The Aging Tsunami and Senior Healthcare Development in China

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China faces an aging tsunami. By the end of 2016, the number of older adults aged 60 and older reached 230 million. This number is projected to reach 418 million by 2035 and peak at 487 million by 2053. The number of individuals aged 80 and older, the oldest adults, reached 26 million and continues to grow by 1 million a year. The socioeconomic context, characterized by an inverted pyramid family structure and the number of “empty nesters,” has greatly compromised traditional Chinese family support for older adults. This article aims to provide an overview of geriatrics development in China. It begins with a brief account of the dramatic demographic shift, major socioeconomic factors, China’s healthcare system, and reform related to senior health with a historical perspective. It then describes recent advances in government policy and support and development of a geriatrics physician workforce, care models, primary care networks, and privately owned senior care facilities and support services. Although it is impossible to cover all aspects of the topic, it is hoped that this article provides readers an overall picture of Chinese geriatrics and senior healthcare development in a complex and evolving healthcare system. Geriatrics communities in the United States and around the world will undoubtedly learn and benefit from the unparalleled and continued efforts to address this unprecedented opportunity and challenge in China.

Key words: aging; senior healthcare; geriatrics; healthcare reform; China

China’s Aging Tsunami and Its Socioeconomic Context

Dramatic demographic shift and its effect on health

Whereas aging demographic shifts are often referred to as “waves” elsewhere, the shift in China can be characterized as a “tsunami,” as the following staggering demographic statistics support. The number of older adults (aged ≥60) reached 230 million in China at the end of 2016 and is projected to reach 418 million by 2035—39% of the older adult population of the world. It is expected to peak at 487 million by 2053.1,2 According to data from the China Health and Retirement Longitudinal Study presented at Columbia-Fudan Global Summit on Aging and Health,3,4 one-third of Chinese elderly adults have severe depression, and the prevalence of hypertension is 53.6% and of diabetes is 23.9% in this population. In addition, 500,000 older adults go missing in China every year, as reported by Zhongmin Social Assistance Institute under China’s Ministry of Civil Affairs, approximately one-quarter of them being diagnosed with Alzheimer’s disease or dementia and 72% with memory impairment.3 Moreover, the number of people aged 80 and older, the oldest adults, most of whom need intense geriatrics care and support, reached 26 million at the end of 2016 and is projected to grow at an annual rate of 1 million. Data from the Chinese Longitudinal Healthy Longevity Study demonstrate that, although mortality in older Chinese adults is declining, they experience marked annual decline in physical and cognitive functioning,5 highlighting the increased need for geriatrics care and support. With the largest and fastest-growing aging population in the world, China is facing an unprecedented senior healthcare challenge and will continue to do so for decades to come.

The socioeconomic context

The socioeconomic context in China must be considered when discussing this aging tsunami. First, the one-child policy implemented in the 1970s has led to an “inverted pyramid” structure for many Chinese families. This structure is different from the commonly referred to “4:2:1” paradigm (a social family structure of 4 grandparents, 2

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adult children, 1 grandchild) in that many families now have great grandparents who are in their late 80s and 90s.1 The Chinese government has recently abolished the one-child policy. Although future birth rates are hard to predict, they are not expected to increase dramatically.6 In addition, rapid economic development in certain areas has caused many young and middle-aged individuals to leave home for job opportunities, resulting in a migratory workforce over 280 million.7 These workers have no choice but leave their elderly family members behind. As a result, older adults and young children are often the only people living in many rural areas and less economically developed regions. Although China has a culture of strong family values, emphasizing that younger family members care for elderly family members, termed “filial piety,” such traditional family support is unsustainable. It is estimated that more than 100 million Chinese older adults are “empty nesters,” living alone or with their elderly spouses. Furthermore, with economic development and improved living standards, more older adults and their families are looking for high-quality senior healthcare and support and for better quality of life. Such desires will only become stronger.

The Chinese healthcare system and reform related to senior health

To better understand current senior healthcare development in China, a brief discussion of China’s complex, evolving healthcare system and its recent reform related to senior health and a brief historical account of geriatrics in China are in order. Figure 1 illustrates China’s healthcare reform from a historical perspective.8,9

Public hospitals in China are categorized into three levels and, within each level, into 3 subgroups. Community and county hospitals are Level 1 and 2 hospitals, and large academic medical centers are typically Level 3A hospitals. Public hospitals are the backbone of the Chinese healthcare system because China lacks private clinics or primary care networks.2 Most people seek all their medical care, from the common cold to most severe and complicated conditions, at Level 3A hospitals.10,11 As a result, clinics at these large tertiary care facilities are crowded, and physicians see many people and therefore can only spend very little time with each. Admissions to inpatient services are difficult to obtain, and wards are highly specialized (e.g., rheumatology, nephrology). Physicians tend to have a narrow knowledge base, focusing only on diseases in their subspecialty.2,8 Thus, individuals receive disease-oriented, fragmented care with little continuity or coordination, which is particularly challenging for older adults and their families.12

Historically, geriatrics in China, referred to as “Bao-Jian,” meaning health protection or health maintenance, was developed in the 1950s primarily for high-rank government officials and military cadres.13 Physicians in departments of Bao-Jian needed to have a subspecialty for their academic credentials and promotion, so geriatrics became further subspecialized (e.g., geriatric cardiology). Geriatricians were at great disadvantage when competing against other subspecialists for limited resources. Therefore, geriatrics in China during those early years was seldom noticed in the medical community, with little opportunity for academic advancement or scholarly exchange, let alone much development. In the early 1980s, the Ministry of Health (currently National Health and Family Planning Commission, NHFPC) formed a Special Committee on Geriatrics. The Chinese Medical Association (CMA) Geriatrics Branch and Chinese Journal of Geriatrics were also established,12,13 although the development of geriatrics overall was slow throughout 1980s and 1990s. As described next, it has greatly accelerated since the 2000s.

Geriatrics and senior healthcare development

An overview of the demographic characteristics and geriatrics in China with a focus on long-term care (LTC) and

Figure 1. Schematic illustration of the timeline of China’s healthcare reform with major reform measure initiation and subsequent healthcare characteristics listed in the box above the respective years. Four stages indicated below the timeline are arbitrary. Events listed under 1949, 1985, and 2003 are major events occurred during those years. Although most reports describe that the reform was reinvigorated in the late 2000s, pilot testing of the New Cooperative Medical Scheme (NCMS) and Urban Resident Medical Insurance (URMI) was started in 2003. The horizontal timeline is not to scale with the actual time between the indicated years. SARS=severe acute respiratory syndrome.
nursing homes was published in 2007. Progress has been phenomenal since then. Although it is impossible to cover all aspects of the topic, several major and exciting areas of progress are described below.

**Government policy and funding**

China does not have health insurance specifically for older adults—equivalent to Medicare or LTC insurance in the United States. Since the late 2000s, the Chinese government has implemented the New Cooperative Medical Scheme (NCMS, for rural residents) and the Urban Resident Medical Insurance (URMI, for urban residents including those who are self-employed or unemployed), which together provide coverage for more than 97% of Chinese citizens, including older adults. Systematic evaluation of the effect of NCMS and URMI on senior health is unavailable. One study of older adults living in rural areas showed improvement in their physical and cognitive function and a reduction in mortality but no effect on self-reported general health or out-of-pocket healthcare expenses.

The central Chinese government has also issued a number of national policies on senior healthcare and support. For example, one policy aims to promote a senior support model, termed “9064” in Beijing and “9073” in most other cities and regions, which means that 90% older adults will age at home, 6% or 7% in the community, and 4% or 3% in an institutional setting. To help implement this policy, the Ministry of Civil Affairs provides funding to support community senior daycare centers. It also provides substantial funding to subsidize LTC facilities and services (more on LTC below). For academic geriatrics development, the NHFPC has issued a policy that all large public hospitals are required to have a geriatrics clinical program. Along with this policy, a number of leading medical schools, such as Peking Union Medical College (PUMC), have established departments of aging and geriatrics that offer graduate courses on aging and geriatrics clinical rotations for medical students and residents. The NHFPC also provides funding to support Centers of Excellence in geriatrics. The initial cycle of funding was issued in 2015 to 32 large hospitals across China. In 2016, the NHFPC established the National Center on Geriatrics—the third national center, after one for cancer and one for cardiovascular diseases—demonstrating the emphasis on geriatrics and senior healthcare development at the national level. In addition, the Ministry of Science and Technology (MOST) has prioritized geriatrics and aging research for funding and provided grant support for aging research. In 2017, MOST funded 6 clinical research centers for geriatrics across the country. These are just a few examples of national government policy and support. Provincial and local authorities are developing numerous supportive policies and new initiatives for geriatrics and senior healthcare development. For example, the Jiangsu provincial government recently issued policies that will provide financial support and incentives in its jurisdiction, including incentive payments for nursing staff who have provided services to older adults for 5 years or more; funding for building a large senior care facility on the west side of Yangtze river in Nanjing; funding for establishment and operation of 1 to 2 older adult day care centers in at least 90% of communities and villages across the province; and other supportive measures, including an increase in monthly supplemental income for older adults with financial difficulties, with higher amounts for those aged 80 and older or with disability, senior meal services, travel services, and installation and maintenance of elevators in high-rise older adult housing.

**Geriatrics physician workforce development**

With efforts from major national professional organizations (Table 1) and support from the government, geriatrics has been established as a medical subspecialty. Physicians who work in geriatrics can be promoted as geriatricians and geriatric researchers without requiring academic credentials from another subspecialty. This, along with the above-mentioned government policies and support, has begun to attract more talented medical school graduates and trainees to the field. There is no board certification in geriatrics or other medical subspecialty. Instead, China has national qualification examinations for academic promotion to associate professor and professor levels. Such qualification examinations have also been established for geriatrics. There are no published data or estimates of the number of geriatricians, either those who are physicians from previous departments of Bao-Jian or those who have recently entered geriatrics programs.

There have been several recent initiatives on geriatrics physician workforce development. In 2014 and 2015, Dr. Xiaoying Li, the immediate past president of the CMA Geriatrics Branch, in collaboration with Dr. Sean Leng, a geriatrics faculty member at Johns Hopkins University (JHU) and a member of the American Geriatrics Society (AGS), successfully organized 2 national advanced geriatrics training courses for leaders in geriatrics across China. Other AGS experts, including Drs. Richard Besdine and Stefan Gravenstein, also served as teaching professors. This “train the trainers” initiative provided 10-day intense geriatrics training for geriatrics program directors from Level 3A hospitals across China. Certificates were awarded to those who passed the final examination. Graduates were expected to lead the effort on further workforce development across China, and many have developed geriatrics training courses in their respective provinces and regions.

The AGS Geriatrics Review Syllabus, Sixth Edition, was translated into Chinese and served as a textbook for the advanced training course described above. Several series of national geriatrics textbooks published under the supervision of NHFPC also provide standardized content for geriatrics teaching at medical schools and postgraduate education program, the most recent being the textbook series on Chinese Senior Care from the Chinese Geriatrics Society. The Chinese Journal of Geriatrics and other professional periodicals publish peer-reviewed geriatrics clinical and research work. The China Medical Tribune, a major medical newspaper that reaches 2 million Chinese physicians, has
Table 1. Major National Medical and Geriatrics Professional Organizations in China

<table>
<thead>
<tr>
<th>National Professional Organization</th>
<th>U.S. Equivalent</th>
<th>Website</th>
<th>Year Established</th>
<th>Organizational Structure</th>
<th>Major Role</th>
<th>Annual Scientific Conferences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
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<tr>
<td>CMA</td>
<td>American Medical Association</td>
<td><a href="http://www.cma.org.cn">www.cma.org.cn</a></td>
<td>1915</td>
<td>NGO with branches in all provinces and major cities, 88 subspecialty societies</td>
<td>Academic and scholarly activities, research</td>
<td>Subspecialty conferences, schedules determined in early January</td>
</tr>
<tr>
<td>CMDA</td>
<td>American College of Physicians</td>
<td><a href="http://www.cmda.net">www.cmda.net</a></td>
<td>2002</td>
<td>NGO with branches in all provinces and major cities</td>
<td>Medical school curriculum development, physician training</td>
<td>Subspecialty conferences, schedules determined in early January</td>
</tr>
<tr>
<td><strong>Geriatrics</strong></td>
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</tr>
<tr>
<td>CMA Geriatrics Branch</td>
<td>American Geriatrics Society</td>
<td><a href="http://www.cma.org.cn">www.cma.org.cn</a></td>
<td>1981</td>
<td>Under CMA, branch offices in provinces and major cities</td>
<td>Academic and scholarly activities, research, training</td>
<td>Annual meeting in May Chinese Congress on Gerontology and Health Industry in September</td>
</tr>
<tr>
<td>CMDA Geriatrics Branch Chinese Geriatrics Society</td>
<td><a href="http://www.cmda.net">www.cmda.net</a></td>
<td>2005</td>
<td>Under CMDA, branch offices in provinces and major cities</td>
<td>Scholarly activities, geriatric training curriculum development</td>
<td>Information unavailable</td>
<td></td>
</tr>
<tr>
<td>Chinese Geriatrics Society</td>
<td>Gerontological Society of America</td>
<td><a href="http://www.zglnyxxh.com">www.zglnyxxh.com</a></td>
<td>2015</td>
<td>NGO with branches in provinces and major cities</td>
<td>Scholarly activities, geriatrics workforce (e.g., physicians, nurses, nurses’ aides)</td>
<td>Annual meeting in April</td>
</tr>
</tbody>
</table>

Chinese Geriatrics Society website is in Chinese (Mandarin) only. All others are bilingual (English and Mandarin).
Chinese Medical Association (CMA) and its Geriatrics Branch used to be part of the Chinese government. They and other professional organizations with long history of establishment became nongovernment organizations (NGOs) in 2015.
CMDA = Chinese Medical Doctors Association.

Table 2. Major U.S.-Based Medical Philanthropy Toward China

<table>
<thead>
<tr>
<th>Name</th>
<th>U.S. Office Location</th>
<th>Bilingual Website</th>
<th>Year Established</th>
<th>Brief History</th>
<th>Areas of Interest</th>
<th>Funding Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMB</td>
<td>Boston, MA</td>
<td><a href="https://chinamedicalboard.org">https://chinamedicalboard.org</a></td>
<td>1914</td>
<td>Rockefeller Foundation initially established CMB for PUMC. CMB withdrew from PUMC and China in 1950. After returning to China in 1980, CMB has expanded to other medical institutions across China and Southeast Asia. In 2016, it established its China office at PUMC Hospital.</td>
<td>Medical research, education, policy</td>
<td>Grant application submission by invitation. Funding decision made through internal review process.</td>
</tr>
<tr>
<td>MMAAP Foundation</td>
<td>New York, NY</td>
<td><a href="http://www.mmaapf.org">www.mmaapf.org</a></td>
<td>2012</td>
<td>Howard P. Milstein established MMAAP Foundation. It is supported by China’s National Health &amp; Family Planning Commission, China Association for International Exchange of Personnel, and State Administration of Foreign Experts Affairs. The foundation has established collaborations with more than 50 academic medical institutions and corporations in China and the United States.</td>
<td>Ima and Paul Milstein Program for Senior Health (Geriatrics)(^1); dermatology; stem cell research and regenerative medicine; translational medicine; reproductive medicine</td>
<td>Grants submitted through bilingual website and reviewed by expert panels in China and United States. More information available on website.</td>
</tr>
</tbody>
</table>

\(^1\)Irma and Paul Milstein Program for Senior Health provides additional funding for research on the aging immune system and viral infections in frail older adults.
CMB = China Medical Board; MMAAP = Milstein Medical Asian American Partnership; OUMC = Peking Union Medical College.
published a monthly Special Geriatrics Series. These efforts promote knowledge dissemination for geriatrics development as a subspecialty overall and facilitate geriatrics physician workforce development in particular.

Many national and regional conferences have served as geriatrics training platforms using a continuing medical education mechanism, including annual scientific meetings of national geriatrics professional organizations (Table 1) and annual PUMC Hospital–JHU geriatrics conferences.

International scholarly exchange and collaborations have increasingly been developed in geriatrics. For example, the annual Chinese Congress on Gerontology and Health Industry invites speakers from outside China to participate, and the Journal has published the presented work in abstract form each year in its September supplement since 2013.

At the same time, geriatricians and geriatric researchers in China present their work at international conferences, including those of the AGS, Gerontological Society of America, and International Association of Gerontology and Geriatrics (IAGG), and geriatrics conferences in other Asian countries, Europe, and Australia. With financial support from Chinese funding agencies and academic institutions and grants from U.S.-based medical philanthropies (Table 2), including the China Medical Board (https://chinamedicalboard.org) and the Irma and Paul Milstein Program for Senior Health, Milstein Medical Asian American Partnership Foundation (www.mmaapf.org), talented Chinese scholars are able to obtain training and conduct collaborative research at leading academic institutions overseas. Almost all of these trainees return to China and will undoubtedly have a significant effect on the development of geriatrics and senior healthcare in China for decades to come. A major objective of this article is, in many ways, to facilitate further international scholarly exchange and collaborations.

DEVELOPMENT OF GERIATRICS CARE MODELS

Inpatient and outpatient geriatrics care models

The interdisciplinary geriatrics care model was introduced through a collaboration project between PUMC and JHU funded by the China Medical Board. PUMC Hospital internists, nurses, nutritionists, pharmacists, physical and occupational therapists, and neuropsychologists who obtained geriatrics training at JHU have served as the backbone of the interdisciplinary care team upon their return. They have also established protocols and care pathways for the prevention and treatment of geriatric syndromes (e.g., delirium, falls, pressure ulcers, polypharmacy). The experience of this international collaboration was reported in 2010. The Department of Geriatrics at PUMC Hospital has since led the development of several care models, including comprehensive geriatrics assessments (CGA); geriatrics consultation to surgery and other specialties and other hospitals and senior care facilities; and more recently, palliative care. Many hospitals across China have started to develop and implement inpatient and outpatient geriatrics care models that fit into their own local healthcare environment. For instance, Dr. Flaherty led the effort to develop an Acute Care for the Elderly unit at West China (Hua Xi) Hospital in Chengdu, Sichuan Province (Dr. Joseph Flaherty, personal communication).

Community-based senior healthcare and support

In China, the vast majority of older adults age in the community, which requires robust community-based health care and support. There are a variety of service models—some are new, some are old and long lasting; some are effective, and others do not work well. For example, many community older adult daycare centers, which the government once heavily promoted and funded, have low attendance. That said, the long-lasting informal network is strong in most communities across the country. Retired volunteers who have lived in the neighborhood for many years primarily organize and run this network. It functions in many different ways: for example, monitoring (e.g., telephone call or short visit to check in); helping with groceries or household chores; organizing morning exercises in the park, dancing, and other social activities. Grassroots government units, such as neighborhood and village committees, also provide some level of support and services. The home support model, “baomu,” or hiring a live-in maid, is a commonly seen option, particularly among “empty nesters.” One innovative model, which the Department of Geriatrics at PUMC Hospital and Pine Tree, Inc., a nonphysician home care organization with local offices in the community, developed jointly, aims to combine web-based remote geriatrics consultation with regular visits by professionally trained nonphysician home care agents. Through an intelligent monitor known as “little fish at home,” geriatricians can make real-time assessments and recommendations for frail, homebound older adults while physical therapy or other low risk healthcare services being performed. This model has now been replicated in Shanghai and other cities. Initial promising results were presented at the 21st IAGG conference.

LTC and nursing homes

There have been several extensive reviews of LTC and nursing homes. LTC development in different regions and quality at existing facilities in different areas of China are highly variable. For instance, better-quality LTC facilities and those in more convenient and economically developed areas are in great demand, and older adults typically need to wait for several years to be admitted, whereas other facilities have a large number of beds vacant. One challenge is the lack of LTC quality standard and monitoring. Although the government subsidizes nursing home beds and encourages private investment in LTC development, no regulation on the quality of LTC has been developed or implemented, and it is unclear who will lead and be responsible for such effort. This was true as pointed in 2009 and remains true.

Development of primary care networks and privately owned older adult care facilities and support services

Efforts to develop primary care networks and support services for older adults are considered to be an integral part of
geriatric healthcare development in China. In the Chinese healthcare system, there are no primary care clinics in the community. Community hospitals are largely underused because most people prefer to seek their medical care at Level 3A hospitals. Most community hospitals lack talented physicians, making people even less likely to use them, reducing their quality, and damaging their public image, a vicious cycle that is hard to break.\(^2\)\(^,\)\(^10\)\(^,\)\(^11\) To address this, the Chinese government has recently issued policies and established funding mechanisms to develop primary care networks. A medical subspecialty of general practice, or general medicine, has recently been established, and the government provides funds to support training programs at Level 3A hospitals. Physicians are also permitted to practice at multiple sites or open private clinics in the community.\(^9\) A requirement has recently been established that Level 3A hospitals develop collaborative and referral relationships with their local community hospitals. The new NCMS and URMI policies strongly encourage and, in some regions, demand that routine healthcare services be provided at community hospitals, with only complex and severe cases referred to Level 3A hospitals. At the same time, Level 3A hospitals should collaborate with community hospitals in training general practice physicians and providing necessary expertise.\(^9\) Taken together, these efforts are expected to help establish primary care networks for older adults living in the community.

Government policies also encourage private investment in developing healthcare infrastructure and support services. Privately owned older adult care facilities have been and will continue to be built.\(^41\)\(^,\)\(^42\) For example, Tai Kang Group, a large life insurance company, has built and continues to build large geriatric care facilities in Beijing, Shanghai, Nanjing, Suzhou, Hangzhou, Chengdu, Wuhan, Guangzhou, and Sanya, some of which are in operation.\(^43\) Geriatric support services that have been targeted for development include rehabilitative services, food and nutrition, travel, and services supporting other recreational and social activities for older adults. Although their effect on older adult health remains to be seen, with proper quality standards and monitoring, such efforts in the private sector hold great potential for further development.\(^18\)\(^,\)\(^42\)\(^,\)\(^44\)

**Challenges and future perspective**

China is a large country that dedicates only a small percentage of its gross domestic product to healthcare, making it difficult to meet the healthcare needs of its large and rapidly growing older adult population. In addition to the highly subspecialty-focused and fragmented care provided at large public hospitals described above, one challenge is the current payment system. For example, inpatient consultation service charges are typically small and symbolic, providing little incentive for cross-specialty or subspecialty care or collaboration. Physicians are not compensated based on the time and effort they spend with their patients. Nevertheless, hospitals can charge large amounts for tests (e.g., laboratory tests, imaging studies) and a mark-up for medications, leading to overtesting, overprescribing, and a tendency to use expensive tests and medications.\(^2\)\(^,\)\(^8\)\(^,\)\(^9\) Recent efforts, some of which are still being pilot tested, include an increase in physician fees for outpatient and inpatient services, a reduction of charges for laboratory tests and imaging studies, and a separation of pharmacy and hospital charges. It is believed that addressing this challenge will be an important step to improving healthcare services for everyone, but particularly for older adults.

Another challenge is related to building robust primary care networks necessary to provide person- and family-centered care, with continuity for older adults living in the community. The efforts described above are important initial steps, but much more work is still needed, such as providing incentives for medical school graduates to enter general practice training and subsequently practice at community hospitals, aligning interests between Level 3A and community hospitals, and establishing links and communications between physicians’ clinics and local hospitals. It is equally important to collect evidence through geriatrics clinical research demonstrating the effectiveness of these efforts, or lack of it, so that informed decisions can be made on proper next steps.

There are also challenges specific to the development of geriatrics workforce and care models. For instance, there is a critical shortage of allied geriatrics healthcare providers, including gerontologically trained nurses, nursing aids, therapists, and social workers. Although government policies such as the one in Jiangsu province described above may help retain nursing staff in geriatric healthcare, the CMA Geriatrics Branch and CGS have recommended systematic efforts and funding for the education and training of allied geriatric healthcare providers across the country. Regarding the development of geriatrics care models, there are concerns about implementation of their required components and quality standards, as well as how to customize them for Chinese older adults. The lack of quality standards and monitoring mechanisms for LTC described above is one example. Another example is CGA. In an attempt to standardize the content and address quality of CGA, web-based modules with portal access and training have been developed.\(^45\) To this end, it is proposed that readers may help address any or all of these challenges by contributing to geriatrics clinical research and knowledge dissemination across China through scholarly exchange and international collaborations or through direct and indirect participation in senior healthcare service model development, partnership building, or other means that are acceptable and practical to all parties involved.

Recognizing these challenges and potential ways to address them, China has made phenomenal progress in geriatrics development over the past decade at a pace that could never have been imagined before, and this progress will continue to accelerate. The aging tsunami dictates the urgent and unprecedented need for quality geriatrics care and senior support. With improved living standards, more Chinese older adults are demanding better quality of care and support. The question now is not whether there should be geriatrics and senior healthcare development in China but how fast and well can it be achieved. To that end, the Chinese government should allocate more resources. In addition, the healthcare market in China has recently been opened to private investment and international joint ventures, which will help further inject capital and increase competition. International scholarly exchange and collaboration can help train the next generations of
geriatrics leaders who will continue to accelerate geriatric healthcare development with vigor and innovation. The road is long, seemingly with no end. The work has been and will continue to be hard, but the future is bright! It is hoped that the geriatrics communities in the United States and around the world will learn and benefit from this magnificent journey.

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REFERENCES