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Population Aging and Long-Term Care Policy in China and the United States

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**Population Aging and Long-Term Care Policy in
China and the United States**

by

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Chapter I: INTRODUCTION

For the past several decades, China has experienced falling fertility rates and increasing longevity, and those two demographic indicators reveal that China is becoming an aging society (Zhang & Goza, 2006). China's one child per couple policy (OCP), which is established in 1979, has affected the aging of China's population with falling fertility rates (Zhang & Goza, 2006). According to the census data provided by the China National Committee on Ageing (CNCA) and China Research Center on Aging (CRCA), China's population over the age of 60 will exceed at least 400 million by 2033, with an average annual increase of 10 million. By 2050, this population is expected to reach 1/3 of China's national population (Accelerated Aging of Population in China, 2015). Combined with the market-driven reform of social services and rapid erosion of family support, the provision of affordable and accessible social care services to older people has already become an urgent issue for the Chinese government to address (Wong & Leung, 2012).

In the meantime, as the baby-boom generation starts to reach age 65, the United States (U.S.) is also experiencing the challenge of an increasing aging population. According to the Administration on Aging (AoA), the population age 65 and over reached 44.7 million in 2013, with an increase of 8.8 million or 24.7% since 2003. This represents 14.1% of the U.S. population, which is about one in every seven American. By 2040, it is predicted that this number will grow by 21.7% and reach 82.3 million, over twice their number in 2000. The 85+ population is projected to more than double from 6 million in 2013 to 14.6 million in 2040 (Profile of older American's, 2014).

The rapid increase of an aging population can bring great challenges to the existing health care systems in both China and the United States to continuously provide the same or higher quality services to older people in long-term care. Health insurance provides financial resources to the health care system and ensures that people have adequate access to the public healthcare services (Zhang et al., 2014). With the phenomenal increases in medical fees, more people are facing poverty because of their inability to pay high medical expenses. Health care policy reform thus has once again emerged as a high priority national policy issue in both countries (Chapman, 2008; Li & Zhang, 2013). With various disparity factors (e.g., such as disease types, cultural, economic and political backgrounds), the two governments are facing very different obstacles in long-term care for older populations.

Both countries have implemented programs in response to these challenges. China has announced three different types of health insurance programs, Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and New Cooperative Medical Scheme (NCMS), to try to transform its health care system during the past few decades (Li & Zhang, 2013). In the United States, the Patient Protection and Affordable Care Act (ACA) was initiated by the Obama Administration. The ACA is seen as the most significant health care legislation since Medicare and Medicaid launched in 1965, over fifty years ago (Kaplan, 2011a). Along with policies on public pensions and medical care, the long-term care policies, which aim to enhance the quality of life and increase the long-term independence of older population, especially those with disabilities, is at the top of the priority list for policymakers across the globe.

This literature review aims to investigate and compare different health care policies and health care reforms for long-term care in both China and the United States, by reviewing and studying the established research. Pros and cons of different policies will be demonstrated throughout this literature review. At the end of the literature review, challenges and recommendations for each country's policy-making will also be discussed. I reviewed and analyzed the representative academic research journals and literature from 1997-2016, to find consistent and contrasting views, to compare the long-term care policy and practice from both China and the United States and to investigate the strategies that have been carried out to overcome the challenge.

Although there are differences in the economic and political backgrounds between China and the U.S., there are still many areas that the two governments can consider gaining experience from each other to help solve their respective problems and issues. Many areas of aging health care are common besides the disparities, such as disease treatment, community-based programs, and the efforts to better convert economic growth into the actions and programs in aging people care (Xu, 2010).

Facing an unclear future of health care reform and long-term care services, there is a great deal of work to be done and significant potential to improve in both China and the United States. Changes are often not easy to make and take a long time to implement, especially at the federal level. Both China and the U.S. governments are trying to make sure that older people are able to get affordable and high-quality health care services. And governments need to take actions immediately and effectively with the emergence of population aging and increasing demands of long-term care services.

Chapter II: LITERATURE REVIEW

The rapid growth of an aging population and increased demand for primary health care have influenced both China's and the United States' health care systems in long-term care (He, Cyran, & Salling, 2009; Yuan & He, 2010). In 2000, almost 10 million people needed some form of long-term care in the United States. Almost 70% of people turning age 65 will need long-term care at some point in their lives (*The Basics-Long-term Care Information*, 2015). According to national surveys, studies suggest that 8.1 million elders needed long-term care in 2010, it is estimated that 27 to 43 million people (based on different estimates) need long term care in 2050 (Wu, 2012). According to the 2010 census in China, the number of population aged over 60 was 177 million, or 13.26% of the total population (National Bureau of Statistics of China, 2010). However, just 1.5–2.0 percent of people ages sixty-five and older live in residential care facilities in China. As the aging population continues to growth rapidly in China, the demands for long-term care services have been escalating as demographic shifts and socioeconomic changes have eroded traditional elder care (Feng, Liu, Guna, & Mor, 2012).

Long-Term Care Services are a range of services and supports for individuals with a chronic illness or disability, such as dementia, hearing loss, eye disorders, osteoporosis, arthritis, ischemic cardiovascular diseases, and stroke. Most long-term care is not medical care, but to assist people with Activities of Daily Living (ADLs), such as dressing, bathing, and using the bathroom (Matthews, 2010). Other common long-term care services and supports are Instrumental Activities of Daily Living (IADLs), such as preparing meals, managing medication, and housekeeping (*The Basics-Long-term Care Information*, 2015).

“Long-term care can be provided at home, in the community, or in a facility. Long-term care services and supports include, but are not limited to, nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment as well as assistance provided by a family caregiver. Care planning and care coordination services help beneficiaries and families navigate the health system and ensure that the proper providers and services are in place to meet beneficiaries’ needs and preferences; these services can be essential for long-term care beneficiaries who often have substantial acute care needs as well.” (Reaves & Musumeci, 2015, p 2).

According to Wang Zhenyao, the former Director of Social Welfare and Philanthropy Promotion Office from Civil Affairs Ministry, by 2009, China had about 9.4 million disabled elders (China Daily, 2009). Therefore, long-term care services for the partial or total disabled elderly are particularly important. However, there is significant inequality among the disabled individuals who lived in urban and rural areas in China (Zhang et al., 2014). Long-term care service has been highly unequal in the aspect of medical care and incomes because of the big gap between urban and rural areas. In addition, low-income individuals have limited or no formal health care and many families were driven into poverty because of the high medical expenses (Liu, 2002).

The increasing number of older adults and few young people to care for them have raised the question how the U.S government can assist in the financing of those Long-Term Care services and the right source of financing (Burke & Feder, 2015). In addition, a study documented that there is a significant lack of knowledge about basic long-term services and supports related information such as cost, need, and payment method (Robison, Shugrue,

Fortinsky, & Gruman, 2013). Long-term services and supports are delivered in institutional and home and community-based settings. Most of the Long-Term Care is delivered by family members. A relatively small percentage of people in U.S. are institutionalized. Home-and community- based services (HCBS) is becoming the one that underscores the values of being able to provide services outside of an institutional setting (Burke & Feder, 2015).

With dramatically different economic and political backgrounds, the two governments are facing different obstacles in long-term care for older population. Li and Zhang (2013) stated that the Chinese government is struggling more with health care insurance coverage, equality across different social classes, out-of-pocket expenditures, and the consequences of the one child per couple policy. While Chapman (2008) pointed out that the United States is more focused on controlling health care costs to be sustainable and limiting gaps in coverage and increasing the access to care.

For the purposes of this project, long-term care policy and practice of both China and the United States are compared, and the health care policy reforms from the two countries are analyzed. In addition, relevant literature is reviewed and analyzed to investigate strategies in order to overcome the common challenges.

China

Since 1978, Chinese economic reforms transformed China's health care system "from a centrally planned system to the world's largest market-oriented health system" (Li & Zhang, 2013, p.59). Rural residents in China as well as people with low income have experienced a large and universal reduction in health care access after the economic reforms in the late 1970s (Gu, Zhang & Zeng, 2009). As the aging population continues rapid growth in China, and as

demographic shifts and socioeconomic changes have eroded traditional elder care, the demands for long-term care services have been escalating (Feng, Liu, Guna, & Mor, 2012). In addition, China's one child per couple policy (OCP), established in 1979, has been dramatically affecting China's health care system and long-term care services (Zhang & Goza, 2006).

The OCP increased the aging population ratio and produced issues on "the sandwich generation, those who oftentimes care for both younger and older generations" (p.151). The increasing aging population is also producing profound social and economic complications that require the development of appropriate policies. According to the most recent census data released in 2010, there were 177.6 million people that were age 60 years or older in China or 13.26% of the total Chinese population. In 2050, this number is expected to reach 437 million, or about 30% of the population (Li & Zhang, 2013).

China's One Child Policy (OCP)

China's one child per couple policy (OCP) was established in 1979, with its significant effects on falling fertility rates for the past several decades. Since then numerous studies (e.g., Logan & Spitze, 1996, Ward & Spitze, 1998 and Zeng, 1991) (as cited in Zhang & Goza, 2006) have documented the effects of the OCP on the aging of China's population. The increasing proportion of elderly people in China is producing profound social and economic complications that require the development of appropriate policies (Zhang & Goza, 2006).

In order to examine the changes in family structure and the provision of eldercare caused by the China's one child per couple policy (OCP), Zhang and Goza (2006) conducted a study based on 15 interviews conducted in Shanghai, Hangzhou and a rural village in Inner Mongolia in 2000. The study was focusing on the "Sandwich Generation" which represents the middle-

aged generation who are often responsible for caring for both younger and older generations. Respondents were selected from various segments of Chinese society in an attempt to include the views of diverse groupings. Ten interviews were conducted in urban areas and five in rural regions. Zhang and Goza (2006) found that most parents in urban areas accept that it would be impossible for a single child to care for two parents and four grandparents (4-2-1 model), and have started making their independent plans for their future retirement. However, many rural residents, the vast majority of the population, were unable to afford the luxury of financially planning for their future retirement.

Zhang and Goza (2006) stated that it is both necessary and urgent for China to solve the issues related to aging emanating from the one child policy. And they also indicated that the efforts of solving those issues and continuously growing its economy are mutually supplemental rather than mutually exclusive. Solving these problems should be seen as part of a strategic move to ensure China's continued economic growth. China needs to simultaneously challenge its aging issue in order to maintain its goal of a sustainable economic growth (Zhang & Goza, 2006). Continued economic development may in return help resolve some of the most challenging consequences of the low fertility generated by the one child policy (Zhang & Goza, 2006). New industries that target the needs of the elderly population, such as recreational activities or in-home residential care, may even enhance future economic growth. Therefore, the issue of who will care for China's elderly people will become the first priority to be addressed and fully resolved (Zhang & Goza, 2006).

Starting January 1, 2016, all Chinese couples were allowed to have two children. This marks the end of China's one-child policy, which has restricted the majority of Chinese families to only one child for the last 35 years (Feng, Gu, & Cai, 2016).

Long-Term Care Services

In China, the age of 60 is used as a marker of old age. Under the regulations of the social security system in China, male workers retired at age 60 and female workers retired at age 55 (Song & Chu, 1997). China has the largest elderly population in the world, which accounts for one-fifth of the world's total aged population (Zhang et al., 2014). From 1950 to 2003 life expectancy increased from 41 to 71 years (Zheng, 2004; PRB, 2004). The 6th China's National Population Census results showed that China had a population of 1.37 billion in November 2010 with an annual growth rate of .57% (National Bureau of Statistics of China, 2010). According to the 2010 census, the number of people aged over 60 was 177 million, or 13.26% of the total population. This number was up by 2.93 percentage points as compared with the results of the 2000 population census (National Bureau of Statistics of China, 2010). Should these patterns continue, by 2040 there will be 400 million Chinese at least 60 years old (Zhang & Goza, 2006). As the aging population continues to grow rapidly in China, the demands for long-term care services have been escalating as demographic shifts and socioeconomic changes have eroded traditional elder care (Feng, Liu, Guna, & Mor, 2012).

Patterns of long-term care in China have been dominated for thousands of years by the Confucian tradition of filial piety, or *xiao*, which requires adult children to care for their elderly parents physically, financially, and emotionally. Family support for older people is a long and cherished Chinese tradition (Wong & Leung, 2012). After the establishment of the People's

Republic of China, this traditional practice was further codified by law in Article 49 of its constitution: “Parents have the duty to rear and assist their minor children, and children who have come of age have the duty to support and assist their parents” (State Council information Office, 2006).

Since 1979, the impact of the one child policy has resulted in a decline the availability of adult children to take care of their elders. This raises the question of whether two married children, born in the 1980s without brothers or sisters, could bear the responsibility of raising one child and caring for both sets of parents when they are 50 years old in the 2030s (Zhang, et al., 2014). Some parents living with their married child might consider moving to institutions to give their child more space at home and avoid in-law conflict (Wong & Leung, 2012). On the other hand, 56 percent of older adults who moved into an institution because they were living alone or there are no children living nearby (Zhan, 2013). In a recent national study, over 70 percent of older people in large cities and half of elder people in rural and urban China were reported to live in empty-nest families (Zhan, 2013).

Despite being faced with the heavy burden of an aging society, no national health insurance program for older people (e.g., Medicare in the United States) or publicly funded safety net program covering institutional elder care exists in China currently (Feng et al., 2011). Hospital care for older Chinese people is paid for depending on their health insurance, and after long hospital stays patients are discharged to home without institutional or community-based post-acute care. Recent government policy initiatives promoting the development of home- and community-based elder services, such as cash allowances for paid home care, community health centers, senior housing, recreational facilities, and adult day care programs (Feng, et. al, 2011).

In 2009, the Chinese government (National Development and Reformation Department and Civil Affairs Department) proposed a model of “family providing primary care; community serving as a back-up, and institutional care being only a supplement” to a guiding principle of elder care services development. For instance, in Beijing, 90% of elders age in place (at home), 6% are to be cared for in/by the community and 4% in an institution—such a model is described as “90-6-4” (Wu & Du 2012). In Shanghai, the ratio is “90-7-3.” In a nutshell, the government continues to expect the family to take the major LTC responsibilities.

Feng, Liu, Guan and Mor (2012) analyzed China's evolving long-term care landscape and investigated the major government policies and private-sector initiatives that have been shaping it. In their research, they found that there was a great push for community-based services with 2.1 billion dollars invested during 2001 to 2004 and 32,000 senior centers has built nationwide. However, due to the poor management and dwindling support from the government, those efforts have failed to make community-based self-sustaining care services almost existent. On the other hand, institutional care is expanding with little regulatory oversight. The research indicated that Chinese policy makers are facing great challenges to manage the rapidly growing of the residential care sector, given the tension arising from policy inducements to further institutional growth, a weak regulatory framework, and the lack of enforcement capacity. Based on their findings, the authors recommended addressing these challenges by starting from the following efforts: building a balanced system of services and avoiding an "institutional bias" that promotes rapid growth of elder care institutions over home or community-based care; strengthening regulatory oversight and quality assurance of information systems; and prioritizing education and

training initiatives to grow a professionalized long-term care workforce (Feng, Liu, Guna, & Mor, 2012).

In 2013, the Chinese Government announced its intent to improve and accelerate the elder care services, aiming to build up an elder care service system based on home care and cooperate with community services by 2020. The government also provides several financial supports with the tax incentives to encourage investigator to help with establishing the elderly long-term care system (State Council of the People's Republic of China, 2013).

Health Care Policies

Health care policies (health insurances) provides financial resources to the health care system and ensures that people have adequate access to public health care (Zhang et al., 2014). In China, urban employees' basic health care services are covered under the Urban Employee Basic Medical Insurance (UEBMI). Unemployed urban residents' health care services are covered under the Urban Resident Basic Medical Insurance (URBMI). And rural residents' health care services are covered under the New Cooperative Medical Scheme (NCMS).

The health system reform and the collapse of the 1960s and 1970s Cooperative Medical System have caused health inequalities in the rural areas of China. " Only civil servants and urban workers were entitled to social welfare and government or employer sponsored health care under the 1960s and 1970s Cooperative Medical System, whereas the majority of people in rural areas are not covered" (Yuan & He, 2010, p. 1210). The other major problem with China's reformed health system was " the dramatic drop in the health insurance coverage, therefore reducing people's access to health care, increasing out-of-pocket expenditures, and widening disparities in health and health care" (Li & Zhang, 2013, p. 59).

Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and New Cooperative Medical Scheme (NCMS)

Like many other nations undertaking health care reform, China puts health care reform as a high priority policy issue (Liu, 2002). The Ministry of Labor and Social Security (MOLSS), was established in 1997 to take charge of the reforms as an effort to solve the problems that existed in the health care system at that time. The Chinese government and MOLSS have since announced three different types of health insurance programs: Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and the New Cooperative Medical Scheme (NCMS) in the last 20 years (Li & Zhang, 2013, p. 59).

Before 1998, China's urban health insurance system mainly consisted of Labor Insurance Scheme (LIS) and Government Employee Insurance Scheme (GIS), in which only employees of the government and state-owned institutions and enterprises are covered. They have played an important role in providing China's urban working population with health protection, thereby contributing to economic development and social stability for about four decades (Liu, 2002). They also contributed to China's rapid health care cost inflation and inefficient resource allocations. Meanwhile, several major problems in the health insurance system required further reforms, such as unaffordable prescription drugs and medical services, increasing out-of-pocket expenditure, and an increasing number of inadequate coverage on urban residents' health insurance (Liu, 2002). In December 1998, the Chinese government announced the establishment of the Urban Employee's Basic Medical Insurance System, known as UEBMI. UEBMI expanded the coverage to all private and smaller public enterprises and provided more stable financing with its risk pool at the city level (Liu, 2002). UEBMI aimed to provide financial access to

available, and focus on equity and quality of services. However, the worker's dependents were not covered anymore (Li & Zhang, 2013).

Zimmer, Kaneda, and Spess (2007) investigated variations in mortality among older populations across urban and rural areas of China using the data of a multi-wave longitudinal survey from the China Health and Nutrition Survey (CHNS). The survey was designed to cover household members aged 50 and older, and the sample size ranged from about 2,700 to 3,800 across waves, the survey is also followed up with a community questionnaire. They found that mortality rates in rural areas were about 30% higher than in urban areas. There was a great differentiation in economic and social life between urban and rural China, and this appears to be negatively influencing survival chances of older adults in rural areas (Zimmer, Kaneda, & Spess, 2007).

Despite the advantages, implementation of China's health insurance reform program was still facing several major challenges, including risk transfer from work units to municipal governments, diverse needs and demands for health insurance benefits, and incongruent roles of the central and regional governments (Liu, 2002). These challenges may reflect practical difficulties in policy implementation as well as some deficiencies in the original program design. In the 1990s, "China's long-standing Cooperative Medical System collapsed as the country's economic system moved from a planned economy to a socialist market model. The financial obstacles caused by the lack of insurance impeded the rural residents in trying to get access to essential health care services and making them extremely vulnerable in case illness strikes a household member" (Luo & Han, 2011, p. 21).

In an effort to solve these problems, the State Council made the decision to create a New Rural Cooperative Health Care System (NCMS) to re-establish health insurance for the nation's entire rural population. Initiated in only 310 rural counties in 2004 (Luo & Han, 2011), the coverage had rapidly expanded to 2451 counties by the end of 2007, accounting for 86% of all rural counties in China (Lei & Lin, 2009). About 95% of rural counties in China have been covered by the program by the end of 2009, with a total of 0.83 billion participants (Li & Zhang, 2013). More than 57% of China's population was living in rural areas in 2010 (Central Intelligence Agency, 2010). However, due to insufficient financing, the insurance coverage is typically limited. Many services, particularly outpatient care, are not covered or only partially covered. Payments from patients are still high, with high deductibles, low ceilings, and high coinsurance rates (Gao, Lindelow, Wagstaff, & Xu, 2009; Lei & Lin, 2009).

Yuan and He (2010) conducted a series of surveys from 2003 to 2008 to study the impact of the NCMS on inequalities in rural areas of Jiangxi Province in China. The study questionnaire was adopted from a national survey designed by the Ministry of Health. Graduate students from the School of Public Health, Nanchang University conducted in-home interviews with participants. The "health inequalities" or the magnitude of socioeconomic inequalities in health were measured. Consistent with Zimmer, Kaneda, and Spess's (2007) study, lower income status was associated with a higher prevalence rate of chronic diseases and health inequalities. Yuan and He (2010) also found that NCMS reduces health inequalities for general rural populations but not significantly for older populations (p. 1211).

Another study exploring the impact of the NCMS was conducted by Lei and Lin (2009) using a longitudinal sample drawn from the China Health and Nutrition Survey (CHNS). They

also employed individual fixed-effect models, instrumental variable estimation, and difference-in-differences estimation with propensity score matching to correct the potential selection bias. They found that participating in the NCMS significantly decreased the use of traditional Chinese folk doctors and increased the utilization of preventive care, particularly general physical examinations. However, there was no apparent evidence of NCMS decreasing the out-of-pocket expenditure or increasing utilization of formal medical services or improving health status, as measured by self-reported health status, sickness or injury in four weeks.

Compared to Lei and Lin's (2009) study, Luo and Han's (2011) study on NCMS found that being enrolled in NCMS reduced the out-of-pocket expenditure of rural residents of China. However, being enrolled in NCMS neither improved health conditions of the beneficiaries nor increased the utilization of preventive and formal health service by the sick, which are consistent with Lei and Lin's (2009) study. Both studies indicated that despite the wide rapid expansions of coverage on geographic areas, the impacts of the NCMS are still limited.

The Urban Resident Basic Medical Insurance (URBMI) was launched in 2007, to provide health insurance to primary and secondary school students, young children, and other unemployed urban residents (Feng, Liu, Guan & Mor, 2012). It started in 10 % of China's urban counties and was scheduled to roll out nationwide to cover all urban elderly people by 2020 (Feng, Liu, Guan & Mor, 2012). Su (2010) conducted a survey and interviews with urban residents in three pilot cities in Fujian Province (Xiamen, Fuzhou, and Nanping) to analyze the operational issues of the URBMI in 2008. The study found that the out-of-pocket expenditure has been decreased since the launching of this program and residents showed a great willingness to renew their insurance. However, the ratio of participates in the rural area is low. Thirty-three

point five percent of the family members are not enrolling in the program because of unawareness of the policy. Eighteen point three percent are not qualified and eight percent cannot afford the insurance payment. Su (2010) pointed out that the reasons for those issues are the unreasonable medical service rates, inability to meet community needs, the inefficiency in management services, and limited capacity of community medical services.

In order to examine how Urban Employee Basic Medical Insurance (UEBMI), Urban Resident Basic Medical Insurance (URBMI), and New Cooperative Medical Scheme (NCMS) affect the health care utilization outcomes among the older people in China, Li and Zhang (2013) analyzed the data from the survey of the China Health and Retirement Longitudinal Study (CHARLS Pilot). The CHARLS Pilot is a broad-purposed social science and health survey of the older population in China collected from July to September in 2008. The CHARLS Pilot sample is representative of people aged 45 or older, and their spouses, living in households in the two provinces of China, Zhejiang and Gansu, which have significant differences in geographic location, economy, and culture. They found that people with UEBMI and URBMI are more likely to use outpatient services and people with UEBMI have less out-of-pocket payments in Zhejiang province. On the other hand, in Gansu province, people with NCMS are less likely to have outpatient visits, while people with UEBMI are more likely to be hospitalized. In addition, among those who have at least one outpatient visit, different insurance types do not make much difference in terms of the number of outpatient visits in both provinces.

Consistent with Lei and Lin's (2009) research, Li and Zhang's (2013) study also found that there was the lack of evidence that NCMS could increase utilization of outpatient and inpatient services, or decrease the out-of-pocket payments in both Zhejiang and Gansu provinces.

Li and Zhang (2013) indicated that the lack of improvement in health care services could be due to the following reasons. First of all, the deductibles are generally high. Secondly, the enrollees do not get reimbursement immediately or it is very difficult to get reimbursed if the enrollees use the health facilities in other counties or cities. And thirdly, although NCMS in many counties have household individual medical savings accounts (MSAs) that cover outpatient care, the budget for the MSAs is very limited, and therefore the coverage is typically minimal. Furthermore, they found that people with NCMS coverage in Gansu province are even less likely to use outpatient services than those without any insurance. Their study also used the data from CHARLS data set to provide quantitative measures of the cost of medical insurance in inland poorer Gansu province and the coastal prosperous Zhejiang province. The results showed that urban residents have experienced much better health care than rural residents. (Li & Zhang, 2013)

Following is a review of long-term care policies and practice in the United States. A brief review of population aging in the U.S. will be provided. Financing and operation of long-term care services and related health care policies will be discussed.

United States

In the United State, people over 65 years old make up 13.4% of the total 2012 population (United States Census Bureau, 2012), and the overall U.S. population reached 320 million by the end of 2014 (United States Census Bureau, 2015). The Administration on Aging projected that by 2030, one in five Americans is expected to be 65 and over, comprising 20% of the total U.S. population (Administration on Aging, 2014). By 2060, this percentage is expected to reach 25%, increasing from 15% in 2014. The fastest growing segment of American's population consists of

those 85 and older (Colby & Ortman, 2015). In 2010, there were 5.8 million people aged 85 or older. By 2050, it is projected that there will be 19 million people aged 85 or older (Colby & Ortman, 2015).

Long-term services and supports (LTSS), traditionally and often referred to as long-term care (LTC) is provided to people who need assistance to perform routine daily activities over an extended period due to disability or chronic illness (Robison, Shugrue, Fortinsky, & Gruman, 2013). Among people age 65 and over, an estimated 70 percent will use LTSS, and people age 85 and over – the fastest growing segment of the U.S. population – are four times more likely to need LTSS compared to people age 65 to 84 (Reaves, & Musumeci, 2015). The number could grow from 5.7 million in 2008 to 19 million by 2050, as the baby boom generation move into this age category according to the U.S. Census (2012).

In the United States, the vast majority of older persons needing long-term care services receive the assistance from their families and other unpaid caregivers. There are two broad sources financing LTSS: personal resources and public program funding. Personal resources include unpaid care provided by family and friends, out-of-pocket spending, and private insurance. LTC insurance covers services in both institutional and community-based settings. Public funding sources include Medicaid and Medicare, Veterans Administration, and state-funded programs such as those administered through the Older Americans Act (Robison, Shugrue, Fortinsky, & Gruman, 2013). Medicaid is the primary payer for institutional and community-based long-term services and supports. Under Medicare, home health services are only covered for beneficiaries who are homebound. Post-acute nursing facility care is covered for up to 100 days following a qualified hospital stay. Over the last twenty years, there has been

a shift toward serving more people in home and community-based settings rather than institutions due in expanded home and community-based services (HCBS) beneficiary options under the Affordable Care Act (ACA) (Reaves & Musumeci, 2015).

Health Care Policies

During the beginning of the 21st century, health care systems underwent tremendous changes in the United States, including increased disparities in health care, changing demographic characteristics, advanced developments in medical technology, increased life expectancy, inequalities in access to health care, and increased public and private financing of the health care system (Almgren, 2007). However, there are still additional problems and dissatisfactions with the U.S. health care system, including lack of attention and concern to long-term care, chronic disease, and people with disabilities; inadequate emphasis on population health through public health programs, lack of access to health care, and increasing costs (Kovner & Knickman, 2008). There are still many inequalities to access health care with regards to different economic status, and many rural areas have shortages of doctors, dentists, and other health professionals. Many doctors refuse to treat patients who have Medicaid – or even Medicare-coverage. When comparing reimbursement rates among health insurance plans, Medicaid is the lowest payer, meaning it's not a good moneymaker for doctors' offices (Kovner & Knickman, 2010).

Medicare and Medicaid

At present, Medicaid is the main source of public funding in the U.S., with the expenditure of over \$130 billion annually for LTC services for impoverished older and younger disabled individuals. 60 percent of this revenue goes directly into for-profit nursing homes and assisted

living facilities (Kaiser Family Foundation, 2012). Medicare covers limited post-acute LTSS for up to 100 days, but does not fund ongoing LTSS. According to the Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Accounts data, total national spending on LTSS was \$310 billion in 2013. 51 percent of total expenditures are covered by Medicaid, out-of-pocket spending covers 19%, private insurance covers 8%, and 21 % are covered by other public funds (Reaves & Musumeci, 2015).

Medicare and Medicaid were jointly enacted by the U.S. Congress in 1965 (Almgren, 2007). Medicare was designed as a health insurance program for people age 65 or older, or people younger than age 65 with certain disabilities or permanent kidney failure. Medicaid "provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities" (Medicaid.gov, p1), based on the definition from Center for Medicare & Medicaid Services (CMS). Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. There is a baseline of coverage that states must agree to if they are providing Medicaid. Some people may qualify for both Medicare and Medicaid (Medicaid, 2015).

Medicare provides coverage for items and services for over 52 million beneficiaries as data shows in July 2013. It included 81% of whom qualify as aged beneficiaries, 18% qualify on the basis of disability and 1% on the basis of the end-stage renal disease eligibility criteria (Medicare Enrollment, 2013).

A major concern with Medicare is its gaps in coverage. While almost 97% of Americans over age 65 have Medicare coverage, the program has substantial patient cost-sharing provisions and serious gaps in coverage. Medicare deductibles are fairly high for hospital care and outpatient care with approximately 20% substantial co-payments. Many elderly Americans have supplemental coverage for some of these expenses (Medigap plans), either through their employer/retirement plan or by purchasing it directly. But more than 20% of the elderly population (35% of low-income elderly) have no supplemental coverage and are exposed to serious financial risks and potentially substantial barriers to access (Kovner & Knickman, 2010). Private long-term care insurance is inaccessible. The market for this insurance product is relatively small. In 2011, the average annual premium is \$2,283 per individual policy, which could be burdensome for individuals and families with limited incomes (Reaves & Musumeci, 2015).

Out-of-pocket costs and cost-sharing requirements are another concern. The Medicare program covers slightly less than 50% of the total healthcare expenditures of Medicare beneficiaries (Almgren, 2007, p.123). Most physicians who treat Medicare patients accept the program's approved fees as full payment for their services, but others exercise their right to charge beneficiaries an additional restricted fee. The cost of physician fees, omissions in coverage, premiums, deductibles, and copayments add up to the significant amount that must be paid either out-of-pocket or with supplemental insurance. About 20 % of beneficiaries purchase private Medigap, or Medicare Supplement Insurance, to provide coverage for the gaps in Medicare coverage, and less than 31% receive supplemental coverage through employee retirement benefits (Kaiser Family Foundation, 2008). About 14% have Medicaid coverage

through the Medicare buy-in program, and 12% participate in Medicare HMOs (Kaiser Family Foundation, 2005).

The level of uninsured among the elderly population is very low (0.8%), reflecting the dramatic improvement brought by the Medicare program, which provides almost universal coverage for Americans age 65 and over (Kovner & Knickman, 2010, p.448). But Medicare has substantial restrictions on long-term care. Only 2% of older adults' nursing home costs are paid by Medicare (Kovner & Knickman, 2010).

On the other hand, the Medicaid program provides a broader coverage. Currently, there are over 72.2 million people enrolled in the Medicaid program (CMS, 2015). Those low-income elderly Americans that qualify can benefit from Medicaid for comprehensive coverage which covers most services (including drugs and long-term care) with few restrictions or co-payments (Kovner & Knickman, 2010). However, a large number of providers do not participate in Medicaid. In 2004-2005, more than 20% of physicians would not accept new Medicaid patients (Cunningham & May, 2006).

The Affordable Care Act of 2010, signed by President Obama on March 23, 2010, redefined the national Medicaid minimum eligibility level for nearly all American people under age 65 to be 133% of the federal poverty level (\$29,700 for a family of four in 2011). This Medicaid eligibility expansion went into effect on January 1, 2014 (Medicaid & CHIP, 2015). As of January 2015, twenty-seven states and the District of Columbia had implemented this expansion. There is no deadline for when a state must decide whether to expand Medicaid. Many states are still considering their options. The enrollment criteria of the Medicaid expansion vary, some of the states had expanded their coverage to parents and other adults at income levels

above the previous federal required level. Many states previously covered parents only at the minimum required income levels and often did not cover other adults without disabilities who are under age 65 at all (Medicaid & CHIP, 2015).

The Affordable Care Act

The Affordable Care Act was enacted on March 23, 2010. Comprehensive health insurance reforms have been carried out under this act aiming to put consumers back in charge of their health care. Evidence has been emerging pointing to the conclusion that, The Affordable Care Act is making health care more affordable, accessible and of a higher quality, for families, older adults, businesses, and taxpayers alike. And it has been bringing the benefit to previously uninsured Americans and Americans who had insurance but without adequate coverage and security (Kovener & Knickman, 2010).

As mentioned earlier, with the already established health care system existing for half a century, it is very difficult to move forward with significant changes considering the pressures from many different groups. But facing the great challenges of a population aging, the U.S. government must reform its health care system in order to manage the overall costs of health care, for example, the Affordable Care Act has been going through years of debates and the full implications of the new program is still unclear nowadays. But it is on doubt that would affect aging people's future to a great extent in the United States (Kaplan, 2011a). Tilly (2010) discussed and promoted the Administration on Aging's (AOA) Health, Prevention, and Wellness program, which is a community-based, chronic disease self-management program. The program has addressed the growing prevalence of chronic conditions, aimed to better help the participants maintain and manage their health condition thus reduce the needs for professional medical

treatments for sickness. Such a program is designed to address the need for community-based, evidence-based programs, and specifically focus on self-care, offering classes to older adults in local communities in non-clinical settings, and teach participants how to modify their existing health self-management through group interaction and reinforcement (Tilly, 2010).

With the Obama Administration's \$27 billion of American Recovery and Reinvestment Act (ARRA) funds, the AOA has the opportunity to expand the reach of this program across the country. An estimated 50,000 participants will be served and also states will develop the infrastructure necessary to ensure those programs become an integral part of their health care systems (Tilly, 2010).

Similar tendencies are also shown in Kaplan's (2011a) paper. Recent changes that the Affordable Care Act (ACA) has made to Medicare and Medicaid are introduced in this article. With already expanding coverage on preventive services, ACA added annual wellness visits program with no charge to enrollees. The ACA aims to improve people's health conditions and detect diseases before they got worse in order to avoid expensive medical interventions down the road. The policy on coverage of prescription drugs is also improved in order to close "the donut hole", referred to an existing unreasonable configuration of drug coverage. But it is also stated that the drug coverage gaps closing will phase in gradually over a ten-year period, and generic drugs remain more expensive as a percentage of cost paid by the enrollee until the end of a phase-in period. The ACA also makes major budgetary cuts to Medicare Advantage plans since it costs the federal government approximately 14 percent more per beneficiary than the traditional Medicare program. The consequences of such cuts cannot be predicted but are unlikely to be positive (Kaplan, 2011a).

Overall the basic structure of health care financing for older Americans are left intact over nearly half a century, and individual components of the Medicare program are basically unchanged. Only considerably variance is ACA's impact on individual older American, which depends upon the specific enrollee's medical circumstances and present financial abilities.

In addition, Kaplan (2011b) further expanded the discussion on the Affordable Care Act (ACA) reform of older Americans. Besides the already addressed discussions on topics such as prescription drugs policy changes, Preventative Services, and Medicare Managed Care. The ACA also curtailed related tax benefit for affected employers and plan sponsors on Employer Drug Plans. The ACA increased cost component for upper-income Medicare beneficiaries in order to support the policy changes on prescription drugs. Discussion on long-term care is emphasized in this article. It demonstrated how the new legislation address long-term care in two separate and distinct contexts, namely Community Living Assistance Service and Supports (CLASS), and a range of additional disclosures by long-term care facilities to facilitate better informed individual placement decisions. Changes that the ACA made on early retirees are also addressed in this article. The critical area of long-term care is addressed by ACA as well, but it is directed towards younger workers and some near-retirees rather than current retirees. So it is still unclear for most older Americans how to be financial affordable to extended long-term care services (Kaplan, 2011b).

In Xu's (2010) research, besides the extensive review of history and objectives of the Affordable Care Act (ACA), debates on several topics between different political forces are covered in detail which provided a clear picture of the challenges that the ACA is facing. Firstly, whether or not the government should take over and manage the public health insurance system.

On one side it could help to improve the efficiency of health insurance and expand the insurance coverage, but on the other hand it violates the "freedom" of the market and has a potential to cause less competition between insurance products and services and potentially lower the quality of health service. Secondly is whether the expansion of insurance coverage should also cover immigrants, especially undocumented immigrants. Thirdly is how to raise the money to make it implementable, as it requires, at least, one trillion dollars. This issue is particularly serious in aging people care policy making since the cost is extremely high and contributes a significant portion to government input to health care. And lastly is how to maintain the benefit and profit of existing health insurance industry. The American Medical Association raised an objection to the government creating public health insurance plans, which will significantly influence the physicians' benefit. Meanwhile, drug companies will still try maintaining their technology advantages and market share (Xu, 2010).

In the following chapter, the method of analyzing the literature and studying the long-term care and health care policies in both China and the United States will be described. After comparing long-term care policy and the health care system from the two countries on aging population, the strategies that have been carried out to overcome the challenge are investigated.

Chapter III: CONCLUSIONS AND RECOMMENDATIONS

In order to investigate and study different long-term care policies and health care policies from both China and the United States, academic research journals and literature from 1997-2016 were reviewed and analyzed to find consistent and contrasting views. The relevant articles and research were gathered utilizing electronic searching systems including CINAHL, PubMed, Google Scholar, AgeLine, PsycINFO Pubmed, and Social Services Abstracts. The long-term care policies and practice from the two countries are compared after reviewing and studying the established researches. Pros and cons of different policies are discussed throughout this literature review.

Lack of Long-Term Care Coverage

Both China and the United States need to expand the coverage and increase the access to long-term care and health care in general. Most of the long-term care, home care, and residential care services are not covered by insurance and other health care programs in both countries.

In China, over 85% of residential or long-term care facilities are primarily paid by private payers especially in urban areas (Feng, Liu, Guna, & Mor, 2012). Coverage of hospital care for older Chinese people depends on their health insurance. After long hospital stays, most patients are discharged to home without institutional or community-based post-acute care. Only individuals who have no children and no income are provided with free institutional care. For the rest of the elderly population who need institutional LTC assistance, they have to pay out of their own pockets. Even some facilities started to accept resident's health care insurance to pay their medical bill during their stay, but residents still need to pay most of the long-term stay costs by their own. In the past 20 years, China has announced several different types of health insurance

programs to provide broader coverage of health services in both urban and rural areas. Those reforms have expanded the population of health care coverage. However, the impacts are still limited. There are still high out-of-pocket costs, inequalities in health care qualities between rich and poor areas. The deductibles are generally high; the enrollees do not get reimbursement immediately or it is very difficult to get reimbursed if the enrollees use the health facilities in other counties or cities.

In addition, the big income gap between urban and rural areas also leads to the highly unfair access to medical care and long-term care. So, the government should pay more attention to those people with poor socioeconomic status and set up long-term care insurance systems to support those elderly to maintain their normal life.

In the United States, an estimated 50.7 million Americans lacked insurance coverage in 2009 and millions more have inadequate coverage (Kovener & Knickman, 2010). Medicaid is the primary payer of long-term care services. However, people become eligible for Medicaid only after they spend down most of their resources paying for long-term care and health care, or if they have very limited income and assets. Although the recent reforms expanded the coverage, there are still many rural areas have that shortages of doctors, dentists, and other health professionals (Kovener & Knickman, 2010). Many doctors refuse to treat patients who have Medicaid – or even Medicare-coverage. This issue also needs to be considered in China as the rural area has less access to the health care. Medicare only covers skilled short-term care in a nursing home following a three-day hospital stay. Private health insurance does not pay for most long-term care. Disability insurance, even long-term disability insurance does not pay for long-

term care either. In addition, private long-term care insurance in U.S. is unaffordable and inaccessible.

So both countries need to improve health care and long-term care's access and expand the coverage. It is time for both governments to extend more public support to the families and provide the care that is needed for its vulnerable population.

Caregiver Characteristics

Despite the qualitatively different culture and political economy, reviews show that there are more areas that are fundamental and common between the two countries. Another common obstacle is that the family provides most of the care for the older population in both China and the United States.

In China, older people are less likely to live in a nursing home or assisted living because of the deep influence by the Confucian tradition of filial piety, or *xiao*, which requires adult children to care for their elderly parents and it is also regulated by law. "For thousands of years, filial piety was China's Medicare, Social Security and long-term care, all woven into a single family value" (Feng, Liu, Guna, & Mor, 2012, p. 2765). Adult children are being the caregivers most of the time. The percentage of elders who are cared in institutions is much lower in China than in the United States. In addition, as the emerging "4-2-1" family structure (four grandparents; two parents, neither of whom has siblings; only child in the family) influenced by the one child per couple policy in China, it is more difficult for the younger generation to take care of their parents or even grandparents at the same time. On the other side, health care providers in the long-term care facilities will more likely to provide professional and appropriate care for the elder adults. Even though China has changed one child per couple policy into two

children per couple, the effects towards caregiver structures and long-term care for at least twenty years. Considering the traditional filial piety and the unique “4-2-1” family structure, China should put more efforts on developing home and community-based long-term care services and supports, and make it accessible and affordable. Education also needs to be presented for both younger and older generations in China to increase their awareness of benefits utilizing long-term care services in the community.

In the United States, the vast majority of older persons needing long-term care services receive the assistance from their families and other unpaid caregivers as well. However, there has been a shift toward serving more people in home and community-based settings rather than institutions due in expanded home and community-based services (HCBS) beneficiary options under the Affordable Care Act (ACA).

Financial Issues

In the United States, there are several major issues and concerns that health care leaders have been focused on in recent years. The most critical task is to manage the financial budget and reform the health care system so that it can be sustainable. This issue is also being experienced by China.

In the United States, the government is focused on controlling the cost to make health care systems sustainable and fill in the gaps in coverage and increase the access to care. The Affordable Care Act (ACA) signed by President Obama on March 23, 2010, is working to make health care more affordable, accessible and of a higher quality for families, seniors, businesses, and taxpayers alike, as well as expanding coverage for preventive care. The ACA also expanded the Medicaid minimum eligibility to cover parents and other adults whose incomes are above the

level required by federal law. In the meantime, research showed significant concerns that the government cost for the ACA will be too high to be sustainable (Kaplan, 2011a).

Although there is no clear solution to either China and the United States, one should consider studying the positive efforts of the other. For example, as the United States is trying to control medical costs by promoting preventive care by ACA, it could also benefit China if the government would make the push in this direction. This would allow people to obtain early diagnosis and treatment, to help avoid more serious health problems.

In addition, Long-term care services for older people in China is facing the challenges of insufficient financial investment, inadequate and low-quality provision, low levels of private and nongovernmental organizations involvement, and poor monitoring of standards as mentioned above. The long-term care system in China is currently more centralized and controlled by the government, which may increase financial burdens and challenges to government budgeting over the time. There is uneven distribution of health care resources, inadequate government public funding for the government-owned and the non-government-owned facilities, and unevenly distributed health care. So, I think China should develop an active market and for-profit in providing long-term care services. And the position of the Chinese government will have great implications not only for the long-term care but also the future development of the social welfare services in China.

Professional Education

The other aspect that China need to improve is China need a better systematic guideline to build up more professional and effective long-term care facilities or home-care services. In China, long-term care is the biggest and most priority issues for the older population. Although

the government announced regulations and suggestions to encourage more people involving in long-term care and establishing more private and community-based services, I think professional education for health care providers and government still need to be improved to help establish better knowledge about the long-term care services. And also learning from the already advanced community care service system in the United State could bring values to the Chinese government's policy making.

Other Care Options

In addition, there are other care options: respite, rehabilitative, palliative, and end-of-life care. A proportion of the older adult population is faced with heavier burdens from poor health and illness in older age that overwhelms informal and unpaid care (provided by family and friends) or does not fit easily within the bulk of formal care (provided in community-based or institutional settings). Additionally, otherwise, healthy older adults who need rehabilitative care after an acute health conditions. They may face a tremendous declining of function and dependence if they fail to receive the care. These individuals, and often their families, need viable alternative types of care such as rehabilitative, palliative, respite, or end-of-life care options (He, Goodkind, & Kowal, 2015). As population aging and the prevalence of chronic disease is increasing, medical decisions over the course of serious and chronic illness have become complex and unprepared. Advanced care planning (ACP) is a process traditionally focused on the documentation of preferences for a surrogate and life-prolonging procedures (e.g., mechanical ventilation) in an advance directive (AD). However, due to the traditional culture, Chinese are barely having the end-of-life conversation with their family. From this point of view, I think what China can learn from the U.S. is to increase the awareness of end-of-life care.

Government should put more attention training health care providers for end-of-life care as well as other care options, including encourage patient to complete the healthcare directive, in order assist the health care providers to make more appropriate medical advice.

In conclusion, there is a clear and urgent need for both China and United States governments to take the big step for their long-term care policy and practice. The prospects of both governments lie in the ability of meeting the different challenges in Long-Term Care Services.

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