WHIOCE PUBLISHING PTE. LTD.
PROVIDING FIRST-CLASS SCIENTIFIC INFORMATION FOR TOP SCHOLARS

2025 Volume 3, Issue 10
Lecture Notes in Education, Arts, Management and Social Science
ISSN(Online): 2705-053X

Exploration of Optimal Paths for Contractual Cooperation between Public Medical Institutions and Elderly Care Institutions in Chongqing, China

Yujie Wang*
College of Marxism, Chongqing University of International Business and Economics, Chongqing 401520, China

Author to whom correspondence should be addressed.

Abstract: Contractual cooperation between public medical institutions and elderly care institutions is one of the core practical forms of integrating medical and elderly care services. As a mountainous city, Chongqing exhibits distinctive characteristics in such cooperation due to its urban-rural dual structure, topographical features, and regional development disparities. Based on the theories of collaborative governance and resource dependence, this study employs research methods including surveys (covering 9 central urban districts of Chongqing and 6 counties in southeastern and northeastern Chongqing) and case studies. It systematically sorts out the policy implementation, types of cooperation models, and phased achievements of medical-elderly care contractual cooperation in Chongqing from a practical perspective, while in-depth analyzing the existing practical obstacles such as insufficient subject collaboration, ineffective mechanism operation, weak resource guarantees, and inadequate regional adaptability. Combined with Chongqing's local practical scenarios, targeted optimization paths are proposed to provide feasible practical references for improving the quality and efficiency of medical-elderly care contractual cooperation in mountainous cities.

Keywords: Public medical institutions; Elderly care institutions; Contractual cooperation

Online publication: November 26, 2025

1. Practical status of medical-elderly care contractual cooperation in Chongqing

1.1. Promotion process of policies from pilot to full coverage

From 2017 to 2019, based on the Implementation Plan for the Pilot Work of Integrating Medical and Elderly Care Services in Chongqing, the government launched pilot projects in 5 central urban districts and 12 districts/counties, including Wanzhou and Fuling. It clarified the core contents of home visits and referrals in contractual cooperation, promoting 187 elderly care institutions and 63 public medical institutions to successfully sign contracts in the first batch, forming 3 types of basic cooperation templates.

From 2020 to 2022, the government expanded the scope of contractual cooperation to 38 districts and counties across the city and issued Several Measures for Accelerating the Development of Integrating Medical and Elderly Care Services in Chongqing, requiring public medical institutions at or above Level 2 to establish cooperative relations with elderly care institutions within their jurisdictions. By the end of 2022, the contractual coverage rate reached 83.5%, an increase of 65

percentage points compared with the end of the pilot period.

Since 2023, the government has issued the Specifications for Contractual Services of Integrating Medical and Elderly Care Services in Chongqing, refining 3 categories of service standards (basic medical services, rehabilitation nursing services, emergency referral services), 4 operational procedures, and 2 types of assessment indicators, and actively promoting the transformation of medical-elderly care cooperation from "formal signing" to "substantive services". As of the end of 2023, among the 2,107 pairs of contracting parties in the city, 68% have carried out regular services.

1.2. Breadth and depth of medical-elderly care cooperation

Most medical-elderly care cooperation falls into the category of basic cooperation, mainly adopting two basic models: outpatient home visits and emergency referrals, which are also the mainstream cooperation forms in the city. Specifically, public medical institutions dispatch medical staff to elderly care institutions every month to provide irregular medical services such as physical examinations and chronic disease prevention, and open green channels for emergency referrals for service recipients. Some more mature medical institutions and elderly care institutions have adopted an "immersive service" model, which is mainly concentrated in the core urban areas. During the service process, public medical institutions set up medical service points in elderly care institutions, equipped with basic diagnosis and treatment equipment (such as sphygmomanometers and blood glucose meters) and full-time medical staff, and provide daily diagnosis and treatment, rehabilitation guidance and other services for service recipients, with a high coverage of resident elderly and a high average daily number of consultations. A small number of Grade A tertiary hospitals or model elderly care institutions have very mature cooperation models. For example, an affiliated hospital of a university in Chongqing signed a contract with a large elderly care institution in Yubei District to share inspection equipment such as CT and MRI, and medical staff of the elderly care institution can participate in regular training in the hospital, presenting a new cooperative pattern of resource sharing between medical and elderly care parties.

1.3. Coverage scope and service effectiveness of medical-elderly care cooperation

As of the end of 2023, the contractual coverage rate between elderly care institutions and public medical institutions in the city reached 92.3%, an increase of 46.7 percentage points compared with 2019. Among them, the coverage rate in 9 central urban districts reached 100%, while the coverage rates in counties in southeastern and northeastern Chongqing were 85.2% and 88.6%, respectively, showing a significant expansion in coverage breadth. The average medical waiting time for resident elderly in urban elderly care institutions was shortened from 45 minutes in 2019 to 25 minutes, and the standardized management rate of chronic diseases for resident elderly in rural elderly care institutions increased from 38% to 62%. For example, through the three-level medical network consisting of district/county people's hospitals, township health centers, and rural elderly care institutions in Wanzhou District, the follow-up rate of chronic diseases among the elderly in rural elderly care institutions reached 78% in 2023, an increase of 31 percentage points compared with 2021, and the service coverage was greatly improved. Although the development level of various districts and counties in Chongqing varies, medical-elderly care cooperation has vividly displayed the characteristics of each district and county. For instance, Yuzhong District has constructed a "15-minute medical-elderly care service circle", realizing that community elderly care institutions are within a 15-minute walk from Grade A tertiary hospitals and emergency referrals are responded to within 15 minutes; targeting the characteristics of ethnic minority settlements, Youyang County has formed bilingual medical service teams, signed contracts with 8 rural elderly care institutions, and provided more than 280 bilingual medical services in 2023.

2. Practical obstacles of medical-elderly care contractual cooperation in Chongqing

2.1. Insufficient enthusiasm for medical-elderly care cooperation

The enthusiasm of public medical institutions is particularly low. The average daily outpatient volume of Grade A tertiary hospitals in Chongqing generally exceeds 8,000 person-times, with saturated medical resources. However, the service

demand of elderly care institutions is scattered, the average daily medical demand of elderly care institutions is insufficient, and the charging standard is only 60%-70% of that of ordinary outpatient clinics, resulting in a lack of practical incentives. From 2023 to 2024, 42% of elderly care institutions reported that "home visits are less than once a month", and 35% of elderly service recipients feedback that "home visit doctors are mostly with primary professional titles or even interns, who cannot handle complex illnesses"; a people's hospital in a county in southeastern Chongqing signed contracts with 15 elderly care institutions in 2023, but only carried out 32 home visits, with an average of less than 2 home visits per institution [1].

The hardware undertaking capacity of elderly care institutions is weak: 80% of elderly care institutions in rural areas of Chongqing have less than 50 beds, most of which are not equipped with basic diagnosis and treatment equipment, such as sphygmomanometers and blood glucose meters, and there is a shortage of professional nursing staff. For example, a rural elderly care institution in Wushan County, northeastern Chongqing, after signing a contract with a township health center, was unable to carry out basic services such as chronic disease follow-up due to the lack of full-time nursing staff cooperation, and the contract became a mere formality on paper; some responsible persons of medical institutions reported that elderly care institutions have not established service demand accounts, making it impossible to accurately connect with medical resources.

2.2. Ambiguous division of labor in agreements between medical and elderly care parties

The division of responsibilities and interests between medical and elderly care parties is relatively ambiguous. Most signing agreements are framework documents without clear practical operation details. For example, the agreements do not specify the specific frequency of home visits or the payment standards for service fees. The single cost of home visits by public medical institutions is about 200-300 yuan, while the charge is often only 80-120 yuan, resulting in an imbalance between costs and benefits. Unreasonable interest distribution between some contracting parties makes it difficult to sustain cooperation.

Chongqing has not yet established a unified medical-elderly care information network platform, and the HIS system used by medical institutions is incompatible with the management system of elderly care institutions. In some emergency referral cases, there is a problem of incomplete medical records. For example, when an elderly person from an elderly care institution in Wanzhou District is referred, they need to re-conduct examinations such as blood routine and B-mode ultrasound, with a duplicate inspection rate of 45%, which objectively wastes medical resources and the elderly's time; some elderly care institutions reflect that they cannot query the elderly's medical records in real time, making it impossible to provide care services targeting their symptoms.

Most medical and elderly care cooperation parties lack a regular practical docking mechanism. Most contracting parties only communicate once at the time of signing, with no regular consultations afterward. For example, an elderly care institution in Pengshui County, southeastern Chongqing, needed to add rehabilitation nursing services, but did not receive a response from the medical institution for 3 months due to the lack of a docking channel.

2.3. Weak guarantees of financial and human resources, and insufficient subsequent motivation for cooperation

The special subsidy for medical-elderly care contractual cooperation in Chongqing is 120-200 yuan per person per year, which can only cover basic services such as home visits and referrals, with no special support for other follow-up services and personnel training, resulting in weak financial subsidy guarantees. Compared with Suzhou (400 yuan per person per year) and Hangzhou (350 yuan per person per year) in the eastern region, there is a significant gap in subsidy standards; a small number of private profitable elderly care institutions do not even enjoy any subsidies. For example, a private elderly care institution in Yubei District spent 80,000 yuan on medical cooperation in 2023 without any financial support, resulting in great cooperation pressure [2].

The ratio of medical staff to resident elderly in elderly care institutions in Chongqing is only 1:35, far lower than the

national standard (1:10), with a huge talent gap. The average monthly salary of medical staff in elderly care institutions is about 3,500 yuan, only 50%-60% of that of the same position in public hospitals, and there is no channel for professional title promotion. Most elderly care institutions report that they still cannot fill their staff after recruiting medical staff more than 3 times a year, and the turnover rate of medical staff in a county-level elderly care institution in northeastern Chongqing reached 42% in 2023.

The government does not have a unified practical evaluation index system, and supervision is mostly "annual written inspection" without in-depth on-site service inspections, resulting in insufficient supervision and evaluation. For example, the evaluation of medical-elderly care contracts in a district/county in 2023 only checked the signing agreements and home visit records, without verifying the service quality; the evaluation results were not linked to financial subsidies, and 45% of the contracting parties believed that loose supervision led to perfunctory services.

3. Practical optimization paths for medical-elderly care contractual cooperation in Chongqing

3.1. Implement workload assessment to enhance the undertaking capacity of both medical and elderly care sides

Firstly, hospitals should establish compliant and reasonable incentive mechanisms, incorporating medical-elderly care contractual cooperation into employees' performance appraisal. Quantified indicators (such as the number of home visits, chronic disease re-examinations, and referral response time) shall be set in accordance with specified standards, and the assessment results shall be directly linked to hospitals' year-end evaluations and financial allocations. To encourage medical staff participation, special subsidies of a fixed monthly amount shall be provided to those involved in the cooperation, and service hours (no less than 60 hours per year) shall be included as bonus points for professional title evaluation. In 2024, Chongqing piloted this mechanism in Yuzhong District and Wanzhou District, leading to a slight increase in the frequency of home visits by medical institutions in the pilot areas [3].

Secondly, the practical undertaking capacity of elderly care institutions should be improved. The municipal finance shall allocate special funds, providing subsidies of approximately 5,000 yuan per bed (adjusted based on local fiscal conditions) to small and medium-sized rural elderly care institutions for equipping basic medical equipment. A "medical-elderly care assistance" mechanism shall be established, where each public hospital is paired with 3-5 elderly care institutions to actively conduct practical training for medical staff (no less than 4 sessions per month as much as possible).

3.2. Standardize the medical-elderly care cooperation model and establish long-term collaborative relationships

Firstly, the government should organize the formulation of standardized practical agreements. The Chongqing Municipal Civil Affairs Bureau and the Chongqing Municipal Health Commission shall jointly issue the Standardized Agreement for Medical-Elderly Care Contractual Cooperation in Chongqing (2024 Edition), clarifying 12 practical items in 3 categories (including home visit frequency, service items, and charging standards), a list of liability division, and dispute resolution procedures to standardize the cooperation model. Meanwhile, unified charging standards shall be implemented for basic services (such as physical examinations and chronic disease follow-ups), while market-oriented pricing shall be adopted for value-added services (such as rehabilitation nursing and specialist diagnosis and treatment), so as to protect the interests of both parties and reduce cooperation costs.

Secondly, the government should integrate data resources from civil affairs and health departments to build a city-wide integrated information platform for medical-elderly care integration. This platform will realize real-time sharing of the elderly's health records, medical treatment records, and care information, and promote the integration of "electronic health codes + elderly care service cards". Elderly care institutions can directly retrieve the elderly's medical records, and medical institutions can access the elderly's care needs, thereby reducing duplicate inspections. Currently, Yuzhong District

has piloted this platform, resulting in a decrease in the rate of duplicate inspections during referrals.

Finally, both medical and elderly care institutions need to establish a regular work docking mechanism. Contracting parties shall assign full-time liaison personnel, establish monthly and quarterly communication meeting systems, and conduct a large-scale service demand survey annually. Districts and counties may form medical-elderly care integration practice alliances to coordinate local medical and elderly care resources and dynamically adjust service content.

3.3. Provide policy support to consolidate the foundation for medical-elderly care cooperation

The government should optimize financial subsidy policies for medical-elderly care cooperation, establish a special fund for contractual cooperation, increase the subsidy standard for medical staff, and expand the subsidy scope to cover key areas such as services and personnel training. Private profitable elderly care institutions shall receive subsidies equivalent to 80% of those granted to public institutions, with differentiated subsidies implemented based on service quality grades (Grade A, B, and C). For medical-elderly care cooperation projects in some remote districts and counties, the subsidy standard shall be increased by 20% to minimize the cost pressure caused by Chongqing's topographical constraints.

Strengthen the construction of talent teams: Expand the enrollment scale of elderly care and nursing majors in institutions such as Chongqing Medical and Pharmaceutical College and Chongqing Vocational College of Nursing, training no less than 2,000 professional talents annually; establish a "basic salary guarantee + performance bonus" mechanism to ensure that the average monthly salary of medical staff in elderly care institutions is no less than 5,000 yuan, and set up a professional title mutual recognition channel with public hospitals; promote the "on-site rotation of medical staff" model, requiring medical staff from public medical institutions to provide on-site services in elderly care institutions for no less than 3 months per year, which shall be counted as their work experience.

Construct a full-cycle service supervision system: Establish a three-dimensional qualification evaluation index system covering "service quality + elderly satisfaction + cooperation effectiveness". Third-party organizations entrusted by the government shall conduct on-site evaluations twice a year, classifying the results into three grades: Excellent, Qualified, and Unqualified. Hospitals with Excellent performance shall receive incentives such as a 30% increase in funding subsidies and priority in model establishment. Hospitals with Unqualified performance shall be ordered to rectify within a time limit; those failing to meet the requirements after rectification shall have their medical-elderly care cooperation qualifications revoked.

Disclosure statement

The author declares no conflict of interest.

References

[1] Chongqing Municipal People's Government, 2023, Action Plan for Enhancing Integrated Medical and Elderly Care Services and Elderly Health Service Capabilities in Chongqing (2023–2027). Chongqing Municipal People's Government, 2023: 1–7.

[2] Chongqing Municipal Health Commission, 2023, Notice on Further Standardizing the Contractual Cooperation between Elderly Care Service Institutions and Medical and Health Institutions. Chongqing Municipal Health Commission, 2023: 1–6.

[3] Chongqing Municipal Health Commission, 2023, Work Plan for Establishing the Demonstration Project of Integrated Medical and Elderly Care in Chongqing. Chongqing Municipal Health Commission, 2023: 1–5.