Introduction of Long-term Care Insurance in South Korea

Soonman KWON, Soo-Jung KIM and Youn JUNG
(School of Public Health, Seoul National University, South KOREA)

Background

In July 2008, Korea introduced social insurance for long-term care. There are several important demographic and social changes leading to the introduction of long-term care (LTC) insurance, including the rapid ageing of population as a result of the increase in life expectancy and the sharp decline in fertility. Total fertility rate is below 1.1 in 2005 (NSO, 2007). The proportion of the elderly (persons over 65) in Korea is 9% in 2005, but it is forecasted to increase at an unprecedented rate. The proportion of the elderly is estimated to be 16% by 2020 and 38% by 2050, resulting in an old-age dependency ratio of 70% in 2050 (NSO, 2007).

With population ageing, demand for long-term care has increased. But family structure has also changed, and the proportion of the elderly living with adult children has decreased to 38% in 2004. Availability of informal or family care givers diminishes as women's labor participation is increasing and their willingness to provide care decreases. 36% of those who receive long-term care get care from their spouse. Problems of social admissions of the elderly also arise because the supply of LTC facilities is limited and there is no public financing for long-term care, while health care is covered by health insurance program.

Economic Wellbeing of Elderly People

Ability to pay for long-term care is also limited for the elderly. In spite of the high labor-force participation of the elderly, household income is relatively low because the working elderly are largely informal sector workers. In a survey by the MOHW and KIHASA (2001)[1], over half of the elderly who were surveyed have a monthly household income below 700,000 KRW (Korean Won) or about USD$ 700.[2] Although there is a loose relationship between

[1] Based on a nation-wide survey of 5,058 elderly people (average age of 72.5 years, 38% male, 60% in urban areas), who did not stay in residential facilities or institutions. The survey was administered by the Ministry of Health and Welfare (MOHW) and Korean Institute of Health and Social Affairs (KIHASA) from May 28 to July 10, 2001.

[2] The poverty line based on 4-member households was 930,000 KRW in 1999. According to that definition, 18.8% of the population is below that poverty line.

household income level and age, household income level does vary significantly depending on the type of household. Single elderly persons are the most disadvantaged in terms of income: 72% of the single elderly have a monthly income below 300,000 KRW, and only 4.5% have incomes over 700,000 KRW.

The wage income of the household head is the major source of income for approximately half of the elderly who were surveyed, while 20% of the elderly depend on financial assistance from family members as the major source of income (Table 1). Major source of income differs for the elderly with different types of living arrangements. For 46% of the elderly single, the major source of income is financial assistance from family members who do not cohabitate with the elderly person. Government aid is the major source of income for 21% of the elderly single, the most financially disadvantaged group. As the national pension system was implemented in 1998, only 5.6% of the elderly who were surveyed rely on pension (or retirement allowance) as their major source of income. Overall, government aid is a major source of income for only 7.2% of the elderly who were surveyed, implying that the capacity of the public welfare program is also limited. For those who live with their adult children, dependence on the income of household head as the primary source of income can be considered to be financial assistance from family members. Therefore, while the government welfare program is rather constrained, family-based welfare continues to play an important role in the economic well-being of the elderly. In the future, changes in the family structure will result in a decrease in cohabitation with adult children and will ultimately necessitate more active roles for public programs and private saving.

<Table 1>

The spending level of the better off elderly is greater than that of the worse off, in the range of 6,025 KRW for the poorest income quintile and 29,045 KRW for the richest income quintile (Table 2).[3] Food and housing account for the largest share of the spending of the elderly household. The percentage of expenditure on food and housing out of total household spending ranges from 36% to 53%, depending on the income quintile. Health care accounts for the third largest share of spending of the elderly for all income strata except for the 5th income quintile (richest), which implies that health care cost still can be a financial burden for the elderly.

[3] It is based on a survey of 5,133 elderly household from October 2005 to January 2006, by the National Pension Service (National Pension Research Institute).

<Table 2>

Policy Process

Rapid aging of population, change in family structure, increase in labor participation of women, limited ability to pay of the elderly, and financial burden of elderly care in health insurance system (social admissions in acute care hospitals) has all contributed to the consideration of a new (5^{th}) social insurance scheme in Korea –long-term care insurance for the elderly. The introduction of LTC insurance will be a major development in the social policy and welfare state of Korea.

Government established a Planning Committee for Elderly LT Care in 2000, and President Kim DJ formally suggested the need to introduce LTC insurance in 2001. In 2003, President Rho MH decided to launch LTC insurance in 2007. Legislation was made in April 2007, and its implementation was delayed by one year and LTC insurance was introduced in July 2008. LTC insurance was proposed and implemented by progressive governments that strongly supported the expansion of the welfare state (Kwon and Holliday, 2007). Government's reluctance to expand public assistance program for long-term care of the (poor) elderly has also contributed to a rather early adoption of a universal financing scheme based on premium contribution. National Health Insurance Corporation (NHIC), the single payer of health insurance program supported the LTC insurance because it provides an opportunity to extend its operation and mitigate the pressure of downsizing/employment adjustment.

LTC insurance has multiple sometimes unclear goals. From a social welfare perspective, it aims to ease the financial burden of the elderly with universalism. It appealed to health insurance by promising to reduce the financial burden of health insurance by reducing social admissions. Ministry of Health and Welfare has tried to persuade the Ministry of Finance and Economy by the potential of LTC insurance to enhance employment by extending social service such as LT care. Whether the LTC insurance can achieve all of the above goals is uncertain now, and will depend on the details of the LTC insurance program.

Long-Term Care Insurance of Germany and Japan

Because there are many similarities among the social health insurance schemes of Germany, Japan, and Korea, Korea learned from the experience of long-term care insurance

of those two countries (Kwon, 2008a). Although both countries introduced social insurance for long-term care, there are differences in institutional details between the two systems. In Germany, sickness funds are the insurer of the long-term care insurance, while local governments are the insurer in Japan. Local governments in Japan are also the insurer of health insurance for the self-employed and have been responsible for providing welfare services for the elderly. German long-term care insurance is solely funded through contribution of the insured, while it is funded through tax (45%), contribution (45%), and co-payment (10%) in Japan. In terms of population coverage, German long-term care insurance provides coverage to all who need long-term care due to disability regardless of age, whereas Japan's system covers only aging-related long-term care.

In German long-term care insurance, benefits are "fixed," based on the level of eligibility (dependence) regardless of actual long-term care costs because it aims to provide benefits that can cover only the basic or minimum need for long-term care (Schneider, 1999). As a result, the long-term care financing system of Germany seems more financially sustainable in the long run than that of Japan. However, the insufficient benefits of long-term care financing in Germany may lead many poor old people still to rely on additional support and welfare programs offered by local governments (Naegele & Reichert, 2002).

In the German system, beneficiaries can choose between cash benefits and service benefits. The amount of cash benefits is comparable to only half of the service benefits, but the majority of people have chosen cash benefits, contributing to the fiscal health of the system (Rothgang, 2002). In contrast, cash benefits are not available in Japan because of opposition from many Japanese women, who were worried that if cash benefits were available there would be strong pressure on informal caregivers, who are mostly women, to provide long-term care (Campbell & Ikegami, 2003).

Social Insurance for LT Care

Tax-based financing was not given a serious consideration from the beginning of the discussion on long-term care financing. Contribution-based social insurance financing is adopted because the Korean welfare state is based on social insurance such as health insurance, pension, unemployment insurance, and workplace injury compensation. LTC insurance can save administrative costs by using the existing administrative structure of the health insurer, National Health Insurance Corporation.

Path dependency also affects the financing mix, and the LTC insurance in Korea is not a pure social insurance, but a mixed financing with contribution playing a bigger role than tax

subsidy. As in the case of health insurance, Ministry of Health Welfare and Family (MHWF) will play key roles in the policy for LTC insurance and tightly monitor the insurer. National Health Insurance Corporation (NHIC), the single payer of health insurance, strongly supports the LTC insurance as an opportunity to extend its operation and mitigate the pressure of downsizing/employment adjustment.

LTC insurance, separate from health insurance, has the potential benefit of de-medicalization of long-term care. It is also easier for the government to persuade the public to pay contribution, which is exclusively for long-term care. However, the separation of LTC financing from health insurance may be a barrier to the coordination between health care and long-term care when two different financing schemes try to dump their financial burden to the other.

Population Coverage

LTC insurance provides coverage for long-term care for the elderly (aged 65 or above) and age-related long-term care of those younger than 65 years old. It is a political compromise because everybody should pay contribution and everybody is eligible when he/she has LT care needs due to *age-related* health problems, and it is much less likely that the younger have a chance to get LTC insurance benefits. Korean LTC insurance does not provide coverage for disability-related long-term care. Government has put policy priority on population ageing and related problems, rather than aiming to solve problems related to long-term care. Korean LTC insurance, targeting to cover only aged-related long-term care, will have a limited effect on social solidarity.

Visiting team from the branch offices of the insurer (NHIC: National Health Insurance Corporation) assesses the functional status for eligibility, using 56 evaluation items. There are 3 levels of functional status/limitations, leading to different amount of benefit levels. Assessment committee in the regional offices of NHIC consists of less than 15 members including social worker and medical doctor (or traditional medical doctor). Decisions of the committee are based on the assessment (ADL) made by a visit team and doctor's report.

Contrary to health insurance, where people do not need to get approval through the assessment of need, LTC insurance requests the eligibility tested by the assessment of the need for long-term care measured by functional limitation. The elderly may not understand that difference, and appeal can increase especially at the beginning of the development of

LTC insurance.

The current assessment scheme targets 3-4% of the elderly to be eligible for LTC insurance benefits, but it seems fall short of the demand for long-term care, facing criticisms that the limited coverage threatens the universalism of the LTC insurance. Government plans to increase the population coverage incrementally, but its speed will depend on the financial sustainability of the LTC insurance.

Government started pilot programs of LTC insurance in 2005. According to the 2nd-year pilot programs, based on 8 sites (3 big urban cities, 2 small urban cities, and 3 rural towns) in April 2006 – April 2007, 17.2% of people over 65 applied and 3.3% of the elderly were approved with 1.07% in level 1 (most serious), 0.78% in level 2, and 1.48% in level 3. 66% of the approved used LT care services: 46% of them used institutional care, 39% used home-based care, and 15% received cash benefits (for exceptional cases). Reasons for not using LT care insurance (34% of the approved) included getting family care (43.3%), hospitalization (17.1%), financial barrier (7.1%), others.

Level and Type of Benefits

Contribution to LTC insurance is determined as a fixed percentage (currently 4.05%) of health insurance contribution, and the two contributions are collected together. Overall financing consists of government subsidy of 20%, copayment of 20% (institutional care) or 15% (home-based care), and contribution of 60-65%. The poor are exempted from copayment. Meals and private rooms are not covered by LTC insurance. Long-term care delivery in Korea is pre-dominantly private, and private providers can have perverse financial incentives to induce demand for the un-covered areas of service, resulting in financial burden on the elderly.

LTC insurance provides service benefit in principle, and cash benefits are provided only in exceptional cases (e.g., when no providers are available in the region). Benefits depend on the level of functional limitations determined in the assessment process. There are ceilings on the benefits for non-institutional care, ranging from 1,097,000 Korean Won (about 1,000 USD) per month for level 1 to 760,000 Korean Won per month for level 3. The type of payment to providers varies such as pay per hour for home care, pay per visit for visiting nursing and visiting bath, and pay per day for institutional care and day/evening care.

Limited role of cash benefits needs to be re-considered in Korea (Kwon, 2008a). Cash benefit was not adopted because of the potential abuse and the low quality of care by informal care givers although feminist movements, worried about the potential pressure on women to provide care in case of cash benefits, did not play a role. However cash benefits can have positive effects on consumer choice and competition among formal and informal care givers. Cost saving is also possible when the level of cash benefits is lower than the service-in-kind. Cash benefits can also mitigate the problems associated with the insufficient supply of long-term care providers in Korea.

Delivery of Long-term Care

The number of (private) providers in the long-term care sector has increased rapidly. But insufficient number of long-term care providers is still a concern, and variation across localities is a persistent problem. As of 2008, there are 1,530 long-term care institutions with 64,671 beds, covering 1.28% of those aged 65 and over (Seok, 2008). There are 8,011 home care providers, which are estimated to cover 2.2% of the elderly. Entry of providers will depend on the generosity of compensation and fee, set by the government.

Quality of care is a critical issue. There is a broad spectrum in quality of care across LTC institutions. Government should monitor and disseminate the quality of long-term care providers. Payment to providers needs to be differentiated based on structural measures (facility, personnel) or service evaluation. Training and work conditions of long-term care workers will affect the quality of long-term care too.

Concluding Remarks

Introduction of LTC insurance is a major change in the long-term care system of Korea. It will also have a big impact on health care system because the elderly accounts for a large share of health expenditure and social admissions have been increasing. Coordination between health insurance and LTC insurance will be a key to the continuum of care and the prevention of the need for long-term care. Benefit coverage of LTC insurance needs to be coordinated with that of health insurance, where out-of-pocket payment amounts to more than 30% of total health expenditure (Kwon, 2008b). Relative generosity of the payment to LTC hospitals (paid by health insurance) and that to LTC institutions (paid by LTC insurance) will also affect provider incentives.

Long-term care should be closely coordinated with welfare service. In the long-term care delivery in Korea, the role of local governments is very limited. They play a role only in the area of financing for long-term care of the poor (through public assistance program) and the regulation and certification of LTC institutions. Long-term care policy needs to empower local governments for the effective coordination between long-term care and welfare services.

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<Table 1> Major Source of Income of the Elderly

(Unit: %)

	All	Elderly Single	Elderly Couple	Cohabitation with Children	Others
Wage Income of HH Head	50.9	21.8	36.5	72.8	30.1
Wage Income of non-HH Head	8.2		8.3	11.6	9.1
Capital Income or Rent Income	6.4	6.9	11.1	3.9	7.2
Pension or Retirement Allowance	5.6	3.2	10.8	3.8	9.1
Fin Assistance by Family Members who not live together	20.1	45.8	27.0	4.1	33.5
Government Aid	7.2	20.8	5.0	2.2	9.6
Others	1.5	1.5	1.4	1.6	1.4
Total	100.0	100.0	100.0	100.0	100.0
(Number of HH)	(4,043)	(875)	(967)	(1,992)	(209)

Source: MOHW and KIHASA (2001).

<Table 2> Spending of the Elderly (+65) Household by Income Levels

(Unit: 1,000 Korean Won; %)

	1st Quintile	2nd Quintile	3rd Quintile	4th Quintile	5th Quintile
Food	1,917 (31.8)	2,664 (31.0)	3,742 (26.0)	4,474(22.7)	6,920(23.8)
Housing	1,267 (21.0)	1,575 (18.3)	2,323 (16.1)	2,557 (13.0)	4,187 (14.4)
Clothing	186 (3.1)	258 (3.0)	472 (3.3)	651 (3.3)	1,517 (5.2)
Transportation/Communication	564 (9.4)	910 (10.6)	1,633 (11.3)	2,466 (12.5)	4,314 (14.9)
Culture	137 (2.3)	227 (2.6)	354 (2.5)	756 (3.8)	2,300 (7.9)
Health Care	867 (14.4)	1,028 (11.9)	1,980 (13.7)	2,436 (12.4)	2,008 (6.9)
Others	645 (10.7)	1,182 (13.7)	2,242 (15.6)	3,420 (17.4)	3,630 (12.5)
Total (Annual)	6,025 (100)	8,604 (100)	14,404 (100)	19,705 (100)	29,045 (100)

Source: National Pension Service (2006)

One USD is equal to about 950 Korean Won at the time of the survey