The introduction of long-term care insurance in South Korea

Soonman Kwon

Background
In July 2008, Korea introduced a new social insurance scheme for long-term care (LTC). Several important demographic and social changes have contributed to the introduction of LTC insurance, including the rapid ageing of the population as a result of the increase in life expectancy and the sharp decline in fertility which fell below 1.1 in 2005. The proportion of older people (those over sixty-five) in Korea was 9% in 2005, but is forecast to increase at an unprecedented rate. Older people are expected to account for 16% of the population by 2020 and 38% by 2050, resulting in an old-age dependency ratio of 70%.1

With population ageing the demand for LTC has increased. Family structures have also contributed; the proportion of older people living with adult children had decreased to 38% by 2004. The availability of informal or family caregivers is diminishing, given that female labour participation is increasing and thus they are less willing to provide care. Only 36% of those who receive LTC also receive care from their spouse. However there are difficulties in obtaining residential care because the supply of LTC facilities is limited and, unlike health care which is covered by the health insurance programme, there had been no similar system for LTC.

In response to these challenges, the government established a Planning Committee for Long-Term Care for Older People in 2000, and President Kim DJ formally suggested the need to introduce LTC insurance in 2001. In 2003, President Rho MH decided to launch a LTC insurance scheme in 2007. Legislation was passed in April 2007, but its implementation was delayed by a year, with the scheme finally coming into operation in July 2008. LTC insurance had been proposed, and indeed was ultimately implemented, by a series of progressive governments that strongly supported the expansion of the welfare state.2 The government’s reluctance to expand the public assistance programme for long-term care of (poor) older people has also contributed to the rather early adoption of a universal financing scheme based on premium contributions.

Social Insurance for long-term care
Tax-based financing was never given serious consideration from the beginning of discussions on a possible LTC financing system. Contribution-based social insurance financing was adopted because the Korean welfare state is based on various social insurance schemes such as health insurance, pensions, unemployment insurance, and workplace injury compensation. By making use of the existing administrative structure of the health insurer, the National Health Insurance Corporation (NHIC), LTC insurance can minimise administrative costs.

Path dependency also affects the financing mix: LTC insurance in Korea is not a pure social insurance, but financing from contributions has a greater role than tax subsidies. As in the case of health insurance, the Ministry of Health Welfare and the Family (MHWF) will play a key role in the policy for LTC insurance and tightly monitor the insurer. The NHIC, the single payer of health insurance, also strongly supports LTC insurance as an opportunity to extend its own operation and mitigate against the pressure of downsizing/employment adjustment within its own organisation.

LTC insurance, separate from health insurance, also has the potential benefit of being able to the ‘de-medicalise’ LTC. It is also easier for the government to persuade the public to pay contributions which are exclusively for LTC. However, the separation of LTC financing from health insurance may be a barrier to coordination between health and LTC if the two different financing schemes try to offload their financial burdens on each other.

Population coverage
The new LTC insurance scheme provides coverage for all those over the age of sixty-five, as well as age-related LTC needs for younger people. As a result, the Korean LTC insurance scheme does not provide coverage for disability-related care needs. The government has prioritised population ageing and related problems, rather than aiming to solve problems related to LTC. Thus the new LTC insurance, targeted to cover only aged-related care needs, will have a limited effect on social solidarity.

In contrast to health insurance, individuals need to obtain prior approval for services through an assessment of functional limitations. In order to determine eligibility, a visit team from the local branch office of the NHIC assesses the functional status of individuals using a fifty-six item evaluation. There are three levels of functional status/limitations, each with different benefit levels. Local assessment committees comprise no more than fifteen members, including a social worker and medical doctor (or traditional medical doctor). All decisions of the committee are based on the assessment of ability to perform activities of daily living (ADL) undertaken by the visit team, alongside a doctor’s report.

The difference in entitlements compared to health care may not immediately be understood by older people. Initially there may be many appeals for reassessment of eligibility (functional status) as the LTC scheme is rolled out. The current

Soonman Kwon is Professor of Health Economics and Policy, School of Public Health, Seoul National University, South Korea. Email: kwons@snu.ac.kr
assessment scheme will reach about 3-4% of the older population. This, however, appears to fall short of the demand for long-term care, leading to criticisms that the limited coverage threatens the universalism of LTC insurance. The government does though have plans to increase population coverage incrementally, but progress in achieving this will depend on the financial sustainability of the LTC insurance system.

**Level and type of benefits**

Contributions to the LTC insurance are determined as a fixed percentage (currently 4.05%) of the health insurance contribution, with the two contributions collected together. Overall, financing consists of a government subsidy of 20%, co-payment of 20% (institutional care) or 15% (home-based care), and an insurance contribution of 60–65%. The poor are exempted from co-payments. Meals and private rooms are not covered by LTC insurance. As LTC delivery in Korea is pre-dominantly private, one potential challenge is that private providers might have perverse financial incentives to induce demand for these additional areas of service, resulting in an increased financial burden on older people.

LTC insurance provides largely service benefits. Cash benefits are provided only in exceptional cases (for example, when no providers are available in the region). Benefits depend on the level of functional limitation determined in the assessment process. There are ceilings on the benefits for non-institutional care, ranging from 1,997,000 Korean Won (about US$1,000) per month for level one to just 760,000 Korean Won per month for level three. The type of payment to providers varies from pay per hour for home care, pay per visit for home nursing and baths, and pay per day for institutional care and day/evening care.

The limited role of cash benefits needs to be re-considered in Korea. A cash benefit system was not adopted because of the potential for abuse and the low quality of care provided by informal care givers. The feminist movement, worried about the potential pressure on women to provide care in the case of cash benefits, did not influence the development of the system. Nonetheless, cash benefits can have positive effects on consumer choice and competition among formal and informal caregivers. Cost savings may also be possible when the level of cash benefits is lower than that for services. Cash benefits can also mitigate some of the problems associated with the insufficient supply of LTC service providers in Korea.

**Delivery of long-term care**

While the number of (private) providers in the LTC sector has increased rapidly, lack of access to care providers still remains a concern, with variation across localities a persistent problem. As of 2008, there were 1,530 LTC institutions with 64,671 beds, covering 1.28% of those aged 65 and over.4 There are 8,011 home care providers, which are estimated to cover 2.2% of the older population. Entry of new providers will depend on the generosity of compensation and fees set by the government.

Quality of care is a critical issue. There is a broad spectrum in quality of care across LTC institutions. The government needs to monitor and disseminate information on the quality of these providers. Payments to providers need to be differentiated along structural lines (facility, personnel) or service evaluation. The training and working conditions of long-term care workers will also affect the quality of LTC.

**Concluding remarks**

The introduction of LTC insurance represents a major change for social care in Korea. It will also have a significant impact on the health care system because older people account for a large share of health expenditure and admissions for social care needs have been increasing. Coordination between health insurance and LTC insurance will be a key to the continuum of care and the prevention of unmet need. Benefits provided through LTC insurance should be coordinated with those of health insurance, where out-of-pocket payment amounts to more than 30% of total health expenditure. The relative generosity between payments to long-term care hospitals (paid by health insurance) and those to long-term care institutions (paid by LTC insurance) will also affect provider incentives.

LTC should also be closely coordinated with welfare services. At present however, the role of local government is very limited in the provision of LTC. It is only active in the area of financing for the long-term needs of the poor (through the public assistance programme) and the regulation and certification of LTC institutions. Going forward LTC policy needs to empower local governments, so as to help facilitate effective coordination between LTC and welfare services.

**References**


---

**International Conference on ‘Markets in European Health Systems: Opportunities, Challenges, and Limitations’**

The European Observatory on Health Systems and Policies and the Ljubljana based Centre of Excellence in Finance (CEF) are organising an International Conference on ‘Markets in European Health Systems: Opportunities, Challenges, and Limitations’. This conference, which will take place in Kranjska Gora, Slovenia from 16 to 17 June 2009, will focus on how health systems’ financing can be reformed to ensure the most efficient resource allocation. It will address a number of questions concerning the extent to which the use of market mechanisms and competition are effective for better containing cost and improving health systems performance and how it relates to the reality of health systems in the Central and Eastern European region.

More information on the event at [http://www.cef-see.org/health/](http://www.cef-see.org/health/)