to unclear responsibilities (Chen Jihua and Wen Jingxian, 2024). For example, the scope of medical insurance reimbursement is restricted to disease treatment, and there is no unified standard for rehabilitation and healthcare costs. Medical institutions confront the contradiction between economic benefits and low willingness to transform into older adults care facilities, while medical departments within older adults care institutions are constrained by restrictions on medical insurance access and professional qualifications (Xie Tian and Wang Canyou, 2024). Conflicting policy goals between

departments (such as the National Health Commission being focused on public health and the Ministry of Civil Affairs concentrating on welfare) further exacerbate the fragmentation of the service chain. Tension is between the shortage of beds in tertiary hospitals in cities and the vacancy of primary care institutions, while rural areas face the loss of medical talent and a lack of older adults care facilities. In addition, the rigid land policy is a challenge for private institutions to obtain construction land, further limiting the flexibility of service provision. The interests of the government, market, and communal forces are hard to reconcile (Wei Huaqi et al., 2024). Municipal hospitals, under performance pressure, exclude "non-profit" older adults care services, while social capital remains hesitant due to long return cycles. The stigma surrounding traditional "family-based" older adults care and institutional care still hinders service acceptance (Ge Xin et al., 2024). Families, influenced by traditional beliefs, resist institutional care (Cao Xinning and Wang Yutao, 2024), creating a meaningful tension between policy expectations and grassroots practices.

Methods

Compared to standard systematic reviews, rapid literature reviews are a kind of evidence synthesis that can provide timely information for decision-making and evidence-based practice. This paper takes a narrative review approach and method, using CNKI as the database source. The search keywords include "medical and healthcare integration," "structural dilemma," "institutional barriers," "resource misapplication," and "digital governance." The search scope is restricted to articles published between January 2024 and December 2024 in order to identify the most up-to-date literature. The reference lists of each included article were searched manually to obtain the potentially eligible articles. Titles and abstracts of the retrieved records were first screened to exclude articles that were evidently irrelevant. The full texts of potentially relevant papers were further reviewed to examine their eligibility. Reviewers selected articles based on inclusion/exclusion criteria (defined keywords and time span). Reviewers conducted critical and rigorous evaluations within the defined criteria and produced abstracts.The literature base covers the theoretical discussion of high-quality service systems by authoritative scholars such as Gu Jiayu and Lu Fang (2024), Shi Jihong (2024) based on the empirical analysis of pilot cities, Zhang Bin and others (2024)'s comparative research on urban and rural differences, and introduction by Chen Jihua and Wen Jingxian (2024) on the experience of international long-term care insurance. At the same time, it is deeply embedded in the existing medical and pension decision-making framework at the national level, focusing on the Healthy China Action (2019-2030) for the promotion of older adults' health, the "14th Five-Year Plan" Healthy Aging Plan (National Health Aging Development [2022] No. 15) and the relevant policy documents of the National Health Insurance Administration of China on the pilot of the long-term care insurance system ensure that the research problems and countermeasures are closely in line with the national strategic orientation and practical needs.

Results

The following results are obtained according to the combing literature. The development speed of the combination of urban and rural medical care is different. The dual structure of urban and rural areas leads to the uneven distribution of medical resources, and it is difficult for the rural older adults to obtain

long-term healthcare and chronic disease management services that are the same as urban ones.

Table 1: Summary the process and the output of the rapid literature review

Author/Year	Literature Source
Li Guangyao and Yan Bo, 2024 [7]	PUBLISHED
Chen Jihua and Wen Jingxian, 2024 [2]	CONSULTATION WITH EXPERTS
Yun Zhao Lin et al, 2024 [16]	GREY
Penghao Fan et al, 2024 [11]	GREY
Xie Tian and Wang Canyou, 2024 [14]	PUBLISHED
Wei Huaqi et al, 2024 [13]	PUBLISHED
Ge Xin et al, 2024 [4]	PUBLISHED
Cao Xinning and Wang Yutao, 2024 [1]	PUBLISHED
Zhang Bin et al, 2024 [17]	PUBLISHED
Gu Jiayu and Lu Fang, 2024 [5]	CONSULTATION WITH EXPERTS
Yao Huiling et al, 2024 [15]	PUBLISHED
Lou Ting et al, 2024 [8]	PUBLISHED
Zhang Xupeng, 2024 [18]	PUBLISHED
Shi Jihong, 2024 [12]	CONSULTATION WITH EXPERTS
Nupur Vasdev et al, 2024 [9]	GREY
He Lei, 2024 [6]	PUBLISHED
Paulo Sergio Altman Ferreira, 2024 [10]	GREY
Emily de Souza Ferreira et al, 2024 [3]	GREY

The dilemma of system and resources

Under the current medical and healthcare service system, institutional difficulties restrict the development of medical and healthcare service system, and cause problems such as solidification of medical and healthcare resources, mismatch between supply and demand, and alienation of supply.

The functional barriers between medical services and older adults care have solidified. The root cause of the blurred boundaries and functional fragmentation between "medical" and "care" lies in the policy fragmentation under a bureaucratic system. Medical institutions, limited by a performance evaluation system centered on treatment, tend to prioritize acute conditions. In contrast, older adults care facilities, lacking medical qualifications and emergency capabilities, struggle to respond to post-surgical rehabilitation or chronic disease management needs (Ge Xin et al., 2024). For instance, some incapacitated seniors are forced to frequently shuttle between home and hospital owing to the inability of older adults care facilities to handle sudden cardiovascular or cerebrovascular diseases, creating a "revolving door" effect. The institutional exclusion in the health insurance payment system further exacerbates this service fragmentation: current health insurance only covers medical expenses during hospitalization, with rehabilitation, healthcare, and long-term care costs being self-funded at rates exceeding 70% (Zhang Bin et al., 2024). This payment logic makes it difficult for rehabilitation departments within medical and healthcare integration institutions to turn a profit, leading to the paradoxical situation where rehabilitation beds are vacant while medical beds are overburdened.

Additionally, the division of responsibilities among departments makes it challenging for the health department-led "medical" services and the civil affairs department-led care services to establish unified service standards, resulting in high inter-departmental collaboration costs and low efficiency in resource integration (Gu Jiayu and Lu Fang, 2024).

The mismatch in supply and demand structures derived from the imbalance between market mechanisms and public welfare. The stratification of payment capabilities directly distorts the supply structure of medical and healthcare integration services (Gu Jiayu and Lu Fang, 2024). High-income groups can enjoy "private doctors + customized care" at high-end medical and healthcare integration institutions with monthly expenses ranging from 20,000 to 50,000 yuan, while ordinary families, due to excessively high out-of-pocket costs (with some rehabilitation projects having a medical insurance coverage rate of less than 30%), are forced to choose low-quality services or home-based care. The situation is even more pronounced in rural areas: although township nursing centers and healthcare homes have attempted integration, they are constrained by weak collective economies and struggle to bear the costs of equipment updates and personnel training (Chen Jihua and Wen Jingxian, 2024). In a county in Sichuan, the "nursing center + healthcare home" model, lacking basic facilities such as CT scanners, can only provide primary services like blood pressure monitoring, not complying with the post-surgical recovery needs of disabled seniors. The resource gap between urban and rural areas has further widened: the utilization rate of beds in urban medical and healthcare integration institutions reaches 85%, whereas in rural areas it is less than 40%, mostly focusing on daily care (Zhang Bin et al., 2024). The essence of this supply-demand mismatch lies in the imbalance between market mechanisms and public welfare, where social capital avoids risks due to unclear profit expectations, and government subsidies are able to cover inclusive needs.

The service supply distortion triggered by the administrative evaluation mechanism. Driven by rigid indicators such as "bed capacity" and "institution coverage," local governments have a tendency to invest in hardware rather than improving service quality. Some counties, in order to respond to evaluation targets, convert idle school buildings into healthcare homes, but due to a lack of medical facilities, these projects become mere formalities. For instance, a new healthcare home in a county in Henan Province was ultimately transformed into a bizarre combination of a "healthcare home + traditional Chinese medicine shop" because it did not receive approval for medical land use. The "cost control first" orientation of the medical insurance fund also stifles service innovation: to avoid overruns, some regions strictly limit the drug list and treatment items for medical and healthcare integration institutions, leading to the management of chronic diseases like hypertension and diabetes relying solely on basic medications (Wei Huaqi et al., 2024). More seriously, cross-departmental supervision results in blurred responsibilities—— the health department focuses on medical safety, the civil affairs department emphasizes daily care, and the medical insurance department closely monitors cost control. Conflicting standards among the three parties is a challenge for institutions to cope with inspections, making it hard to improve service quality (Chen Jihua and Wen Jingxian, 2024).

Comparison of urban-rural differentiation models

Urban resource concentration coexists with institutional fragmentation. Although urban medical and healthcare integration services are focused, the separation of "medical" and "healthcare" functions is prominent. Major cities like Beijing and Shanghai integrate resources through models such as older adults care communities or the addition of geriatric departments in tertiary hospitals. However, the compartmentalization of medical insurance policies and older adults care subsidies leads to deficient service continuity. For example, the barrier of medical insurance payment has not been broken down; physical therapy projects within —— older adults care institutions are not covered by medical insurance, and older adults rehabilitation and palliative care services are not part of the medical insurance directory. This is a challenge for medical institutions within older adults care facilities to obtain designated medical insurance status, resulting in a "two-skin" phenomenon between medical and healthcare integration services. Consequently, high-end services can only cover self-funded individuals, while ordinary seniors are still required to shuttle between hospitals and healthcare homes (Zhang Bin et al., 2024). Moreover, high operating costs and market positioning errors further exacerbate resource misapplication, making it difficult for the general older adults population to afford these services.

The contradiction between rural resource scarcity and service accessibility is needing to be more pronounced. In Bazhong City, Sichuan Province, the "family doctor signing + neighborhood mutual aid" model has been explored. By transforming idle beds in township health centers (with about 50 healthcare beds renovated per county), a team of general practitioners provides chronic disease management, covering 80% of older adults left behind, and reducing annual medical expenses by 15% (Yao Huiling et al., 2024). However, due to the shortage of medical resources and insufficient fiscal investment in rural areas, the medical and healthcare integration often relies on the transformation of grassroots health centers (such as the models in Deqing and Taizhou, Zhejiang), providing "medical-care within healthcare" services through the utilization of idle beds. Nevertheless, the shortage of healthcare personnel (Lou Ting et al., 2024) and inadequate payment capabilities lead to poor sustainability of services, with a high turnover rate of healthcare staff in counties reaching 40%. Moreover, innovative rehabilitation programs added after the transformation of health centers (such as acupuncture and massage) are not covered by health insurance, resulting in actual reimbursement rates below 20%. A deeper contradiction lies in the allocation of administrative resources —— the health system concentrates high-quality medical and healthcare resources in county hospitals, leaving township health centers long-term facing the dilemma of "having equipment but no talent," which keeps medical and healthcare integration services at a basic level (Chen Jihua and Wen Jingxian, 2024). Additionally, pilot programs for long-term care insurance in rural areas (such as those in Shandong) have attempted to alleviate payment pressures, but the single-source funding and limited coverage is therefore difficult to support systemic needs.

Table 2: Comparison of urban and rural models

Comparative dimensions	Urban model	Rural model
Core contradictions	Resource concentration and institutional separation coexist	The contradiction between lack of resources and service access is highlighted
Characteristics of resources	Medical and maintenance resources are highly concentrated, and high-end services cover self-paid people	There is a shortage of medical resources and insufficient financial investment
Service model	Retirement communities/hospitals have added geriatric departments, and the "separation of medical care" has led to poor service continuity	"Family doctor contract + neighbourhood mutual assistance", revitalize the idle beds of township health centers
Institutional obstacles	The medical insurance policy is divided	Imbalance in the allocation of administrative resources
Payment difficulties	The barriers to medical insurance payment have increased the burden on older adults, and high-end services only cover self-paid people	The reimbursement rate of rehabilitation projects is less than 20%, and the long-term care insurance fund has a single source and limited coverage
The plight of talent	Not directly mentioned	There is a serious shortage of nursing personnel
Special phenomenon	Medical care "two skins"	Low-level service maintenance
Typical innovative cases	Beijing and Shanghai: Retirement Community/Geriatric Department of Hospital	Bazhong, Sichuan: Family doctor contract + idle bed transformation; Deqing/Taizhou, Zhejiang: Health centre transformation combination of medical care
Structural dilemma	Institutional barriers hinder the integration of resources	Systematic resource shortage restricts service upgrade

Strategies to break structural dilemmas

Build a cross-departmental collaborative system of authority and responsibility lists. The core to breaking down the barriers in the integration of curative care and older adults care lies in establishing a clearly hierarchical

system of power lists. State Council's Joint Office for the Medical and Healthcare Integration should take the lead in formulating the Handbook of Authority and Responsibilities for Medical and Healthcare Integration Institutions, clearly defining that the health department is responsible for medical qualification supervision, the civil affairs department leads service quality assessment, the medical insurance institution handles payment method innovation, and the development and reform department coordinates resource allocation (Chen Jihua and Wen Jingxian, 2024). Specifically, we can build on the experience of Shenzhen's "Big Health Administration," integrating 28 approval powers from seven departments into a single window, reducing material submission by 60% and compressing the approval time to 20 working days. On the legislative level, there is an urgent need to enact the Medical and Healthcare Integration Service Law to establish the legal status of medical and healthcare integration institutions, set standards for healthcare level evaluations (such as referring to Japan's five-level care classification system), and establish a mechanism for dividing medical accident liability. Additionally, a special fund for medical and healthcare integration should be attached to the provincial level to compensate underdeveloped regions through transfer payments. For example, Shandong Province has established an annual 500 million yuan guidance fund, leveraging social capital investment in medical and older adults care projects to reach 2.3 billion yuan, covering 97% of county-level administrative units across the province.

Create a dynamic and flexible land and medical insurance adjustment mechanism. Promoting innovation in land supply mechanisms is essential for resolving the imbalance of urban and rural resources. It is recommended revising the "Regulations on the Implementation of the Land Management Law," allowing rural collective business construction land to be directly used for medical and healthcare integration projects, with land sale revenues returned to village collectives according to a set ratio (Gu Jiayu and Lu Fang, 2024). In Lin'an District of Hangzhou City, under the pilot model of "village collective land + enterprise investment," 41 rural medical and older adults care centers have been constructed, increasing bed utilization rates to 78%. Medical insurance reform should construct a multi-level payment system of "basic universal + personalized supplementary": incorporating 23 services such as rehabilitation healthcare and chronic disease management into the basic medical insurance directory, controlling excessive medical treatment in tertiary hospitals through DRG (Diagnosis-Related Groups) (Zhang Xupeng, 2024); introducing commercial insurance coverage for personalized needs (such as high-end care packages). Dongcheng District, Beijing has piloted family beds, hospice care and other expenses to be included in medical insurance reimbursement, and the average annual medical expenditure for a single person has been reduced by 4,200 yuan. Additionally, exploring a cross-regional settlement model for medical insurance in the Yangtze River Delta region, establishing a regional procurement platform for medical and healthcare integration services, can promote the cross-domain circulation of medical resources (Shi Jihong, 2024).

Improving the accessibility of digital governance-driven services. Building a cohesive national big data platform for medical and healthcare integration services to break down barriers between residents' electronic health records in the health department, civil affairs older adults care information systems, and medical insurance settlement databases

(Shi Jihong, 2024). Digital services can effectively alleviate the growing imbalance between demand and resources. Shanghai has integrated 14 functions, including older adults care maps, remote consultations, and chronic disease management, into the "Suishenban" APP, achieving real-time aggregation of health data for 500,000 older adults. Using algorithms to compile, transmit, and analyze patient data, combining machine learning with artificial intelligence allows for effective individual-level clinical monitoring and supervision of various diseases through remote access and algorithms (Nupur Vasdev et al., 2024). Promoting the application of Internet of Things technology, such as installing millimeter-wave radar fall detection devices in the homes of older individuals living alone, reducing warning response times to within 30 seconds; applying AI algorithms to analyze wearable device data, with the accuracy rate of predicting cardiovascular disease risks reaching 89% (He Lei, 2024). The "Smart Healthcare Home" in Wuzhen, Zhejiang, utilizes an unobtrusive monitoring system to automatically adjust indoor temperature, humidity, and lighting brightness, increasing the efficiency of healthcare staff by 40%. However, it is important to be wary of the risks associated with technological dependency and establish a manual review mechanism to prevent service omissions due to algorithmic biases. Technological empowerment should be demand-driven, developing age-friendly interfaces to avoid the governance paradox of "smart TVs being unable to change channels" (Li Guangyao and Yan Bo, 2024).

Table 3: A typical case of breaking the structural dilemma

Areas of reform	Core strategy	Best practices at the county/regional level
List of Powers and Responsibilities System	Cross-departmental coordination mechanism	Shenzhen established the "Great Health Administration Bureau" to integrate 28 examination and approval powers in 7 departments.
Land and medical insurance adjustment	Land supply innovation	Hangzhou Lin'an "Village Collective Landing + Enterprise Investment" Model
	Medical insurance payment reform	The Yangtze River Delta region explores medical insurance off-site settlement and regional service procurement platforms
Digital Governance Empowerment	Unified Data Platform	Shanghai's "Applying" APP gathers 500,000 older adults health data
	Application of intelligent technology	Wuzhen, Zhejiang Province adopts the insensitive monitoring system of smart nursing home

Conclusion

The key to exit the structural deadlock lies in building a resilient governance framework with Chinese characteristics (Chen Jihua and Wen Jingxian, 2024). Germany's "long-term care insurance" experience shows that a system

design featuring mandatory participation and tiered payment can achieve home-based care for 78% of disabled older adults. China can explore the construction of a demand-side elastic subsidy mechanism: the "medical security voucher" system is being explored, and differentiated subsidies are implemented according to the level of inability, and effectively guide the allocation of resources to community and institutional services. This demand-side subsidy model based on accurate assessment provides a cost-controllable solution for developing countries to improve the access of care. At the same time, it is necessary to be wary of the incompatibility of institutional transplantation, such as the fiscal pressure faced by Japan's care insurance system (premiums accounting for 10% of pensions), which suggests that China should strengthen the government's responsibility to ensure basic needs (Chen Jihua and Wen Jingxian, 2024). In healthcare services, managing operational flexibility goes beyond customary adaptive and social-technical models (Paulo Sergio Altman Ferreira, 2024). The future institutional design needs to establish a hierarchical governance and dynamic adjustment framework: authorize local elastic adjustment service catalogs under national unified standards (such as the inclusion of oxygen therapy in plateau areas), and establish a dynamic evaluation mechanism for service quality, forming a hierarchical governance structure of "top-level design and local innovation". The framework significantly enhances the adaptability of the system to regional heterogeneity, surpassing the traditional static welfare supply model. In the 21st century, technological advancements based on mobile health (mobile healthcare) aimed at managing health services and care, along with the accompanying numerical transformation in health, will become increasingly important (Emily de Souza Ferreira et al., 2024). Ethical risks such as privacy leakage and algorithm discrimination brought about by smart old-age care have not yet formed an effective regulatory framework. It is urgent to formulate laws to regulate the security management of medical and nursing data, promote the application of block chain technology in the whole process of medical and nursing services, and build an intelligent supervision infrastructure. At the same time, we pay forward-looking attention to the ethical risks of privacy and algorithms in smart old-age care, providing a regulatory paradigm that focuses on "technical empowerment" and "rule constraints" for the governance deficit in the global digital health transformation. Finally, it is necessary to learn from the financial pressure of Japan's care insurance and reshape the government's market responsibility boundary. China's plan emphasizes that the government focuses on the function of "guaranteeing the basics" and provides a key institutional anchor for the welfare state to reconstruct financial sustainability through subsidy coupons rather than comprehensive replacement of the market. Its balanced logic of "effective market and effective government" has universal reference value for economies facing aging and financial pressure.

These practices together constitute the four-in-one Chinese-style pension governance framework of "precise subsidies-elastic governance-intelligent supervision-balance of responsibilities". Its core contribution is to provide a systematic plan for global pension reform that takes into account coverage expansion, financial sustainability, service quality assurance and technology integration governance. In particular, it has opened up a new path for developing countries to overcome the structural dilemma of welfare rigidity and resource constraints. In the future,

deepening the research on the complementary mechanism of informal care and formal systems will further enrich the local knowledge system of global aging management.

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