Long-term Care of Older Persons in the Republic of Korea

BANGKOK, 2015
Acknowledgements

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Acronyms

ECBS  Elderly Care Basic Services
ECPS  Elderly Care Package Services
LTCI  Long-term Care Insurance
NHIC  National Health Insurance Corporation
NSO  National Statistics Office
OECD  Organisation for Economic Co-operation and Development
1 Introduction

1.1 Research context and purpose

The Republic of Korea is one of the fastest-ageing countries in the world. Most Organisation for Economic Co-operation and Development (OECD) countries took more than 50 years to transition from a 7 per cent to a 14 per cent ageing level.1 The Republic of Korea is projected to take only 19 years to make the same leap, reaching the 14 per cent ageing level by 2018 (Kim and Choi, 2013). This is a quite a fast speed of population ageing, even when compared with Japan, which took 24 years (ibid.).

Asia is rapidly ageing, and the number of older people is “expected to triple, from 438 million in 2010 to more than 1.26 billion by 2050”.2 In this context, the Korean experience in dealing with the rapid ageing of its population is worth a close study by other Asian countries.

To cope with an expanding older population, two policy areas considered most important are: public pensions and long-term care services. Most countries developed public pensions in the twentieth century by adopting social insurance schemes, provident funds or tax-based allowances. But the development of comprehensive long-term care services is relatively new to most Asian countries (excluding Japan). One of the key reasons is that long-term care services were regarded as family responsibility rather than state responsibility (and more specifically, the responsibility of female family members). Due to women’s enlarged participation in the labour force and declining fertility rate, however, it has become increasingly difficult to leave the caregiving responsibility to the family. Therefore, it has become an imperative for national governments to organize care services for older persons.

This report presents analysis of the Korean system of long-term care provision and financing, from its inception to implementation, including its impact on beneficiaries and their family members. While these services, inspired by the long-term care insurance model in Japan, have greatly enhanced the welfare of older persons and relieved families from the burden of care, limitations and gaps within the system have been noted. The research for this study mainly looked at secondary data from previous studies, government reports and surveys, including the Korean Welfare Panel Data. Interview findings from civil servants and care workers in June and July 2013 were also factored in.

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1 Ageing society: 7–14 per cent of the population is 65 years or older; aged society: 14–21 per cent of the population is 65 years or older; and hyper-aged society: 21 per cent or more of the population is 65 years or older.

2 Available at: www.unescap.org/our-work/social-development/ageing/about (accessed 19 October 2014).
1.2 Structure of the report

The first part of this report discusses the socioeconomic factors contributing towards the development of the long-term care system in the Republic of Korea, including a brief history and overview of the long-term care system. The review that follows in the second part covers types of services, eligibility, coverage, delivery, regulation and financing. Part three focuses on key issues of the long-term care system, particularly the adequacy and equity of services, such as to what extent long-term care services meet the care needs of older persons and whether they are equitable, for example, between older persons who are severely disabled and mildly disabled, older persons in urban and rural areas and between adults with disabilities and older persons with disabilities. The section further analyses the quality of the long-term care services, issues relating to service delivery and financial sustainability of the long-term care system. The report concludes with policy recommendations for the long-term care insurance (LTCI) scheme in the Republic of Korea and for other Asian countries as well.

1.3 Socioeconomic factors contributing towards the development of system of long-term care provision and financing

Since the 1990s, Korean society has transformed significantly in many aspects. The rapid decline in fertility rate and the rapid ageing of the population are consequences of socio-economic changes. Total fertility rate fell to 1.08 in 2005 from 1.47 in 2000, and although it rose back to 1.22 in 2010 (NSO, 2011), few experts are optimistic about increasing birth rates in the near future. Because of persistently low fertility and advances in longevity, the ageing of the population in the Republic of Korea is expected to continue. As shown in Table 1, the proportion of the population aged 65 or older will reach an estimated 20 per cent in 2026. Realizing that the speed of population ageing in the Republic of Korea could inhibit further economic growth, the Government started developing a comprehensive long-term care system in 2000.

### Table 1. The pace of demographic ageing since the late-nineteenth century in selected countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of the population aged 65+ years</th>
<th>Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7%</td>
<td>14%</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>2000</td>
<td>2018</td>
</tr>
<tr>
<td>France</td>
<td>1864</td>
<td>1979</td>
</tr>
<tr>
<td>Italy</td>
<td>1927</td>
<td>1988</td>
</tr>
<tr>
<td>United States</td>
<td>1942</td>
<td>2015</td>
</tr>
<tr>
<td>Germany</td>
<td>1932</td>
<td>1972</td>
</tr>
</tbody>
</table>

Source: NSO, 2011.
In addition to the ageing of the population, a transformation in family structures has been another noticeable trend during this period. In particular, since the Asian economic crisis that began in 1997, the Republic of Korea has experienced a rapid breakdown in the traditional three-generational households (Choi, 2006). People’s perception of intergenerational support has also changed. In 1998, according to the National Statistical Office (Table 2), when asked who should be responsible for taking care of older persons, 90 per cent of surveyed persons aged 60 or older answered that it was the family’s responsibility and 40 per cent answered that sons and their wives should be responsible. Fourteen years later, in 2012, 36 per cent answered that the family should bear the responsibility and only 6 per cent thought that sons and their wives should be responsible. It seems clear that the traditional Confucian idea that sons and family provide welfare for elderly parents is no longer strong in Korean society. Ochiai’s research (2013) further revealed that more than 80 per cent of Korean women disagreed or strongly disagreed with the statement, “Men work outside the home and women take care of the home”. Given the Government’s ambition to promote female labour force participation, this would also have an implication for long-term care of older persons.

### Table 2. Survey Results on “Who Should Support Elderly Parents (Aged 65 or Older)”

<table>
<thead>
<tr>
<th></th>
<th>Family (per cent)</th>
<th>Sons and their wives (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>90</td>
<td>40</td>
</tr>
<tr>
<td>2002</td>
<td>75</td>
<td>29</td>
</tr>
<tr>
<td>2012</td>
<td>36</td>
<td>6</td>
</tr>
</tbody>
</table>

*Source: NSO, 2003 and 2012.*

Other socioeconomic factors contributing towards the development of the long-term care system in the Republic of Korea include a large proportion of older persons living in poverty, an increase in older persons living with dementia and rising incidence of abuse of older persons. The elderly poverty rate in 2010 was 47 per cent, the highest among OECD countries (OECD, 2013).

### 1.4 History and overview of the long-term care system

The legislation on the LTCI scheme for older persons was passed in April 2007 and implemented in July 2008, but the first discussion dates back to 1999 during the Kim Dae-Jung government. The pro-welfare Kim government overhauled the social security programmes, including public pensions, health insurance and employment insurance. Upon recommendation of social welfare experts to introduce system for long-term care provision and financing, the Ministry of Health and Welfare began to examine the possibilities (Lee and Cho, 2012). As ageing and low fertility became heavily debated social issues, the Government promised to introduce the LTCI scheme in 2002.
One of the main issues at that time was the medical expenditure of older persons. Total medical expense for older persons in the National Health Insurance scheme was increasing rapidly. With family support for older persons rapidly collapsing without alternative services, there was grave concern that unnecessary medical expense for older persons would increase too much.

The participation of civil society organizations has been a prominent feature of welfare developments in the Republic of Korea, but it was not the case with the development of the LTCI. Instead, welfare bureaucrats had the most important role in the long-term care policy-making process. However, the opinions of all stakeholders were not fully addressed in the design of the LTCI scheme. In 2005, the Government announced the proposed LTCI scheme and initiated the pilot testing in six areas. The bill was submitted to the National Assembly in 2006 and finally passed in April 2007.

Public care services for older persons who have difficulty performing daily living activities existed before 2008, which local governments managed. The services were limited to impoverished older persons who had no family support, however, and most services were in the form of institutional care rather than home-based care. According to Sunwoo (2013), about 1 per cent of the elderly population benefited from the long-term care services in 2007. Among them, 60 per cent received residential care, whereas only 40 per cent received home-based care services. Compared with the previous services, the new law provides universal coverage irrespective of an individual's income or assets. It adopted the contribution-based social insurance method rather than tax-based financing, which does not mean that those contributing to the scheme for a designated period are eligible for the service. It is a pay-as-you-go financing method in which the contributions by the current generation are used for providing care services to older persons who have difficulty performing daily living activities. And the focus is more on home-based care services than on residential care. As well, the new system encourages competition between the service providers, thus increasing beneficiaries’ choices. Under the new LTCI scheme, 6.1 per cent of the older population (older than 65) in 2013 benefited, which was much larger than the beneficiaries of the former fragmented long-term care services (NHIC, 2013).

In addition to the LTCI scheme, the Government introduced elderly care voucher programmes in 2007. These voucher programmes supplement the LTCI scheme. Despite the universal coverage of the LTCI scheme, its eligibility is restricted to older people living with a severe disability. The voucher programmes were designed to support those who were not eligible for the long-term care insurance services but needed care services. The two key voucher programmes are the Elderly Care Package Services and the Elderly Care Basic Services. The Package Services provides home-based care services for those not eligible for the LTCI but are living with a mild disability and are relatively poor. Single elderly households can receive regular visits and welfare check-up services through the Basic Services voucher programme. Details of these services are described in the next section.
2 Long-term care insurance scheme in the Republic of Korea

2.1 Long-term care services

The most comprehensive and universal long-term care coverage in the Republic of Korea is the long-term care insurance scheme, which provides home-based care and institutional care services. The number of beneficiaries has been significantly increasing since its inception in 2008; awareness of and satisfaction with the scheme are reportedly high among older people and their family members (NHIC, 2013). According to a survey by the Ministry of Health and Welfare (2014b), 89.1 per cent of beneficiaries’ families said they were satisfied with the services, and 90.5 per cent answered that it reduced the family’s financial burden. The satisfaction rate increased from 83 per cent in 2011 to 89 per cent in 2014. Because the insurance scheme does not cover all older people with care-related needs, the central and local governments have introduced various small to medium-sized programmes for older people with a mild disability or living on their own. Figure 1 illustrates the country’s public system of long-term care provision as of 2012.

In addition to the LTCI scheme, the Government provides the Elderly Care Package Services for older persons living with a mild disability and the Elderly Care Basic Services for older persons living alone. The Government also introduced an emergency care programme for older persons living alone and a financial subsidy to cover health insurance for low-income older persons.

Local governments have introduced many supplementary programmes to meet the extra care-related needs. One of the most prevalent programmes is a cash subsidy to beneficiaries’ out-of-pocket payments. Beneficiaries cover 15–20 per cent of the co-payment when they use the programme, whereas older persons who are poor do not have to pay or have to pay only 7.5–10 per cent of the total cost (Choi and others, 2013). Media reports, however, indicate that there are some non-poor older persons who are reluctant to use the LTCI scheme because they must pay 15–20 per cent of the total cost (Hankyoreh, 2009). Other minor programmes for older persons living alone or with a mild disability are being implemented, some of which were developed before the introduction of the LTCI scheme.

While these support programmes are directed at individual recipients, there are various forms of support for care facilities provided by local governments. The government mainly at the local level provides various subsidies to local welfare centres for older persons, group homes and shelters for older persons who have been abused. In some regions, the local governments run their own one-stop centres for older persons and day-care centres.
This section highlights the three most significant programmes in terms of coverage and financing: long-term care insurance, Elderly Care Package Services and Elderly Care Basic Services.

**FIGURE 1. LONG-TERM CARE PROVISION AND FINANCING IN THE REPUBLIC OF KOREA**

- Care services for older persons with dementia (14)
- Cash subsidy to national health insurance contribution for low-income elderly households
- Cash subsidy for family caregivers who live with persons aged 80 or older (5)

**Support for facilities**
- Subsidies to private local welfare centers for older persons (20)
- Subsidies to shelters for older persons who are abused (1)
- Building multi-functional facilities for older persons (2)
- Subsidies to running seniors welfare centres and care workers wages (206)
- Senior citizen centre workers (1)
- Subsidies to nursing homes (143)
- 365 day-care centers (Gyeonggi-do) (24)
- Group home for older persons living alone (15)
- Cash subsidy to running in-home helper services (135)
- One-stop service centres for senior welfare services (31)

**Note:** Shadowed box: local government programmes, non-shadowed box: central government programmes. Numbers in the blanks: number of local governments implementing the programmes. ECPS=Elderly Care Package Services. ECBS=Elderly Care Basic Services.

**Source:** Author's own creation and calculation.
2.2 Long-term care insurance scheme

2.2.1 ELIGIBILITY AND SERVICE BENEFITS

Benefits are available for all insured persons aged 65 and older or younger than 65 with geriatric diseases, depending on the extent of their care needs. To be eligible for care services under the LTCI scheme, an applicant must request an assessment of their care needs, which is carried out by the National Health Insurance Corporation (NHIC). Once an applicant applies for the long-term care services, NHIC staff visit their house and assess their care needs using the LTCI eligibility checklist.

The checklist includes the applicant’s medical and functional status, covering five categories: physical function (dressing and undressing, toileting, etc.), cognitive function (awareness of current date, place, age, etc.), behavioural problems (paranoia, depression, hallucination, etc.), nursing needs (pressure sores, dialysis needs, etc.) and rehabilitation needs (movement disability, joint problem, etc.). The scores for each category are summed and converted into a 100-point scale. Based on the eligibility level, as shown in table 3, the applicant receives different types of services. Applicants who do not attain a score of more than 45 points are disqualified for LTCI coverage. Older persons with a long-term care approval score of level 5 are only eligible for the service in case of dementia. There are extra-levels A and B, beyond the standard level 1 to 5. These extra levels and non-levels are for older persons with moderate to substantial care needs but who are not eligible for the LTCI services. They can apply for the Elderly Care Package Services.

TABLE 3. LONG-TERM CARE ELIGIBILITY LEVEL

<table>
<thead>
<tr>
<th>Level</th>
<th>Mental and physical status</th>
<th>Long-term care approval score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Requires help in all aspects of daily life</td>
<td>Score &gt; 95</td>
</tr>
<tr>
<td>2</td>
<td>Requires help in most parts of daily life</td>
<td>75 ≤ score &lt; 95</td>
</tr>
<tr>
<td>3</td>
<td>Requires help in part of daily life</td>
<td>60 ≤ score &lt; 75</td>
</tr>
<tr>
<td>4</td>
<td>Requires some help for daily living because of the functional disability</td>
<td>51 ≤ score &lt; 60</td>
</tr>
<tr>
<td>5</td>
<td>Dementia patients</td>
<td>45 ≤ score &lt; 51</td>
</tr>
</tbody>
</table>

Note: The eligible level changed in 2014 from a 3-level to a 5-level system. Previously, the score of level 3 ranged from 53 to 75.
Source: See www.longtermcare.or.kr/portal/longtermcare/sub03_02_02.jsp.

The final decision is made by the eligibility committee. It is organized by the local government and consists of 15 members. The NHIC appoints eight members, and seven members

3 Geriatric diseases: Alzheimer’s disease, cerebrovascular disease, Parkinson’s disease and other diseases set by Presidential Decree; see www.longtermcare.or.kr
are appointed by the mayor or the head of local government. At least one conventional doctor and one doctor of traditional Chinese medicine should be part of the committee.

According to the Long Term Care Insurance Statistical Yearbook (NHIC, 2013), 685,852 older persons applied to the LTCI service in 2013, and an estimated 378,000 applicants received either home-based care or institutional care (Table 4). Approximately 157,000 persons received extra-level A or B during the same year. The number of beneficiaries has substantially increased since 2009. In 2013, more than 6 per cent of all older persons received long-term care services. Although it is a significant development, this share in the Republic Korea is still smaller than in most OECD countries, such as Germany and Japan, where it was more than 10 per cent in 2008 (OECD, 2011).

Home-based care and institutional care through the LTCI scheme are provided as in-kind benefits. Home-based care benefits include domiciliary services, day and night care, short-term respite care and welfare equipment service. Domiciliary services include home visit care (home help and support with daily activities), home medical services (home nursing care) and home visit bathing. Institutional care services are provided through care homes, geriatric hospitals and elderly group homes. Cash benefits are provided only in special occasions, such as to older persons living in remote areas where in-kind services are not accessible. In 2013, about 48.2 per cent of the NHIC expenses on the LTCI scheme were used for home-based care services, which was lower than the 56.7 per cent in 2009 (Table 5). During the same period, institutional care expenses increased by 8.5 per cent. The statistics indicate that older persons are increasingly using institutional care.
TABLE 4. NUMBER OF LONG-TERM CARE INSURANCE SCHEME APPLICANTS AND BENEFICIARIES, UNIT: PERSONS

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older people (65+)</td>
<td>5 286 383</td>
<td>5 448 984</td>
<td>5 644 758</td>
<td>5 921 977</td>
<td>6 192 762</td>
</tr>
<tr>
<td>Applicants</td>
<td>522 293</td>
<td>622 346</td>
<td>617 081</td>
<td>643 409</td>
<td>685 852</td>
</tr>
<tr>
<td>Levels 1–3 and extra-level A, B</td>
<td>390 530</td>
<td>465 777</td>
<td>478 446</td>
<td>495 445</td>
<td>535 328</td>
</tr>
<tr>
<td>Levels 1–3</td>
<td>286 907</td>
<td>315 994</td>
<td>324 412</td>
<td>341 788</td>
<td>378 493</td>
</tr>
<tr>
<td>Eligible persons among older persons (65+), (per cent)</td>
<td>5.40</td>
<td>5.80</td>
<td>5.70</td>
<td>5.80</td>
<td>6.10</td>
</tr>
</tbody>
</table>

Note: *This was calculated by dividing levels 1–3 by older people (65+).
Source: NHIC, 2013.

TABLE 5. NHIC EXPENSES ON HOME-BASED CARE AND INSTITUTIONAL CARE SERVICES, UNIT: US$ MILLION

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expense</td>
<td>1 736.9</td>
<td>2 402.3</td>
<td>2 588.2</td>
<td>2 717.7</td>
<td>3 083.0</td>
</tr>
<tr>
<td>Home-based care</td>
<td>985.6</td>
<td>56.7</td>
<td>1 374.0</td>
<td>57.2</td>
<td>1 370.4</td>
</tr>
<tr>
<td>Institutional care</td>
<td>751.3</td>
<td>43.3</td>
<td>1 028.3</td>
<td>42.8</td>
<td>1 217.8</td>
</tr>
</tbody>
</table>

Note: Exchange rate is based on 1,000 won to $1.
Source: NHIC, 2013.

In the case of institutional care, the maximum amount of benefits is decided in terms of the dependency level. The maximum amount for daily benefits for institutional care is presented in Table 6. Home-based care also sets a limit for the total amount of benefits depending on the dependency level, at US$1,140.6, $1,003.7, $878.9 (level 1, 2 and 3, respectively).4 Beneficiaries can use the service within the limit.

See www.longtermcare.or.kr, long-term care benefits (accessed on 28 November 2014).
TABLE 6. THE MAXIMUM AMOUNT OF DAILY BENEFIT FOR INSTITUTIONAL CARE, UNIT: US$

<table>
<thead>
<tr>
<th>Category</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential home (under the welfare of the Aged Act)</td>
<td>40.29</td>
<td>36.5</td>
<td>32.7</td>
</tr>
<tr>
<td>Residential home (converted from short-term respite care)</td>
<td>45.18</td>
<td>41.32</td>
<td>37.46</td>
</tr>
<tr>
<td>Geriatric care facility (under the welfare of the Aged Act)</td>
<td>51.02</td>
<td>47.26</td>
<td>43.48</td>
</tr>
<tr>
<td>Senior group home</td>
<td>48.9</td>
<td>45.29</td>
<td>41.67</td>
</tr>
</tbody>
</table>

Note: Exchange rate is based on 1,000 won to $1.

TABLE 7. TYPES OF HOME-BASED CARE AND THEIR COSTS, UNIT: US$

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visit care</td>
<td>30 min.</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Home-visit nursing</td>
<td>Less than 30 minutes</td>
</tr>
<tr>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Home-visit bathing</td>
<td>Using a bathing vehicle</td>
</tr>
<tr>
<td></td>
<td>73</td>
</tr>
</tbody>
</table>


2.2.2 ENSURING THE EFFECTIVE FUNCTIONING OF THE DELIVERY SYSTEM

The National Health Insurance Corporation administers and supervises the overall LTCI scheme. The NHIC collects the insurance premium, manages individual applications and the assessment of care needs and conducts the evaluation of the service providers. Local governments issue the licenses to the service providers, based on the guideline from the central Government and regulate the service providers (Figure 3). Although local governments are responsible for regulating the service providers, their regulatory system is not adequately developed to manage the rapidly expanding service market. Consequently, various forms of illegal practices by service providers have become a serious issue. To reduce the illegal activities, the NHIC adopted a reward system for those reporting illegal practices in the LTCI scheme. The amount of reward is based on the severity of the reported illegal or unfair activity carried out by long-term care facilities.
To minimize the failures in service delivery, contracts are issued between the long-term care service providers and beneficiaries. The majority of care services is provided through for-profit service providers, which have markedly increased during the past six years. In 2011, the ratios of for-profit providers of home-based care services were 81.2 per cent for home-visit care and 76.8 per cent for home-visit nursing. In the case of residential care, 61.3 per cent of service providers were for-profit (Lee, 2014). The total number of LTCI service providers increased from 14,979 in 2010 to 16,543 in 2014, as shown in Table 8. In the case of home-based care, it is common that one organization provides more than one service, such as home-visit care together with home-visit bathing.

There is a national certification system for LTC workers to ensure quality of care. The certification course comprises two parts: 240 hours of training (theory 80 hours, practice 80 hours and apprenticeship 80 hours) and the qualification examination (Table 9). Governors or metropolitan city mayors certify the carers who pass the qualification process. All LTCI service providers are required to hire only certified elderly care workers. Since April 2009, elderly care worker certificates have been issued to 456,633 people, but only one fourth of the recipients have found employment. In 2009, the average monthly wage of full-time care workers in elderly care homes was approximately $1,300 (Cho and others, 2009), which was less than half of the average worker’s monthly wage, at about $2,700 (KOSIS, 2015). The low wage for elderly care work has been a problem since 2009, but the situation has not changed much (Hankyoreh, 2014).
**TABLE 8. NUMBER OF LTCI SERVICE PROVIDERS**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>14,979</td>
<td>14,918</td>
<td>15,056</td>
<td>15,704</td>
<td>16,543</td>
</tr>
<tr>
<td><strong>Home-visit care</strong></td>
<td>9,164</td>
<td>8,709</td>
<td>8,500</td>
<td>8,620</td>
<td>9,073</td>
</tr>
<tr>
<td><strong>Home-visit bathing</strong></td>
<td>7,294</td>
<td>7,162</td>
<td>7,028</td>
<td>7,146</td>
<td>7,479</td>
</tr>
<tr>
<td><strong>Home-visit nursing</strong></td>
<td>739</td>
<td>692</td>
<td>626</td>
<td>597</td>
<td>586</td>
</tr>
<tr>
<td><strong>Day and night care</strong></td>
<td>1,273</td>
<td>1,321</td>
<td>1,331</td>
<td>1,427</td>
<td>1,688</td>
</tr>
<tr>
<td><strong>Short-term care</strong></td>
<td>199</td>
<td>234</td>
<td>257</td>
<td>368</td>
<td>322</td>
</tr>
<tr>
<td><strong>Assistive devices</strong></td>
<td>1,278</td>
<td>1,387</td>
<td>1,498</td>
<td>1,574</td>
<td>1,599</td>
</tr>
<tr>
<td><strong>Aged-care facility</strong></td>
<td>1,078</td>
<td>1,352</td>
<td>1,646</td>
<td>2,494</td>
<td>2,714</td>
</tr>
<tr>
<td><strong>Geriatric care facility</strong></td>
<td>450</td>
<td>411</td>
<td>369</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Aged care facility (previous law)</strong></td>
<td>415</td>
<td>334</td>
<td>244</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Aged care facility (converted to short-term respite care)</strong></td>
<td>465</td>
<td>392</td>
<td>329</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Senior congregate housing</strong></td>
<td>1,343</td>
<td>1,572</td>
<td>1,739</td>
<td>2,150</td>
<td>2,157</td>
</tr>
</tbody>
</table>

*Source: NHIC, 2014.*

**TABLE 9. TRAINING REQUIREMENTS FOR ELDERLY CARE WORKER**

<table>
<thead>
<tr>
<th>Course</th>
<th>Training time</th>
<th>Individual fee ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner</td>
<td>240 hours</td>
<td>400–800</td>
</tr>
<tr>
<td>Care worker with prior experience</td>
<td>120–160 hours</td>
<td>300–600</td>
</tr>
<tr>
<td>Other related national certification holders (nurse, social workers)</td>
<td>40–50 hours</td>
<td>150–250</td>
</tr>
</tbody>
</table>

*Source: See [http://silver.busan.go.kr/03system/02_01.jspm](http://silver.busan.go.kr/03system/02_01.jspm), introduction of the LTCI by Pusan City (accessed 28 November 2014).*

Evaluations are conducted under section 54 of the Elderly Long term Care Act, 2008. The NHIC evaluation team visits service providers as well as beneficiaries to gather information. Home-based care and institutional care service providers are evaluated biannually. The evaluation framework focuses on five areas: (i) leadership and management, (ii) safety and environment, (iii) beneficiaries’ rights and providers’ responsibility, (iv) the service delivery process and (v) the outcome of service provision. The result of the evaluation is publicized through the LTCI homepage ([www.longtermcare.or.kr/portal/site/nydev/)](http://www.longtermcare.or.kr/portal/site/nydev/). Only evaluation grades from A (best) to E (worst) are open to the public, while the detailed individual reports
are treated as confidential. The NHIC rewards the high-quality service providers by providing 5 per cent additional cash transfer of the stipulated amount. In 2010, 5,794 home-based care service providers (of 19,947) were evaluated, and increased to 9,186 (of 19,505) in 2011. As shown in Table 10, the evaluation score (100 scale) varies significantly.

TABLE 10. EVALUATION SCORES FOR HOME-BASED CARE SERVICE PROVIDERS

<table>
<thead>
<tr>
<th>Number of evaluated organizations</th>
<th>Average score</th>
<th>Maximum</th>
<th>Minimum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>9,186</td>
<td>73.8</td>
<td>81.2</td>
</tr>
<tr>
<td>Home-visit care</td>
<td>5,194</td>
<td>72.4</td>
<td>81.1</td>
</tr>
<tr>
<td>Home-visit bathing</td>
<td>2,065</td>
<td>73.8</td>
<td>78.6</td>
</tr>
<tr>
<td>Home-visit nursing</td>
<td>170</td>
<td>79.8</td>
<td>86.5</td>
</tr>
<tr>
<td>Day and night care</td>
<td>887</td>
<td>80.4</td>
<td>88.8</td>
</tr>
<tr>
<td>Short-term care</td>
<td>87</td>
<td>76.1</td>
<td>84.5</td>
</tr>
<tr>
<td>Welfare equipment</td>
<td>783</td>
<td>55.1</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: The average score in 2012 does not include assistive devices in order to compare it with the score in 2010.
Source: MOHW, 2013.

The average evaluation score heavily reduced from 81.2 in 2010 to 73.8 in 2012. The main reason is that the evaluation was voluntary in 2010, whereas it became mandatory in 2012. In other words, providers willing to improve tended to be evaluated in 2010, but all had to receive the evaluation in 2012. Also, according to the Ministry of Health and Social Welfare (2013), detailed indicators had changed and became stricter to improve the evaluation in 2012. Table 11 presents the results of institutional care service providers and the variations among them in terms of size and ownership.
### TABLE 11. EVALUATION SCORE FOR INSTITUTIONAL CARE SERVICE PROVIDERS, BY SIZE AND OWNERSHIP, UNIT: SCORE

<table>
<thead>
<tr>
<th>Type</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;= 9 persons</td>
<td>67.7</td>
<td>63.2</td>
</tr>
<tr>
<td>10–29</td>
<td>74.7</td>
<td>69.9</td>
</tr>
<tr>
<td>30+ persons</td>
<td>84.7</td>
<td>80.8</td>
</tr>
<tr>
<td>Ownership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local governments</td>
<td>89.1</td>
<td>84.9</td>
</tr>
<tr>
<td>Social welfare corporation (non-profit)</td>
<td>83.1</td>
<td>77.3</td>
</tr>
<tr>
<td>Individual providers (for-profit)</td>
<td>70.2</td>
<td>66.0</td>
</tr>
<tr>
<td>Others</td>
<td>71.3</td>
<td>70.9</td>
</tr>
</tbody>
</table>

Source: Sunwoo, 2014.

### 2.2.3 FINANCING

The LTCI scheme is financed through a national uniform rate, which is currently 6.6 per cent of the National Health Insurance premium, shared equally by employers and employees. Because the premium is about 6 per cent of a monthly salary, the actual contribution for the LTCI scheme is about 0.4 per cent of a monthly salary. However, self-employed persons are responsible for 100 per cent of the contribution. The State funds 20 per cent of the expected annual budget for long-term care insurance to the NHIC. Central and local governments are responsible for LTCI administrative costs, and the NHIC also pays its share of the administrative costs for managing applicants’ eligibility process and decision.

### TABLE 12. AVERAGE LONG-TERM CARE INSURANCE FEE (6.6 PER CENT OF THE NATIONAL HEALTH INSURANCE PREMIUM)

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total insurance premium (million US$)</td>
<td>2,369.7</td>
<td>2,542.1</td>
</tr>
<tr>
<td>Average insurance monthly fee per household (US$)</td>
<td>5.48</td>
<td>5.70</td>
</tr>
<tr>
<td>Average insurance monthly fee per person (US$)</td>
<td>2.38</td>
<td>2.52</td>
</tr>
</tbody>
</table>

Note: Exchange rate is based on 1,000 won to $1.

Source: NHIC, 2013.

According to the Ministry of Health and Welfare (MOHW, 2010), nearly 0.3 per cent of gross domestic product was spent on long-term care in 2010. In principle, 80 per cent of the LTCI spending is from the NHIC and 20 per cent from the Government, using a general tax. However, the actual contribution from the Government has been below 20 per cent (NABO, 2014). The expenditure of the LTCI funds amounted to $3.5 billion in 2013, and approximately $3
billion was spent by NHIC in 2010 (Table 13). The Government subsidizes the rest, at about 17 per cent of the total cost.

### TABLE 13. ANNUAL LONG-TERM CARE INSURANCE BENEFITS

<table>
<thead>
<tr>
<th>Year</th>
<th>Benefit (US$ million)</th>
<th>NHIC expense (US$ million)</th>
<th>NHIC expenses multiplied by benefits (percentage)</th>
<th>Average monthly benefit per one beneficiary (US$)</th>
<th>Average NHIC monthly expense for one beneficiary (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1,971.8</td>
<td>1,736.9</td>
<td>88.1</td>
<td>952.2</td>
<td>838.9</td>
</tr>
<tr>
<td>2010</td>
<td>2,745.6</td>
<td>2,402.3</td>
<td>87.5</td>
<td>958.6</td>
<td>838.9</td>
</tr>
<tr>
<td>2011</td>
<td>2,969.1</td>
<td>2,588.2</td>
<td>87.2</td>
<td>944.9</td>
<td>823.7</td>
</tr>
<tr>
<td>2012</td>
<td>3,125.6</td>
<td>2,717.7</td>
<td>86.9</td>
<td>956.9</td>
<td>832.1</td>
</tr>
<tr>
<td>2013</td>
<td>3,523.4</td>
<td>3,083.0</td>
<td>87.5</td>
<td>996.7</td>
<td>872.1</td>
</tr>
</tbody>
</table>

**Note:** Exchange rate is based on 1,000 won to $1.

**Source:** NHIC, 2013.

The beneficiary charges are 15 per cent of the total cost for home-based care services and 20 per cent of the total cost for institutional care services. Expenses relating to food, beauty care and some extra costs from care facilities are not covered by the LTCI funds. The beneficiaries of public assistance can use the services free of charge; older persons from the lower income group and the near-poor pay a lower rate of 7.5 per cent for home-based care and 10 per cent for the institutional care.

### TABLE 14. INDIVIDUAL MONTHLY OUT-OF-POCKET FEE FOR THE HOME-BASED CARE AND INSTITUTIONAL CARE SERVICES, UNIT: US$

<table>
<thead>
<tr>
<th>Level</th>
<th>Home-based care</th>
<th>Residential care</th>
<th>Senior group home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>171.09</td>
<td>315.9</td>
<td>303.14</td>
</tr>
<tr>
<td>Level 2</td>
<td>150.555</td>
<td>293.1</td>
<td>279.5</td>
</tr>
<tr>
<td>Level 3</td>
<td>131.835</td>
<td>270.3</td>
<td>257.58</td>
</tr>
</tbody>
</table>

**Note:** Exchange rate is based on 1,000 won to $1.

**Source:** See www.gbmng.go.kr/, introduction of the LTCI by Mungyeong City (accessed 28 November 2014).

#### 2.2.4 ELDERLY CARE PACKAGE SERVICES

The eligibility system for the LTCI scheme includes additional levels (extra-level A and B) for older persons with moderate care needs. The people categorized in extra-level A or B can
apply to the Elderly Care Package Services. The Package Services is a tax-based programme operating through a local government. Persons aged 65 or older can apply for eligibility with the local authority, and after the means tests, those whose household income and assets are below 15 per cent of the average household income and assets are entitled to the Package Services. In the case of dementia patients and those paralyzed after a stroke, the threshold is 200 per cent below the average household income and assets. The Package Services is operationalized through the voucher system, without any cash benefits.

**TABLE 15. ANNUAL BUDGET AND NUMBER OF BENEFICIARIES OF THE ELDERLY CARE PACKAGE SERVICES, UNIT: US$ MILLION, PERSON**

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td>53.5</td>
<td>62.2</td>
<td>62.2</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>26,745</td>
<td>31,125</td>
<td>31,125</td>
</tr>
</tbody>
</table>

**Note:** Exchange rate is based on 1,000 won to $1.

**Source:** Choi and others, 2013.

Similar to the LTCI scheme, beneficiaries of the Package Services need to pay out-of-pocket fees. The monthly fee is based on the beneficiary’s income and the amount of services accessed (Table 16). The standard service cost for long-term care is set by the central Government, which is 9,200 won ($9) per hour (Choi and others, 2013). A care worker should receive at least 75 per cent of the service cost, and the remaining cost can be used by the organization. The benefits are capped, and the Government primarily bears the cost. It covers the service cost from 212,400 to 322,920 won per person (approximately $212–$322) (Choi and others, 2013). The Package Services are funded by general taxation, and the central Government and local authorities co-pay the service costs. Local authority resources are mainly from the government grants and supplemented by their own funding through local taxes and user service charges.

**TABLE 16. ELDERLY CARE PACKAGE SERVICES USERS’ CO-PAYMENT, UNIT: US$**

<table>
<thead>
<tr>
<th></th>
<th>National assistant beneficiary</th>
<th>Lower-income group</th>
<th>Above lower income group</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 hours (9 days per month)</td>
<td>Free</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>36 hours (12 days per month)</td>
<td>8.3</td>
<td>24</td>
<td>48</td>
</tr>
</tbody>
</table>

**Note:** Exchange rate is based on 1,000 won to $1.

**Source:** Choi and others, 2013.
2.2.5 **ELDERLY CARE BASIC SERVICES**

Elderly Care Basic Services is the check-up service for those aged 65 years or older who live alone and do not need care services from the LTCI scheme or the Package Services. Older persons living alone reportedly are at higher risk of committing suicide or dying a “solitary death” (Kim, 2012). The Basic Services enhances the welfare of older persons living alone and decreases their social risks. The check-up worker visits or calls the beneficiaries to check on their safety and supports their emotional needs. The service worker visits at least once a week and calls two or three times a week. The service worker is also required to provide a range of information to the beneficiaries on living arrangements, health or welfare services that are available in the local area. On average, one service worker takes care of about 25 persons (Choi and others, 2013). In 2012, 142,000 older persons received the service free of charge. The Basic Services are funded by both the central and local governments.

**TABLE 17. ELDERLY CARE BASIC SERVICES PROVIDERS**

<table>
<thead>
<tr>
<th>Elderly community centre</th>
<th>Welfare community centre</th>
<th>Local authority</th>
<th>Local self-help centre</th>
<th>Domiciliary service provider</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>33</td>
<td>27</td>
<td>9</td>
<td>60</td>
<td>29</td>
<td>248</td>
</tr>
</tbody>
</table>

*Source:* Choi and others, 2013.
3 Analysis of the long-term care system in the Republic of Korea

The analysis now focuses on the LTCI scheme, which is the primary programme of the Government’s long-term care provision. The strengths of the Korean LTCI are first explained. Then, the LTCI is analysed in terms of the adequacy and equity of the services, the service delivery and the financial sustainability of the scheme.

3.1 Strengths of the Korean long-term care insurance scheme

Since its introduction, the LTCI scheme has greatly contributed towards improving the welfare of older persons and their family members. First, the selective and residual long-term care services were transformed into universal care services. As noted earlier, just before the introduction of the LTCI scheme, only 1 per cent of the older population benefited from public long-term care services (Sunwoo, 2013). Family care provision was taken for granted before the scheme’s introduction and was a considerable burden for the family, particularly the women. The introduction of the LTCI scheme has benefited many families by relieving their burden of care. Now, more than 6 per cent of older persons are eligible for the services (NHIC, 2013). The LTCI is the “insurance” scheme, but it does not exclude those who have not contributed to it. Additionally, the Elderly Care Basic Services are available to those persons who are not eligible for the LTCI services and to single-household older persons.

Second, the LTCI has shifted from provider-centred to beneficiary-centred long-term care services. In the previous system, beneficiaries did not have the right to choose a service provider. But, in the new system, they can choose a service provider—a dynamic that is designed to enhance service quality by competition between providers.

Third, the LTCI scheme has coped with the rapidly expanding service demands in a relatively effective way due to three factors. First, the voucher system created a large number of for-profit service providers without spending much to establish publicly managed care facilities. While the marketization strategy (examined further on) has produced some negative effects, it is undeniable that the new structure of service delivery has greatly contributed to meeting the care demands. Second, it established a system that identifies who needs care (Figure 2). It did not exist before the introduction of the LTCI scheme. Third, without creating a new type of taxation, the LTCI scheme uses the National Health Insurance scheme to finance the services. By increasing the National Health Insurance contribution by only 0.4 per cent of a monthly salary, it avoided public resistance against increasing taxation.

As a result, the satisfaction rate of the LTCI scheme among beneficiaries’ families markedly increased, from 74.7 per cent in 2009 to 86.9 per cent in 2011 and then 89.1 per cent in 2014 (MOHW, 2014b). Also, according to a satisfaction survey among beneficiaries (MOHW,
2014b), 78 per cent of older persons surveyed said that their health condition had improved and 90.5 per cent said that the care burden had relieved after receiving the LTCI service. In an evaluation of 40 public policies by a Korean newspaper and a university research institute (Dongailbo, 2014), the LTCI scheme was deemed the best public policy.

The LTCI scheme not only created more employment by relieving the care burden but also directly created care jobs. The number of care workers markedly increased from 37,684 in 2008 to around 252,000 in 2013 (NHIC, 2013). There is no doubt that the LTCI scheme has made a sea change for persons who need long-term care and for families providing care. That does not mean that the LTCI scheme is without shortcomings, however, as the following sections explain.

3.2 Adequacy and equity of services

Before analysing the adequacy and equity of LTCI services, it is essential to discuss the scope of care and care needs. Broadly, care consists of medical care and social care, the latter is the focus of this discussion. In the Republic of Korea, lengthy discussions have taken place on the interpretation of the care terminology. On one hand, some interpret “care” as “taking care of or protecting those who are unable to perform daily activities”. Others criticize that this definition tends to regard those with care needs as passive and even inferior beings. They prefer to define “care” as a “range of support and activities to enable those who are unable to perform daily activities to live independently” (Sipilä and Kröger, 2004). The LTCI scheme seeks to facilitate older persons’ independent living and improve the socioeconomic status of family members by relieving their burden of care.

In terms of the scope of social care, the literature tends to propose four care areas: physical support, housework support, mobility support and emotional support (Choi and others, 2013). Physical support is the most basic service for personal maintenance; it includes bathing dressing, using the toilet, etc. It also includes basic nursing services. Housework support includes cleaning and cooking services, and mobility support enables care recipients to move around for shopping, doctor’s appointments, etc. Emotional and psychological support is regarded as an increasingly important service area. While care services for adults younger than 65 living with disabilities contain all these elements, the LTCI scheme does not include mobility support.

OVERVIEW OF CARE SERVICE NEEDS AND ACTUAL ACCESS

This study looks at the difference between the care services accessed and the services needed. The equity issue is analysed against the findings from the supplementary survey on people with disabilities in the sixth wave (2011) of the Korean Welfare Panel Data. The survey asked 294 older persons living with a disability about their “actual access” of 14 care-related services during the previous month and their need for these services (Figure 4). The 14 services were

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5 This section is largely based on Choi and others (2013).

6 There is no clear academic definition about adequacy in care services. But, in this report, adequacy is roughly measured by how much care needs are met by care services.
divided into five areas. The first three directly relating to care services were physical support, housework support and mobility support. The remaining two were related to employment services, including employment counselling and job training, and leisure services.

**FIGURE 4. CARE NEEDS OF PEOPLE AGED 65 OR OLDER**

As shown in Figure 5, respondents with “higher degree of care needs” tended to need more physical, housework and mobility support, whereas there was low demand for leisure and employment support. One of the noticeable findings is that the most severely disabled group (group 1) tended to have a lower need for housework and mobility support, partly because they were living with caregivers, either with family members or in care facilities, or they did not expect to go out much and thus require mobility support.

Figure 5 illustrates disparity between older persons’ actual access and their need for welfare services. Compared with accumulated service needs, their actual access was much lower. There was about a 70 per cent gap between the actual access and the need for services for the group scoring a 1 (the most severely disabled). The need for services of the group scoring a 2 were not being met, thus the gap was almost 100 per cent. These two figures indicate that the care needs of older persons living with a disability are not being met adequately. Note that the figures are based on how many services they need or access rather than on how much they use each service. Currently, the maximum hours of home-based care service offered by the LTCI is about 72 hours per month, or two to three hours per day. Many criticize the shortage of service hours, which is insufficient for creating an enabling environment for care recipients and their family members to live independently. Therefore, as shown in Table 5, people tended to increasingly use institutional care rather than home-based care services. Level 1 older persons can only receive two to three hours of daily home-based care services but they can receive 24 hours services in residential care. This has resulted in an unintended incentive for older persons and their families to prefer residential care over home-based care, which is against the spirit of “community care”.

Source: Korea Welfare Panel Data, 2011.
Note: Horizontal axis represents degree of care needs. Score 1 means older persons with a severe disability. Vertical axis represents the accumulation of needs (whether they have needs, %) and actual use (whether they actually use, %) in five areas.

Source: Korea Welfare Panel Data, 2011.
3.3 **Equity issues in access to the long-term care insurance scheme**

Older persons encounter several equity issues in terms of access to the LTCI scheme. First, in 2012, 150,000 older persons received the extra-level A or B who could otherwise apply for the Package Services. However, only 30,000 older persons received the Package Services, and 120,000 older persons were denied the service because their income and assets were more than the designated threshold for eligibility. Some older persons with little income were also excluded from the service because of their assets, mainly because they owned a house or because of their co-resident family members’ income (Choi and others, 2013). In some local areas, the Package Services are not fully functional due to budget constraints.

Second, there is disparity between the types of care services available in the rural and urban areas. The number of older persons living in rural areas exceeds the number in urban areas, but there is lack of home-based care service providers for them. For-profit providers tend to prefer urban areas where the population density is high and it is easy for them to recruit new home-based care workers. According to Choi and others (2013, p. 104), for example, the number of care workers per 100 LTCI beneficiaries was 42 in Seoul, whereas the number was 29 in Chunbuk Province and 32 in Gyeongnam Province, both of which have large rural areas. A civil servant in a rural area interviewed for this study expressed concern that rural areas tend to have more older persons, fewer service providers and weaker local governments, making it difficult for the local authorities to establish adequate and equitable care systems. The study by Choi and others (2013), using administrative data, also confirms this finding. However, in terms of institutional care, most facilities tend to be located in rural areas where the price of assets, such as land, is much lower than in urban areas. This is increasing the disparity between types of care services available in the rural and urban areas.

Finally, the NHIC reported that many older persons who are eligible for the LTCI scheme are not accessing it because they prefer family care rather than care by non-family members. As shown in Table 18, in 2009 about 30 per cent of eligible older persons responded that they did not access the service because they preferred care by their family members (Anti-Corruption and Civil Right Commission, 2010). In fact, many older persons do not apply for the service for this reason. The Government, as in Japan, highly limits the cash benefit to informal family caregivers. While it is true that many older persons with care needs still prefer their family members, more than 50 per cent of the total benefit-related fraud cases identified by the Ministry of Health and Welfare involved family care. It seems that many family caregivers received the payment but failed to provide care. Special cash benefits are therefore only provided to older persons living in remote areas who can prove that there is no other means of long-term care but the family. The benefit level was restricted to $150 per month.
### TABLE 18. REASON FOR NOT USING THE LTCI SCHEME

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Reason for not using</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Using long-term care hospitals</td>
<td>36.2</td>
</tr>
<tr>
<td>2</td>
<td>Direct care by families</td>
<td>31.5</td>
</tr>
<tr>
<td>3</td>
<td>Needs for medical treatments</td>
<td>7.5</td>
</tr>
<tr>
<td>4</td>
<td>Including the process of service contract or in the waiting list</td>
<td>3.8</td>
</tr>
<tr>
<td>5</td>
<td>Financial burden (because of high out-of-pocket expenses)</td>
<td>3.0</td>
</tr>
<tr>
<td>6</td>
<td>Other (death, long-term leave, no contact, losing eligibility, etc.)</td>
<td>3.0</td>
</tr>
</tbody>
</table>


There is an increasing number of family members completing the formal training courses offered by the Government and are qualified as formal caregivers. Upon completion of training, they take on caregiving responsibilities. The proportion of older persons taken care of by their qualified co-resident family members has markedly increased, from 1.8 per cent in August 2008 to 23.5 per cent in March 2010 (NHIC, 2010). If older persons cared by qualified non-resident family members are included, the proportion is expected to be much higher, at around 40 per cent (NHIC, 2010). Due to the increase in the number of qualified family caregivers, the Government reduced the level of payment to family caregivers. In 2011, family caregivers engaged in other types of paid work were not allowed to receive any cash benefit. The Government also limited service hours to 90 minutes per day for co-habiting family care workers and 4 hours for non-cohabiting workers. Both types of workers could provide the services for a maximum of 30 days per month. In August 2011, the service hours were reduced to 60 minutes per day and a maximum of 20 days per month, regardless of the family care workers’ living arrangement with an elderly family member (Bokjiro, 2013).

Concerns have been raised because the reduction in paid service hours could negatively affect many family caregivers who solely look after an older person without any other source of income (Hankyoreh, 2011). Some argue that the introduction of unconditional cash benefits for family caregivers could be the solution, but others, especially disability civic groups, are concerned about the misuse of such benefits.

#### 3.4 Long-term care delivery system

##### 3.4.1 MARKETIZATION OF CARE SERVICES

One of the most significant changes introduced by the LTCI scheme was the shift from being provider-oriented to beneficiary-oriented. Previously, beneficiaries could not choose a service provider because it was arranged by local governments.
But under the new voucher system, beneficiaries are free to choose their service provider. It is designed to increase their choices and promote competition between the providers, as mentioned earlier, as well as improve the quality of care. However, service quality remains questionable.

Many studies have reported that instead of increasing the quality of care, the system’s reliance on for-profit individual providers only creates excessive competition that benefits the providers because they are able to secure more beneficiaries (Lee and Kim, 2012; Choi and others, 2013). The service providers attract beneficiaries from other providers by offering an exemption on their co-payment, typically at 15 per cent of the total cost. In other cases, the providers coach possible beneficiaries on how to behave during home visit assessments. Also, according to Choi and others (2013), social workers and care workers have noted that excessive competition between providers is undermining local welfare-related community networks.

Cases of fraud also have been reported against residential care providers who had received stable financial support from their local government under the old system without much competition but are now required to compete. According to the NHIC, many residential care providers have wrongly claimed the LTCI benefits. In 2012, among 1,970 providers, 1,160 providers, or nearly 60 per cent, received more reimbursement than they should have and the cases of fraud increased to 70 per cent in 2014 (News1, 2014). The nature of fraud varies, from overreporting on the number of elderly residents in facilities to not hiring enough care workers as per the regulation.

As a result, older persons tend to prefer publicly managed care centres and larger facilities mostly run by local governments and non-profit organizations. As shown in Table 11, the evaluation scores were much higher in larger facilities with 30 older persons or more (80.8 in 2013) than smaller ones with fewer than 10 persons (63.2 in 2013). Also, publicly managed facilities and non-profit facilities had higher scores, at 84.9 and 77.3, respectively, in 2013, compared with for-profit individual providers with a score of 66. It is worrying that the evaluation score of the for-profit service providers fell 4–5 per cent between 2011 and 2013.

There have been governmental efforts to reduce fraud in the LTCI scheme. For example, the providers who cheated their bill are now excluded from LTCI benefits. They cannot provide LTCI services during some periods. The period of exclusion depends on the amount of money that they bilked the Government. Also, the Government has implemented special on-the-spot inspections to detect fraud cases and recover the money to the NHIC (MOHW, 2014a). Some observers argue that the Government should introduce an independent care inspection organization, similar to Care Quality Commission in the United Kingdom (Lee and Kim, 2012).
3.4.2 FRAGMENTED DELIVERY SERVICES

As discussed earlier, there are other long-term care services for those older persons not eligible for the LTCI scheme. If an applicant is not qualified, the information needs to be transferred to their local government so they can arrange other tax-based care programmes, such as the Package Services or the Basic Services. Care services provided by local governments are important in that they enable potential LTCI recipients to stay healthy. Local governments are responsible for guiding older persons with extra-level A and B to various care services, social welfare centres or local health care centres. However, due to the weak coordination between the NHIC and local governments, some 42,000 people received the extra level in July 2012, but only 15,640 people, approximately 37 per cent, were connected to local services (Yoo and Lee, 2012). Among them, 1,500 older persons received the Package Services, 600 people were included in the Basic Services system, 5,000 people were guided to local health care centres, and 8,600 people were linked to private services.

Previous studies identified three reasons for the lack of coordination. First, the major programmes such as the LTCI, Package Services, Basic Services and even the local programmes have independent computer networks for administering contributions and benefits. This makes it difficult for civil servants to check the details of beneficiaries in terms of their eligibility or service requirement, resulting in delays in work (KIHASA, 2013).

Second, in line with the expansion of social services in the Republic of Korea, civil servants or public social workers are under great pressure due to the increasing demand for social services. Due to the lack of civil servants specializing in social services and public assistance, the existing staff are overstretched and finding it difficult to meet expected performance.7

Third, in relation to the second reason and partly due to the Private Information Protection Law, the NHIC workers are rather passive and reluctant in sharing information with the local governments (Choi and others, 2013).

3.4.3 WORKING CONDITIONS OF CARE WORKERS

Some challenges in the delivery system are partly inevitable due to the process of rapid expansion of the care infrastructure. While Japan introduced its long-term care insurance when care infrastructure was well established at the local level, the Republic of Korea had to establish the comprehensive infrastructure as it introduced the LTCI scheme. The excessive competition has created negative impact on the delivery system and has affected the working conditions of the care workers. Care workers, one of the most important components in the infrastructure, receive an average of $1,300 per month when working at institutional facilities and $7 per hour for home-visit care (Lee and Kim, 2013).

The care workers are poorly paid when compared with average full-time workers whose monthly wage was about $3,000 in 2012 (KOSIS, 2015). The working conditions are reported

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7 There were four suicide cases of government social workers due to the tremendous work pressure in 2013.
as generally poor, with long working hours and low wages, even with some cases of abuse. Their work at home-based care facilities is paid on hourly basis and this leads to further deterioration of their situation as the supply of home-based care provision exceeds the care demands. With care workers not able to secure sufficient service hours, they seem to earn little income (Lee and Kim, 2013). Therefore, people tend to avoid working as care workers even after obtaining a care worker certificate. As explained earlier, only one fourth of people with the certificate found employment in that field. Furthermore, in this context, it is difficult to expect good-quality care provided by care workers facing poor working conditions.

The 240 hours training for the care workers is insufficient and their placement is not carried out systematically. Although it cannot be simply compared, care workers in Japan undergo a training of more than 1,800 hours to receive their certificate. Since the universal LTCI scheme required many care workers immediately, the training period was kept short. Nevertheless, it gives a general impression that care work for older persons is unprofessional and of low quality, which might influence future development of the LTCI scheme.

According to the Long-term Care Basic Plan, 2012, wages of full-time care workers in residential care facilities would be raised to $1,570 per month and a standard contract would be introduced to improve their situation and ensure better treatment. After its evaluation of the facilities, the Government recommended relieving the heavy workload, better treatment for care workers and job stability (MOHW, 2012). Strengthening of the training curriculum, reinforcing the prevention of musculoskeletal disease and hiring of consultants to manage grievances would help improve the working environment.

However, it is questionable whether the facilities will accommodate the Government’s recommendations. The finance of the facilities heavily relies on the LTCI benefit, which is based on each beneficiary per day. In other words, the Government mainly controls the level of the LTCI benefit—not the care workers’ wage. Because for-profit providers could have incentives to reduce care workers’ wages or management costs to achieve higher profits, the Government set the minimum wage of care workers. The minimum wage could have a role in maintaining the quality of care. But, many providers argue that it is not possible to improve working conditions for care workers without increasing the LTCI benefit (Bokji News, 2014).

3.4.4 LACK OF COORDINATION BETWEEN AGED CARE FACILITIES AND LONG-TERM CARE HOSPITALS

The long-term care hospitals incurred heavy expenses before the introduction of the LTCI scheme. After it was launched, there were critical referral issues between the aged-care facilities and the long-term care hospitals in terms of residential care because the long-term care hospitals did not change their function. In other words, the two types of institutions perform similar functions: taking care of older persons. Because the LTCI payment and the National Health Insurance payment are separate, it is not easy to connect services for users with medical needs. For example, once an older person in an aged care facility is moved into a long-term care hospital due to their health deterioration and stays in the hospital for treatment for nine nights, then only 50 per cent of the payment is paid to the facility. An older
person who needs to stay in the hospital for more than 10 days is categorized as a serious case and automatically discharged from the facility. Therefore, the facility has an incentive to not refer cases to a long-term care hospital. As a result, an older person with serious medical needs could be kept in a care facility that is not equipped for medical treatment. This leads to a medical blind spot (Choi, 2011).

Vice versa, a long-term care hospital has the incentive to keep an older person who needs little medical treatment because they could receive the reimbursement from both the LTCI scheme and from the National Health Insurance scheme (Choi and Lee, 2010). According to Kim and others (2013, cited in PSPD, 2014), about 40 per cent of older persons who were in long-term care hospitals stayed primarily for care, not for medical treatment. Because one of the goals of the LTCI scheme is to control the rapidly increasing medical expenses for older persons, it would be desirable to redefine the role of long-term care hospitals to provide short-term medical treatment and rehabilitation to help older persons return to their community.

3.4.5 **FINANCIAL SUSTAINABILITY OF THE LONG-TERM CARE INSURANCE SCHEME**

Total spending on the LTCI scheme was 0.07 per cent of GDP in 2008, but this rapidly increased to 0.26 per cent in 2010, largely due to the significant increase in the number of beneficiaries (Kim and Choi, 2012). As discussed, for-profit providers have actively reached out to older persons with care needs, and the amount of spending on care services has risen quickly. The spending is expected to continuously rise in line with the outreach and the maturation of the LTCI scheme.

However, it is difficult to predict the future spending of the LTCI scheme because there are many variables involved, such as demographic changes, the number of beneficiaries and the expansion of the scheme. According to Yoon (2010), the most conservative projection of LTCI spending in 2040 is nearly 0.4 per cent of GDP, whereas it could be 2.3 per cent of GDP, depending on the proportion of single elderly households, the economic growth rate and so on. It seems that it is too early to discuss the financial sustainability of the LTCI because of the uncertainty. Instead, the discussion needs to focus on the effective type and structure of the LTCI.
4 Recommendations

The long-term care system of the Republic of Korea and the LTCI scheme developed rapidly and, despite the limitations, contributed towards improving the lives of older persons with care needs and their families. Based on the Korean experiences, this section proposes policy recommendations towards strengthening long-term care.

4.1 Road map to comprehensive long-term care system

The LTCI scheme is a key policy area for Asian countries to explore. Because it is more important to “prepare” than “repair”, early consideration and design of the long-term care system is important. Before introducing a long-term care system, it is important to assess the existing policies and programmes in place. Although the insurance modality was introduced by Japan and the Republic of Korea, there is a weak insurance principle in the LTCI scheme. Also, the benefits could either be in the form of services, vouchers or cash, each having different implications.

The Korean system is based on the insurance principle, in which the benefits are given as a right, resulting in the rapid increase in the number of beneficiaries and expansion of the care infrastructure within a short time. However, the Government is dependent on the private actors, mostly for-profit ones that characterize the delivery of the Korean LTCI scheme and have led to issues such as excessive competition, benefit fraud and inferior working conditions. The long-term road map to the stable and effective long-term care system is essential. It should be based on a country’s socioeconomic conditions. The road map could include the development plan of the care infrastructure, including facilities, care workers and the relationship between the central Government, local governments and private providers, including non-profit and for-profit providers. In addition, it could discuss the benefit types and levels, including their allocation process.

4.2 Slow but firm: Infrastructure building

The reliance on for-profit providers helped the Government meet the care needs after the introduction of the LTCI scheme, but it has many negative aspects. It is still unclear whether the negative aspects regarding the quality of services and benefit frauds are transitional or embedded in the system, but there are some lessons. First, instead of the marketization right after the introduction, it is important to take some time to slowly but firmly establish the care infrastructure, including care facilities, delivery systems, monitoring systems and care workers’ expertise. In particular, it would be helpful for local governments to establish publicly managed providers, which can set the standard of services in terms of quality and costs for the for-profit and private providers. A combination of public–private care providers is desirable.
4.3 Integrated delivery system

One of problematic features of the Korean system is its fragmented delivery system and lack of coordination between the central Government, the NHIC, local governments and between the public sector and private sector providers. Also, the long-term care scheme and delivery system for older persons were developed separately from the scheme for adults living with a disability. It is questionable whether these fragmented schemes and their tailor-made services have enhanced older persons’ welfare. The findings of several studies argue that instead of increasing the quality of care, some services are overlapping, and those with care needs are left out of the system due to the lack of coordination.

In this case, the types and forms of services and providers may vary, but the administration, including the care-needs assessment and computer networks, should be integrated. Better coordination and integration would not only make the system more efficient but promote equity and adequacy of the services. One of the ultimate measures would be to introduce one comprehensive LTC scheme, as found in Germany or Sweden, to meet the different care needs, instead of introducing many small programmes.

The coordination between health care and social care is important for designing and building an integrated infrastructure. The conflict between long-term care centres and long-term care hospitals in the Republic of Korea is not only due to the marketization but also to the lack of coordination between the healthcare and social care system. Although the Ministry of Health and Welfare manages both systems, the coordination has not been as effective as per expectations. Because the distinction between the two care systems for older persons is unclear, any further design and delivery of the system should seriously consider the coordination aspect.

4.4 Increasing equity and adequacy

It is evident that the LTCI services, particularly home-care service, are not adequate for beneficiaries and their family members to live independently, resulting in the increased use of institutional care services. There are two related issues, first is the financial sustainability of the system and the other is the definition of “adequacy” of the service level. The latter requires social consensus on the “care mix”, such as shared responsibility between families, the market and the State. This should be an essential element of the road map, and there would be no “one-size-fits-all” answer. The combination of pensions and care services and equitable and fair access to services could be considered during the system design process.

The Korean LTCI scheme is generally equitable because services are provided irrespective of the income level. But as mentioned, the service delivery could be improved. Better coordination and integration of existing care programmes could promote equal access to services and minimize the blind spots within the system. For older persons in rural or remote areas who do not benefit from the system due to the shortage of service providers and care workers, the Government should set up different levels of financial support for service providers to encourage them to go into the less populated areas. Family caregivers could have an important role in caring for older persons in remote areas and enhance equity, but initiatives to promote family caregivers need to be closely studied before their roll-out.
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