

Postprint: Service Quality Evaluation of Medical-Elderly Care Integration in Nursing Homes: A Public-Private Perspective

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Abstract

Background: In recent years, there have been numerous research reports on the service models and influencing factors of integrated medical and elderly care in China, but studies on the service quality of integrated medical and elderly care in nursing institutions are relatively scarce, and comparative studies on the differences in service quality of integrated medical and elderly care among different types of nursing institutions are lacking.

Objective: To evaluate the service quality of integrated medical and elderly care in public and private nursing institutions.

Methods: From October 2020 to September 2021, a stratified random sampling method was used to conduct questionnaire surveys in four regions: Baotou City in Inner Mongolia, Xi'an City in Shaanxi Province, Yichang City in Hubei Province, and Shaoxing City in Zhejiang Province. A total of 1,106 elderly individuals from 25 nursing institutions were selected. A service quality evaluation index system for integrated medical and elderly care was constructed through the SERVQUAL model, comprising five dimensions (reliability, timeliness, assurance, standardization, and empathy) and 15 secondary indicators. The entropy weight method and fuzzy comprehensive evaluation method were combined to calculate and compare the service quality scores of integrated medical and elderly care in public and private nursing institutions, respectively.

Results: The comprehensive evaluation scores of elderly individuals' satisfaction with the service quality of integrated medical and elderly care in public and private nursing institutions were 41.66 and 38.82 points, respectively. Among them, all 15 secondary indicator scores in public nursing institutions were above 40.00 points, while 13 secondary indicator scores in private nursing institutions were below 40.00 points.

Conclusion: There are certain differences in the comprehensive evaluation results of elderly individuals' satisfaction with the service quality of integrated medical and elderly care between public and private nursing institutions, with relatively large differences in the scores of the standardization and empathy dimensions, and relatively small differences in the scores of the reliability, timeliness, and assurance dimensions. This provides a reference for identifying problems in integrated medical and elderly care services across different dimensions and promoting high-quality integrated medical and elderly care services in nursing institutions.

Full Text

Quality Evaluation of Integrated Medical and Elderly Care Services in Nursing Institutions: A Comparative Study of Public and Private Sectors

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Abstract

Background

In recent years, numerous studies have examined the models and influencing factors of integrated medical and elderly care services in China. However, research on service quality evaluation remains limited, particularly comparative analyses of quality differences between public and private nursing institutions.

Objective

To evaluate and compare the quality of integrated medical and elderly care services between public and private nursing institutions.

Methods

From October 2020 to September 2021, we conducted a questionnaire survey using stratified random sampling across four regions: Baotou (Inner Mongolia), Xi'an (Shaanxi), Yichang (Hubei), and Shaoxing (Zhejiang). A total of 1,106 elderly residents from 25 nursing institutions were selected. Using the

SERVQUAL model, we constructed a service quality evaluation index system comprising five dimensions (reliability, timeliness, supportability, normativity, and empathy) with 15 secondary indicators. The entropy weight method and fuzzy comprehensive evaluation method were employed to calculate and compare service quality scores between public and private institutions.

Results

The comprehensive evaluation scores for service quality satisfaction were 41.66 points in public institutions and 38.82 points in private institutions. All 15 secondary indicators in public institutions scored above 40.00 points, while 13 secondary indicators in private institutions scored below 40.00 points.

Conclusion

Significant differences exist in satisfaction with integrated medical and elderly care service quality between public and private nursing institutions, with notable disparities in normativity and empathy dimensions, but smaller differences in reliability, timeliness, and supportability. These findings provide a reference for identifying service deficiencies across different dimensions and promoting high-quality development of integrated care in nursing institutions.

Keywords

Health care quality, access, and evaluation; Healthcare disparities; Health systems agencies; Integrated elderly care and medical services; Public institutions; Private institutions; Health facilities, proprietary; SERVQUAL model; Entropy weight method

Introduction

By 2020, China's population aged 65 and above reached 190.64 million, accounting for 13.5% of the total population. Approximately 75% of elderly individuals suffer from chronic diseases, with over 40 million experiencing disability. Chronic diseases and disability-related conditions contribute to more than 80% of elderly mortality and over 70% of the total disease burden. In response, China has implemented a series of policy initiatives: in September 2013, the State Council issued "Several Opinions on Accelerating the Development of Elderly Care Services" (Guo Fa [2013] No. 35), proposing the integration of medical and elderly care services to provide comprehensive support including daily living assistance, chronic disease management, and rehabilitation care. Between 2016 and 2020, 16 supporting policies were released by multiple ministries. The November 2021 "Opinions of the CPC Central Committee and State Council on Strengthening Elderly Care in the New Era" called for building a coordinated home-community-institution system combining medical care, elderly care, and wellness. The February 2022 "14th Five-Year Plan for Healthy Aging" further emphasized expanding integrated service supply.

Nursing institutions represent crucial providers of integrated medical and el-

derly care services. By the end of 2021, 6,492 qualified institutions nationwide offered 1.75 million beds, with over 90% of nursing institutions providing medical services in some form. The February 2022 “14th Five-Year Plan for National Elderly Care and Service System” mandated that by 2025, all nursing institutions should possess integrated medical-elderly care capabilities. However, current implementation faces challenges including superficial integration, fragmented service delivery, and inadequate quality due to poor coordination between elderly care and medical services, limiting policy effectiveness. The July 2022 “Guiding Opinions on Further Promoting Integrated Medical and Elderly Care Development” specifically called for enhancing service capacity and supporting qualified medical institutions to provide basic public health and family doctor services for the elderly, while enabling nursing institutions to offer basic elderly care and home-based care contracting services.

Existing research primarily focuses on service supply, care models, and elderly health outcomes, with two major gaps: limited evaluation of integrated service quality encompassing daily care, medical treatment, rehabilitation, and nursing; and a lack of comparative studies examining quality differences across institution types. This study addresses these gaps by developing a service quality evaluation index system based on SERVQUAL model dimensions (reliability, timeliness, supportability, normativity, and empathy), combined with entropy weight and fuzzy comprehensive evaluation methods to compare service quality between public and private institutions, identify problems across dimensions, and inform high-quality development.

Methods

1.1 Study Subjects From October 2020 to September 2021, we conducted surveys in four regions selected based on economic development level, population aging degree, and geographic location: Baotou, Xi'an, Yichang, and Shaoxing. Using stratified random sampling, we selected 25 nursing institutions (4-8 per region) that provided medical services, following the principle of optimal matching between public and private institutions. From each institution, 50-60 elderly residents were randomly selected, yielding a total of 1,106 participants.

Inclusion criteria: (1) aged ≥ 60 years with >12 months residency; (2) adequate physical and mental condition to complete the survey independently or with assistance; (3) informed consent. **Exclusion criteria:** (1) severe cognitive, language, hearing, or visual impairments; (2) severe psychiatric conditions. This anonymous survey focused on service quality satisfaction without involving personal privacy or medical conditions, thus requiring no ethical approval.

1.2 Survey Method We used a self-designed questionnaire to assess elderly residents' subjective perceptions and satisfaction with integrated medical and elderly care service quality. The research team comprised three faculty members

and six master's students. Quality control measures included: (1) pre-survey training and simulation exercises to enhance understanding; (2) one-on-one conversational interviews with responses recorded and verified against nursing staff records to minimize errors; (3) daily questionnaire review and data cleaning to address potential issues. SPSS 20.0 was used for reliability and validity testing.

1.2.2 SERVQUAL Model and Index System While SERVQUAL traditionally measures service quality through gaps between expected and perceived service levels, research by Cronin Jr et al. demonstrates that perceived service levels alone can effectively reflect quality. This study applied SERVQUAL to evaluate integrated medical-elderly care service quality using a 5-point Likert scale for satisfaction ratings.

Drawing from policy documents including “Several Opinions on Accelerating Development of Elderly Care Services” (Guo Fa [2013] No. 35) and “Basic Service Standards for Integrated Medical-Elderly Care Institutions,” and referencing previous studies, we developed an evaluation index system guided by principles of equity, value, and needs satisfaction. Recognizing that standardization represents a new development trend, we incorporated normativity as a fifth dimension.

Following consultation and multiple revisions with 15 senior experts (9 male, 6 female; mean age 43.5 years; 13 with graduate degrees; from “985” universities, health administration departments, and nursing institutions), the final index system comprises five dimensions with 15 secondary indicators:

- **Reliability:** Service comprehensiveness (X1), service professionalism (X2), health service commitment fulfillment (X3)
- **Timeliness:** Medical service timeliness (X4), emergency response efficiency (X5), problem-solving availability (X6)
- **Supportability:** Service trustworthiness (X7), staff courtesy (X8), service coordination (X9)
- **Normativity:** Staff qualification compliance (X10), facility quality grade (X11), operational management level (X12)
- **Empathy:** Elderly care concern (X13), service personalization (X14), health rights protection (X15)

Following Fornell et al., we assessed convergent validity through standardized factor loadings, composite reliability (C.R.), and average variance extracted (AVE) using AMOS 17.0 for confirmatory factor analysis.

1.2.3 Entropy Weight Method and Fuzzy Comprehensive Evaluation

The entropy weight method provides objective weighting. Combined with fuzzy comprehensive evaluation, this approach maps evaluation results to attribute characteristics, fuzzifies indicator weight vectors, and uses membership matrices to reflect relationships between evaluation factors and results, calculating weights through information entropy to avoid subjective bias.

Entropy Weight Calculation: 1. Normalize indicators to obtain positive and inverse values, calculating the proportion of each indicator's evaluation value across i questionnaires. 2. Calculate information entropy (E) and utility values ($D = 1 - E$) for each indicator, where K is a constant. Higher utility values indicate greater weight. 3. Calculate indicator weights (W).

Fuzzy Comprehensive Evaluation: 1. Determine the fuzzy relationship matrix R where $r = M/N$ represents the membership degree—the ratio of elderly satisfied with specific service aspects to total respondents. 2. Calculate the fuzzy evaluation result matrix $S = W \times R$. 3. Defuzzify using measurement scale $I = (50, 40, 30, 20, 10)$ based on satisfaction levels, yielding comprehensive evaluation scores $B = S \times I$.

To analyze the importance (weight) and satisfaction of each secondary indicator, we constructed a four-quadrant plot with importance on the x-axis and satisfaction on the y-axis. Using Excel, we divided the plane into four zones based on mean values: (1) **Advantage Zone** (high satisfaction, high importance); (2) **Maintenance Zone** (high satisfaction, low importance); (3) **Opportunity Zone** (low satisfaction, low importance); and (4) **Improvement Zone** (low satisfaction, high importance), indicating priority areas for targeted interventions.

Results

2.1 General Characteristics We distributed 1,106 questionnaires, recovering 1,011 valid responses (91.41% response rate). Participants included 339 from public institutions (33.53%) and 672 from private institutions (66.47%). Demographics: 445 male (44.02%), 566 female (55.98%); age distribution: 226 aged 60-69 (22.35%), 368 aged 70-79 (36.40%), 417 aged ≥ 80 (41.25%); education: 537 with primary school or below (53.12%), 354 junior high (35.01%), 92 senior high (9.10%), 28 college or above (2.77%); marital status: 418 married (41.35%), 593 unmarried/widowed (58.65%); household registration: 786 non-agricultural (77.74%), 225 agricultural (22.26%); self-reported financial status: 109 very adequate (10.78%), 167 adequate (16.52%), 396 barely adequate (39.17%), 221 inadequate (21.86%), 118 severely inadequate (11.67%); medical insurance: 568 urban employee insurance (56.18%), 255 urban-rural resident insurance (25.22%), 126 other insurance (12.46%), 62 no insurance (6.14%); self-reported health: 114 good (11.28%), 531 fair (52.52%), 366 poor (36.20%).

2.2 Reliability and Validity Cronbach's α coefficients for all latent variables approached or exceeded 0.700, with overall questionnaire reliability of 0.910. KMO values ranged 0.623-0.706 with robust Bartlett's test results; overall validity was 0.895. See Table 1.

2.3 Confirmatory Factor Analysis Standardized factor loadings ranged 0.546-0.831, indicating good convergent validity without requiring variable deletion. Composite reliability (C.R.) values ranged 0.700-0.806, meeting the recommended threshold of 0.700 and demonstrating good internal consistency. AVE values exceeded 0.500 for most latent variables (with supportability and normativity approaching 0.500), indicating acceptable convergent validity (AVE 0.360-0.500 is acceptable, >0.500 is ideal). See Table 2 .

2.4 Evaluation Results Comprehensive satisfaction scores were 41.66 points for public institutions and 38.82 points for private institutions. Public institutions scored higher on supportability (42.51) and normativity (41.96), with all 15 secondary indicators exceeding 40.00 points. Private institutions showed higher scores on supportability (39.79) and normativity (38.97), but lower scores on reliability (38.32) and empathy (38.43), with 13 secondary indicators below 40.00 points. While differences existed between institution types, disparities were greater for normativity and empathy, and smaller for reliability, timeliness, and supportability. See Table 3 .

Quadrant analysis revealed that public institution indicators primarily distributed in the Maintenance, Opportunity, and Improvement Zones: X1, X5, X11, and X14 fell in the Improvement Zone; X3 and X13 in the Opportunity Zone; and remaining indicators in the Maintenance Zone. Private institution indicators distributed across Advantage, Maintenance, and Improvement Zones: X8 and X13 in the Advantage Zone; X2, X3, X6, X7, X9, X10, and X12 in the Maintenance Zone; and remaining indicators in the Improvement Zone, with X1, X11, and X14 at the lowest Improvement Zone positions. See Figure 1 [Figure 1: see original paper].

Discussion

3.1 Main Findings First, public institutions demonstrated higher overall satisfaction scores, particularly in supportability and normativity dimensions. Serving vulnerable populations including “three-no” (no family, no income, no legal guardian) and “five-guarantee” (food, clothing, medical care, housing, funeral expenses) beneficiaries, public institutions operate as social welfare entities receiving substantial government support in funding, land, financing, and taxation. They offer greater security in staffing, compensation, and career development, ensuring standardized, stable, and continuous service delivery. However, indicators X1 (service comprehensiveness) and X5 (emergency response efficiency) require improvement to fully leverage public institutions’ resource advantages and leadership role.

Second, private institutions showed moderate overall satisfaction, with lower scores on reliability and empathy. Thirteen secondary indicators scored below 40.00 points, with X1, X11 (facility quality grade), and X14 (service personal-

ization) positioned at the lowest quadrant points. Two critical factors constrain private institution quality: (1) systemic barriers including inter-departmental “silos,” inconsistent medical insurance reimbursement policies, and difficulties converting beds between medical and elderly care functions; and (2) workforce challenges characterized by “three lows” (low compensation, education, and social status) and “three highs” (high turnover, workload, and age). These factors, combined with inadequate medical facilities and staffing, hinder service quality and personalized care delivery. Private institutions should enhance facility quality while maintaining strengths in service professionalism, commitment fulfillment, and operational management.

Third, significant differences between public and private institutions reflect their distinct characteristics in target populations, government support, operational models, and social functions. Private institutions face competitive disadvantages in talent recruitment, cost management, and policy support, with difficulties in financing, construction costs, operational efficiency, and resource shortages. Most provide only basic short-term care, reluctantly accepting severely disabled or chronically ill elderly. A 2019 study of 1,699 nursing institutions in Shandong found only eight private institutions specialized in semi-care, full-care, special-care, and professional nursing services.

3.2 Policy Recommendations First, eliminate systemic barriers to medical-elderly care integration. Both public and private institutions face integration challenges requiring coordination across health, civil affairs, human resources, finance, and other departments through unified management structures. We must improve pricing mechanisms and medical insurance payment policies, gradually including institutional medical departments in reimbursement scopes. While insurance coverage is relatively accessible when elderly care is provided within medical institutions, non-medical institutions face reimbursement difficulties. We should expand coverage step-by-step in health assessment, disease screening, rehabilitation, and diagnostic quality, clarifying reimbursement content, scope, and standards while promoting contracted cooperation between nursing institutions and medical facilities.

Second, optimize service content and supply quality. Institutions should develop differentiated, classified management pathways based on their resource advantages. Public institutions should adopt centralized layouts and intensive operations to increase nursing bed supply and enhance service efficiency. The National Health Commission will support approximately 1,000 public institutions in adding nursing beds during the 14th Five-Year Plan period, enabling larger institutions to establish medical departments eligible for insurance reimbursement. For private institutions, we should increase targeted support in funding, financing, taxation, operational subsidies, and talent recruitment, while expanding service content and coverage through quality improvement initiatives and star-rating systems.

Third, develop sustainable human resources through multiple channels. We

should encourage universities and vocational schools to strengthen gerontology and healthcare programs, cultivating interdisciplinary talent in integrated care, elderly health, nutrition, and psychological counseling, while establishing incentives for graduates to work in nursing institutions. Additionally, we must enhance workforce training, coordinate development across institution types, and provide policy support for compensation, professional title evaluation, and continuing education. Establishing exchange and training mechanisms between medical institutions and nursing facilities, strengthening training for nursing assistants, and encouraging retired medical staff and volunteers to participate in integrated care services are essential. Institutions should also leverage smart health monitoring, wearable devices, and intelligent care services to optimize resources and improve service quality.

Conclusion

This study developed a service quality evaluation index system based on SERVQUAL model dimensions, applying entropy weight and fuzzy comprehensive evaluation methods to compare public and private nursing institutions. The findings reveal significant differences in satisfaction, particularly in normativity and empathy dimensions, providing a reference for identifying service problems and promoting high-quality integrated care development. A limitation is SERVQUAL's reliance on subjective elderly evaluations; future research should incorporate objective quality indicators to construct more comprehensive and scientific evaluation systems.

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