Proceedings of the 2nd International Conference on Financial Technology and Business Analysis
DOI: 10.54254/2754-1169/73/20230514

The Current Situation and Demand Drivers of Rural Home Elderly Care Services in the Context of Rural Revitalisation

--- Taking Chengdu City as an Example

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Abstract: Based on a sample of 487 rural elderly people from five counties (cities and districts) in Chengdu City, this paper investigates the main demand drivers affecting rural home-based elderly care service consumption willingness based on structural equation modelling. The results of the study show that (1) the overall satisfaction level of the demand for rural home-based elderly care services in Chengdu is 40%, with insufficient service relevance and low cost-effectiveness; at the same time, the service functions of the basic facilities for the elderly are not sufficiently fulfilled, and the resources are not effectively utilised. (2) The willingness to participate in home care services in rural Chengdu is mainly driven by spiritual and cultural, medical and health care and other demand factors. (3) Life care has a positive effect on rural elderly's participation in home care to a certain extent, but it is not significant. Safety and security indirectly affect rural elderly's willingness to age in place by influencing medical and health care. Therefore, the government, enterprises, communities, and families should work together in an orderly and coordinated manner to form a family-centred, community-based, and professional service-dependent socialised service for the rural elderly living at home, with the main content of solving daily life difficulties, and supplemented by spiritual and cultural services, in order to guard the rural elderly in their later years of happiness.

Keywords: Rural revitalization, Rural home care, Demand-driven factors, Chengdu

1. Introduction

Data from the Seventh National Population Census[1] show that China has a large elderly population, and the process of ageing is accelerating markedly, creating an urgent demand for elderly care services, especially home-based elderly care services. Compared with urban areas, there is an exodus of young adults, and the degree of aging in rural areas is significantly higher than that in urban areas; secondly, rural areas are lagging behind in terms of policy provision and resource protection, and the demand for home-based elderly care services is even more urgent. The rural population of Chengdu City is 4,444,800, a decline of 19.43 per cent compared with the sixth national census in 2010, with the rural population in a negative growth trend, and there are 1,143,900 rural older persons aged 60

[1]Seventh National Population Census Bulletin_China.gov.cn (www.gov.cn)

DOI: 10.54254/2754-1169/73/20230514

and over, accounting for 25.74 per cent of the rural population, a proportion that is actually much higher than that of cities and towns, so that rural older persons are facing a serious challenge to their life care and financial resources.

Developed countries such as Europe and the United States have formed a more complete system in the field of home-based elderly care services, P. Schopflin[1] believe that the elderly need not only financial support, but also more life care and spiritual comfort.Angel[2] also believes that emotional support, along with material and service support, are all indispensable factors for old age.Otero A et al[3], Wark S et al[4] argue that rural older people lack formal health and social care support compared to urban older people, and that home care services are rare in rural areas.Numerous scholars have made recommendations to address such issues.Eriko[5] proposed interventions for quality of life as well as mental health of older people to promote high quality and sustainable home care; Lang A[6] suggested that a safe home environment can reduce the incidence of chronic diseases in older people; in addition, Bernabei R[7], Béland[8], Lee[9], Lew[10] suggest that the intervention of telemedicine technology, the construction of supporting infrastructure in the home, and the development of long-term care measures can also guard the health of the elderly to a certain extent.

China's level of economic development and the basic conditions of the country determine that institutional care is not the main channel, Mu Guangzong [11], Guo Jingcheng[12], Cui Shuyi[13] believe that family-based and community-based home care will inevitably become the dominant form of rural care.In fact, at present, home care services are mainly concentrated in the more economically and socially developed urban areas, and there is a serious mismatch between supply and demand for home care in rural areas, which has been developing slowly. Feng Hongxia et al. [14] argued that most of the elderly in rural areas in Northwest China are willing to accept market-based home care services, but the willingness to serve should be characterised by diversity and complexity. Wang Junwen et al.[15], Li Fen[16], Zhang Zhiyuan[17], and Du Zhimin et al.[18] believe that rural home care needs have not been effectively met, and that existing rural elderly care services tend to focus on basic services, but pay little attention to the personalised needs of the elderly, such as door-to-door medical care, door-to-door delivery of medicines, and relief of boredom and chatting, which are the most important needs of the elderly. Yuan Guoling et al.[19] argued that rural old-age care should be demand-oriented to improve old-age care services from the perspective of the integration and development of social resources as a whole. Yao Zhaoyu et al.[20] believe that it is necessary to increase the policy support for home care services, optimise the supply mechanism of rural home care services, and improve the level of rural home care services.

Against the backdrop of an aging population, it is crucial to establish a sound rural home-based elderly care service system. Existing literature has conducted a relatively systematic study on the existing deficiencies and improvement methods of rural home-based elderly care services from the perspective of rural elderly care service development, which can provide theoretical reference and a logical starting point for this study. However, for a long time, scholars have focused on analysing the impact of the demand for home-based elderly care services from the aspects of the basic characteristics of the elderly individuals and groups, family characteristics and socio-economic characteristics, etc., and the type and degree of demand that affects the willingness of the rural elderly to participate have not been sufficiently discussed, not to mention empirically proved. Therefore, on the basis of existing excellent results at home and abroad, this study will take the promotion of rural elderly care under the strategy of rural revitalisation as the starting point to explore the status quo and demand drive of rural home-based elderly care services in rural revitalisation, and explore the reasons for the restriction of the development of elderly care services industry while understanding the factors influencing the willingness to participate in elderly care services, so as to provide references for the improvement of rural elderly's quality of life.

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2. Research hypothesis and modelling

Based on the existing literature and related theories, the demand drivers of rural elderly living at home for life care, health care, spiritual culture and safety and security are the four main motives influencing the willingness to participate. Based on SEM's validated factor analysis and path analysis, this paper identifies the main demand drivers of rural home-based elderly care services, and quantifies the paths affecting rural elderly people's willingness to participate, as well as the magnitude of the influence factor of each demand driver. We asked rural elderly people, "To what extent do you think the home-based elderly care service is helpful to you?", "Are you willing to participate in the consumption of home care services?" and "Do you think that your sense of well-being will be improved in the process of experiencing the home-based elderly care service?" The responses were set as the willingness to participate factor to set the willingness to participate. Based on the practical experience and literature survey, it is hypothesised that the above four demand-driven factors will have a direct or indirect impact on the willingness to participate. Based on this, the conceptual model and related hypothesis table are constructed.

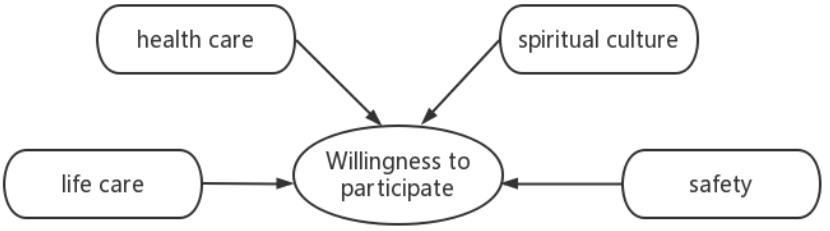

Figure 1: Conceptual diagram of structural equations.

Table 1: Table of model assumptions.

	model assumption
H1	Life care has a positive effect on willingness to participate.
H2	Health care has a positive effect on willingness to participate.
H3	Spiritual culture has a positive effect on willingness to participate.
H4	Safety care has a positive effect on willingness to participate.

3. Programme design and organisational implementation

According to the results of the seventh population census, the degree of aging in Sichuan Province ranks third in the country, and as the capital city of Sichuan Province, the aging situation in Chengdu City is also very serious. In recent years, the Chengdu Municipal Government has introduced rural pension policies such as comprehensively opening up the pension market, stimulating social forces to invest in the elderly[2], deepening home or community-based pension services, building a comprehensive pension service platform, dynamically grasping the situation of the elderly at home[3], and providing basic old-age subsidies to specific families in difficulty[4]. It has a demonstrative role for other cities to promote and improve the rural home care service system. Therefore, this paper

[2] *Implementation Opinions on Deepening the Comprehensive Reform of Elderly Services and Improving the Quality of Elderly Services*

[3] *Implementation Programme on Care for the Elderly at Home and in the Community in Chengdu Municipality*

[4] *Opinions of the General Office of the People of Chengdu Municipality on Further Improving the Basic Old-Age Service Subsidy System for the Elderly in Difficulty* (https://www.ioaging.org/aging-in-america.)

DOI: 10.54254/2754-1169/73/20230514

selects rural elderly people in Chengdu City as the object of empirical analysis and organises relevant field surveys to verify the hypothetical model of the factors influencing the willingness to participate in rural home-based elderly care shown in Figure 1.

3.1. Sample Selection

First, stratified sampling was conducted according to the proportion of the population aged 60 and above in each administrative village in Chengdu City, and the survey area was set as five strata in Chengdu City: Jianyang City, Chengdu East New District, Pengzhou City, Qionglai City, and Dayi County. Then, based on the proportion of rural population in each area of Chengdu City in 2020, 17 towns were selected as clusters in the five districts using the whole cluster sampling method and the proportional sampling method, respectively, within each county and urban area. Finally, from the 17 clusters selected for sampling, 28 elderly people aged 60 and above were randomly selected for questionnaire survey in each cluster respectively according to the principle of random sampling.

3.2. Questionnaire design

The design of the questionnaire revolves around the hypothesis model of influencing the willingness to participate in rural home-based elderly care services, mainly on the basis of literature research, fully absorbing the research methods of the previous researchers, and combining the actuality of this paper, the questionnaire is designed for the various hypotheses in the model, and the closed-ended questions are used for designing the specific questions; at the same time, a small pre-survey is carried out in the city of Chengdu and the questionnaire is amended based on the practicality of the actual operation. The formal questionnaire mainly consists of nearly 40 questions in four aspects: respondents' basic characteristics, health status, service conditions and needs, and willingness to participate, and mainly understands and grasps the demand-driven factors that may affect the willingness to consume rural home-based elderly care services.

3.3. Survey methodology

In order to avoid the rural elderly reducing the authenticity and validity of the questionnaire responses due to understanding bias, this survey was conducted through one-on-one interviews and answering the questionnaire on the spot. The survey was divided into pre-survey and formal survey. The pre-survey was carried out in four established villages in Chengdu City, 110 questionnaires were distributed, 101 questionnaires were valid, and the pass rate was 92%. On the basis of the pre-survey, the questionnaire was further modified and improved, and 502 questionnaires were distributed in the formal survey, with 487 valid questionnaires and a pass rate of 97%. The whole survey was completed in February 2023.

4. Statistical description of the sample

4.1. Basic Characteristics of Respondents

As shown in table 2, the male-to-female ratio of the respondents is 1:1.21, which is basically balanced; their age is mainly concentrated in 60-70 years old, which meets the requirements of the survey respondents; their educational level is mainly in junior high school and primary school and below, accounting for 34.362% and 35.802% respectively; and they live with their spouses accounting for 65.638%. Overall, the vast majority of respondents were interested in the content of the survey, and the credibility of the answers ensured that the results were true and reliable.

DOI: 10.54254/2754-1169/73/20230514

4.2. General Market Conditions

4.2.1. Respondents' Health Condition

The physical health of the elderly in rural Chengdu City was rated as healthy by 46.30 per cent of the sample, taking the first place, followed by those whose physical health was average. The actual physical health of the rural elderly in Chengdu City is as follows: the proportion of the sample that is very healthy is 42.59%, the proportion of the sample that is healthy is 27.16%, the proportion of the sample that is average is 12.96%, the proportion of the sample that is unhealthy is 11.73%, and only a small proportion of the respondents have a very unhealthy physical health condition, accounting for 5.56%. As far as the sample is concerned, the physical health status of rural elderly in Chengdu is relatively good, but there are still rural elderly with poor health status.

4.2.2. Status of Service Provision

Table 2: Statistical description of the sample.

Name	Options	Frequency	Proportion	Name	Options	Frequency	Proportion
Age (years)	60-70	328	67.49	academic qualifications	Primary and below	174	35.80
	71-80	121	24.90		Junior high school	167	34.36
	81-90	34	7.00		High School or Secondary School	103	21.19
	>90	3	0.62		College	40	8.23
genders	female	266	54.73		Bachelor degree or above	2	0.41
	male	220	45.27	Annual income (yuan)	<3000	86	17.70
Residence	Living with spouse	319	65.64		3001-6000	122	25.10
	Living with children and grandchildren	98	20.16		6001-9000	127	26.13
	Residential homes for the elderly	35	7.20		9001-12000	98	20.16
	Living alone	27	5.56		12001-18000	40	8.23
	Other	7	1.44		>18000	13	2.68

Of the 12 home care services surveyed, the majority of respondents indicated that there was no home care service around them or they were not sure if there was such a service, and only a few respondents indicated that there was a particular home care service. The most frequently provided home care services are cultural and sports activities and regular health check-ups, with a provision rate of more than 40 per cent; the least frequently provided are meal assistance services, with a provision rate of less than 30 per cent, which generally fail to meet the needs of the elderly in rural areas.

5. Model construction and empirical analysis

5.1. Sample Reliability and Validity Test

In order to verify the credibility and validity of the questionnaire, this study used SPSS to statistically analyse the results of the questionnaire, and the results are shown in the table. In terms of questionnaire reliability test, generally speaking, Cronbach Alpha coefficient higher than 0.8 indicates that the questionnaire reliability is very good, Cronbach Alpha coefficient between 0.6 and 0.8 indicates that the questionnaire reliability is good, and Cronbach Alpha coefficient lower than 0.6 indicates that the questionnaire reliability is poor. The Cronbach Alpha of the questionnaire are higher

DOI: 10.54254/2754-1169/73/20230514

than 0.8, which indicates that the reliability of the questionnaire is good. Regarding the validity test of the questionnaire, generally speaking, the KMO value is higher than 0.5 and the Bartlett's sphere test result is significant, which indicates that the questionnaire has structural validity and is suitable for factor analysis. The KMO values of the questionnaire are all higher than 0.5, and the Bartlett's sphere test reaches a significant level (sig<0.001), which meets the requirements of the validity test index in statistics, indicating that the validity of the questionnaire is good.

Table 3: Reliability and validity analysis of the questionnaire

	Cronbach's α	KMO	Bartlett's test of sphericity		item count
Life care	0.883	0.882	approximate chi-square	1198.009	5
			df	10	
			P	0.000***	
Health care	0.929	0.717	approximate chi-square	640.414	3
			df	3	
			P	0.000***	
Spiritual culture	0.842	0.582	approximate chi-square	363.45	2
			df	1	
			P	0.000***	
safety	0.801	0.576	approximate chi-square	286.18	2
			df	1	
			P	0.000***	

5.2. Structural equation modelling

In this paper, Amos 23 software was used as a software tool for structural equation modelling analysis, and in fitting the model, it was found that all the variables except willingness 3 showed significance at the level while their standardised loading coefficients were greater than 0.4, which can be considered as having enough variance explained to show that the variables can be presented on the same factor. Willingness 3 standardised loading coefficient value is too low and not significant at level. Meanwhile the paired term safety and security significance p-value is 0.626 and does not present significance at the level, so the model is asymptotically corrected to finally achieve a better model as shown in Figure 2.

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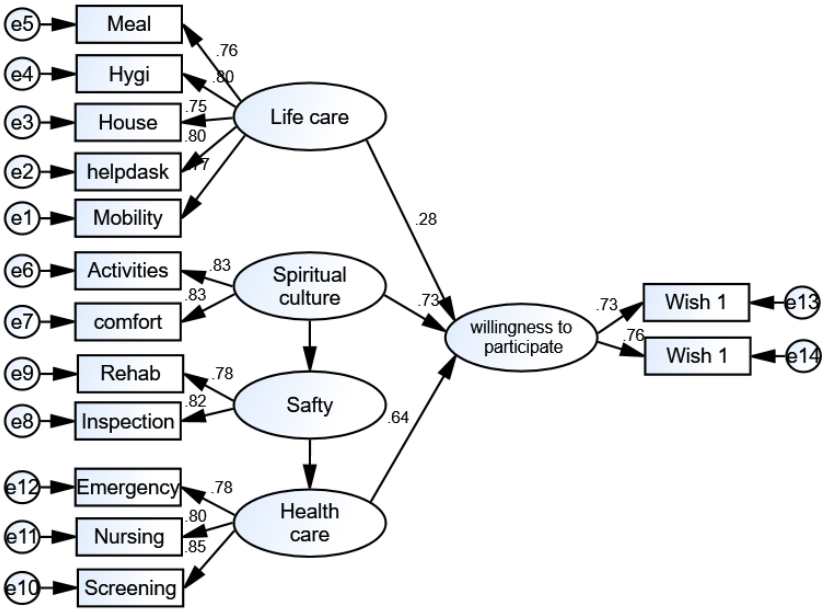

Figure 3: Path diagram of the modified structural equation model.

5.2.1. Analyses of model fit goodness of fit

According to the analysis of the modified structural equation model, all the indicators except RMR have reached the excellent value of fit, which indicates that the modified model explains the factors of willingness to participate in rural home-based elderly care services better, and the model can be accepted.

Table 4: Results of the goodness-of-fit analysis of the modified structural equation model

	χ^2	df	P	chi-square ratio of degrees of freedom	GFI	RMSEA	RMR	CFI	NFI	NNFI
Good	-	-	>0.05	<3	>0.9	<0.10	<0.05	>0.9	>0.9	>0.9
amended	198.89	71.00	***	2.801	0.953	0.061	0.334	0.969	0.953	0.961

5.2.2. Path analysis of the revised model

Table 5: Unstandardised coefficient analysis of the modified model

Path interpretation			Unstandardised coefficients	Standardised coefficients	Standard errors	Z	P
Life care	→	willingness to participate	0.258	0.278	0.139	1.859	0.063*
Health care	→	Willingness to participate	0.607	0.639	0.202	2.998	0.003***
Spiritual culture	→	willingness to participate	0.659	0.730	0.252	2.618	0.009***
safety	→	Health care	-0.967	-0.924	0.057	-17.096	0.000***
Spiritual culture	→	safety	0.886	0.976	0.047	18.840	0.000***

Table 5 gives the path coefficients, standard errors, critical ratio values and significance of the model of factors influencing the willingness to participate in rural home care. The results show that the path

DOI: 10.54254/2754-1169/73/20230514

coefficients of medical and health care as well as spiritual and cultural factors to the willingness to participate are ideal, pass the significance test, and are consistent with the assumptions of the model, H2 and H3.

The direct benefit of spiritual culture to the willingness to participate in rural home-based elderly care service is 0.730, and its path coefficient is the largest, from which we can judge that it is the most critical factor affecting the willingness to participate in rural home-based elderly care service. The direct benefit of health care on the willingness to participate in rural home-based elderly care services is 0.639, and its path coefficient is also large, so health care also has a strong positive influence on the willingness to participate in rural home-based elderly care services. Living care only passes the significance test at the 10% level, indicating that living care has a weaker impact on the willingness to participate in rural elderly home care services. Safety and security is not a direct factor affecting the willingness to participate in rural home care services, but it can indirectly affect the consumption demand through the influence of medical care and health care. Based on the path from safety and security to medical health and spiritual culture to safety and security, the significance P value is less than 0.001, which shows significance at the level, so the path is valid, and its influence coefficient is -0.924 and 0.976, respectively, i.e., safety and security has a negative influence on medical health at the level of 1%, and spiritual culture has a positive influence on safety and security at the level of 1%, and safety and security indirectly acts on the willingness to participate in rural home-based elderly care services.

Table 6: Indicator internal path coefficients

Path interpretation			standardised coefficients
Life care	<---	Meal Assistance	0.756
	<---	Hygiene Service	0.802
	<---	Housekeeping	0.749
	<---	Helpdesk Service	0.803
	<---	Mobility Services	0.767
Health care	<---	Emergency Care	0.787
	<---	Nursing Care	0.799
	<---	Health Screening	0.845
Spiritual culture	<---	Spiritual comfort	0.821
	<---	Cultural and Sports Activities	0.832
willingness to participate	<---	Wish 1	0.73
	<---	Wish 2	0.775
safety	<---	Rehabilitation for the Elderly	0.818
	<---	Safety Inspection	0.784

From the perspective of the influence within the indicators, the path coefficients of the observed variables on the indicators are all above 0.7, and most of them are located above 0.75 with a strong positive and significant influence. It shows that the questionnaire design questions can truly reflect the actual situation of each indicator. From the perspective of life care, changes in personal hygiene services and proxy services cause changes in life care to a greater extent, which in turn affects the willingness to participate in rural home care services; health checkups affect the willingness to

DOI: 10.54254/2754-1169/73/20230514

participate in rural home care services by influencing medical care; and spiritual comfort and cultural and sports activities in spiritual culture are factors that affect the willingness to participate. In conclusion, health check-ups, cultural and sports activities and spiritual comfort are the main factors that affect the willingness to participate in rural home-based elderly care services.

6. Conclusions and Recommendations

6.1. Research Conclusion

Through the above empirical analysis, the main conclusions of this paper are as follows: (1) The overall satisfaction degree of the demand for rural home care services in Chengdu City is 40%, with insufficient service targeting and low cost-effectiveness; at the same time, the service functions of the basic facilities for the elderly are insufficiently performed, and the resources have not been effectively utilised. (2) The willingness to participate in home care services in rural Chengdu is mainly driven by spiritual and cultural, medical and health care and other demand factors. Among them, both spiritual comfort and cultural and sports activities significantly affect spiritual culture, and the spiritual needs of rural elderly living alone and empty nesters are more likely to influence their participation in home-based elderly care services than their material needs. The positive influence of health checkups on healthcare is more significant, reflecting the rural elderly's demand for front-loaded and convenient services based on the accessibility of home-based elderly healthcare services. (3) Life care has a positive effect on rural elderly people's participation in ageing in place to a certain extent, but it is not significant. Safety and security indirectly affects the rural elderly's willingness to age in place by influencing health care. When the rural elderly's demand for safety and security rises, their demand for medical care and health will fall.

6.2. Countermeasure Suggestions

6.2.1. The government widely absorbs and introduces social capital

Under the background of rural revitalisation, the Chengdu municipal government should seize the opportunity of rural development and make full use of various policies and financial resources. In view of the phenomenon of insufficient relevance and low cost-effectiveness of rural home care market services, the Chengdu municipal government should provide corresponding policy subsidies and tax exemptions, lower the entry threshold of social services, provide policy and financial support to relevant enterprises, improve the welfare level of relevant staff, and encourage social capital and private capital to enter the market-based home care. capital and private capital to enter the market-based home service system construction. At the same time, establish reward, punishment and exit mechanisms to ensure the orderly outcome of service provision.

6.2.2. Enterprises promoting various types of services in sequence

Enterprises in Chengdu City can establish a menuised service provision model, and on the basis of meeting the demand for basic medical and health services, focus on increasing the demand-driven factors that have a greater impact on the willingness to participate in rural in-home elderly care, pay attention to the spiritual and cultural services for the elderly in rural areas of Chengdu City, and increase the provision of social interaction activities.

6.2.3. Community Strengthening of Infrastructure

Rural communities in Chengdu should be orientated towards providing basic public services, and make up for the demand-driven factors that have less impact on the willingness to participate in rural

DOI: 10.54254/2754-1169/73/20230514

ageing in place. By improving the accessibility of roads and staircases in rural communities, improving fitness facilities and activity venues, and providing regular visits and home safety guidance for the rural elderly, the needs of the rural elderly can be met through the enhancement of community welfare. Secondly, through medical prevention of epidemics, health and safety education, organisation of free clinics and other community welfare activities, rural elderly people's knowledge of safety and nursing care and health care has been improved, and their awareness of healthy ageing has been cultivated.

6.2.4. Effective fulfilment of maintenance obligations by children

Children of rural families should still effectively shoulder the responsibility of supporting the elderly, and ensure that the economic, material and spiritual needs of the rural elderly are met. In addition to focusing on the basic aspects of the elderly's lives and health, children should also strengthen their psychological communication with the elderly and encourage them to participate in appropriate social activities.

Appendix

We are grateful for the support of the National Innovation and Entrepreneurship Training Programme for Undergraduates "Research on the Status Quo, Problems and Innovation of Guiding Mode of Social Capital Participation in Rural Elderly Care in the Rural Construction Action" (202210619025).

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