



Research on the Quality Enhancement of Community Home-Based Elderly Care Services: Dimensional Differences and Realistic Approaches

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Abstract. Community home-based elderly care services, which are family-based, community-based and supplemented by institutions, have become the optimal path to alleviate the pressure of ageing, and are the focus of China's socialised elderly care system, with the quality of services directly affecting the quality of life of the elderly in their twilight years, and have become a livelihood issue of the greatest concern to all sectors of society. Based on the SERVQUAL model, we divided the community home-based elderly care service into five types, refined 25 evaluation indicators and determined the dimensions, and conducted research on 502 elderly people in Harbin City. The research found that there is a significant difference between service quality perception and expectation, the service quality level of reliability and responsiveness dimension is higher, and the service quality level of tangibility, assurance, empathy dimension is lower. Accordingly, a number of feasible recommendations have been put forward to effectively meet the urgent needs of the elderly for elderly care services.

Keywords: community home-based elderly care services; service quality; SERVQUAL model; Harbin City; feasibility recommendations

1 Introduction

From the end of the twentieth century to the beginning of the twenty-first century, China's elderly population was characterised by rapid growth, large base, and ageing before it was ready and before it was rich. In the face of the increasingly severe aging situation, the continuous growth of service demand makes it difficult for traditional elderly services to meet the current situation: family pension is mainly based on children's support, and the endogenous impetus and resource supply of the "four-two-one" family pension model is seriously insufficient, and the phenomenon of elderly people living alone has become the norm; institutional pension is subject to the traditional concept of "raising children to prevent old age", and most of the elderly are unwilling to accept the pension institutions' services. In the reality of the gradual

weakening of the traditional model of old age care and the rising number of elderly people, the implementation of the model of combining community and home care for the elderly provides ideas to alleviate the pressure on the elderly and safeguard the basic livelihood of the people. Harbin City is actively exploring inclusive community home-based elderly care services, gradually establishing a demand-oriented, government-led, community social workers and social organisations to participate in the operation of the "three-society linkage" framework of the elderly service system, to provide the elderly with more convenient and affordable home services.

Based on this, the research combines the SERVQUAL model to construct a service quality evaluation system, conducts a field research on the quality of community home-based elderly care services in Harbin, counts the perceived expectation scores of various types of services through questionnaires, analyses the results of the service quality evaluation and formulates the best strategies.

2 Literature review

2.1 Current status of foreign research

Research on the quality evaluation model of community home-based elderly care services. Parasuraman (1988) and others proposed the SERVQUAL model, the theoretical core of which is the Service Quality Gap Model (SQGM), which suggests that the quality of a service is determined by the degree of difference between the user's perceptions and the user's expectations of the level of service ^[1]. While (2020) and others using the SERVQUAL model in combination with NVivo rooted analysis, found that caregiver professionalism, trust of older adults, ease of expression of needs, and accessibility of items contributed to service quality by measuring the difference between service perceptions and expectations ^[2].

Research on improving the quality of community home-based elderly care services. John (2020) and others believe that community managers should use formal and informal resources to establish a community intelligent service platform, rely on data quality management tools to improve the matching of service supply and demand, strengthen the construction of resource sharing ^[3]. Mello (2021) argues that the government should guarantee the effective supply of services through policy support and financial funds, unblock the interaction channels between public welfare organisations, hospitals, community volunteers and the elderly, provide assessment and professional training for service providers based on the needs, integrate the community's strengths to achieve the stability of the nursing team and improve their skills ³. Phillips (2021) and others analysed that community home-based care services should take into account the differences in the types and modes of services for the elderly in different cultures, improve the level of informal care for women and the elderly living alone ^[5].

2.2 Current status of domestic research

Research on the quality evaluation model of community home-based elderly care services. Zhang (2011) and others took the elderly receiving services in Shanghai as the survey object, and based on the SERVQUAL model, they changed "tangibility" to "perceivability" dimension, and constructed an indicator system covering four types of services: meal assistance, cleaning assistance, medical assistance, recreation, and five dimensions: perceivability, reliability, responsiveness, assurance, empathy [6]. Bai (2016), Xiao (2019), Yang (2020) and others expanded the dimensions of mobility assistance, emergency services, accessibility on this basis respectively, explained in detail the impact of demographic variables on the quality of community home-based elderly care services [7,8,9].

Research on improving the quality of community home-based elderly care services. Bai (2022) and others believe that government support, supply and demand should be considered within the scope of community home-based care services to build a socialised governance pathway [10]. In terms of government support, Liu (2023) and others believe that policy support should be increased, funding channels should be broadened, community disposable resources should be aggregated, and information technology should be upgraded [11]. From the perspective of welfare pluralism, Feng (2023) and others believe that the roles of for-profit organisations, non-profit organisations and informal networks should be brought into play to clarify the boundaries of responsibilities of the supplying entities, form cooperative and interactive relationships, and build a community home-based elderly care service model with "two-way participation and multi-party response" [12]. In terms of supply and demand, Hu (2023) argues that the supply and demand concepts of "stratification + linkage" and "classification + matching" should be established, and that a mechanism for care assessment and dynamic supervision should be constructed, as well as channels for volunteering and feedback on demand, to improve the standardisation and precision of services [13]. The level of based on the micro perspective, Ma (2023) and others believe that service personnel should be organised to conduct systematic training, strengthen the cultivation of professional nursing talents, and provide personalised services for disabled and other special groups in combination with the characteristics of the local aging and the rules of life, so as to make up for the shortcomings of the community home-based elderly care services [14].

3 Research design

3.1 Applicability analysis and modelling

SERVQUAL model is constructed by PZB based on a survey sample of five companies in three industries: telephone repair, retail banking and insurance. By comparing the results of perception and expectation to obtain the "gap scores" of the five dimensions, representing the service quality evaluation, calculate formula as follows:

$$SQ = \sum_{i=1} (P_i - E_i) \text{ , } P_i \text{ and } E_i \text{ are the scores of the } i\text{th factor in terms of customer}$$

perceptions and expectations respectively. The SERVQUAL model divides service quality into five dimensions: Tangibility, Reliability, Responsiveness, Assurance, Empathy, examines the level of service quality by issuing questionnaires with perception and expectation scores for each service item.

The research establishes a model for evaluating the quality of community home-based elderly care service based on the above five dimensions (Fig. 1), dividing the service content into five types: meal assist, life care, medical care, cultural entertainment, spiritual comfort as the primary indexes; tangibility, reliability, responsiveness, assurance, empathy as the secondary index dimensions, which correspond to the twenty-five evaluation standards to form the evaluation system table of community home elderly care service quality (Table 1).

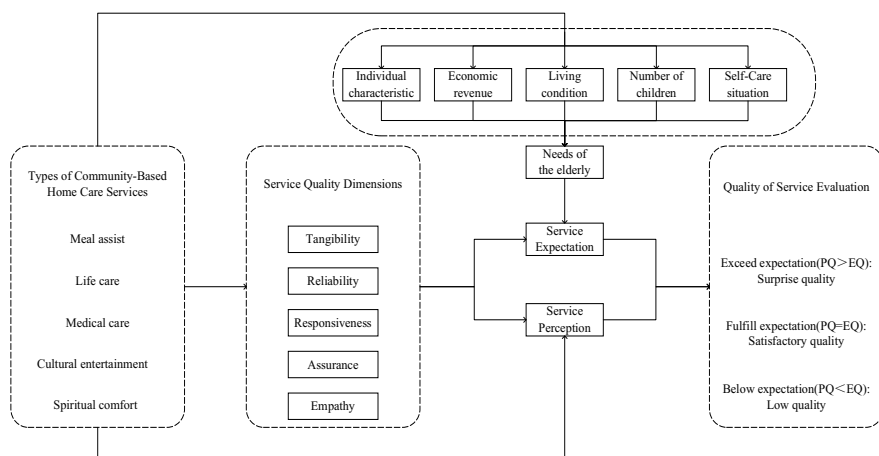


Fig. 1. Service quality evaluation model

Table 1. Service quality evaluation system table

Entry	Level 1 indicators	Entry	Secondary indicator dimensions	Secondary indicators
MA	Meal assist	MA1	Tangibility	Clean environment and well-equipped catering facilities
		MA2	Reliability	Timely provision of meal-assist type services by service personnel
		MA3	Responsiveness	Friendly service staff
		MA4	Assurance	Good quality of meals provided by service staff
		MA5	Empathy	Provision of meals by service personnel based on the dietary habits and financial situation of the elderly

LC	Life care	LC1	Tangibility	Good environment and living facilities
		LC2	Reliability	Timely provision of life-care type services by service providers
		LC3	Responsiveness	Kind service staff
		LC4	Assurance	Good quality of services provided by service providers and trust felt by older persons
		LC5	Empathy	Service personnel provide personalised services based on the differentiated needs of the elderly
MC	Medical care	MC1	Tangibility	Environmental hygiene, advanced medical equipment
		MC2	Reliability	Timely provision of medical-care type services by attendants
		MC3	Responsiveness	Friendly service staff
		MC4	Assurance	Providers are proficient in nursing skills Service providers develop targeted treatment programmes based on the condition and economic status of the elderly
		MC5	Empathy	Reasonable layout of activity venues, reasonable configuration of leisure and recreational facilities
CE	Cultural entertainment	CE1	Tangibility	Service staff organise recreational activities at appropriate times
		CE2	Reliability	Service personnel are interactive and approachable
		CE3	Responsiveness	Activities to help older persons maintain their physical and mental well-being
		CE4	Assurance	Service personnel organise personalised recreational activities according to the physical fitness and interests of the elderly
		CE5	Empathy	The atmosphere in the counselling room is peaceful, bright and comfortable, with a high degree of privacy
SC	Spiritual comfort	SC1	Tangibility	Timely provision of spiritual-comfort type services by service personnel
		SC2	Reliability	Service personnel are interactive and gentle
		SC3	Responsiveness	Service personnel with relevant qualifications and professional counselling skills
		SC4	Assurance	Psychological counselling by service personnel according to the individual characteristics of the elderly
		SC5	Empathy	

3.2 Variable definitions and data sources

The questionnaire included two subscales, namely service perception and expectation, and was designed around five types of services: meal assist, life care, medical care, cultural entertainment and spiritual comfort. At the perception level, they are represented by SMA, SLC, SMC, SCE, SSC; at the expectation level, they are represented by EMA, ELC, EMC, ECE, ESC, forming a scale-like questionnaire that covers 10 factors and 50 question items. Meanwhile, a five-level Likert scale was used to assign scores to the measurement items, the service perception and expectation were divided into "strongly disagree, disagree, general, agree, strongly agree" and "strongly undesired, undesired, general, expect, strongly expect", corresponding to the Likert scale "1, 2, 3, 4, 5".

The research is based on the formula $n = \frac{t^2 \times p(1-p)}{e^2}$ (n is the sample size of

the inferences; t is the critical value corresponding to the confidence level; e is the sampling error) to obtain the sample sizes of the different sampling error requirements at the 95% confidence level (Table 2), a total of 553 elderly people in 2-3 care centres and service stations in each district were selected by multi-stage stratified and random sampling to distribute the questionnaires. 502 valid questionnaires were obtained after sorting and screening, and the effective recovery rate of the questionnaires was 90.78%, which meets the needs of the research.

Table 2. Sample sizes for different sampling error requirements at the 95% confidence level

Allowable sampling error e (%)	Sample size n	Allowable sampling error e (%)	Sample size n
1.0	10000	6.0	277
1.5	4500	6.5	237
2.0	2500	7.0	204
2.5	1600	7.5	178
3.0	1100	8.0	156
3.5	816	8.5	138
4.0	625	9.0	123
4.5	494	9.5	110
5.0	400	10.0	100
5.5	330		

Note: t=2 at 95% confidence level; $p(1-p)$ reaches its maximum value at p=0.5.

4 Empirical analyses

4.1 Scale Data Reliability Tests

In the research, SPSS27.0 and AMOS26.0 software were used to analyse the reliability and validity of the scale questionnaire data, the Cronbach α coefficient was used to describe the level of reliability; KMO values and Bartlett's spherical test values were used to determine whether it was suitable for factor analysis, and principal component analysis and maximum variance method were used to extract and rotate the factors to validate the data's level of validity; the combined reliability (CR value), average variance extracted (AVE value), and AVE square root value to reflect the explanatory ability of the analysed items on the factors and the level of variation.

Table 3. Reliability test of service quality evaluation scale

Factors (latent variables)	Analytical terms (explicit variables)	Cronbach α coefficient	KMO value	Bartlett's test of sphericity Sig.	Cumulative variance explained (after rotation)
SMA	SMA1-SMA5	0.862			
SLC	SLC1-SLC5	0.836			
SMC	SMC1-SMC5	0.844	0.896	0.000	63.556%
SCE	SCE1-SCE5	0.845			
SSC	SSC1-SSC5	0.882			
EMA	EMA1-EMA5	0.899			
ELC	SLC1-SLC5	0.933			
EMC	SMC1-SMC5	0.938	0.912	0.000	72.515%
ECE	SCE1-SCE5	0.867			
ESC	SSC1-SSC5	0.866			

As can be seen from Table 3, the minimum Cronbach α coefficients of the five service type perception and expectation subscales are 0.836 and 0.866 respectively, which meet the requirement of greater than 0.8, indicating that the questionnaire data are more reliable. The KMO values are 0.896 and 0.912 respectively, which meet the criterion of greater than 0.6. The p-value of the significance probability corresponding to the Bartlett's sphericity test is all 0.000, which meets the criterion of less than 0.05, indicating that the research data are suitable for factor analysis. The two sets of factors extracted 63.556% and 72.515% of the information content of the question items respectively, meeting the criterion of greater than 0.6.

Table 4. AVE and CR indicator results

Factor	AVE value	CR value
SMA	0.556	0.862
SLC	0.507	0.837
SMC	0.521	0.844
SCE	0.523	0.846
SSC	0.598	0.882
EMA	0.640	0.899
ELC	0.740	0.934
EMC	0.753	0.938
ECE	0.567	0.867
ESC	0.565	0.867

As can be seen from Table 4, the minimum CR values of the five latent variables in the service perception and expectation subscales are 0.837 and 0.867 respectively, which meet the criterion of being greater than 0.7; the minimum AVE values are 0.507 and 0.565 respectively, which meet the criterion of being greater than 0.5, and have good convergent validity.

Table 5. Distinguishing validity: Pearson's correlation and AVE square root values

Factor	SMA	SLC	SMC	SCE	SSC
SMA	0.746				
SLC	0.359	0.712			
SMC	0.341	0.319	0.722		
SCE	0.351	0.265	0.283	0.723	
SSC	0.308	0.267	0.241	0.237	0.774
Factor	EMA	ELC	EMC	ECE	ESC
EMA	0.800				
ELC	0.419	0.860			
EMC	0.332	0.295	0.868		
ECE	0.288	0.184	0.275	0.753	
ESC	0.164	0.177	0.275	0.316	0.752

As can be seen from Table 5, the AVE square root values of perceptions and expectations of services in the categories of meal assist, life care, medical care, cultural entertainment, spiritual comfort are 0.746, 0.712, 0.722, 0.723, 0.774 and 0.800, 0.860, 0.868, 0.753, 0.752 respectively, which are greater than the correlation coefficients between the latent variables, and they have good differentiation validity.

4.2 Paired samples t-test

Paired samples t-tests are used to analyse the contrasting relationship of differences between paired quantitative data and to infer whether there is a significant difference between two overall means. In the research, service perception and expected quality were paired at the indicator dimension level, and the significance level α was set at 0.05 to assess the degree of difference in the means and elaborate on it.

Table 6. Paired samples t-test by dimension

Designation	Mean difference	Standard deviation	Standard error margin	95% confidence interval of the difference		t	df	Sig.	
				lower limit	upper limit				
Pair1	SMA1-EMA1	-0.988	1.800	0.080	-1.146	-0.830	-12.296	501	0.000
Pair2	SMA2-EMA2	-0.946	1.735	0.077	-1.098	-0.794	-12.222	501	0.000
Pair3	SMA3-EMA3	-0.946	1.735	0.077	-1.098	-0.794	-12.222	501	0.000
Pair4	SMA4-EMA4	-1.038	1.756	0.078	-1.192	-0.884	-13.245	501	0.000
Pair5	SMA5-EMA5	-1.118	1.771	0.079	-1.273	-0.962	-14.135	501	0.000
Pair6	SLC1-ELC1	-0.962	1.924	0.086	-1.131	-0.793	-11.205	501	0.000
Pair7	SLC2-ELC2	-0.791	1.835	0.082	-0.952	-0.630	-9.656	501	0.000
Pair8	SLC3-ELC3	-0.847	1.892	0.084	-1.013	-0.681	-10.026	501	0.000
Pair9	SLC4-ELC4	-1.201	1.796	0.080	-1.359	-1.044	-14.982	501	0.000
Pair10	SLC5-ELC5	-0.976	1.885	0.084	-1.141	-0.811	-11.603	501	0.000
Pair11	SMC1-EMC1	-1.183	1.594	0.071	-1.323	-1.043	-16.631	501	0.000
Pair12	SMC2-EMC2	-1.046	1.615	0.072	-1.187	-0.904	-14.513	501	0.000
Pair13	SMC3-EMC3	-1.147	1.621	0.072	-1.290	-1.005	-15.856	501	0.000
Pair14	SMC4-EMC4	-1.193	1.625	0.073	-1.336	-1.051	-16.456	501	0.000
Pair15	SMC5-EMC5	-1.285	1.654	0.074	-1.430	-1.140	-17.407	501	0.000
Pair16	SCE1-ECE1	-0.697	1.554	0.069	-0.833	-0.561	-10.052	501	0.000
Pair17	SCE2-ECE2	-0.785	1.574	0.070	-0.923	-0.647	-11.174	501	0.000
Pair18	SCE3-ECE3	-0.695	1.581	0.071	-0.834	-0.557	-9.852	501	0.000
Pair19	SCE4-ECE4	-0.962	1.552	0.069	-1.098	-0.826	-13.893	501	0.000
Pair20	SCE5-ECE5	-0.769	1.517	0.068	-0.902	-0.636	-11.355	501	0.000
Pair21	SSC1-ESC1	-0.863	1.714	0.076	-1.013	-0.712	-11.276	501	0.000
Pair22	SSC2-ESC2	-0.825	1.611	0.072	-0.966	-0.683	-11.468	501	0.000
Pair23	SSC3-ESC3	-0.821	1.637	0.073	-0.964	-0.677	-11.236	501	0.000
Pair24	SSC4-ESC4	-0.918	1.578	0.070	-1.057	-0.780	-13.038	501	0.000
Pair25	SSC5-ESC5	-0.771	1.644	0.073	-0.915	-0.627	-10.504	501	0.000

As can be seen from Table 6, the Sig. of each evaluation indicator is 0.000, which is less than 0.05, indicating that there is a significant difference between the perceived and expected quality, the alternative hypothesis is accepted. The SQ values of the

service quality gap of tangibility, reliability, responsiveness, assurance, empathy are -0.938, -0.878, -0.891, -1.063, -0.984, the mean differences of tangibility, assurance, empathy are larger, and the level of service quality is relatively low, which is in line with the situation of the t-test ($t \times$ standard error). The dilemma is as follows:

First, the financial input mechanism is not sound. The Government limited financial allocations are mainly invested in elderly care facilities in newly built neighbourhoods, with some of the facilities lying unused and resources being wasted; insufficient purchasing power is being used in older urban areas, leading to a lag in the construction of service facilities and a lack of material resource supply. At the same time, the relevant supporting facilities of some care centres and service stations are still incomplete, which is reflected in the rudimentary environment of meal and bathing services, and the lack of common tools and professional equipment for cleaning, emergency, mobility services; the poor conditions of medical care services, and the lack of the necessary facilities for treatment of diseases and health care; and the fact that the activity venues of cultural entertainment services are usually arranged in the care centres, their opening hours are relatively unstable, which results in differences in the quality of services in the tangibility dimension.

Second, there are deficiencies in the service system. Care centres and service stations are still in a small range of operations, the community support network has not yet been formed, resulting in the timeliness, accuracy of the service, and the level of synergy between multiple supply subjects are low. At the same time, care centres and service stations at all levels have not yet formed a systematic system of remuneration, welfare and promotion, the uncertainty of development prospects has led to poorer incentives for service personnel, making it impossible to satisfy the demand for elderly care services in the dimensions of reliability and responsiveness.

Third, there is a lack of service capacity. At present, the main body of the service mainly consists of migrant workers, unemployed groups, part-time workers, who rely on their accumulated experience in providing basic services such as daily care, blood pressure measurement, medical knowledge popularisation for the elderly, there is a lack of professional knowledge reserves, poor coordination skills, and unskilled application of professional skills. At the same time, the trend of diversified demand has led to a significant increase in the heterogeneity of the elderly population, it is difficult for a single mode of supply for service personnel to respond to the preferences of the needs of different elderly people, restricting the room for the development of the services of assurance and empathy dimension.

5 Conclusions and recommendations

On the basis of combing the relevant literature of scholars at domestic and abroad, the research combines the SERVQUAL model to construct a service quality evaluation system, tries to explore and analyse the perception and expectation of service quality, draws the following conclusions: the quality level of reliability and responsiveness services is relatively high, and the quality level of tangibility, assurance, empathy services is relatively low. Inadequate financial input mechanisms, deficiencies in the

service system, and a lack of service capacity are the root causes of the low level of service quality in each dimension. It is recommended that the following measures be taken to improve the quality of community home-based elderly care services:

First, taking a leading role in government, optimising the funding structure. It should fully grasp the distribution and density of the elderly population, coordinate the location and scale of care centres and service stations, budget the necessary funds separately, adjust the spatial layout and projects of elderly care facilities in newly constructed districts in accordance with local conditions, and focus on strengthening the construction of care centres and service stations in old districts through the use of property resources, idle state-owned buildings and the restructuring of enterprises in difficulty. In accordance with the relevant standards and design specifications to focus on the reconstruction and construction of a number of elderly service facilities suitable for the needs of the elderly, creating a "15-minute circle of convenient services for the elderly".

At the same time, build additional meal and bathing service points, continue to promote the construction and operation of "canteens for the elderly", sign agreements with qualified public bathing establishments and elderly institutions; provide information bracelets, locator mobile phones, emergency pagers and other intelligent safety equipment, dynamic monitoring of the physical condition of the elderly; prepare cleaning appliances such as hoovers, care machines, and assistive devices such as canes, walking aids. Investment in intelligent medical equipment, such as intelligent blood pressure monitors, intelligent medical check-up devices and rehabilitation aids, implement the functions of home hospital beds. Care centres and service stations should build community bookstores, calligraphy painting rooms and other venues, support the opening of all kinds of cultural, educational, sports public service facilities to the elderly free of charge and at preferential rates.

Second, improving the service system, sound incentive mechanisms. Accelerate the construction of structural elderly service network, with digital technology as the basis, help the elderly service hotline as a link to create the city as a "virtual nursing home". Managers of care centres and service stations should consult with civil affairs, health and other functional departments to formulate refined standards, rules for elderly care services, actively carry out pilot work to gradually improve relevant regulations on service hours and service content.

At the same time, the basic salary and material security level of service personnel should be steadily increased, ensuring that the actual wages and salaries paid are not lower than the minimum wage standard in the market, implementing a mechanism linking work intensity and evaluation grades to salary levels and welfare benefits, granting post allowances, paid leave arrangements and collective household qualifications to those who have worked for a certain number of years. Care centres and service stations should formulate detailed talent promotion standards, set up positions at different levels such as personnel management and professional consultants according to performance and ability, so as to inspire a sense of responsibility and mission among service personnel.

Third, enhancing service capacity, meeting personalised needs. With the gerontology, nursing, psychology and other related courses as resources for the management

and staff of different service projects to carry out training respectively, systematically study theories of elderly care services, practical cases and relevant technologies, introduce social work and healthcare personnel with strong professional abilities to provide skills guidance. Commission third-party organisations to assess training results, so that the service personnel can quickly master nursing skills and improve their service level, create composite talents with professional nursing knowledge and professional application skills, with a focus on the training of meal assist, life care, medical care services.

At the same time, for the disabled and the semi-disabled focusing on providing "five aids" and medical care services, real-time monitoring of health information, increasing service time and service frequency; for more educated and more capable of self-care of the elderly emphasis providing cultural entertainment services, organising to participate in cultural, artistic, sports and other group activities, creating opportunities for social interaction, learning safety knowledge related to the elderly, and providing employment services, enrich the life of the elderly in their twilight years with the goals of "enjoyment for the elderly" and "worthiness of the elderly"; for the elderly in "purely elderly families", the focus is on providing spiritual comfort services, giving more psychological attention, maintaining a positive and healthy state of mind, so that the elderly can truly gain a sense of well-being, belonging and security.

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