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Public Healthcare Policies for the Elderly in the United States: Suggestions from a Comparison between South Korea and the United States

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ABSTRACT

As the aging population percentage rapidly increases across the world, leading to an increase in the necessity of long-term care, it is crucial for the government of the United States to implement changes to create more sustainable, and sufficient programs. This policy brief intends to identify problems in the current United States long-term health care system, and will try to find a possible suggestion to impede the gaps in the system. To bring a direct comparison and possible solutions, this brief will also investigate South Korea, a country with similar aging demographics and economic development as the United States. South Korea ranks 10th in GDP, and the elderly population comprise of 17.5% of the entire population (compared to 16% for the U.S). The South Korean examples of the policy suggest a few practical solutions to the issue, such as an increase in basing long term care eligibility on health status of an individual, rather than an emphasis on income eligibility. Targeted policies such as South Korea's Alzheimer detection program should be more widely utilized for most chronic diseases in the United States. These types of prevention services will be able to help decrease the total amount of funding spent on these patients. Learning from South Korea's policies can provide the U.S. with services that can adequately address the elderly population's need for assistance and care.

Introduction

The evolution of medical technology and the advancement of society has led to the life expectancy of the average population in the United States to increase from 69.77 years in 1960, to 78.79 years in 2019.[1] This indicates that the elderly population will continuously increase in the U.S., leading to care management of the elderly to be one of the most urgent issues to address in the 21st century. This brief intends to analyze the long term care system of the United States. In the status quo, the United States has two main systems to provide support for elderly populations, Medicaid and Medicare, which are systems that provide a certain fee for elderly populations who intend to join care facilities such as nursing homes (or at least partially, as Medicare only provides fees for short term stays at such facilities). United States nursing homes care for nearly 3 million people, and Medicaid spends approximately $235 billion dollars for the population.[2] However, this is hardly enough, as while details regarding Medicaid and Medicare will be regarded in the lateral passage of this brief, the qualification standards to gain support on long term care for Medicaid users are very narrow, hence forcing a large population to depend on informal care systems such as family care or community care. These types of care systems cannot provide sufficient care for the elderly, and forces the working population to exert their time into providing care towards the elderly. The economic impact of this activity leads up to a $44 billion loss, as more than 650000 workers lose their job due to this need of caregiving.[3] Another choice that is common is to hire unauthorized, untrained people with a low wage as caretakers. This serves not only as an unsustainable solution, but it also exploits the labor of vulnerable populations for wages that are under the minimum wage. The recent COVID-19 crisis spotlighted the problems in the long term care system, with the pandemic making it harder for

members of the communities to care for each other, and the incredibly large number of COVID-19 related deaths in nursing homes.

To bring a direct comparison and a possible solution, the brief will also investigate South Korea. While the systems that South Korea incorporates will be investigated in the lateral part of the study, there are two reasons in which South Korea was chosen as a comparative. First is due to the idea of how South Korea ranks 10th in GDP, and holds an elderly population rate of 17.5%. The US's elderly population accounts for 16% of their total population, therefore South Korea, as a country that is experiencing a further developed form of aging society, but still is a developed country, can hold as an adequate comparative.[5] The second reason is that South Korea, unlike the United States, bases their health care system off of the idea of universal health care, hence officially covering 100% of elderly population with their free insurance system. This is unlike the United States, where if a person neither meets the income threshold nor age requirement for public insurance programs, they will have to purchase private insurance. This policy brief intends to identify problems in the current United States long term health care system, and will try to find a possible suggestion to impede the gaps in the system.

Long-term care systems in the U.S.

The definition of long-term care is "a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods," meaning that it includes not only care, but access to medical facilities and materials. During 2021, 7% of American adults did not visit a doctor due to cost, and 8% skipped a medical test or a treatment due to the cost of the examination.[4] One of the reasons for this is that the U.S. has one of the highest medical expenditures in the world. Hence, to investigate the long-term care system of the United States, the systems that insure a) access to care (i.e. nursing homes, visiting care takers) and b) access to elderly disease treatment (eg: Alzheimer's) will be investigated. The brief intends to discuss mainly three different portions of the US long term care system in this part of the passage. Public programs, private systems, and informal care systems. While the motive of this policy brief is to advance the quality of public long term care programs in the US, the way in which services are provided in private systems and informal care systems can act as possible solutions, which is why they will be discussed.

The two main programs that the United States utilizes to provide insurance systems for the elderly are Medicaid and Medicare. While there are other programs that exist to support the two systems, or other systems that support a specific population, because Medicaid and Medicare have the two largest target populations, the social minorities and the elderly, each covering 80.9 million and 60 million people.[6 7] Amongst the two programs, Medicaid, the most funded long term service program in the United States, will be the first program to be analyzed.

Medicaid

Medicaid is a program that is intended to cover the medical fees of low-income adults, children, pregnant women, and elderly adults, and people with disabilities. While Medicaid is not a program that provides coverage for all elderly populations, it is able to provide financial assistance to certain adults who meet the financial threshold, in other words, impoverished. While the standards may vary by state, an elderly individual, in order to qualify for Medicaid, must have an income less than $2353 a month. However, this is just for being eligible for the Medicaid program, which provides you a maximum $2000 fee for general medical care, where the program covers an average of 57~60% of one's medical fee.[8]

To become eligible for long term care support, one must be diagnosed as "requiring nursing home level care," which means that either the individual is diagnosed with elderly diseases such as Alzheimer's or dementia, indicating that one is unable to care for oneself, or the person must have a certain number of ADLs (Activities of Daily Living) that they cannot perform themselves. These ADLs include basic daily activities such as eating, cooking, or dressing.

Once an individual qualifies for this program, there are multiple pathways the receiver of the program can take. One would be to enroll in a nursing home. Medicaid is known to cover 100% of the nursing home fee for ones in their program. Another choice is HCBS (Home & Community Based Services), where they receive a waiver, where the state is taken in charge to provide the users with adequate services, which includes services like daycare, home health aid, respite care, etc.

The first problem of Medicaid is the selectiveness of the program. Only about 15% of the United States elderly population gain access to regulated long term care facilities, and only about 6.5% of the elderly population are able to live in nursing homes or assisted facilities. Moreover, only 12% of the elderly population are enrolled in Medicaid, and only half of that population gains access to long term care support. This results in only 6% of the population receiving support in terms of long-term care. This is due to the fact that Medicaid starts off by creating very strict financial standards, hence even when one may lack the ability to care for oneself, they may not be able to receive financial aid on long term care. [9]

The second issue is the restricted financial support. On average, a surgery in the United States can cost from $4000 to $170000. Common surgeries for the elderly population such as back surgeries, hip surgeries, and knee surgeries costs a minimum of $15000. This indicates that one unexpected event can make an individual become bankrupt or lead to large amounts of Medical debt, meaning that Medicaid's long term care service only accounts for cases in which a person lives a generally healthy life without huge accidents. This can cause problems, since Medicaid is a policy directed towards the impoverished, hence the people who are obtaining this service do not have the ability to pay the cost.

The third issue is that Medicaid is a program that provides individual states freedom to execute Medicaid. This is both an advantage and a disadvantage of the program. While it is true that different states have varying income rates, poverty rates, and therefore must differ the cutline for Medicaid, this also causes problems such as state wise disparities, where some states have a higher Medicaid coverage than others, and some states require a higher number of ADLs than other states. This is due to the fact that 11% of Medicaid's funding relies on state funds, indicating that the state's judgment on the weight of the importance of Medicaid correlates with the quality of medical care the recipients of the program receive. However, the main problem does not lie in varied standards, but the fact that due to the freedom, Medicaid has not expanded in 12 out of the 50 states in the country. There is no state that has a 0% poverty rate, indicating that elderly population who live in those 12 states do not have adequate access to long term care support provided by Medicaid.

The final issue is the way in which Medicaid is financed. Medicaid finance comes solely from federal/state funds. This indicates that as the number of aging population and elderly population continuously grows, the required expenditure will correspond to the rate of growth. Hence, keeping the current system will only lead to benefit cuts, tax increases, or raising eligibility standards, which will provide less effective care for a narrower target population.

Medicare

Medicare is a program that is mainly directed towards the elderly population (65+.) The system that Medicare uses is simpler, as there is no criteria to pass to become eligible for this program. However, the way in which it functions is more complicated. There are four parts in Medicare, each labeled part A, B, C, and D. Part C is a specific plan that allows the user to connect their Medicare finance with private insurance companies to receive extra benefits, and part D is a program that is specified on prescription drugs. Hence, the passage intends to discuss only parts A and B of Medicare. The Part B program of Medicare is the most basic program, where the user must pay a price of a minimum of $170.1, and the price that they must pay varies by income. The Part B program covers basic medical necessities such as ambulances, DMEs, and partial inpatient/outpatient hospitalization, where the enrollee has to account for 20% of the medical fee created. [10] The Part A program is a premium extension of the program, where they can receive inpatient care, short term nursing home/ nursing facility care, hospice services and such. The cost of the program is

free for all citizens who have paid 10+ years of Medicare tax. However, if this is not the case, a person must pay a fee of $274 or $499 per month depending on the amount of tax you have paid. While this is a policy to prevent tax money from being unfairly distributed to ones who have not paid into the program, this would inherently lead to the deterring of the impoverished population who are not impoverished enough to make the cut for Medicaid.[11]

There are three key problems that exist in Medicare. First, Medicare fails to address the most crucial parts of medical care in terms of long-term care, which are health facilities or home care, and prescription drugs. Elderly populations are the most prone to chronic diseases, hence require prescription drugs on a regular basis. Similarly, an aging population are the most likely to fail in daily life activities, hence require the most support from professional, trained facilities. To put extra fees on the two programs inherently deteriorates the effectiveness of the health program.

Second, Medicare inherently does not provide *long term* care services in terms of nursing facilities. Medicare only provides expenses for the short term, only when an expert recommends the usage of such SNF (Skilled Nursing Facilities). Even then, Medicare only provides coverage for 100 days, and after the number of days accumulated exceeds the number, Medicare does not provide any coverage. Hence, Medicare users have to either rely on community care, assistance by the hospice program, or must pay all of the fees out of their own pocket.

Third, Medicare does not support the slightly impoverished. For the elderly population who are impoverished, programs like Medicaid or SLMB provides financial support in enrolling into part B of Medicare. However, the enrollment criteria for these programs are strict, as an individual maximum monthly income is $1269, and the resource limit is $7730. This again highlights the gray area between the extremely impoverished and the wealthy, who nor are able to benefit from the governmental programs, nor are rich enough to pay the expensive fees out of their own pockets.

To address this problem, the government has implemented programs such as PACE, QI, SLMB to fill in the gaps that the programs have. PACE is a program that is targeted towards people who are 55 or older, and are certified as “requiring nursing home level support.” Then, once enrolled, the person is provided with daycare, hospital care, and home care. Basically, PACE provides long term care towards the user of the program. However, there are mainly three problems with this program. First, the criteria of “requiring nursing home level care” is determined by individual states. This indicates that some states that lack finances may raise the standard, while others may lower the standard. This is demonstrated by the fact that while Missouri has established ‘health homes’ to provide early care for the elderly, Tenneses implemented a program to cut unnecessary nursing home stays, hence reducing their state spending on Medicare. Second, one of the requirements of being able to enroll in PACE is that first, the state must have enacted the program, second, the person must live in regions near PACE care centers, and finally, one must be able to safely maintain health with the help of the program. This indicates that the chance of enrolling into the program only exists for a few, and those who are geographically disadvantaged cannot enroll in this program. Third, there is an income limit in this program again, as it is only free for Medicaid enrollees. For normal members, they must pay an extra premium for the consultation with a PACE community group.[12]

By inquiring into the two programs, Medicaid and Medicare, the problems of the current United States long term care system mainly consisted of three parts. First, the partial self-governing of states, and disparities that lead from this issue. Second, the disregard towards the people in the gray area, and finally the lack of focus and insufficient financial support. These problems are not simple problems that come from errors or mistakes made in a single law. Rather, these problems have roots in the inherent medical system of the United States. South Korea is a country that utilizes a medical system that is the converse of the US system. By analyzing the South Korean long term care system, key insight can be gained into discovering the problems and solutions to the US long term care system.

South Korean Long Term Care Systems

To provide a brief overview on the South Korean health system, it is important to discuss a South Korean program called “Citizen Health Insurance program”. This program’s intention is to provide universal health care, where citizens

have to pay a monthly insurance tax which is charged based on the annual income of an individual, and hence allows citizens to receive close to free daily health services or treatment for common diseases in South Korea. Moreover, South Korea provides their own version of Medicaid, where they sort the impoverished into two groups: as type 1, who are impoverished and excluded from the workforce population (elderly, disabled) and type 2, who are impoverished by being included in the workforce. The system has a fee schedule as described in Table 1.[13]

Table 1: Pricing Chart for Health Insurance Program

Type	Care type	Public Center	Step 2	Step 3	Pharmacy	Filming (i.e., CT/ MRI)
1	Admission	Free	Free	Free	-	Free
	Outpatient	$1	$1.5	$2	$0.5	5%
2	Admission	10%	10%	10%	-	10%
	Outpatient	$1	15%	15%	$0.5	15%

This is a direct contrast between South Korea and the United States, where South Korea's policy forces all of its citizens to pay medical tax, hence redistributing the total tax money to better support the elderly and the poor. On the other hand, unless one is poor or elderly, citizens either go for private insurance companies (which accommodate only about 10% of the total population), or decide to pay out of pocket. [14]

By implementing this system, South Korea is able to create an effective elderly long term care system called "Long Term Health Insurance Program." This program, which is targeted specifically towards elderly population over the age of 65, or people with elderly diseases, provides mainly two different types of care. First is visiting care (cognitive/normal/day-night), which includes services like visit bathing, nursing, short term insurances. The second service is financial support to live in nursing homes. The way in which the program functions is as follows: First, people who are elderly and cannot care for themselves can sign up for this program. Then, these people are separated into 5 different classes, where the government uses exacted standards to determine the level of need of care, as described in Table 2 below.

Table 2: Elderly population care requirement class description

Class	Description
Class 1	People who require care for all daily life activities
Class 2	People who require care for most daily life activities
Class 3	People who require care for some daily life activities
Class 4	People who require care for few daily life activities.
Class 5	Alzheimer's patients or people who require general care

The class division determines the monthly limit for all services that the user can receive, and also determines the number of hours of service a person can receive. However, the percentage of the cost that each user must pay is the same: 15% for visiting care, and 20% for nursing homes. Moreover, the program implements a service where the impoverished (recipients of the Medical Fee support program, South Korean Medicaid) pay only half of all the costs that they incur, and the recipients of national living support programs do not have to pay the fee. Also, only people who are in Class 1, 2, or people who do not have family members who are able to support them, can receive the financial support to live in nursing homes.

For this program, nearly 80% of the budget comes directly from the national health care program tax, and 20% of the money comes from national funding. This is in contrast with Medicaid or Medicare, where state/national

funding accumulates over 80% of the total funding.[15] What this indicates is that the program creates more self-sustainability as they fund their program with the money that comes from their own program.

Another important governmental program addresses one of the most common elderly diseases, Alzheimer's. For every adult over the age of 65, the government provides free testing for Alzheimers, where adults can visit the local care center to take a simple MMSE-DS test to determine a diagnosis of Alzheimer's.[16] If diagnosed as "cognitively declined," the patient is moved to a local hospital for more specific testing on the levels of more specific tests and conversations with a professional. After this level, the person takes MRIs and blood tests to determine the existence of Alzheimer's. Then, the person can take lateral steps to participate in other programs that support Alzheimer patients.

While problems such as manipulation and dependence on social services exist in these policies, it is clear that the South Korean program is able to provide long term care to a more necessary population at a more affordable price. The reason in which long term care is made possible, comes from the existence of the national health insurance program, which ensures access to health care to a certain extent for the citizens, hence allowing the government to specify population groups to provide more fundings for. Thus, the simplistic solution to help the United States would be to implement all the policies that South Korea is using, which would not only improve the access to long term care, but also citizen's access to general health care. However, this is not possible in the United States, as there is a large difference between the US health market (which is the most common type seen in OECD countries) and the Korean health market.

In South Korea, doctors are paid a fixed amount of money for each type of care that they provide. The fixed fee is determined by the health insurance assessment committee, and the plausibility of the provision of fees is also determined by the following group. As the health insurance assessment committee, it would be favorable for them to pay the least amount of money towards the doctors' services. Hence, the fees are lower than the OECD average, and the assessment criteria for "adequate treatment" is very strict [17](As an example, if they use ECMO for two patients at the same condition, and one dies and one survives, for the patient who is alive, the fee for using ECMO was determined as adequate, while for the patient who is dead, the fee is determined as inadequate, hence it becomes the hospital's loss). Therefore, although the government is able to fit the total cost into the amount of money created from the medical tax, this leads to lower levels of medical treatment and inferior treatment for doctors. So even without the feasibility issue of implementing the policy as a whole, the system difference makes it impossible to implement this policy into the US without meeting serious sustainability issues. [18]

In regard to the feasibility issues, the implementation of the national health care insurance would be practically impossible, as the structure of the policy forces the richer population to pay an immense fee, however receive less benefits than the impoverished, as they have to pay a higher percentage for all the treatments they receive on behalf of the health care insurance system. This would mean that to implement the policy, the majority of politicians would have to agree to a) Creating additional tax in the country, b) enforcing it to the whole population, and c) creating a larger burden for the rich population, which is highly unlikely. Even when there is a large population of politicians who agree to this idea, they would also face lobbies from insurance companies and hospitals. These two large obstacles make it impossible for the policy to be implemented as a whole in the United States.

Policy Recommendations

Then what would be a practical solution for the United States? The problem with the country's long term care policies is the self-governing of states, and disparities that stem from this issue. The lack of empathy towards the people in the gray area, and finally the lack of focus and insufficient financial support as listed above. The South Korean examples of the policy suggest a few practical solutions to the issue. First, the country must provide clear guidelines and cuts to who is eligible for the specific service. This would lead to the country being able to focus their federal funding to a specific population that they decided to focus on, hence increasing the efficiency of the program. Secondly, the criteria for programs regarding long term care should not be based on the economic status of the

individual, but rather the status of the person, and their necessity for long term care and support as the South Korean policy does. Thirdly, the criteria should provide specific different categories to sort people in, and differ the level of care and support that is given to each assorted population.

This would allow the resource to become more focused to a certain population, increasing the sufficiency of federal support in terms of care. Finally, policies like South Korea's Alzheimer detection program should be more widely utilized for most chronic diseases. These types of prevention services will be able to help decrease the total amount of funding spent on these patients, as the annual cost of treating a patient who's Alzheimer was detected is on average, $8000 lower than the annual cost of treating an undetected Alzheimer patient. This will increase the financial stability of the program, as it will lead to decreases in the cost of long term care in general.

For the long term, a national health care program seems absolutely necessary for the U.S. This is due to the unstable financial status of Medicare and Medicaid that completely depends on the state/federal funds for support. Also, in terms of the general population, many individuals do not want to enroll in private insurance, hence most people are left without medical insurance. To address these problems, the program must be implemented. However, looking at the structure of the US health industry, it would be recommended to create a system in which people who pay a greater amount of the tax burden are able to receive better quality of healthcare, or allow the population to choose an alternate program (like Medicare part C), where the individual can choose to pay a lower tax, but also enroll in a private insurance company (who will be the target of the taxation).

Conclusion

In conclusion, the problems embedded in the United States long term care system are not problems that can be solved with a simple solution like the implementation of a single policy. However, as the aging population percentage rapidly increases across the world, and the necessity for long term care increases day by day, it is crucial for the government of the United States to implement changes to create a more sustainable, sufficient program, in lines with South Korea, to provide services that can adequately address the elderly population's need for assistance and care.

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