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Complement or Disconnection? - the Impact of State-Family Responsibility on Elderly Health under Integrated Medical and Nursing Care Services

Fu Jinguo*

School of Politics and Law, University of Jinan,Jinan,Shandong, China

**Corresponding Author*

Abstract: As population aging deepens in China, whether state and family responsibilities in integrated medical and nursing care services are moving toward complementarity or facing a disconnect has become critical to elderly health. This paper analyzes how their interaction affects the physical and mental health of the elderly. The study identifies three major problems: partial absence of state responsibility, overload of family responsibility, and poor articulation between the two. These issues lead to service fragmentation and weakened health outcomes. State and family responsibilities are not a trade-off but a complementary relationship. Good synergy significantly improves elderly health, while the absence of either party or a disconnect produces adverse effects. This paper proposes that moving from disconnect to complementarity is essential to safeguarding the health and well-being of the elderly.

Keywords: Integrated Medical and Nursing Care; State Responsibility; Family Responsibility; Elderly Health

1. Introduction

As population aging deepens in China, the "silver wave" has brought increasingly prominent composite needs for both medical care and elderly care. By the end of 2024, the population aged 60 and above in China had exceeded 300 million, of which approximately 44 million were disabled or semi-disabled. How to meet the dual needs of this large population, specifically "medical treatment when ill and elderly care when healthy," has become an urgent social governance challenge. In recent years, the Chinese government has promoted the integration of medical and elderly care resources through policy documents such as the "Several Opinions on Deeply Promoting the Development of Integrated Medical and Nursing Care," making the integrated medical and nursing care model an important institutional pathway to address population aging [6].

However, in the practice of integrated medical and nursing care services, a core contradiction remains unresolved. How should the boundary between state and family responsibilities be delineated? Are the two moving toward complementary co-responsibility or facing a disconnect in service provision? From an institutional design perspective, the state has established a basic framework through long-term care insurance pilots, community-based elderly care facility construction, and smart elderly care explorations[5]. From an operational perspective, families still undertake a large amount of daily care, medical accompaniment, and emotional support functions[7]. The problem is that when state services are insufficient or of low quality, families often fall into "care overload." When family care capacity weakens or is absent, standardized public services cannot replace personalized care[2]. More concerning is the widespread lack of articulation mechanisms among institutions, communities, and families. Phenomena such as the inability to follow up with rehabilitation services after elderly patients are discharged from hospitals, and families not knowing which department to turn to for help, are common, resulting in the inability of state and family forces to form a synergy[1].

This practical dilemma raises a research question that urgently needs to be answered. How exactly does the configuration and degree of coordination between state and family responsibilities affect the health and well-being of the elderly? Specifically, through what mechanisms do the "absence" of state responsibility, the "overload" of family responsibility, and the "disconnect" between the two harm the physical and mental health of the elderly? Conversely, what positive effects can a

model of complementary responsibility and efficient synergy produce?

From a theoretical perspective, this study helps to break through the traditional perspective that views the state and family as substitute relationships, instead understanding them as interdependent and co-evolving organic systems [7], deepening the understanding of the "institution care health" linkage mechanism. From a practical perspective, the research findings can provide references for policy making, promoting the transformation of integrated medical and nursing care institutions from "having a framework" to "being efficient," and from "managing separate segments" to "collaborative co-responsibility"[3], ultimately realizing the genuine implementation of the goals "medical care for the sick and elderly care for the healthy" from concept to action.

2. Conceptual Framework and Theoretical Basis

To understand the interactive relationship between state and family responsibilities in integrated medical and nursing care services and its impact on elderly health, it is first necessary to clearly define the core concepts. Integrated medical and nursing care services refer to the organic integration of medical resources and elderly care resources to provide a continuous, integrated health and elderly care management model for older adults. Its essence is not a simple superposition of medical and nursing care services, but rather an emphasis on the coordinated planning and deep articulation of prevention, treatment, rehabilitation, nursing, and daily care[8]. In practice, integrated medical and nursing care mainly takes three forms: institution based, community based, and home based[11]. Within this service framework, state responsibility primarily refers to the functions that the government, as a representative of the public interest, should perform in terms of institutional supply, resource allocation, and quality supervision. These include formulating service standards and regulations for integrated medical and nursing care, establishing financing mechanisms such as long-term care insurance, constructing community based elderly care and medical service facilities, training professionals in geriatric medicine and rehabilitation nursing, and supervising and evaluating service quality. The essence of state responsibility lies in ensuring the accessibility and equity of basic public services[7]. Family responsibility, on the other hand, is rooted in blood kinship and ethical obligations. In integrated medical and nursing care services, it is embodied in daily care, medical accompaniment, medication reminders, emotional support, and spiritual comfort for the elderly. Unlike standardized and large-scale public services, family care is characterized by a high degree of personalization, continuity, and emotional embeddedness, which can compensate for the deficiencies of institutional services. However, the fulfillment of family responsibility is highly dependent on the available time, caregiving skills, and economic affordability of family members[7]. Based on the above concepts, this paper further proposes two key analytical concepts. The first is "responsibility complementarity," which refers to the ideal state in which the state and the family each leverage their respective strengths and achieve seamless articulation. The state provides universal and professional institutional guarantees, while the family undertakes personalized and emotional care functions, forming a synergistic effect of "one plus one greater than two." The second is "responsibility disconnect," which refers to the rupture or misalignment between state and family responsibilities. This is specifically manifested as insufficient state service supply leading to family "care overload,"or the absence of family care that standardized services cannot replace. More commonly, there is a lack of effective referral and communication mechanisms among institutions, communities, and families, resulting in service fragmentation[1].

From a theoretical perspective, synergy theory and welfare pluralism theory provide important explanatory frameworks for analyzing the above issues. Synergy theory holds that through nonlinear interactions among subsystems within a complex system, overall functions can emerge that are not possessed by any single subsystem, namely the synergistic effect of "one plus one greater than two"[4]. Applying this theory to integrated medical and nursing care research implies that state responsibility and family responsibility should not be viewed as substitute or competitive relationships, but rather as complementary and symbiotic organic wholes. Only when institutional supply and family care functionally cooperate with each other and are smoothly articulated in process can the health and well-being of the elderly be truly enhanced.

Conversely, if the two operate independently or are poorly articulated, systemic losses will occur. Welfare pluralism theory advocates that welfare provision should not be borne solely by the government, but should be shared among multiple actors including the state, market, community, and family. This theory emphasizes the functional division and boundary delineation among various actors. The state is responsible for top-level design and resource support, the family provides emotional support and daily care, while the market and community undertake supplementary services[3]. This theory provides a normative criterion for analyzing the question of "responsibility complementarity or disconnect,"namely that the ideal responsibility configuration should be one in which each actor "does its best, has clear boundaries, and achieves smooth articulation."

Projecting the above concepts and theories onto the practical field, three types of typical problems in the current interaction between state and family responsibilities can be preliminarily identified. First, the absence of state responsibility is mainly reflected in the scarcity of universal services in rural and economically underdeveloped areas and the insufficiency of professional care resources, making it difficult for state level institutional guarantees to effectively cover all elderly groups[2]. Second, the overload of family responsibility is common. The one-child generation is often forced to make difficult choices between work and caregiving, bearing triple pressures of economy, physical strength, and spirit, leading to excessive consumption of family care capacity[10]. Third, the disconnect of articulation mechanisms is prevalent. When elderly patients are discharged from hospitals, community rehabilitation services cannot keep up. When families urgently need help, they do not know which department to turn to. This lack of articulation among institutions, communities, and families prevents the forces of the state and the family from forming a synergy[5]. The existence of these problems means that the two forces of the state and the family find it difficult to form a joint force, ultimately damaging the health, dignity, and quality of life of the elderly. Therefore, the following sections will systematically analyze the mechanism through which responsibility configuration affects elderly health and explore the institutional pathway from "disconnect" to "complementarity."

3. Mechanisms of the Impact of State and Family Responsibilities on Elderly Health

TThe configuration of state and family responsibilities in integrated medical and nursing care services is not a simple functional division, but rather a nested and dynamically interactive systemic process. This responsibility structure profoundly affects the physical and mental health of the elderly through different pathways, and its direction of effect depends on whether the state and the family are moving toward "responsibility complementarity" or falling into "responsibility disconnect."

From the perspective of physical health, a well established national medical service system and long-term care insurance system can effectively improve the accessibility of professional medical resources for the elderly, providing professional guarantees for chronic disease management, postoperative rehabilitation, and disability delay[1]. At the same time, the daily care provided by family members, such as dietary management, medication reminders, and cleaning and turning services, constitutes the first line of defense for health maintenance. It can promptly detect and respond to subtle changes in the physical condition of the elderly[7]. When the state and the family form a complementary relationship, institutional services and family care support each other, and the physical health of the elderly is generally well maintained. However, once the responsibility configuration becomes imbalanced, negative effects emerge. If state service supply is insufficient or of low quality, families often cannot bear the burden of professional care alone, resulting in the elderly not receiving timely medical intervention. If family care is lacking and there is excessive reliance on standardized public services, the individualized daily care needs of the elderly cannot be met, which also damages physical health[2]. Research indicates that the coexistence of state responsibility absence and family responsibility overload significantly increases the risk of adverse health events among the elderly, such as malnutrition, falls and injuries, and medication errors[9].

From the perspective of mental health, the configuration of state and family responsibilities also plays a crucial role. Through institutional arrangements such as long-term care insurance, caregiving allowances, and respite care services, the state can effectively alleviate the economic

pressure and time burden on family caregivers, thereby indirectly promoting emotional stability and psychological security in the elderly[3]. The emotional companionship, spiritual comfort, and intergenerational interaction provided by the family, on the other hand, are important barriers against loneliness, anxiety, and depression in the elderly. This kind of emotional support is difficult for standardized public services to replace[4][10]. When state and family responsibilities are well coordinated, the elderly can enjoy both the sense of security brought by institutional guarantees and the sense of belonging brought by family companionship, leading to significantly improved mental health. Conversely, when there is a disconnect in responsibility configuration, excessive family care burden may trigger conflicts and tensions among family members, causing the elderly to develop feelings of self denial and guilt. Poor articulation of service systems, such as the lack of continuous psychological care after hospital discharge and the absence of community based spiritual comfort services, can deepen the elderly's sense of insecurity and confusion. A study of the integrated medical and nursing care practice in Xishan District, Wuxi City, found that poor service articulation was one of the important triggers for increased anxiety among the elderly[5].

In summary, the impact of state and family responsibilities on elderly health is not two independent parallel paths, but rather an intertwined and mutually reinforcing composite mechanism. The improvement of state responsibility can provide institutional support for family care and reduce the burden on families. Adequate family care can compensate for the lack of personalization in institutional services and enhance the elderly's sense of health gain. When the two form a virtuous cycle of complementarity and synergy, both the physical and mental health of the elderly can be significantly improved. Conversely, when either party is absent or the articulation between them is poor, negative effects on elderly health will occur[1]. Therefore, understanding and optimizing the interactive relationship between state and family responsibilities is key to improving the efficiency of integrated medical and nursing care services and effectively enhancing the health outcomes of the elderly. On this basis, the following section will propose specific pathways for building a responsibility system with clear powers and responsibilities and efficient synergy.

4. Recommendations for Optimizing the Responsibility System to Improve Elderly Health

Based on the analysis of the mechanisms through which the configuration of state and family responsibilities affects elderly health, addressing the three major problems identified in current practice, namely the absence of state responsibility, the overload of family responsibility, and the disconnect between the two, requires systematic progress from three dimensions: national institutional guarantees, family capacity support, and synergy mechanism construction. The goal is to build a responsibility system with clear powers and responsibilities, complementarity, and synergy.

At the level of national institutional guarantees, efforts should be accelerated to advance the national legislative process for long-term care insurance and establish a unified service standard and quality supervision system for integrated medical and nursing care, thereby clarifying the boundaries and baseline of state responsibility from the institutional source[2]. Currently, long-term care insurance is only piloted in some cities, with limited coverage and inconsistent financing standards[9]. There is an urgent need to achieve institutional unification and universal coverage through national legislation. At the same time, financial investment should be increased, with a focus on shifting resources toward communities and rural areas. Special funds should be established to guide social capital participation in the supply of integrated medical and nursing care services, filling the gaps in universal services in rural and underdeveloped areas[3]. Furthermore, the training of professionals in geriatric medicine, rehabilitation nursing, and related fields should be strengthened. Smart elderly care technologies should be used to build a service information platform covering urban and rural areas, enabling optimal resource allocation and full process service supervision[5]. Only when the state effectively fulfills its responsibilities of institutional design, resource supply, and quality supervision can it provide solid institutional support for family care.

At the level of family support, the practical difficulties faced by family caregivers should be acknowledged, and public policies should be

used to alleviate their care burden. It is recommended that a national caregiver leave policy be implemented nationwide, with clear provisions on leave duration, compensation, and cost sharing mechanisms, allowing family members to achieve a balance between work and caregiving[7]. At the same time, caregiver allowances and tax incentives for low and middle income families should be explored. Families that provide long-term care for elderly individuals with severe disabilities should receive economic compensation to alleviate their financial pressure[9]. Relying on community health service centers and elderly care institutions, systematic care skills training should be provided to family caregivers, including daily care procedures, first aid knowledge, and rehabilitation exercises, to enhance their professional care capacity and avoid the deterioration of elderly health due to improper care[4]. The essence of family support is not to replace family responsibility, but to enable families to have the capacity and conditions to fulfill their irreplaceable care functions.

At the level of synergy mechanism construction, the key is to clarify the boundaries between state and family responsibilities and establish effective articulation channels between them. The state is primarily responsible for universal service supply and industry supervision, ensuring the accessibility and equity of basic public services. The family undertakes personalized care and emotional support, leveraging the unique advantages of family companionship. The relationship between the two should not be one of substitution, but rather one of functional complementarity and mutual support[1][12]. Specifically, information exchange and referral mechanisms should be established among medical institutions, community elderly care service stations, and families to ensure that elderly patients can smoothly transition to community rehabilitation services after hospital discharge and that families can promptly receive guidance and support from professional institutions when facing care difficulties. At the same time, a scientific synergy evaluation system should be established, incorporating indicators such as the quality of communication between institutions and families, the efficiency of service referral, and improvements in elderly health into assessments, using institutional guidance to promote the formation of synergy among all parties.

In summary, optimizing the state-family responsibility system requires shifting from "disconnect" to "complementarity." The state should neither dominate nor withdraw, nor should the family bear sole responsibility or be marginalized. Systematic institutional design enabling each to perform their roles and complement their strengths is essential to building solid elderly health protection and achieving "medical care for the sick and elderly care for the healthy"[3].

5.Conclusion and Discussion

This paper has systematically examined the interactive relationship between state and family responsibilities within the framework of integrated medical and nursing care services and its profound impact on elderly health. Through step by step analysis of conceptual definitions, theoretical foundations, impact mechanisms, and optimization pathways, the study reveals a core judgment: the health outcomes of the elderly are not the result of a single actor, but rather the systemic product of complex interactions between the state and the family. The three major problems in current practice, namely the partial "absence" of state responsibility, the general "overload" of family responsibility, and the "disconnect" between the two, are key obstacles restricting the efficiency of integrated medical and nursing care services and the improvement of elderly health levels[1][2].

The core findings are as follows. First, state and family responsibilities are not a trade-off but complementary and symbiotic. When well-articulated, they produce a synergistic effect, significantly improving elderly health[4][10]. Second, imbalanced responsibility configuration has a cumulative, bidirectional negative impact: state absence exacerbates family overload, while weakened family care cannot be fully compensated by standardized services, forming a vicious cycle[9]. Third, the key to achieving complementarity lies in building a responsibility system with clear powers and smooth articulation, requiring coordinated efforts from the state, family, and society[7].

From a theoretical perspective, this paper integrates synergy theory and welfare pluralism into integrated medical and nursing care research, replacing the binary opposition of state-family substitution with an interdependent, co-evolving framework. It introduces the core analytical

concepts of "responsibility complementarity" and "responsibility disconnect"[3][12]. Practically, the proposed three-dimensional optimization path offers specific policy directions. National long-term care insurance legislation, caregiver leave policies, and community family referral mechanisms are the most urgent and feasible priorities[5][9].

This paper has two main limitations. First, it is based on theoretical analysis and policy review without systematic empirical testing. Key questions-such as quantifying the synergy between state and family responsibilities-require future verification through survey or panel data. Second, it lacks detailed typological distinctions. Under institution-led, community-embedded, and home-based models, the configuration of state-family responsibilities and their health impact mechanisms may differ significantly[11]. Future research could further compare the responsibility configurations and health effects under different models. Finally, this paper focuses on the two main actors of the state and the family, paying less attention to the roles of the market and social organizations in integrated medical and nursing care. Future research could incorporate multiple actors into the analytical framework to explore the four party synergy mechanism of the state, market, society, and family[12][15].

In summary, this paper addresses whether state and family responsibilities in integrated medical and nursing care are moving toward complementary co-responsibility or facing a disconnect. The findings suggest that while "disconnect" is currently prominent in practice, "complementarity" is a feasible reform direction. Future reforms should avoid simply transferring responsibility between parties, instead focusing on a new institutional design centered on responsibility complementarity, resource integration, and mechanism synergy. Establishing a clear, balanced, and efficient responsibility-sharing mechanism between state and family is essential to achieving "medical care for the sick and elderly care for the healthy" and enhancing the health, well-being, and quality of life of China's elderly population.

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