As of June 9th, 2020, the number of Coronavirus Disease-19 (COVID-19) infections per 100,000 people in Korea was 22.9, with a case fatality rate of 2.3% [1]. In Korea, deaths related to the COVID-19 epidemic and patient age show a clear correlation. One in 4 infected people who are 80 years old or older (134/517, 25.9%) and 1 in 10 infected people who are between 70 and 80 years old (81/775, 10.45%) result in fatality; however, none of the 4,049 infected people who are 29 years old or younger have died. In regions where the epidemic is well controlled, such as Korea, the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is much crueler toward the elderly.

Long-term care facilities worldwide have been directly affected by the COVID-19 epidemic. Korea has also experienced the spread of the disease in a small number of long-term care hospitals (LTCHs), mainly located in Daegu and North Gyeongsang Province, which were the center of the epidemic in March 2020. Controlling the spread of COVID-19 in nursing homes is a major health issue in the pandemic era. The first reason is that the lives of the elderly in LTCHs are at high risk, from a personal perspective. The second reason is that COVID-19 quickly consumes essential medical resources, such as hospital beds for critical patients, from a social perspective.

Kim introduced the response experience which a medical practitioner at a LTCH located in Bucheon performed after being confirmed with COVID-19 [2]. By having an infection control specialist at a private acute care hospital participate in the COVID-19 response, at the request of the local government, to control the spread in the LTCH, comprehensive isolation and examination of the exposed individuals, improvement in hospital environment, and education of medical personnel good results were achieved.

The number of LTCHs is quickly increasing in Korea as the population rapidly ages. According to the National Health and Medical Survey Report published by the Ministry of Health and Welfare, in 2016, there were a total of 1,577 LTCHs with 255,496 hospitalized beds [3]. This accounts for 38.0% of all inpatient beds in all medical institutions. The number of LTCHs increased 44.5% in 5 years from 988 in 2011 to 1,428 in 2016, and the number of inpatient beds in LTCHs increased by a staggering 89.5% in the same time period (Table 1).
establishment of an infection control office is not yet legally mandated in LTCHs. Therefore, COVID-19 infection prevention and control (IPC) in LTCHs is one of the most important and serious factors of the pandemic response in Korea.

The U.S. Centers for Disease Control and Prevention listed core practices in “Preparing for COVID-19 in Nursing Homes” [4]. In the same vein, Kim stated that prevention, screening, surveillance, and rapid responses are essential in LTCHs. He also argues that the installation of IPC-related facilities and securing of the knowledge of IPCs must come first, and that underlying institutions and policies should be in place for a proper response.

However, it is difficult to attain meaningful outcomes, such as changing the health insurance payment system, strengthening the standards of medical facilities, and transforming the care of the elderly into a community-centered system, in a short period of time. In addition, it is not easy to increase national fiscal spending amid the decreasing productivity due to COVID-19. A dangerous enemy is close, and we do not have much time. Apart from efforts to change the fundamental foundation of the care system, we should also mull over unconventional methods to cope with immediate problems.

What are the key issues that make it difficult for LTCHs to perform COVID-19 response activities successfully? Currently, the following two factors are lacking: space and manpower. In 2016, the rate of utilization of hospital beds in LTCHs exceeded 83%. How do we ensure that LTCHs, which are mostly private, can obtain extra space and manpower in a short period of time? If there is no suitable way to increase physical and human resources right away, what about controlling the number of service recipients? The fact that the number of beds in LTCHs has increased by nearly 90% in just 5 years may be interpreted as the supply creating demand, to some extent. If so, will it be an effective short-term policy to require each nursing hospital to reduce the number of operating beds below a certain rate, having the government compensate for their losses, but instead require strict compliance with IPC guidelines?

Active diagnostic testing is one of the key strategies for the COVID-19 response. The Korean government mandates COVID-19 polymerase chain reaction tests on the first day of hospitalization for patients at LTCHs, and the National Health Insurance covers 50% of the cost. However, a new strategy is required based on statistical evidence. In 2016, the average duration of stay among patients in hospitals with 300 or more beds was 85 days. If hospital stays are this long, the inflow of the virus into the faculties is much more likely to result from healthcare workers commuting to and from work every day than to be via a newly hospitalized patient. Therefore, it would be advantageous to conduct regular weekly or biweekly inspections of healthcare workers, as directed by the European Centers for Disease Control and Prevention, to establish a response plan that actively uses diagnostic testing [5].
Geographically, Gyeonggi Province surrounds Seoul and forms the largest local government in Korea with a population of more than 13 million people. Although SARS-CoV-2 was controlled at a LTCH in Bucheon, there are more than 350 LCTHs in Gyeonggi Province. As of June 9th, 2020, the rate of COVID-19 infections per 100,000 people in Gyeonggi Province was 7.4. The fight against the virus is still in an introductory stage. The pandemic is not over until it is over, and we need more wisdom and courage.

SUPPLEMENTARY MATERIAL

Editorial Korean version.

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REFERENCES