

The Impact of the COVID-19 Pandemic on Health Services for Older Adults in China*

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(Abstract)

China's economic slowdown due to the COVID-19 pandemic has greatly influenced not only GDP, but the livelihoods for citizens, particularly health status of older adults. As part of China's response to the COVID-19 pandemic, this paper explored how China's social policy has responded to the Covid-19 crisis, focusing on health services for older adults in China. The paper examined, first of all, China's social security system and its overall performance in response to the COVID-19 pandemic. Secondly, it explored the COVID-19's impact on health services for older adults and their corresponding coping measures. Finally, the paper made an attempt to provide a summary statement for the enlightenment of the COVID-19 prevention and control experience on the services. Moreover, the COVID-19 pandemic has had negative impacts on the services for older adults in China. Five policy implications are recommended to China's health services to mitigate the damages caused by the COVID-19 pandemic to older adults.

Key words : Social policy response, COVID-19 pandemic, Health services for older adults, China

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(초록)

COVID-19 대유행에 따른 경제 둔화는 국내총생산(GDP)뿐만 아니라 중국의 민생, 특히 고령자의 삶의 질에 커다란 영향을 미쳤다. 본 글은 COVID-19 대유행에 대한 중국 정부 대응의 하나인 고령자 건강서비스에 초점을 두면서 중국 사회정책이 코로나19 위기에 어떻게 대응했는지를 살펴보고자 했다. 즉 COVID-19 위기에 대한 사회정책 대응을 고령자의 건강서비스에 초점을 맞추어 분석했는데, 본 글의 내용은 다음의 세 가지로 구성했다. 첫째, 중국의 사회보장제도와 COVID-19 대유행에 대한 중국의 전반적인 성과를 검토했다. 둘째, COVID-19 대유행이 중국의 고령자 건강서비스에 미치는 영향과 그에 상응하는 대처 방안을 집중적으로 다루었다. 마지막으로, 중국의 고령자 건강서비스에 대한 COVID-19 예방 및 통제 경험을 이해하기 위한 간략한 요약문을 제공하고자 했다. 더군다나 COVID-19 대유행은 중국의 고령자 건강서비스에 부정적인 영향을 미쳤다. 이에 COVID-19 대유행으로 인한 중국의 고령자 건강서비스의 피해를 완화하기 위해 5가지 정책 권의를 권고했다.

주제어 : 사회정책 대응, COVID-19 대유행, 고령자 건강서비스, 중국

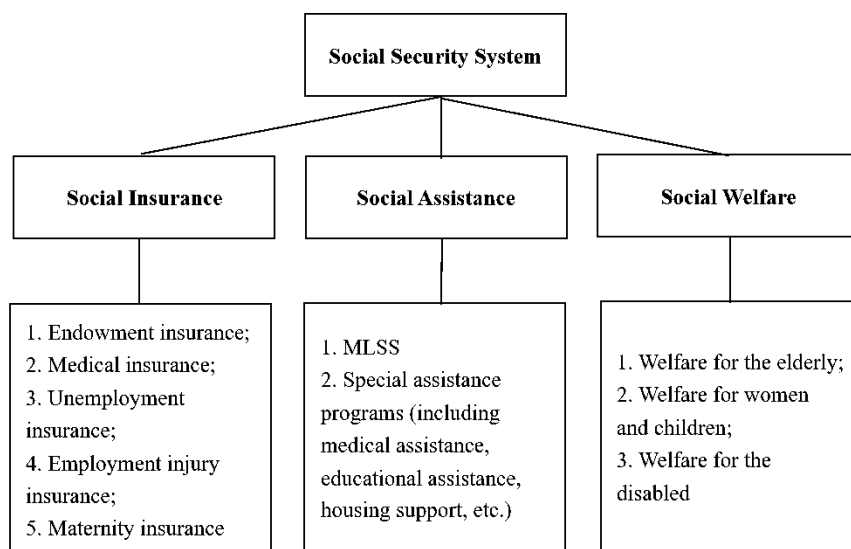
I. Introduction

In the past few decades, China has rapidly expanded its social security programs and established the largest comprehensive social security network in the world. Currently, the social security system in China consists of three main types of social programs; social insurance, social assistance, and social welfare. Chinese employees and their employers and foreign employees are mandated to contribute to China's social security system (Zhou, 2021).

China is currently facing a "population aging tsunami." The population sector aged over 65 years is projected to double between 2010 and 2030. Thus, reforming the social security system to improve coverage, sustainability, and equity becomes more urgent than ever. As shown in Figure 1, China's social insurance is comprised

of five types of insurances; endowment insurance, medical insurance, unemployment insurance, employment injury insurance, and maternity insurance (Zheng, 2008). All of these insurances were only available to urban workers in the past, but the Chinese government has recently undertaken extensive reforms for rural areas by introducing a basic endowment insurance and a basic medical insurance system for urban and rural residents (Cai & Du, 2015).

The number of people participating in public endowment (pension) insurance from 2015 to 2019 is shown in Figure 2. China's public endowment insurance consists of three schemes; the Urban Employees' Pension Scheme (UEPS), the Public Employees Scheme (PES), and the Basic Residents Scheme (BRS). The first two schemes are compulsory while the last one is voluntary (Zheng, 2008). All three schemes have



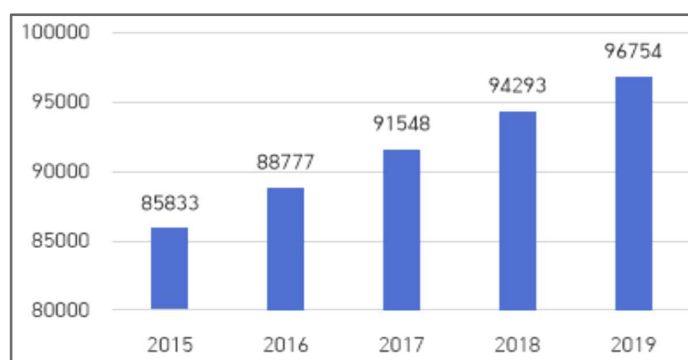
Note: The term ‘MLSS’ stands for Minimum Living Standard Scheme. Figure excerpted from Zheng (2008)

〈Figure 1〉 The social security system in China

two pillars; a defined benefit pillar funded by pooling contributions from employers and fiscal subsidies, and a defined contribution pillar funded by employee contributions. As seen in Figure 2, more than 967 million people had participated in three basic kinds of pension

insurance by the end of 2019.

The UEPS is the most important component of the overall Chinese endowment insurance. In 2019, 312 million workers were insured under the Scheme and there were over 120 million pensioners. The UEPS includes both a “social



Note: Excerpted from the Ministry of Human Resources and Social Security (2022).

〈Figure 2〉 The Number of People Insured by Pension Insurance (Unit: 10,000)

pension” and an “individual account” in China. In principle, the employer’s contribution (20% of earnings until recently) finances the social pension, while the employee’s contribution (8%) goes to the individual account. It was originally intended that the individual accounts would be funded, but in practice contributions were often used to meet transition costs (Chen & Turner, 2014). Currently only a few of these accounts are funded while the remainder are “notional” accounts.

An individual can receive a pension based on the amount accumulated in his/her personal fund after retirement. Current retirement ages in China were set in the 1950s when the life expectancy was less than 50 years. Since then, the statutory retirement age in China has been set at 60 years for men, 55 years for women in managerial positions, and 50 years for other blue-collar female workers. China is planning to raise its retirement age in response to the increasing life expectancy for maintaining an affordable and sufficient national pension systems. Workers become eligible for pension benefits when they reach the statutory retirement age. It is necessary to have at least 15 years of contributions to qualify for a pension benefit. Those who have less than 15 years of contributions may delay retirement until they pay the remaining required contributions, transfer their pension plan to a plan for non-employed rural or urban residents, or receive the entirety of their individual account, including interest, in

a lump sum payment.

This part examines the key issues of the Chinese medical insurance system, with a particular emphasis on basic social medical insurance which has the broadest coverage in China. Health-care financing and payment in China are mainly based on medical insurance. Over the last few decades, the Chinese government has comprehensively launched the Basic Medical Insurance (BMI) due to challenges brought on by an aging population and the increasing demand for health services. The BMI system covers different socioeconomic groups, including employees and residents (Zheng, 2008).

Employees are enrolled in the Urban Employee Basic Medical Insurance (UEBMI), and non-working residents are enrolled in the Urban and Rural Residents Basic Medical Insurance (URRBMI) (Yang, 2018). The UEBMI was established in 1998 and has formed a relatively standardized medical insurance system. All urban employers and their employees at all enterprises, government office, public institutions, social organizations, and private non-enterprise units are required to participate in the UEBMI. The employers and the employees shall jointly pay according to different payment proportions in accordance with the national regulations, which is recorded in the medical insurance fund.

The URRBMI was developed relatively recently (Li, 2020). China established the

URRBMI for the integration of the Urban Resident Basic Medical Insurance (URBMI) and the New Rural Cooperative Medical Scheme (NRCMS) in 2016. This integration was to improve equality between urban and rural areas with the goal of establishing a unified medical insurance system. In October 2002, the NRCMS was initially outlined in the decision of the Party Central Committee and the State Council on further strengthening rural health work. And the pilot program was initiated in 2003, and expanded quickly. On the other hand, the URBMI was piloted in 79 cities during the summer of 2007. The URBMI was mainly for urban minors and residents not covered by the UEBMI such as children, students, older adults and other non-working urban residents, while the NRCMS was mainly for permanent residents in a rural area. In 2016, China decided to merge the URBMI with the NRCMS to establish the Urban and Rural Residents Basic Medical Insurance (URRBMI).

The URRBMI is complex as it includes the BMI for urban workers, the BMI and free medical care for urban residents, and the new rural cooperative medical insurance for the rural population (Han & Ang, 2018). The URRBMI is a heavily government-subsidized voluntary medical insurance program administered at municipal levels. It is funded mainly by individual contributions and partly through government subsidy. Additional government contributions are given to poor or disabled individuals in undeveloped central and western regions (Ren, Zhou, Cao, Ma, Shen, Lai, & Chen, 2022).

Medical insurance covers a portion of the cost to treat workers' illnesses or non-work-related injuries. According to statistics released by the National Health-care Security Administration, more than 95% of Chinese people were covered by the BMI in 2019. In the case of the UEBMI, the employer and the employee must pay for this form of social

〈Table 1〉 The contributions of the Urban Employee Basic Medical Insurance (UEBMI) of the Major Cities in 2019 (Unit: %, Chinese Yuan)

City	Total %age	%age of wages paid by employer	%age of wages paid by employees
Beijing	12.0	10.0	2.0 (+3Yuan)
Shanghai	11.5	9.5	2.0 (+3Yuan)
Tianjin	9.5	7.5	2.0
Chongqing	10.0	8.0	2.0
Guangzhou	8.5	6.5	2.0

Note: Excerpted from the National Bureau of Statistics of China (2019).

insurance on a monthly basis. The UEBMI is administered at municipal levels (Yi, 2021). Employer and employee contributions make up the the UEBMI. As seen in Table 1, the total portion of the UEBMI in Beijing was 12%, in which 10% were paid by employers and 2%

(+3 yuan) by employees. The portions can vary by municipality (National Bureau of Statistics of China, 2019).

As of September 2020, more than 1.35 billion people (over 95% of China's population) are covered by the BMI, making it the world's

〈Table 2〉 The number of recipients of the Minimum Living Standard Scheme (MLSS) in China (Unit: 10,000 persons)

Year	The Urban MLSS	The Rural MLSS	Total
1996	84.9	-	84.9
1997	87.9	-	87.9
1998	184.1	-	184.1
1999	256.9	265.7	522.6
2000	402.6	300.2	702.8
2001	1,170.7	306.8	1,477.5
2002	2,064.7	407.8	2,472.5
2003	2,246.8	367.1	2,613.9
2004	2,205.0	488.0	2,693.0
2005	2,234.2	825.0	3,059.2
2006	2,240.1	1,593.1	3,833.2
2007	2,272.1	3,566.3	5,838.4
2008	2,334.6	4,305.5	6,640.1
2009	2,345.6	4,760.0	7,105.6
2010	2,310.5	5,214.0	7,524.5
2011	2,276.8	5,305.7	7,582.5
2012	2,143.5	5,344.5	7,488.0
2013	2,064.2	5,388.0	7,452.2
2014	1,877.0	5,207.2	7,084.2
2015	1,701.0	4,903.6	6,604.6
2016	1,480.2	4,586.5	6,066.7
2017	1,261.0	4,045.2	5,306.2

Note: Excerpted from the National Bureau of Statistics of China (2019).

largest health-care security network (Yi, 2021). The coverage of social insurance was further expanded and the national insurance was steadily advanced. By the end of 2018, about 200 million employees were covered by unemployment insurance and more than 200 million employees were covered by work accident insurance and about 200 million employees were covered by maternity insurance (Li, Chen, & Zhang, 2019).

For China's assistance system, the most important program is the Minimum Living Standard Scheme (MLSS). The MLSS is a means-tested social assistance program established in the late 1990s in order to deal with the increasing urban poverty caused by the market-oriented economic reform (Ngok, 2015). It covers residents whose per capita income/annual net income is lower than the local minimum living standard in both urban and rural areas. As seen in Table 2, the total number of recipients of the MLSS in China reached about 530 million people by the end of 2017.

The social welfare service scheme provides funding and social care services to ensure the livelihoods of older adults, women, children and disabled persons with special difficulties (Zhang, 2009). Welfare resources such as housing, medical care, education, and foods are heavily concentrated in the urban areas (Zheng, 2008). Social care in China has been challenged by economic, social, and demographic changes.

Regardless of their residential area, people's expectations and demands for social care are rising, which is putting pressure on the government and service providers to provide better services.

II. China's Social Policies in Response to COVID-19

Having had the fastest spread and the widest range of infections, the COVID-19 pandemic has caused a substantial public health crisis in China, posing challenges to the country's socioeconomic development and people's daily lives. The central government has played an active role in addressing these challenges and promulgated a number of important policies in the field of social security, which have effectively alleviated the medical burden of COVID-19 patients and their families. At the same time, the policies fully mobilized social resources to effectively support the resumption of work and production (Lu, Cai, Chen, & Liu, 2020).

The two most severely affected areas of social policy are medical insurance and social assistance. First, during the COVID-19 crisis in China, timely and effective medical security measures, mainly medical social insurance, were taken to prevent patients and their families from worrying about treatment costs during the COVID-19 crisis in China. Shortly after the

outbreak of the COVID-19 pandemic, the state promulgated a number of new policies, including new medicines for the COVID-19 and medical services as part of the payment scope of the medical insurance fund. In addition, the economic burden of the COVID-19 patients at hospitals in China has been lifted by the government financial resources, so that the COVID-19 patients could be hospitalized with no cost. The policy was initially limited to confirmed cases of the COVID-19, but later extended to suspected cases. At the same time, when people seek treatment in the coordination area of the social medical insurance fund, it is stipulated that treatment must be provided first and then paid. For medical institutions that admit a large number of patients, social medical insurance will prepay funds to ensure that the hospital's medical treatment effect is not damaged by the payment policy. The above policies can be summarized as "two guarantees." One is to ensure that no patients are rejected or refused to be treated in time due to medical expenditure or cost problems, and the other is to ensure that designated medical institutions do not control patients' treatment due to budget management regulations of medical insurance fund (Lu et al., 2020). As of April 6, 2020, the total cost of confirmed and suspected COVID-19 cases in China was about 1.49 billion yuan (\$210 million). The per-capita medical expenses for confirmed hospitalized patients reached more than \$3,000 and the

severe cases more than \$21,000 (State Council, 2020). In general, the medical insurance fund paid about two-thirds of the total cost, and the remaining one-third was borne by financial funds at all levels.

Next, a series of social assistance measures were introduced to protect the basic livelihoods for the poor after the COVID-19 outbreak. The Ministry of Civil Affairs of China, being responsible for social administrative affairs under the State Council, has taken a lot of measures. For example, the Minimum Living Standard Guarantee (MLSG), known as 'Dibao (低保),' was considered as a social safety net to help the poor during the period of the COVID-19 outbreak. To qualify 'Dibao' payment, all households must satisfy a means test. The household whose per capita income is lower than the local poverty line has the right to make up a deficiency from local governments. The process of applying for a means-tested 'Dibao' payment could be temporarily suspended in areas severely affected by the COVID-19 pandemic. The amount of cash subsidies for the poor has increased. For instance, Hubei Province stipulated that the amount received by people in need should be increased by 500 yuan (\$70.6) in urban areas and by 300 yuan (\$42.4) in rural areas. Temporary assistance would be provided to those who have difficulties in life due to self-isolation, quarantine, or infection. In principle, social assistance in China is mainly based on the Hukou (户口) system, a

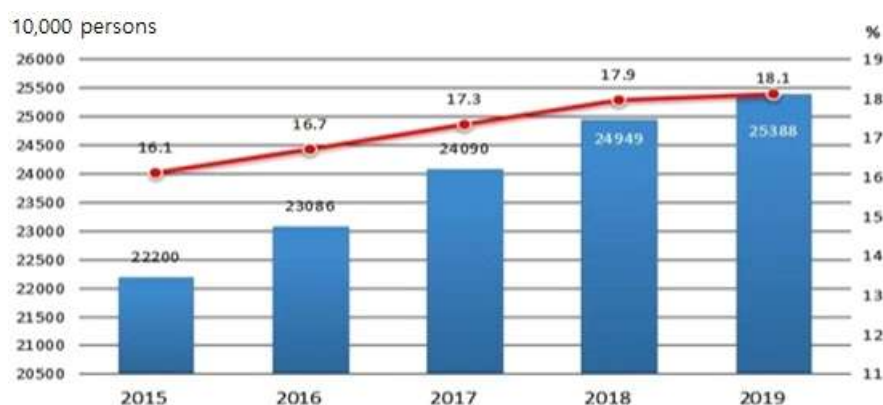
governmental household registration system. The Hukou system in China is the system of household registration that is currently in place, which identifies a person as being a resident of a particular area. However, during the COVID-19 outbreak, temporary accommodation, food, clothing, and other assistance were provided to non-local residents in need (Lu et al., 2020).

III. COVID-19's Impact on Health Services for Older Adults in China

In this section, the impact of COVID-19 pandemic on health services for older adults and its corresponding measures was focused. There are mainly two characteristics to note about China's population. China's population is aging

very rapidly. In fact, China has one of the fastest growing aging populations in the world. As seen in Figure 3, China's total population exceeded 1.4 billion, with more than 253 million people aged 60 and over, accounting for 18.1% of the total population by the end of 2019 (National Bureau of Statistics of China, 2019). Furthermore, more than 190 million people were 65 and over, accounting for 13.5% of the total population, citing data from the seventh national census conducted in 2020 (Office of the Leading Group of the State Council for the Seventh National Population Census, 2021).

As for China's population aged 60 years and older, it will reach 300 million in 2025, and 500 million in the middle of the 21st century (Zhai, Chen, & Li, 2017). By that time, the proportion of them will expected to rise to



Note: The bar graph shows the population aged 60 years and over in China while the line graph shows its proportion among the total population in China.

〈Figure 3〉 Population aged 60 years and over (% of total population) in China (Unit: 10,000 persons, %)

about 35% of the total population. The onset of the COVID-19 has made it more difficult to respond to the problem of population aging and improve elderly care and health services. Older adults are vulnerable to COVID-19 crisis because they may not be fully independent. The negative impact of the COVID-19 crisis on psychological well-being of older adults has become very evident. This negative effect is magnified in older adults largely due to strong lock downs, high threat of illness and death, material loss, high level of isolation, and loss of access to social networks and support (Yang, Li, Zhang, Zhang, Cheung, & Xiang, 2020).

In general, there are three ways by which older adults were influenced by the COVID-19 pandemic. First, the infection rate among older adults was higher. According to data released by the National Health Commission of PRC in February 2020, nearly half of the COVID-19 patients aged 60 years and older among the patients were diagnosed with COVID-19. Also, older adults have experienced higher rates of COVID-19 deaths compared to younger people (Du & An, 2021). The mortality rate of patients increased with age. Through an analysis of more than 72,000 COVID-19 cases by the Chinese CDC (Center for Disease Control and Prevention), it was found that 94% of the dead cases were among those aged 50 years and older, and 80% were aged 60 years and older (Chinese CDC, 2020).

Lastly, the COVID-19 pandemic has broken

the existing means of providing social care for older adults. For example, older residents who returned home temporarily before the COVID-19 pandemic could not return to their senior care facilities in time, and those who were residing in facilities at the onset of the pandemic were unable to enter and exit freely, and their family members' daily visits were severely restricted. On the other hand, due to China's social distancing policy, home care services in some communities could not be carried out normally. As a result, the majority of care-dependent older adults in the community could only be taken care of by their family members. As the COVID-19 pandemic swept rapidly across the China, vulnerable populations including older adults, orphans, and widows often encounter barriers to accessing dining, medical treatment, participation in social activities, and so on (Hu & Zhu, 2021).

As for the impact of the COVID-19 pandemic on health services for older adults, it is known that older patients faced difficulties in seeking medical treatment and medication, mainly demonstrated in the following four aspects (Du & An, 2021). The first aspect was the inconvenience of medical treatment for older adults with chronic diseases. The "Prescription Management Measures" issued by the Ministry of Health in 2007 stipulated that prescription drugs should generally not exceed the 15-day dosage. Therefore, older adults with chronic disease should go to the hospital for follow-up

visits and medicines at least twice a month. In the early stage of the COVID-19 pandemic, closed community management was implemented in communities and institutions. Older patients who needed medical treatment and medicine faced difficulties in accessing communities and institutions, and they would also face a greater risk of infection from going out in public for medical treatment (Feng & Nan, 2020). Also, there were several difficulties in using online medical treatment system. Because the majority of older adults do not have access to the Internet, it is hard to use applications on smart phones, if at all. According to China's Internet Development Report, 6.9% of adults aged 60 years and older used the internet in 2019 (Internet Society of China, 2020). Therefore, it is difficult for aged 60 years and older to make an online appointment or see a doctor online.

The second aspect was that the COVID-19 pandemic has exposed the underlying problems in China's current home-based care services at community levels (Yin, Liu, Huang, Bi, Zhou, & Lv, 2022). As some communities and home service facilities were temporarily closed at the beginning of the COVID-19 pandemic, community home-based care services for older adults were unable to operate normally, and dining tables for older adults were also suspended. Problems with eating or taking care of older adults living alone or being disabled were prominent, especially the needs of care services for the disabled and semi-disabled older

adults could not be effectively met.

The third aspect was that the ability for older adults to obtain health-care information was limited (Liu, Wang, Huang, & Ren, 2021). Older adults have already been experiencing cognitive decline to register information, let alone through unfamiliar technology. Therefore, given the low levels of awareness or knowledge about prevention and control of the COVID-19 pandemic, the majority of older people may not be able to grasp and understand the update of the COVID-19 pandemic in time.

The fourth aspect was that the COVID-19 pandemic has exacerbated social isolation and loneliness of older adults. Except for family members, older adults living in the community have been disconnected from their friends, causing social isolation. Social isolation is more prominent for older adults living. The restriction on family visits and mobility throughout the care facilities may have increased the risk of anxiety, loneliness, and depression among older adults (Wang & Chen, 2021).

IV. Discussion

1. Health services for older adults in the COVID-19 pandemic

The larger the health emergency needs will be for older adults, the more social actors will be involved in the response, and the more

necessary effective cooperation between different parties will become (Zhang, 2019). Since the outbreak of the COVID-19 pandemic, the government, enterprises, and social organizations have worked together to take a series of effective measures, and they have issued a series of policies to help older adults and elderly care service institutions to cope with the epidemic and effectively protect the health of older adults (Du & An, 2021).

A series of policies have been issued at the national level to support the development of health services for older adults, mainly manifested in the following five aspects. First of all, the “long-term prescriptions” for patients with chronic diseases are actively supported. The coverage of prescription dosage has been extended to three months, and grass-roots health service institutions provide door-to-door visits or allow family members to pick up drugs to help older adults with practical difficulties take their medications (Kang, Shang, Liu, & Liu, 2022). In February 2020, the National Health Commission of China issued the “notice on optimizing medical security handling the services and promoting the prevention and control of the COVID-19 pandemic” to support long-term prescription for older patients with chronic diseases. In those times, the Commission also issued the “notice on printing and distributing the guidelines for the provision of medical and health services for older patients with chronic diseases (trial) by primary medical and health

institutions during the prevention and control of the COVID-19 pandemic.”

Next, in terms of health management, it makes full use of mobile applications or we-chat groups to establish communication channels with older adults and their family caregivers, assessing the physical health status of older adults and providing targeted guidance to family caregivers. At the same time, it also emphasizes the importance of providing psychological counseling and spiritual comfort services for older adults with special difficulties (Du & An, 2021). In February 2020, the Ministry of Civil Affairs issued the guidelines for the prevention and control of pneumonia epidemic caused by the COVID-19 pandemic in senior care facilities (2nd edition). Additionally, the State Council’s response to the COVID-19 joint prevention and control mechanism comprehensive team issued the “notice on further doing a good job in the prevention and control of the COVID-19 pandemic in the integrated medical care institutions” and the “guidelines for older adults in senior care facilities during the prevention and control of the COVID-19 pandemic.”

Also, the improved health care services place emphasis on paying attention to the actual needs of older adults, promptly helping those who face practical difficulties in life, seeking medical care, nursing care, and mental health services (Hu & Zhu, 2021). Housekeeping and community care service personnel provides

door-to-door services. In March 2020, the Ministry of Civil Affairs of China issued the “notice on strengthening care services for older adults in special difficulties during the period of epidemic prevention and control” for mental health support. And the National Working Commission on Aging of China issued the “notice on doing a good job in elderly care services in normalized epidemic prevention and control” to expand health services and strengthen health management in May 2020. In addition to this, the Ministry of Civil Affairs issued the “the notice on strengthening the normalization and accurate prevention and control of the COVID-19 pandemic in elderly care institutions and emergency response” to refine prevention and control measures for elderly care institutions in November 2020.

Further, regarding the issue of the “digital divide” for older adults, policies are adopted to effectively integrate older adults in the use of smart technology, and it is emphasized to adhere to the combination of traditional service methods and intelligent services to provide older adults with humane and convenient services (Qin, Li, Luan, Tan, Liu, Zhou, Zhu et al., 2020). In November 2020, the State Council issued the “implementation plan on effectively solving the difficulties of older adults in using intelligent technology” for helping older adults bridge the digital divide.

Finally, the combination of online and offline

services eases the medical difficulties of elderly patients. During the COVID-19 pandemic, online appointments, consultations, prescription dispensing, drug sales, contact-less delivery, medical insurance reimbursement, and other methods developed rapidly in order to meet the needs of people’s health services (Ding, 2022). Also family doctors assist in the prevention and control of the epidemic and act as the “gatekeepers” of residents’ health. They rely on primary medical and health service institutions to provide individualized health services for contracted parties, including basic medical services and basic public health services such as health management services and health education. In addition, it expands older adults’ access to information and emphasizes the value of health education for them.

2. Enlightenment of the COVID-19 prevention on health service for older adults

The pandemic-related crisis has justified an interventionist approach and logic, driven by the state’s welfare system, which favors the “big government” model. But it also needs to be further justified (Lu et al., 2020). At the same time, extensive social safety net does not only include a single social policy field, but also requires more coordinated policy interventions from different fields, including economic policy, employment policy, fiscal policy and social

policy. Policy recommendations below are offered to catalyze further debate.

First, multiple subjects for age-friendly health service environment should be jointly involved. The combination of online and offline medical treatment will be the future development trend of medical services (Feng & Nan, 2020). At the same time, it is also necessary to further improve and standardize online medical treatment standards, clarify the access mechanism of Internet hospitals, and strengthen the government's supervision and management of Internet hospitals.

Second, the optimal allocation of medical and health resources and the capacity-building of community health services should be promoted. Grass-roots medical and health service institutions play an important role in the response to the COVID-19 pandemic. Under the normalization of the epidemic, the construction of medical service system should promote the optimal allocation of medical and health resources and the service capacity of community and rural health institutions (Qin et al., 2020).

Third, special attention should be paid to prevention and publicity to improve health literacy of older adults. On the one hand, big data and other information-based means can be used to improve the health monitoring mechanism for the adults at community levels (Ding, 2022). On the other hand, family doctors, professional social workers, and other social organizations can play an active role in health

education for the adults, and perform door-to-door activities such as spreading awareness of health issues and preventing epidemics.

Fourth, more attention should be paid to mental health of older adults to promote the all-round development of health services. Community staff, aging associations and volunteers can provide opportunities of social participation for older adults by organizing activities or setting up health education and training courses (Hu & Zhu, 2021). In addition, older adults themselves have great potential to become volunteers. Opportunities may be provided for any voluntary and capable one to participate in the community work and promote social connection.

Last but not least, the system and mechanism enhancing the resilience to public health emergencies needs to be improved. For example, the management mechanism of emergency medical materials, mutual assistance mechanism among hospitals should be enhanced (Du & An, 2021).

3. Meeting the demand for elderly health services in the community

Like all social service programs, health services for older adults should be focused on consumers (older adults in the community), not suppliers. This means that the current health services for the adults should be supplemented

in various aspects in order to achieve the original purpose of satisfying the demand for elderly health services in the community (Lu et al., 2020). Above all, when the adults in the community participate in the health service programs, they should be able to receive more efficient and consistent health services.

However, given the current situation of the China's social service infrastructure in the community, this will not be as easy as it sounds. For example, China's history of local autonomy is short, and above all, the financial independence of local governments is very weak. And it is quite difficult to find and provide health services suitable for older adults in the community with complex and diverse health service demands. In particular, demand for community services among older adults has increased significantly during the COVID-19 pandemic. We need to consider the constantly changing needs for health services among older adults in the community and innovate methods on how to respond to these new demands. Therefore, there is a need for a method of providing health services for older adults in an integrated manner through the linkage of various social service entities after analyzing the needs for elderly health services in various aspects.

In this way, health service governance in the community, which attempts to solve problems through a community health service network based on public-private partnerships, can be a

realistic alternative. In particular, it is required to establish a health service network that unites the private sector with the third sector of local governments and communities through health service governance in the community (Yang, 2022). In other words, it is necessary to construct horizontal as well as interdependent governance among elderly health service providers in the community in order to provide efficient services to older adults in the community with complex and diverse health service needs.

Strong support from private organizations and companies in the community as well as local governments is needed for the successful implementation of health service governance for older adults in the community. Recalling the goal of health service programs for older adults to seek independence in the community through the combination of health service and labor, health service programs for older adults cannot be successful without practical supports within the community (Du & An, 2021). Health services for older adults in the community are not something only health service institutions in the community can do for older adults. Health service programs will have a great influence as a way of satisfying the diverse needs of older adults in the community when they move toward health service governance in the community where public-private partnerships work together.

Conflicts of Interest

The Authors declare no conflict of interest.

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