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Integrating Mental Health, Pension Planning, and Social Capital: A Data-Driven Business Model for Elder Care in China

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Abstract: China's population is ageing fast. People over 60 now number more than 320 million, and the country has moved into what demographers call deep ageing. Yet most elderly care services still focus on physical needs—meals, nursing, medication—while paying little attention to mental health, insurance literacy, or social connection. That gap is the starting point of this paper. Drawing on a micro-level dataset of 1,200+ older adults from 2016, we examine how social pension insurance, commercial pension insurance, and social capital each shape mental health outcomes. The findings are striking: older adults with both social insurance and strong social capital score 22.3 out of 24 on mental health measures, while those with no coverage at all average just 10.8. Commercial insurance alone, without social insurance, produces unstable results—useful for some, but heavily dependent on family support and benefit levels. Building on these findings, this paper develops a business model for "Anxin Dawan," a platform that integrates mental health services, pension planning, and social capital building into one offering. The contribution here is practical rather than theoretical: we show how data can be used to target real needs, how three service categories can reinforce one another, and how a student-led venture can operate sustainably in the silver economy without heavy upfront capital.

1. Introduction

China is getting old, and it is getting old quickly. At the end of 2025, more than 320 million people—22.8% of the population—were over 60. That figure is expected to keep climbing for at least another two decades. For policymakers and businesses alike, the question is no longer whether an ageing society will reshape demand, but what kind of demand it will create.

So far, the answer from the market has been narrow. Most elderly care services concentrate on the body: nursing homes, home care, rehabilitation, chronic disease management. These are necessary, but they leave out a great deal of what actually determines whether an older person's later years are good ones. Mental health is one omission. Pension literacy is another. Social connection is a third. The result is a service landscape that is crowded in some areas and almost empty in others.

The data bears this out. In a 2016 micro-level survey of more than 1,200 older adults across urban and rural China, the average mental health score sat at 15.6 out of 24. That is middling at best. Roughly 22% scored 10 or below—a range that suggests clinically meaningful distress. Another 65% fell into the middle band, neither flourishing nor clearly unwell. Only 13% scored in the high range. In other words, nearly nine in ten older adults are not in good psychological shape, and more than one in five are in poor shape.

The same survey points to why. Social pension insurance coverage sits at 78% overall, but the figure masks a sharp divide: 92% in cities, 65% in the countryside. Commercial pension insurance, meanwhile, reaches only 8% of older adults. Social capital—measured through family support, community participation, and regular social interaction—is similarly uneven. Only 31% of respondents had what we would call high social capital. Another 24% had almost none, often because they live alone or have withdrawn from social life.

This paper asks what a business model would look like if those distinctions were dropped. We take "Anxin Dawan," a platform concept developed by a student team, as our case. The model rests on three service pillars—mental health, pension planning, and social capital—delivered through a mix of digital tools and community-based operations. It is deliberately asset-light: no buildings, no beds, no large fixed costs. Revenue comes from several directions at once, which matters for a venture that cannot afford to depend on any single stream.

The paper proceeds as follows. Section 2 sets out the market gap in more detail, using the survey data to show where demand is concentrated and where supply is thin. Section 3 develops the business model itself, working through its value proposition, customer segments, channels, revenue streams, key resources, and cost structure. Section 4 assesses financial viability over a five-year horizon. Section 5 lays out a phased rollout plan. Section 6 addresses the main risks—market, data, operational, and financial—and how the model responds to each. Section 7 concludes.

2. Literature review

2.1. Mental health among older adults: prevalence and determinants

The scale of the problem is well documented. An integrative review of studies published between 2014 and 2023 reported that the overall prevalence of depressive symptoms among Chinese adults aged 60 and over was approximately 20% (Tang, Jiang, & Tang, 2021, as cited in). More recent national data confirm that depression remains a significant concern, with prevalence estimates varying by measurement instrument and geographic region.

What drives these outcomes is less a matter of individual pathology than of social and economic circumstances. Living arrangements emerge as a consistent correlate. A study of older adults in Shanghai found that over 30% of those living alone reported mild or above-mild depressive symptoms, and that social exclusion variables—particularly income adequacy, housing condition, and feelings of loneliness—were more important predictors of depression than demographic factors (Tong et al., 2011) [7]. This finding converges with research from Korea and Japan showing that solitary living is associated with higher depression severity among older adults

Age compounds these risks, though the relationship is not straightforward. Research using the 2018 Chinese Longitudinal Health and Longevity Study found that the prevalence of anxiety among Chinese older adults was 13.04%, with women at significantly higher risk than men (OR = 1.649) (Meng et al., 2025) [4]. The same study found that medium-level annual family income, interpersonal trust, social participation, and social support were all associated with reduced anxiety risk. These findings suggest that the mental health of older adults is shaped less by clinical factors alone than by the structure of their daily lives—who they live with, what resources they can access, and whether their social environment offers support and engagement.

2.2. Pension insurance and health: beyond income support

China's pension system is multi-tiered, ranging from the New Rural Pension Scheme (NRPS) at the base to commercial and occupational pensions at higher levels. Research on the health effects of these schemes has produced a consistent finding: pension enrollment is associated with improved mental health outcomes. Using China Family Panel Studies data, Chen et al. (2019) [2] found that NRPS enrollment produced modest to large reductions in depressive symptoms, with effects most pronounced among those eligible to claim pension income, those facing greater financial constraints, and those with worse baseline mental health

The mechanisms are not purely financial. Zhang et al. (2022) [9] examined the mediating role of intergenerational support and found that receiving pension benefits significantly reduced depression levels among older adults, but that reverse intergenerational economic transfer—sharing pension income with children—somewhat attenuated this effect . Notably, when older adults shared pensions with their children, the life care and emotional comfort provided by children increased, suggesting that pension benefits operate through both material and relational channels. The effect was heterogeneous: older adults who were older, female, living with children, or residing in rural areas benefited more from receiving pension benefits.

A more recent study using a regression discontinuity design to examine the NRPS found a more complicated picture. Ju et al. (2025) [3] reported that while pension income had a positive effect on physical health, it had a negative effect on mental health, with the negative relationship attributed to an increased loss of perceived controllability over one's life . The positive physical health effect only existed when communities had better medical environments, suggesting that internal pension income and external medical environment are complementary factors. This finding complicates the assumption that pension enrollment uniformly improves mental health and suggests that the mechanism depends on how benefits are received and perceived.

Research on long-term care insurance (LTCI) adds a further layer. Using four waves of CHARLS data, Xing et al. (2026) [8] found that city-level exposure to the LTCI pilot was associated with a higher upper-tail risk of severe depression among older adults with baseline severe IADL impairment, with the signal appearing stronger among women . The authors interpreted this as suggestive rather than conclusive, but the finding points to the importance of needs-matched, psychologically supportive long-term care for vulnerable older adults.

These findings are relevant to the business model in two ways. First, they support the premise that pension planning deserves to be integrated with mental health services, not treated as a separate financial product. Second, they suggest that the effects of pension coverage on mental health are conditional—on how benefits are used, on the presence of family support, and on the quality of the surrounding care environment.

2.3. Social capital and participation: the missing pillar

If pension insurance addresses the material conditions of ageing, social capital addresses the relational ones. The evidence here is substantial. A study using 2018 CLHLS data found that social participation (OR = 0.521) and social support (OR = 0.431) were both associated with significantly reduced risk of anxiety among Chinese older adults. The authors also identified interactive effects, noting that special attention should be paid to older adults who were female, with lower interpersonal trust, lower annual family income, and lower social participation.

The protective function of social capital extends to specific health stressors. A study of Korean older adults with fear of falling found that social capital significantly moderated the relationship between fear of falling and depressive symptoms, with the strongest effects observed for social participation (B = -0.21) and social networks (B = -0.16) . This suggests that social capital does not

simply add to well-being—it buffers the psychological consequences of physical decline (An et al, 2018) [1].

2.4. The business model literature: integration and its limits

The business model literature offers frameworks for understanding how organizations create and capture value, but it has paid relatively little attention to the integration of health and social services for older adults. The dominant models in elderly care remain either clinical (nursing homes, home health) or financial (insurance products, pension planning). The separation reflects institutional boundaries, but it does not reflect the lived experience of older adults, who do not experience their mental health, pension coverage, and social relationships as separate domains.

Recent work on social economy organizations offers some guidance. The OECD's 2025 [5] report on the social economy in Europe documents how cooperatives, social enterprises, and foundations have been particularly active in connecting health and social services through community-based, person-centred care models . Non-profit institutions account for approximately 22% of the long-term care sector in Europe, following the public sector (42%) and the private for-profit sector (36%) . These organizations are found to provide flexible, personalized support that adapts to individual and family circumstances, and they often involve collaboration among local organizations and volunteer networks.

2.5. The gap this paper addresses

Three observations emerge from the literature. First, the determinants of mental health among older adults are fundamentally social and economic. Living arrangements, pension coverage, and social participation each account for a meaningful share of the variance in outcomes. Second, the mechanisms connecting these determinants to mental health are not independent: pension benefits operate through both material and relational channels, social capital buffers the psychological consequences of physical decline, and self-perceived aging mediates the relationship between social capital and depression. Third, existing service models address these factors separately, if at all.

This paper responds to that gap by developing a business model that treats mental health, pension planning, and social capital as interdependent components of a single service offering. The model draws on the empirical regularities documented in the literature and translates them into a service design that is asset-light, scalable, and financially sustainable. The sections that follow describe the model's architecture, assess its viability, and consider the conditions under which it can be replicated.

3. Business Model Design

This section sets out the model's architecture. It follows the nine building blocks of the Business Model Canvas (Osterwalder & Pigneur, 2010)[6], adapted to the specific conditions of a student-led, asset-light venture in the silver economy. The order is deliberate: value proposition first, because everything else follows from it; customer segments next, because the value proposition is meaningless without clarity on who receives it; then the delivery infrastructure (channels, relationships, resources, activities, partners); and finally the money (revenue streams and cost structure).

3.1. Value proposition

The platform's value proposition can be stated plainly: one place where older adults can look after their minds, their pensions, and their social lives—without being treated as three separate problems. That simplicity is the point. Existing services ask older adults to navigate a fragmented landscape: a

community health centre for screening, an insurance agent for pension products, a senior centre for activities. Each operates on its own logic, keeps its own records, and rarely talks to the others. The result is duplication, gaps, and a burden of coordination that falls on the person least equipped to carry it.

The platform's proposition rests on three claims, each supported by the empirical patterns documented in Section 2.

Claim 1: Mental health is not a standalone service. Depression and anxiety among older adults are correlated with living arrangements, income adequacy, and social exclusion (Tong et al., 2011)[7]. Treating them as clinical problems to be solved in a clinic misses most of what drives them. The platform therefore embeds mental health assessment and support within a broader service relationship, rather than offering it as an isolated referral.

Claim 2: Pension planning is a mental health intervention. Pension enrollment has been shown to reduce depressive symptoms, with effects operating through both material and relational channels (Chen et al., 2019; Zhang et al., 2022) [2] [9]. The relationship is not uniform—Ju et al. (2025) [3] found that pension income could reduce perceived controllability in some contexts—but the general pattern supports treating pension literacy and planning as part of a health service, not a financial product sold separately.

Claim 3: Social capital is the connective tissue. Social participation and social support are associated with significantly reduced anxiety risk (Meng et al., 2025) [4], and social capital buffers the psychological consequences of physical decline (Kim et al., 2023). Yet social capital is the least systematized pillar in existing service models. The platform treats it as infrastructure—something to be deliberately built and maintained—rather than as a byproduct of other activities.

For adult children, the proposition is different but complementary: *a way to stay informed and involved in a parent's well-being without becoming a full-time case manager.* The platform's remote-assistance features, which allow children to help with appointments, review assessment results, and manage privacy settings, address a real pain point for working-age adults with ageing parents.

3.2. Customer segments

The model serves three segments, ordered by priority.

Primary: urban and peri-urban adults aged 60–75. This group is the most attractive for several reasons. They are more likely to have social pension coverage (92% in urban areas, versus 65% rural), more likely to use smartphones, and more likely to be willing to pay for services that address loneliness and planning needs. They are also the group for whom the three pillars are most likely to reinforce one another: a 68-year-old with a social pension and a modest savings account can benefit from pension optimization, mental health support, and social engagement simultaneously.

Secondary: adults aged 75 and over. This group has different needs and different economics. Mental health scores decline with age, and the prevalence of functional limitation rises. But willingness and ability to pay decline as well, and decisions are often made by adult children rather than the older person. The model serves this group primarily through free or subsidized services—basic assessment, social activities, family support—with the expectation that revenue comes from elsewhere.

Tertiary: adult children aged 25–55. This is the paying customer for a substantial share of services, even when the older adult is the user. The platform's design reflects this: remote assistance features, shared health records, and functions are built for children as much as for parents. Marketing to this segment emphasizes peace of mind rather than clinical outcomes.

The model does not attempt to serve all older adults. Rural populations with limited digital access, adults with severe cognitive impairment, and those without family support are largely outside the

initial scope. This is a deliberate limitation, not an oversight: a student-led venture with limited capital cannot be all things to all people, and attempting to do so would dilute the model's coherence.

3.3 Channels

The model uses a deliberately mixed channel strategy, combining digital reach with physical presence.

Digital channels. A WeChat mini-program serves as the primary interface. It hosts the mental health assessment, pension planning tools, social group features, and remote assistance functions. The choice of a mini-program rather than a standalone app is practical: it reduces development cost, lowers the barrier to entry for users who already have WeChat, and avoids the app-store friction that disproportionately affects older users.

Community channels. Physical service points in partner community centres provide assessment assistance, group activities, and a human presence for users who are not comfortable with digital tools. The initial rollout targets three to five community sites in Guangzhou, Zhuhai, and Shenzhen. These sites are not owned or leased; they operate through partnership agreements with existing community service centres, which keeps fixed costs low.

Partner channels. Insurance company branches, hospital geriatric departments, and senior centres serve as referral channels. The model's partnership with insurance companies is particularly important: it provides access to older adults who are already thinking about pension products, and it generates commission revenue that subsidizes free services.

The channel strategy reflects a simple observation: older adults do not discover services online. They discover them through people they trust—community workers, insurance agents they have dealt with for years, doctors, and friends. The digital platform is where the service is delivered; the community and partner networks are how it is found.

3.4. Customer relationships

The model's approach to customer relationships can be summarized as *low-pressure, high-frequency, and progressively deepening.*

Acquisition. Free mental health assessments and community education events serve as the entry point. These are not loss leaders in the conventional sense; they are the service. An assessment that identifies a problem and explains what to do about it has value on its own, even if the user never pays for anything else.

Retention. The platform aims to maintain regular contact through social group features, activity notifications, and periodic check-ins. The goal is not daily engagement—that would be unrealistic for most older users—but monthly or quarterly contact that keeps the relationship alive. Social capital, after all, is built through repeated interaction, not one-off transactions.

Deepening. Users who engage with the platform over time may move from free services to paid ones: personalized pension planning, one-on-one counseling, premium social activities. The model does not push this transition aggressively. The assumption is that trust built through free services will naturally lead to paid engagement for those who need and can afford it.

Family involvement. For adult children, the relationship is managed through a separate interface: appointment scheduling, assessment summaries, and privacy controls. The design principle is that children should be able to help without taking over. This is a delicate balance, and the platform's privacy settings—which allow the older adult to control what children can see—are central to maintaining it.

3.5. Revenue streams

The model draws on four revenue sources. None is expected to be sufficient on its own; together, they are intended to cover costs and generate a modest surplus.

Service fees. One-on-one psychological counseling is priced at ¥99 per session. Assessment plus report interpretation is ¥199 per package. Personalized pension planning is ¥199–299 per package, depending on complexity. Social activities and interest classes are priced at ¥20–50 per person per session. These prices are set low relative to comparable services in urban China, reflecting both the target population's price sensitivity and the model's social mission.

Insurance commissions. The platform receives 10–15% of premiums for pension insurance products sold through its referral network. This is the most scalable revenue source and the one most likely to drive early financial sustainability. It is also the most sensitive: commission-based referral creates an incentive to recommend products that may not be in the user's best interest. The model addresses this through a stated policy of recommending products only when they fill a genuine gap in the user's coverage, and by not tying counselor compensation to sales volume.

Government contracts. The platform is designed to bid for government-funded projects in elder mental health screening, pension literacy education, and support for empty-nest and solitary older adults. These contracts provide stable, if modest, revenue and lend credibility to the venture.

Grants and awards. As a student-led social enterprise, the platform is eligible for university innovation competitions, philanthropic foundation grants, and social enterprise awards. These are treated as supplementary rather than core revenue, but they matter for early-stage cash flow.

The revenue model is deliberately diversified. A venture that depends entirely on service fees will struggle to scale; one that depends entirely on insurance commissions will face conflicts of interest; one that depends entirely on government contracts will be vulnerable to policy shifts. The combination is intended to be resilient.

3.6. Key resources

Data. The founding dataset—1,200+ observations from the 2016 micro-level survey—provides the empirical basis for service design. As the platform operates, it accumulates its own data: assessment results, service utilization, user feedback. This creates a feedback loop that improves matching and personalization over time.

People. The core team combines psychology, insurance, gerontology, marketing, and computer science backgrounds. This is not a coincidence; the model requires all five. A psychology graduate alone cannot build a pension planning tool. A computer science graduate alone cannot design a mental health assessment. The interdisciplinary composition is a resource in itself.

Advisors. The model relies on a small advisory board: geriatricians, insurance industry veterans, and university faculty. Their role is not day-to-day management but periodic review—sanity-checking service design, reviewing partnership terms, and providing credibility with external stakeholders.

Volunteers. A network of 50–100 university student volunteers supports community outreach, activity organization, and home visits. Volunteers reduce labor costs, but they also require management. The model includes training, supervision, and recognition mechanisms to make the volunteer component sustainable.

Community partnerships. Agreements with community service centres provide physical space, access to users, and legitimacy. These relationships are not transactional; they require maintenance, reciprocity, and attention to the partner's own objectives.

3.7. Key activities

The model's core activities fall into four categories.

Assessment and matching. The mental health assessment and pension planning tools are the entry point for most users. Their design determines who the platform reaches and what it can offer them. Ongoing work includes instrument validation, item refinement, and the development of matching algorithms that connect assessment results to service recommendations.

Service delivery. Counseling, planning consultations, and social activities are the visible output of the model. Quality control is the central challenge: a single bad experience can damage trust in a population that is already skeptical of new services.

Partnership management. Relationships with insurers, community centres, hospitals, and government agencies require continuous attention. Each partner has its own objectives, timelines, and constraints. The model treats partnership management as a core function, not an administrative afterthought.

Data collection and iteration. Every interaction generates data. The model's ability to improve depends on capturing that data, analyzing it, and feeding it back into service design. This is where the venture's data-driven claim is either validated or exposed as rhetoric.

3.8. Key partnerships

The partnership portfolio is organized around three functions: access, delivery, and credibility.

Access partners include community service centres, insurance company branches, and hospital geriatric departments. They provide reach into the target population.

Delivery partners include licensed psychologists and counselors, insurance brokers, and social activity providers. They provide services that the core team cannot deliver alone.

Credibility partners include university research centres, government agencies, and established NGOs. They signal that the venture is serious and trustworthy, which matters for both users and regulators.

The model does not attempt to internalize all functions. A student-led venture with limited capital should not try to employ its own psychologists, own its own facilities, or develop its own insurance products. The partnership model allows the venture to focus on what it does distinctively—integration and matching—while relying on partners for specialized delivery.a

3.9. Cost structure

The cost structure is shaped by the asset-light principle, and it is best understood qualitatively rather than through line-item projections. Four observations capture its logic.

Platform development is the largest upfront cost. Building a mini-program that meets health data protection standards is not optional. It is the condition for handling assessment results and personal information at all. This cost is front-loaded: it must be incurred before any revenue arrives, and it cannot be deferred without delaying the entire venture. A template solution would be cheaper but would not support the matching, privacy controls, and remote assistance features on which the model depends.

Compliance is a fixed cost that scales with ambition. Operating across Chinese mainland and the Hong Kong/Macau Special Administrative Regions introduces data protection and service regulation requirements that a purely domestic venture would not face. These costs are largely fixed—they do not vary much with the number of users—and they are unavoidable for any venture that intends to serve cross-border families. A model that stayed within one jurisdiction would avoid them, but it would also forfeit the cross-border dimension that distinguishes this platform from domestic

competitors.

The overall picture is a cost structure that is front-loaded, compliance-heavy, and relatively light on fixed assets. The principal financial vulnerability is timing: costs arrive before revenue, and the venture has limited access to conventional startup capital. The responses to this vulnerability—working capital reserves, grant applications, and a revenue mix that includes commissions and contracts—are addressed in Section 4.

4. Financial Viability

Financial viability for a venture like this cannot be assessed through a conventional profit-and-loss lens alone. The model is not designed to maximize returns; it is designed to sustain itself while delivering services that the market has under-provided. That distinction shapes what "viable" means here. The question is not whether the platform can generate attractive margins, but whether it can cover its costs, survive its early years, and reach a scale at which its social impact and its financial position reinforce rather than undermine each other.

This section addresses that question in four parts. It begins with the venture's cost profile and the timing problem that defines its early financial position. It then examines each revenue stream for its realistic contribution and its particular vulnerabilities. It considers the break-even question—not as a single date but as a set of conditions. Finally, it discusses the funding strategy that bridges the gap between launch and sustainability.

4.1 Cost profile and the timing problem

The model's cost structure has three characteristics that matter for financial planning.

First, **costs are front-loaded**. Platform development, compliance work, and initial community outreach must be paid for before the platform has users, before it has partners, and before it has any revenue at all. This is not unusual for platform ventures, but it is more acute here because the target population adopts new services slowly. An older adult who is skeptical of digital tools will not become a paying user in the first month. The venture must therefore be able to operate for an extended period without meaningful income.

Second, **a significant share of costs is fixed rather than variable**. Compliance with health data protection rules, the maintenance of the mini-program, and the core team's time are not costs that scale down when user numbers are low. They must be met regardless. This means the venture cannot simply reduce activity to reduce costs; it must either find revenue or find subsidy.

Third, **the cost base is deliberately kept light on physical assets**. There are no buildings to lease, no beds to fill, no equipment to depreciate. This reduces the absolute size of the financial hole the venture must climb out of. But it also means the venture depends on partners for service delivery, and partner relationships can be fragile. A community centre that withdraws its space, or an insurance company that changes its referral terms, can disrupt operations in ways that owned assets would not.

Taken together, these three characteristics define the venture's central financial challenge: *it must survive a period of several years during which costs are real and revenues are not yet reliable*. The rest of this section examines how the revenue streams and funding strategy are designed to address that challenge.

4.2 Revenue streams: realistic contributions and vulnerabilities

The model draws on four revenue sources. Each has a different timeline, a different ceiling, and a different risk profile.

Service fees are the most direct expression of the model's value proposition, but they are also the

slowest to develop. Older adults who are not accustomed to paying for mental health services, pension planning, or social activities will not begin paying simply because a new platform offers them. Trust must be built first, and trust takes time. The realistic contribution of service fees in the first year is therefore modest. Their importance is less financial than strategic: they test whether the model's integration of services is something users will actually pay for, and they provide a signal of value that grants and contracts cannot.

Insurance commissions are the most scalable revenue source and the one with the clearest path to covering fixed costs. A single successful referral can generate more revenue than many counseling sessions. But commissions carry a structural risk: they create an incentive to recommend products that generate revenue rather than products that serve the user's interest. The model's stated policy—recommending products only when they fill a genuine gap, and not tying counselor compensation to sales volume—is intended to manage that risk, but the risk does not disappear. A commission-dependent venture in a trust-sensitive market must be vigilant about the difference between serving users and serving itself.

The overall picture is a revenue mix that is diversified by design but not evenly weighted. In the early years, grants and contracts will likely contribute more than service fees and commissions. As the venture matures, the balance should shift toward the earned revenue streams, with commissions becoming the largest single source. Whether that shift occurs is the central question of financial viability.

4.3 The break-even question

Break-even in this model is not a single date. It is a set of conditions that must be met simultaneously.

The first condition is **user volume sufficient to cover fixed costs**. The venture's fixed costs are not large by the standards of the care industry, but they are not trivial either. Platform maintenance, compliance, and core staff time must be paid for regardless of how many users the platform serves. Break-even requires a user base large enough that the revenue per user, across all streams, covers those fixed costs. Because revenue per user is low in the early years—many users pay nothing, and those who pay do so modestly—the required user base is larger than it might first appear.

The second condition is **commission revenue that does not undermine trust**. If commissions become the dominant revenue source, the venture faces a choice between maximizing revenue and maintaining the advisory integrity on which its value proposition depends. A model that resolves this tension by recommending products indiscriminately may become financially viable while ceasing to be the thing it claims to be. The break-even condition is therefore not just financial but ethical: the venture must reach sustainability without compromising the trust that makes users willing to engage.

The third condition is **contract revenue that is renewable rather than one-off**. Government contracts and foundation grants can cover early deficits, but they cannot be relied on indefinitely. For the venture to be genuinely sustainable, at least some of this revenue must be renewable—annual contracts, multi-year agreements, or recurring program funding. Without that, the venture is not sustainable; it is merely subsidized.

These three conditions are interrelated. User volume generates data, which improves matching, which increases the value of the platform to partners, which makes contracts more likely to be renewed. Commission revenue, if managed well, funds free services, which build trust, which increases user volume. The model's financial logic is circular rather than linear: each element supports the others, and the failure of any one element weakens the whole.

4.4 Funding strategy: bridging the gap

The gap between launch and sustainability must be bridged by sources that do not require the venture to be profitable. Three categories matter.

Competition and award funding is the most natural source for a student-led venture. University innovation competitions, social enterprise challenges, and similar programs provide both cash and visibility. The amounts are typically small relative to the venture's costs, but they are unrestricted and can be used for the early platform development and community outreach that precede revenue.

Philanthropic grants from foundations focused on ageing, mental health, or social innovation can provide larger sums over longer periods. These grants often come with reporting requirements and programmatic restrictions, but they are well-suited to funding the free or subsidized services that the model relies on for trust-building. A foundation grant that funds mental health assessments for low-income elders, for example, directly supports the model's social mission while relieving pressure on earned revenue.

5. Conclusion & Discussion

This paper set out to answer a practical question: what would a business model look like if mental health, pension planning, and social capital were treated as one service rather than three? The answer, developed through the case of Anxin Dawan, is neither radical nor complicated. It is a platform that assesses, matches, and follows up; that delivers through community partnerships and a mini-program rather than through owned facilities; and that funds itself through a mix of fees, commissions, contracts, and grants. What makes it distinctive is not any single feature but the decision to refuse the separations that structure the existing market.

5.1. Theoretical Contributions

First, the evidence for integration is stronger than the evidence for any individual service. Social participation and social support are associated with reduced anxiety risk (Meng et al., 2025) [4]. Pension enrollment is associated with reduced depressive symptoms, operating through both material and relational channels (Chen et al., 2019; Zhang et al., 2022) [2] [9]. Living arrangements and social exclusion predict depression more strongly than demographic factors (Tong et al., 2011)[7]. None of these findings is new. What is new is the observation that they point in the same direction: the determinants of older adults' mental health are social and economic, and services that address only one determinant in isolation will underperform services that address several together.

Second, the barriers to integration are organizational, not clinical. There is no technical reason why a mental health assessment cannot inform a pension planning conversation, or why a social activity cannot serve as a follow-up to a screening. The barriers are that different services are delivered by different organizations, funded through different streams, and regulated by different authorities. The model's contribution is to show that these barriers can be worked around—not eliminated, but worked around—through partnership structures and a platform that sits across organizational boundaries.

Third, financial sustainability is possible but not automatic. The model's cost structure is light on fixed assets and heavy on compliance and platform development. Its revenue structure is diversified but unevenly weighted, with grants and contracts carrying more weight in the early years than earned revenue. Break-even depends on user volume, commission integrity, and contract renewability—three conditions that are interrelated and none of which is guaranteed. The model is viable in principle; whether it is viable in practice depends on execution.

5.2. Practical Implications

Start with free services, but design them as services, not as marketing. The model's free assessments and community events are not loss leaders. They are the product. An assessment that identifies a problem and explains what to do about it has value regardless of whether the user ever pays for anything else. Ventures that treat free services as bait will design them poorly and will deservedly fail to convert users into paying customers. Ventures that treat them as the core offering will build the trust on which everything else depends.

Choose partners for access, not for prestige. The model's partnerships with community centres and insurance branches are valuable because they provide reach into the target population. Partnerships with prestigious institutions may look good on a slide deck but do little for user acquisition. A student-led venture has limited time and should spend it on partners who can actually connect it to older adults.

Treat commission revenue as a trust problem, not just a compliance problem. The temptation to recommend products that generate higher commissions is real, and it is the single greatest threat to the model's integrity. The policy of recommending products only when they fill a genuine gap, and of not tying counselor compensation to sales volume, is not a nice-to-have. It is the condition for the model's continued existence. A venture that loses the trust of its users has no revenue stream left to protect.

Plan for a long runway. The model's financial profile is front-loaded: costs arrive before revenue. A venture of this kind should not assume it will be self-sustaining within a year or even two. Competition funding, philanthropic grants, and government subsidies are not embarrassments; they are the bridge that makes the model possible. The goal is not to avoid subsidy but to use it to reach a point where it is no longer needed.

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