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SNU Health
Graduate School of Public Health

Universal Long-Term Care Insurance Program: South Korea's Experience

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Outline

I. Background

Socio-demographic changes, health and care **needs, policy process**

II. The social LTCI program in Korea

Key building blocks, achievement, and challenges

[Financing, coverage, benefits, providers, workforce, & quality]

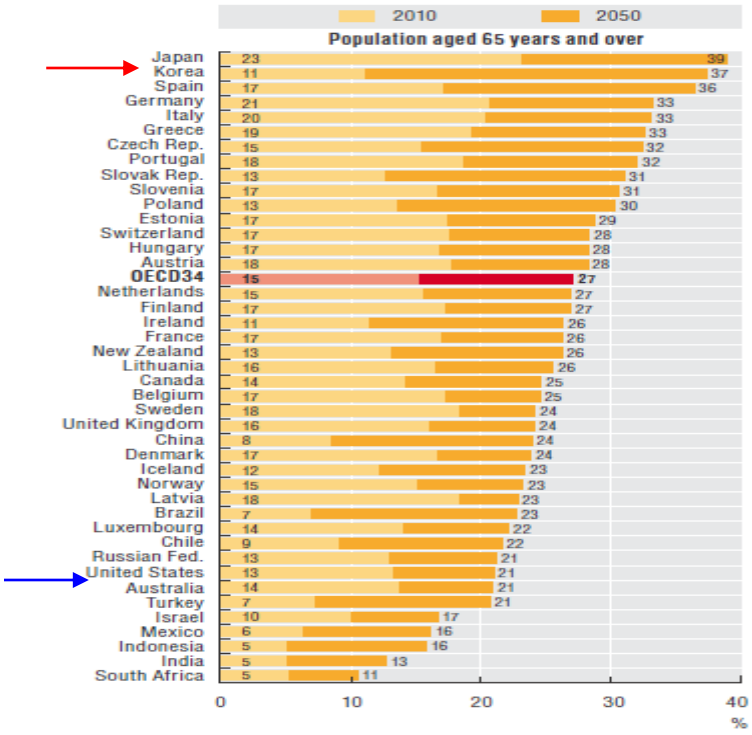
III. Future agenda

I. Background

1. Demographic Changes

- South Korea is expected to be the second most-aged country in the OECD in 2050
- Similar to other East Asian and Pacific countries, the speed of aging will also be much faster than in Western countries

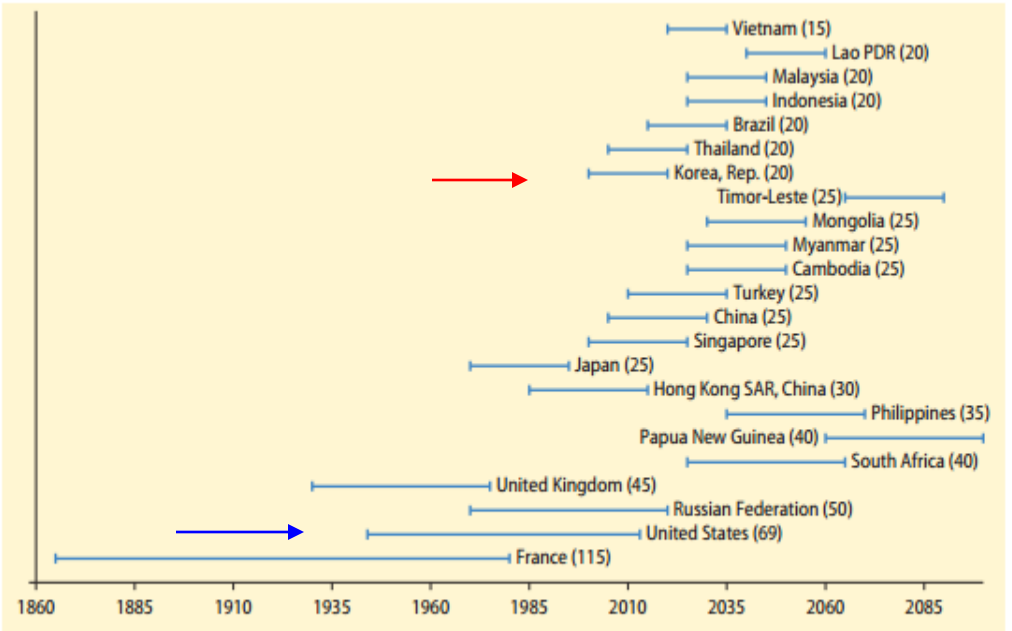
Share of the pop. aged 65+, 2010 and 2050



OECD (2015)

East Asian and Pacific countries are aging more quickly than Western countries did in the past

Years to move from 7 to 14 percent population share 65 and older and the start and end years of transition



Sources: World Bank estimates based on data from UN 2013 and Kinsella and He 2009.
Note: Figure shows starting and ending year for transition from 7 percent (aging) to 14 percent (aged) of population ages 65 and older. Aging and aged thresholds are based on United Nations definitions. East Asia and Pacific economies rounded to five-year increments.

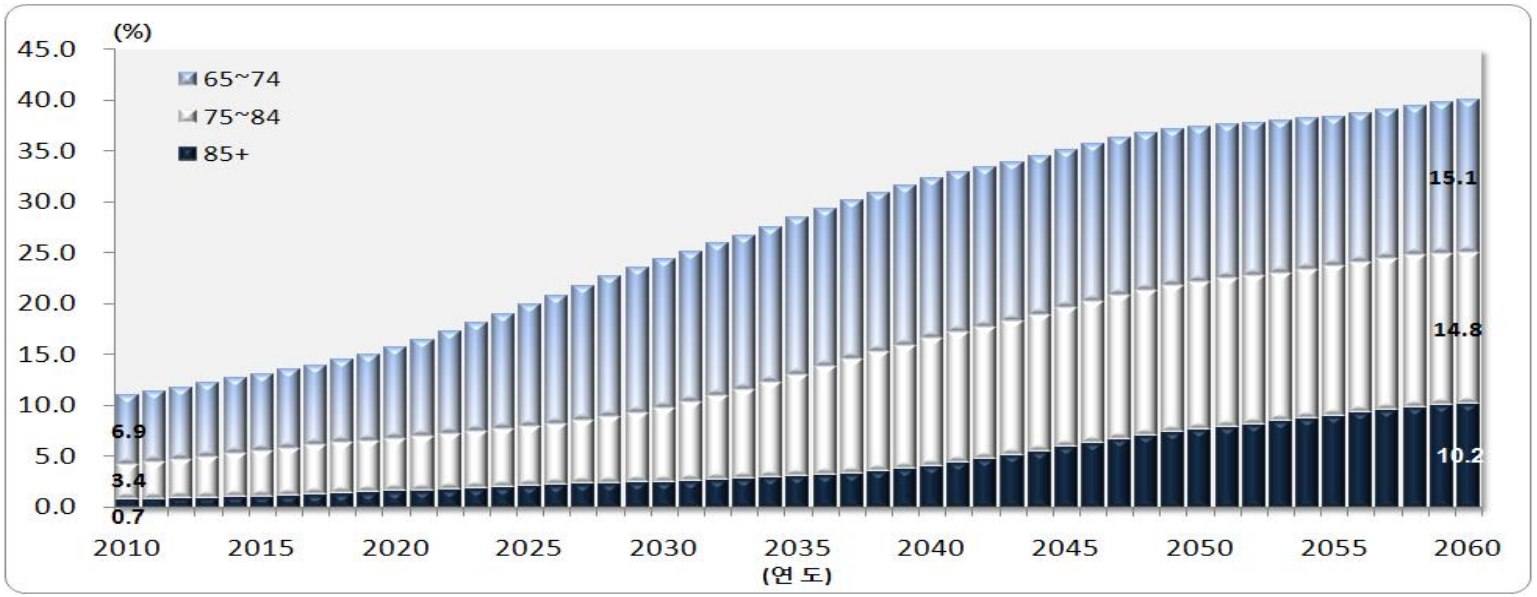
1. Demographic Changes

- **Populating aging**

- Ratio of people age 65+ to total population: 13.1% in 2015 -> 40.1% in 2060.

- Rapid increase in the oldest old (85+): 0.7% (370,000) in 2010 -> 10.2% (1,762,000) in 2060

- Sharp increase in the older population due to the entry of baby boomers (1955-1963): 65-74 yrs. in 2020, 75-84 yrs. in 2023, & 85+ in 2024



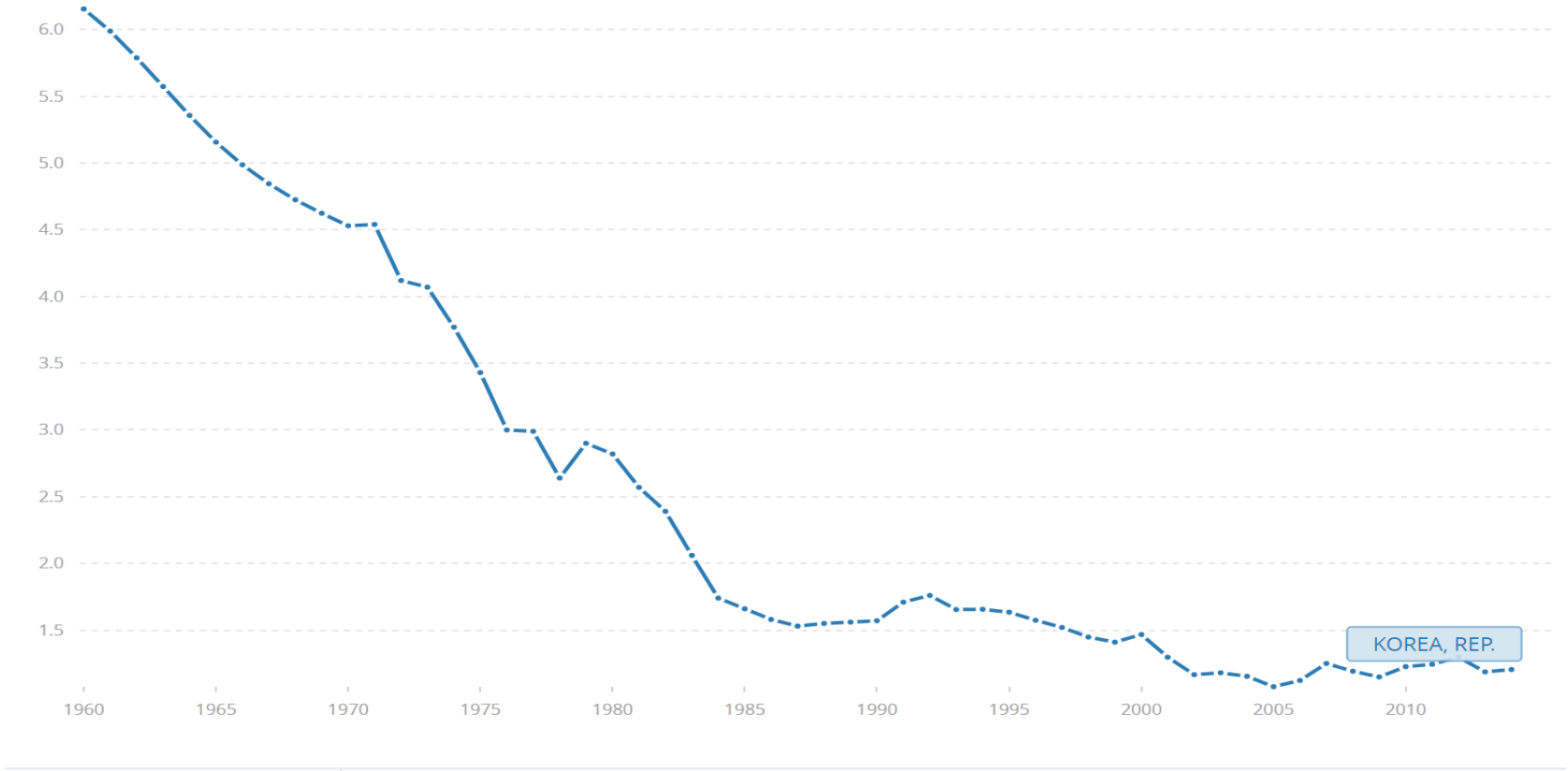
Age-categorized population ratio of elderly to total population, 2010-2060, South Korea

H. Kim (2017): Long-term care system in Korea

KOSTAT (2011)

1. Demographic Changes

- **Fertility rate, total (births per woman)**
- 6.2 in 1960
- 1.2 in 2014



World Bank (2016)

1. Demographic Changes

- **Increase in dependency ratio**

- The **age dependency ratio** will double (17.9 to 38.6) between 2015 and 2030 and double again (38.6 to 80.6) between 2030 and 2060.

- The **aging index** is expected to increase almost twenty times (20 to 394.0) between 1990 and 2060 due mainly to low fertility rates along with increasing life expectancy.

- The **working-age population** is also expected to dramatically decrease.

	Age Dependency Ratio	Aging Index
1990	7.4	20.0
2000	10.1	34.3
2015	17.9	94.1
2030	38.6	193.0
2040	57.2	288.6
2060	80.6	394.0

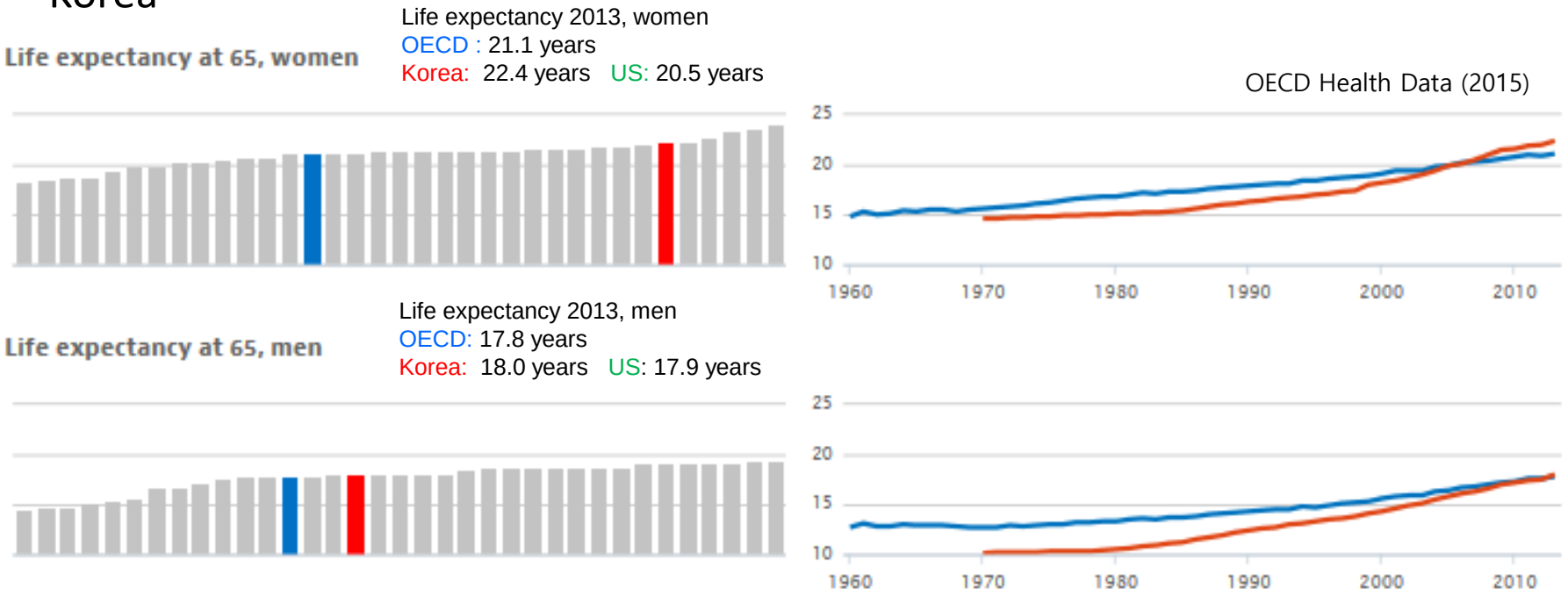
- Age dependency ratio = (population aged 65+/ population aged 15-64) * 100

* Aging index = (population aged 65+/ population aged 0-14) * 100

Aged Statistics (2015)

2. LTC needs: Increasing Life Expectancy

- Rapid increase in **life expectancy** of Koreans over the last 40-50 years
  - Life expectancy in Korea (at birth): 81.8
  - OECD average: 79.8; Japan: 83.4
- Prolonged **life expectancy at 65**
- 18.0 (M) & 22.4 (F) yrs. in Korea vs. 17.8 (M) & 18. 0 (F) yrs. of OECD avg. in 2013
- Yet **disability-free life expectancy** is much lower: 15.2 (M) & 18.2 (F) at 60 in Korea



2. LTC needs: Increasing Health and Care Needs

- **Top 5 reasons for death** of people 65+ are non-communicable diseases (NCDs): cancer, heart disease, cerebrovascular disease, pneumonia, and diabetes
- **Self-reported health**: poor, by 48.7% of older people (M: 38.5, F: 54.4)
- **Older people with chronic diseases**

- Older people with one or more chronic diseases: 89.2%

- **Limitations in ADL and IADL**

- People who have limitations in IADL: 18.2%

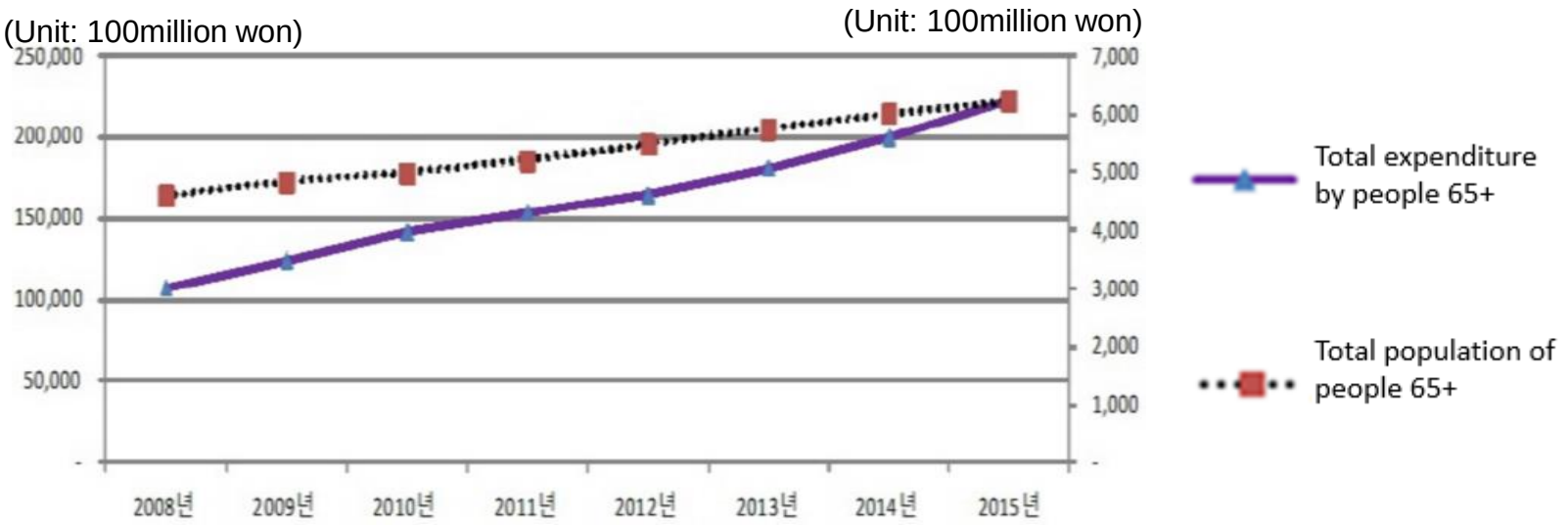
  (IADL limitations only: 11.3%; IADL & ADL limitations: 6.9%)

- **Suicide death rate**: 55 per 100,000 people; #1 among OECD countries
- **Poverty rate**: 12.6%, #1 among OECD countries

OECD (2012, 2015); KMHW (2015)

2. LTC needs: Increasing Healthcare Expenditure

- **Rapidly increasing health care expenditure of older population**: 35.1% of NHI expenditure for people aged 65+ (about 13.1% of total pop.); trend is a consistent increase (607 billion won in 2005 -> 2180 billion won in 2015)
- **Key factors r/t increasing health care expenditure of**
  - Increased need for health services
  - Higher expectations for health and well-being
  - Diversification of medical technology and services
  - Social hospitalizations



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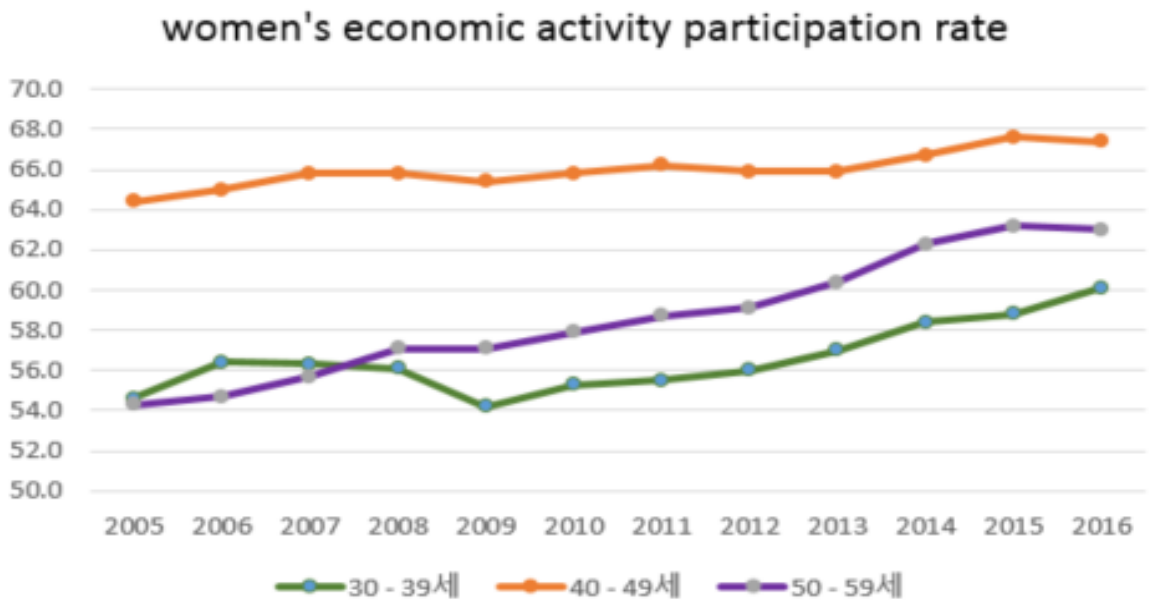
KMHW (2015)

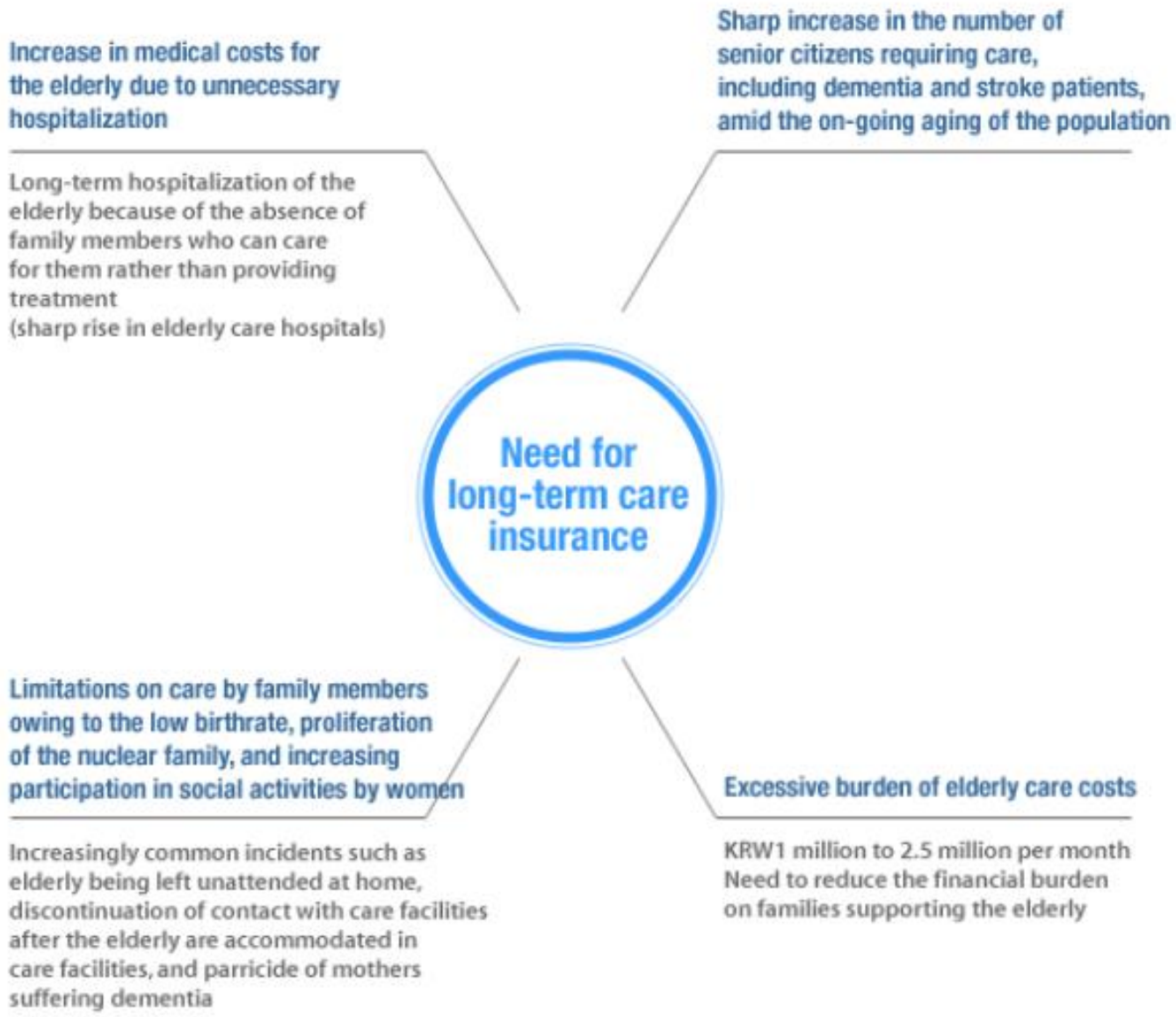
2. LTC needs: Changes in Social-Family Context

- **Changes in Family Structure and Values**
  - The head of one in five households is aged 65+
  - Living alone or with spouse only: 14.2% in 2015; will be double (28.5%) in 2035.
  - Expecting to live with children in the future: 27.6%
  - Increased women's social participation
  - Increasing consensus on social responsibility for caring older people



KOSTAT (2016)

Increasing LTC Needs



KMHW (2014)

II. Social Long-Term Care Insurance Program in **Korea**

Introduction of the LTC Act: **Progression**

’01.8	President’s congratulatory address on the independence memorial day: Suggestion to create the Long-Term Care Security System for the Elderly
’03.3	Establishment & operation of Public Long-Term Care Security Planning & Promotion Team
’04.3	Public Long-Term Care Security System for the Elderly: Establishment of the Committee for Execution and Planning & Implementation Team
’05.5	Arbitration between ministerial party & gov’t. confirms an implementation plan including regulations, etc.
’05.10	Pre-announcement of the Act for Long-Term Care Security for the Elderly
’06.2	Approval of the Act for Long-Term Care Security for the Elderly by the Cabinet Council & submission to Congress
’06.9	Examination by Congress
’07. 4	Establishment of the Act for Long-term Care Security for the Elderly

KMHW (2010)

Policy Context

- Traditionally known as a country with Confucian and/or developmental welfare regime(s)
- Pro-welfare KIM Dae-Jung gov't (1998-2003) overhauled the social security programs; introduction of LTCI as the state's response to social issue of aging and low fertility
- Welfare bureaucrats had the key role in the LTC policy-making process; lack of civil organizations; diverse stakeholders' opinions were not fully addressed in the design of LTCI scheme
  - Implemented in 2008 (NOH Moo-Hyun gov't, 2003-2008): took a relatively short time since its first discussion in 1999
  - High proportion of institutional-care provision; weak role of local government; social care-based LTC model over health care-based model (concerns for medicalization)
  - Social insurance model with mainly private provision and no gatekeeping (maximizing beneficiaries' choice); similar to HI (path dependency) that causes high competition and risk for lower quality to make profit

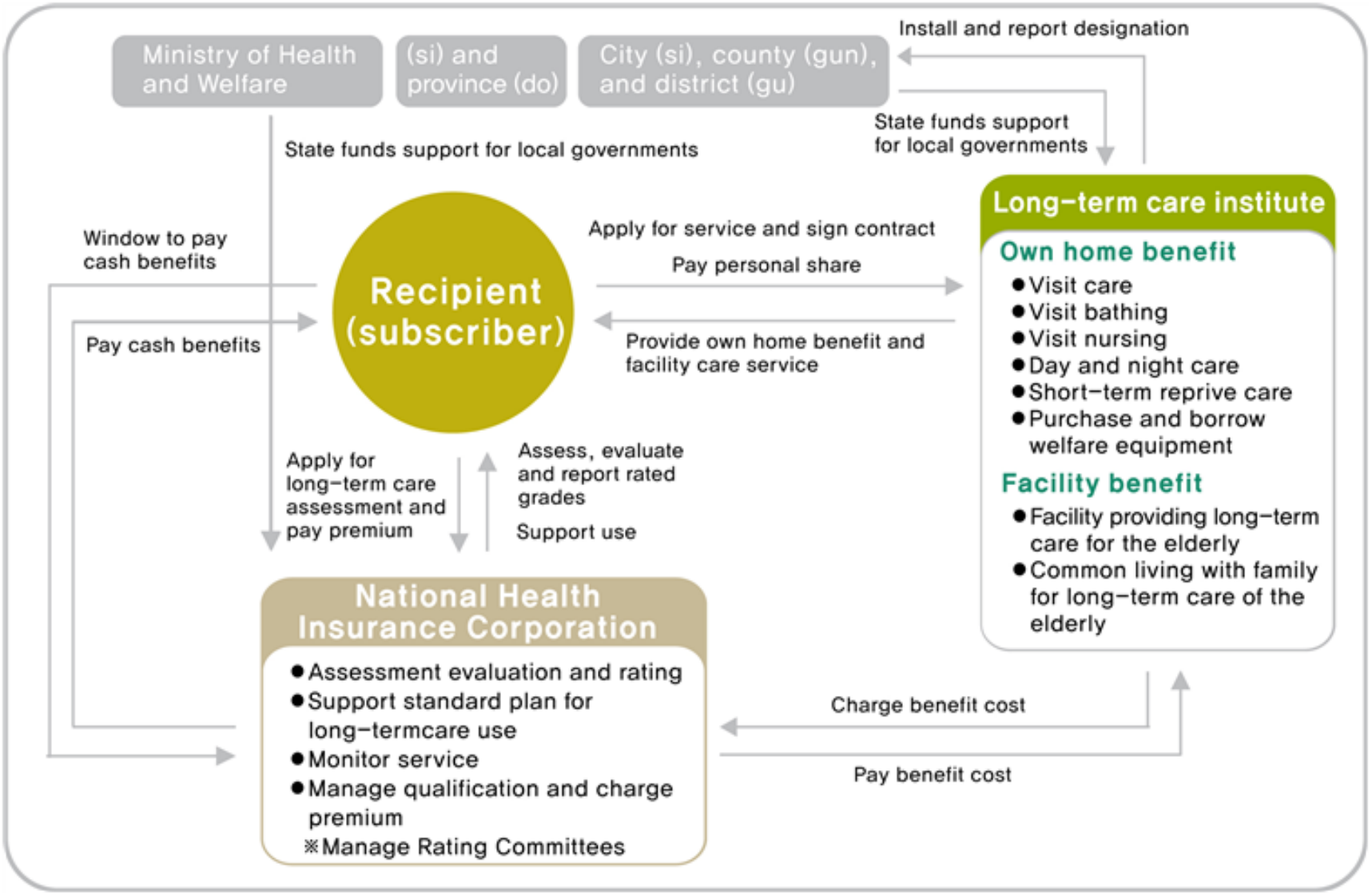
Choi (2015), Kim & Choi (2013)

The LTC System in Korea: Purpose

- Support physical activity or housework for the elderly who have difficulty taking care of themselves due to old age or geriatric diseases
- Promote senior citizens' health and life stabilization as well as improve the quality of people's lives by mitigating the burden of care on family members

  (Article 1 of the Act for LTCI for Senior Citizens)

The LTC System in Korea: How It Operates



H. Kim (2017): Long-term care system in Korea

NHIC LTC (2016)

The LTC System: Key Building Blocks

- Building blocks & issues in organizing the LTC system

1. LTC insurance financing schemes
2. Population coverage & eligibility
3. Types of benefits
4. LTC supply
5. LTC workforce
6. Quality monitoring/assurance mechanism

1. Financing the LTC System (1)

- Introduced in July 2008
- A social insurance scheme
- Contribution-based social insurance financing system (vs. tax-based)
- LTC insurance & health insurance

- Shared governance and administrative bodies

  The Ministry of Health & Welfare (MOHW)

  The National Health Insurance Corporation (NHIC)

- But separate financing schemes causes issues in coordinating health care (including long-term care hospital care) under HI and long-term care under LTCI

Health Policy 119 (2015) 1330–1337

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Delivery of institutional long-term care under two social insurances: Lessons from the Korean experience

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ABSTRACT

Little is known about health and social care provision for people with long-term care (LTC) needs under multiple insurances. The aim of this study is to compare the profile, case-mix, and service provision to older people at long-term care hospitals (LTCHs) covered by the national health insurance (NHI) with those of older people at long-term care facilities (LTCFs) covered by the public long-term care insurance (LTCI) in Korea. A national LTC survey using common functional measures and a case-mix classification system was conducted with a nationally representative sample of older people at LTCFs and LTCHs in 2013. The majority of older people in both settings were female and frail, with complex chronic diseases. About one fourth were a low-income population with Medical-Aid. The key functional status was similar between the two groups. As for case-mix, more than half of the LTCH population were categorized as having lower medical care needs, while more than one fourth of the LTCF residents had moderate or higher medical care needs. Those with high medical care needs at LTCFs were significantly more likely to be admitted to acute-care hospitals than their counterparts at LTCHs. The current delivery of institutional LTC under the two insurances in Korea is not coordinated well. It is necessary to redefine the roles of LTCHs and strengthen health care in LTCFs. A systems approach is critical to establish person-centered, integrated LTC delivery across different financial sources.

1. Financing the LTC System (2)

LTC insurance financing schemes

- LTC Insurance Bill (Contribution: 60-65%)
  - » Imposed under health insurance bill
  - » Managed as an independent account
  - » Insurance bill = health insurance bill x rate of LTC Insurance bill (avg. 6.55% in 2012; 5,211 Won [approx. $5] per month)
- Government Subsidy
  - » About 20% of the expected income from LTC insurance bill
  - » Admin. cost of NHIC (by nat'l. & local gov't.)
- Co-payment
  - » Institutional care (20%) vs. home-based care (15%); discounted or cost-exempted for the low-income population

Health Policy 111 (2013) 166–174

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journal homepage: www.elsevier.com/locate/healthpol

Utilization of long-term care services under the public long-term care insurance program in Korea: Implications of a subsidy policy

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ABSTRACT

Objectives: South Korea introduced public long-term care insurance (LTCI) in 2008. This study examined the patterns of and factors associated with public long-term care (LTC) utilization among older LTCI beneficiaries in Korea, with special attention to the policy for subsidizing the co-payments of lower income populations.
Methods: Using a 5% national representative sample of 280,290 older people aged 65 or older obtained from the 2010 national LTCI claims database, we examined socio-demographic and health factors associated with service utilization decisions, service type chosen, and the intensity of service use.
Results: About 5.48% of older adults in 2010 utilized the LTC provided under the Korean public LTCI, among which about 26.1% received a subsidy. Compared to their counterparts, the subsidized users were more likely to be low-income, female, and living alone. They were more likely to choose institutionalized care and spend to their monthly benefit limit while paying a lower co-payment. The factors associated with pattern and intensity of LTC utilization were not the same between subsidized and non-subsidized users.
Conclusion: The findings imply the subsidy policy promotes equity of access to public LTC services. Further evaluation is necessary on the impact of the policy on the effectiveness of LTC utilization by socially marginalized populations.

<Abstract>

Horizontal Equity in the Use of Home Care and Health Care among Home Care Recipients under the Public Long-term Care Insurance in South Korea

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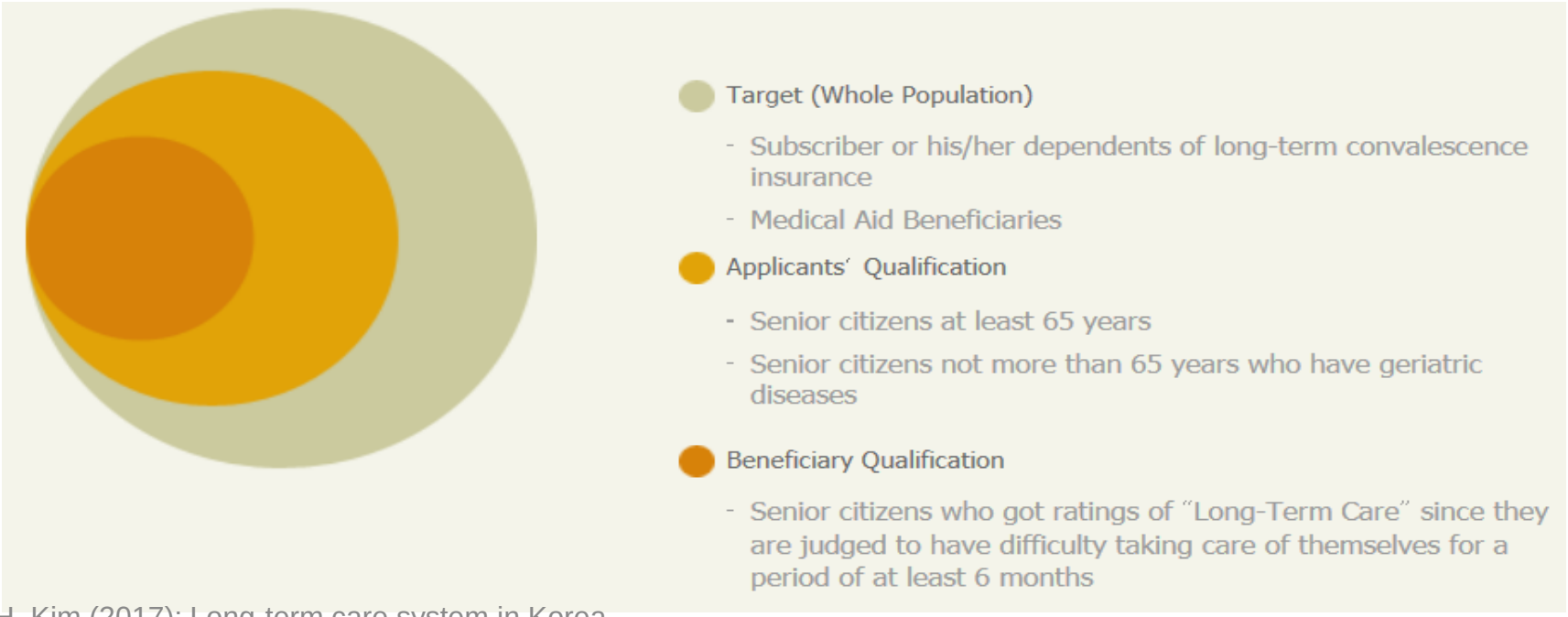
*** Seoul National University School of Public Health, Asian Development Bank (ADB))

The purpose of this study is to evaluate income-related horizontal equity in home care utilization and health care utilization among home care recipients under the public long-term care (LTC) insurance program in South Korea. We analyzed a 5% sample of older people aged 65 or older and their health and LTC insurance data. Income-related inequality in utilization was measured by the horizontal inequity (HIwv) index. Results showed that HIwv index scores in home care utilizations were negative or zero, which implies equitable use for the poor. More frequent service use with a similar level of out-of-pocket payment suggests the appropriateness of home care use under LTC insurance need to be further evaluated. Positive HIwv scores in heath care utilizations (outpatient visits, cost and inpatient days, cost) shows potential unmet health care needs among the poor. Recommended are policy interventions that can improve the coverage of the two social insurance programs, ensuring the income-related horizontal equity.

Jung, Y-I., Kim, H., & Kwon, S. (2016). Horizontal equity in the use of home care and health care among the beneficiaries of public long-term care insurance. *Korean Journal of Health Economics and Policy, 22(4), 59-78.*

2. Population Coverage/Eligibility (1)

- **Population coverage/eligibility**
  - Adults aged 65+ or those below 65 with an age-related disease
  - **And** those past certain thresholds of care needs defined by the nationally standardized care-need certification (CNC) system based on 5 functional levels: Level I (wholly dependent) through Level 4 (moderate dependent) and Level 5 (special level for mild dementia)
- No coverage for people with disability-related needs



H. Kim (2017): Long-term care system in Korea

2. Population Coverage/Eligibility (2)

- **The Care-Needs Certification (CNC) System**
  - A nationally standardized system to determine service eligibility for the Korean LTC insurance program
  - Similar to the Japanese CNC system
- **The initial needs-assessment instrument**
  - 5 areas & 51 items: ADL (12); Cognition (7); Problem Behaviors (14); Nursing Care (9), Contracture (10)
- **Case-mix grouping is based on a decision-tree algorithm developed by the NHIC**
  - Assessors: trained local government officials
  - Decisions: made by the Care-Needs Certification Board based on physician report as well as the algorithm-based grouping based on the assessment results
  - Concerns regarding the initial needs-assessment instrument
  - Need for further validation; concerns for gaming in need assessment process

2. Coverage Expansion

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Trends in Eligible Population

Care Level	2011	2012	2013	2014	2015
a. Population aged 65+	5,644,758	5,921,977	6,192,762	6,462,740	6,719,244
b. Applicants	617,081	643,409	685,852	736,879	789,024
c. Certified (Levels 1-3) & Extra Levels A, B)	478,446	495,445	535,328	585,386	630,757
d. Certified (Levels 1-3)	324,412	341,788	378,493	424,572	467,752
d/c * 100 (%)	67.8	69.0	70.7	72.5	74.2
Population coverage d/a * 100 (%)	**5.7%**	**5.8%**	**6.1%**	**6.6%**	**7.0%**

NHIS LTC (2016)

2. Coverage Expansion

- Recent expansion of coverage
  - » Revision of the Care-Needs Certification system
  - Entry to “Level 3” lowered: 55 → 53 (2012.07) → 51 (2013.07)
  - Extended the LTC-level expiration date: 1-2 → 2-4 yrs. (2016.11)
  - Created special level for older people with dementia (2014. 07)
  - Introduced respite care for caregivers (2014.07)

Changes in level & score

Care Level in 2013	Level 1	Level 2	Level 3	Other
Score	95	75	51	45

Care Level in 2014	Level 1	Level 2	Level 3	Level 4	Other
					Level 5 (Special level for mild dementia)
Score	95	75	60	51	45

NHIC LTC(2016)

2. Coverage Expansion: Continuum of Care
Coverage by the LTCI and tax-based Social Care

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- **The Public LTCI (National)**

  The NLTCI, a nation-wide mandatory social insurance program; services delivered at local level in collaboration with local gov'ts; target the disabled elderly [**Levels 1- 5** in the NLTCI-CNC system]

- **Community Social Care Programs for the Elderly (Local)**

  Local government-funded social welfare services; target the frail/pre-frail elderly [**Extra Levels A & B**] with low income

- **Community Health Care Programs for the Elderly (Local)**

  Chronic-care management services at community health centers (CHCs); local government-funded programs; programs vary across CHCs; target the frail/pre-frail elderly [**Extra Levels A-C**]

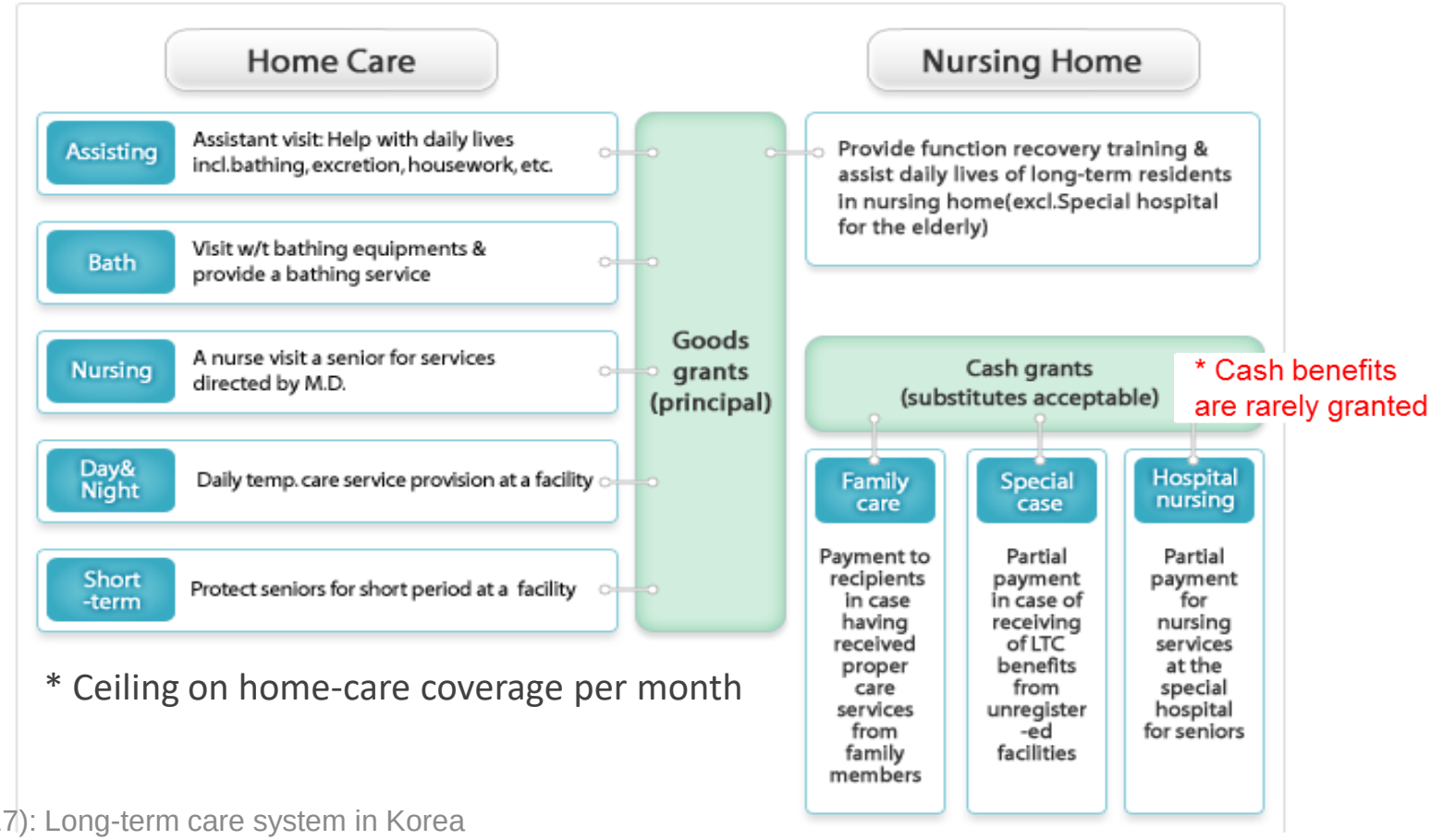
Level 1	Level 2	Level 3	Level 4	Extra Level A Level 5	Extra Level B & C
95	75	60	51	45	B (40-45), C (<40)

The Care-Need Certification (CNC) System in the NLTCI

3. LTCI Benefits (1)

Payment schemes

- Pay-per-day: day & night, short-term, & nursing home care
- Pay-per-hour: assistance & nursing at home
- Pay-per-visit: bathing



* Ceiling on home-care coverage per month

3. Trends in LTC Benefits (2)

	2010	2011	2012	2013	2014
Home-visit care	9,164	8,709	8,500	8,620	9,073
Home-visit bathing	7,294	7,162	7,028	7,146	7,479
Home-visit nursing	739	692	626	597	586
Day and night care	1,273	1,321	1,331	1,427	1,688
Shot-term care	199	234	257	368	322
Welfare kit	1,278	1,387	1,498	1,574	1,599
(Unit: number)					

H. Kim (2017): Long-term care system in Korea

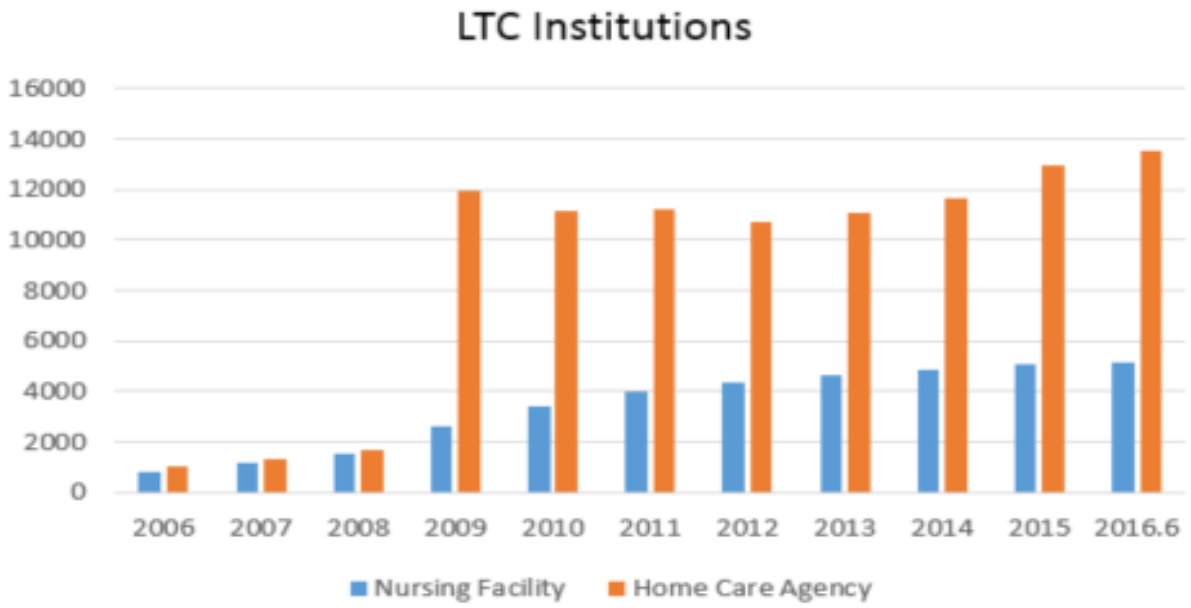
NHIS LTC (2016)

3. LTCI Benefits (3)

- High proportion of institutional care due to high severity of beneficiaries, preference of institutional care
- Consistent efforts to promote HCBS; need to improve quality, quantity, and mix of care
- Lack of mechanism to guide beneficiaries to choose appropriate type and intensity of benefits within and between home-based and nursing home- (institution-) based care
  - Disincentive to use proper but higher co-payment services
  - Potential threat to the appropriateness of LTC
- LTC hospital services are not a benefit of LTC insurance but that of health insurance
  - Substitute rather than complimentary
  - coordination issues

4. LTC Supply (1): A rapid Increase

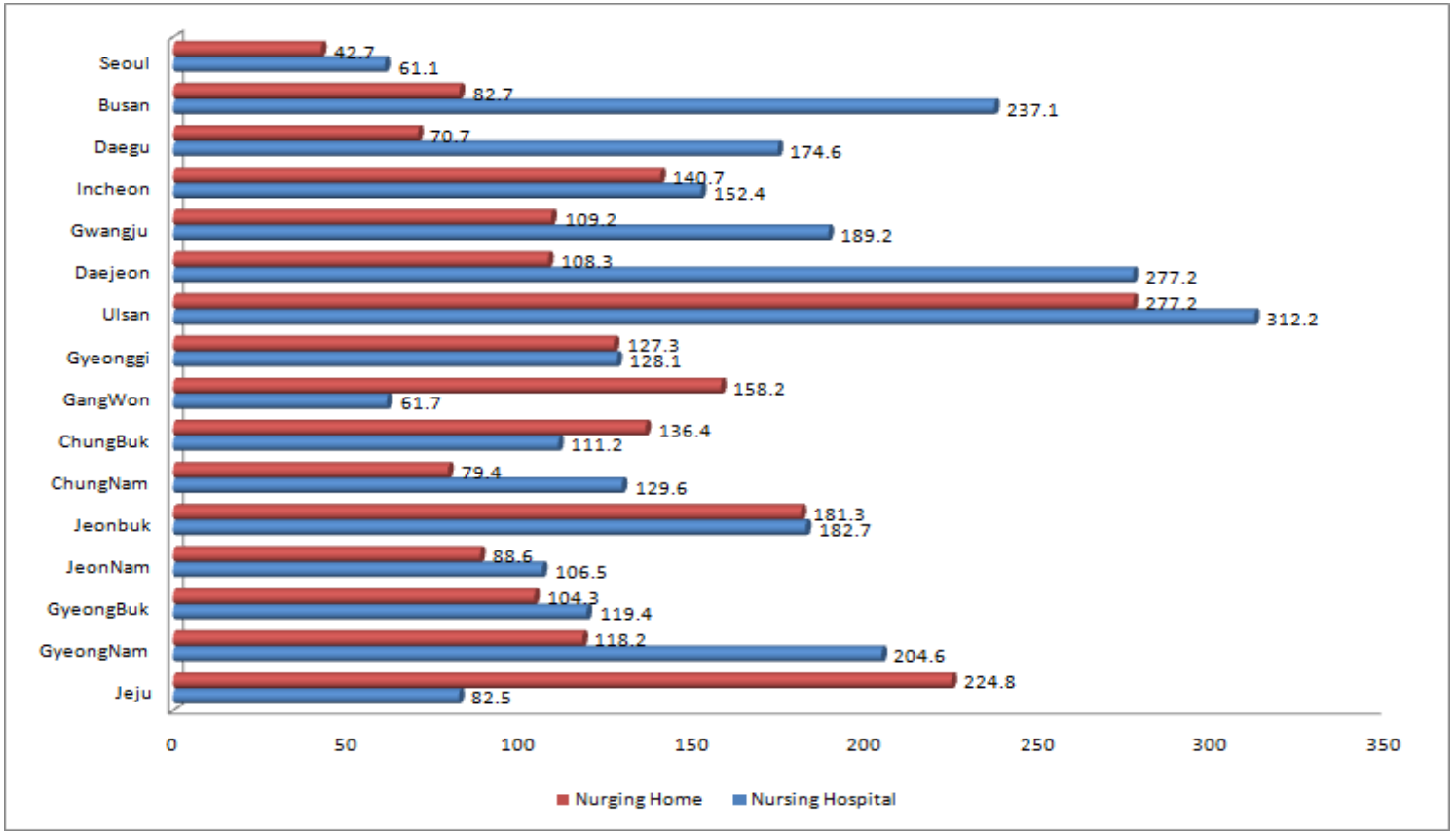
- Lack of community-based LTC institutions (home-care agencies / nursing homes) when the LTCI was introduced in 2008
- Rapid increase in the supply of LTC (high interest of private providers in the new market, loose regulations, etc.)
- Sufficient supply (or oversupply), but concerns about providers with poor infrastructure and staffing -> poor quality
- Challenge to monitor and control quality of care as well as set higher standards



KMHW (2016); Kim (2009)

4. LTC Supply (2): Variations

- Wide geographic variations in the supply of LTC facilities and LTC hospitals
- Need for more active role of local governments in the provision of LTC



Seo (2009)

5. LTC Workforce (1)

- Evidence says the direct-care workforce is a key factor in quality of LTC / proper training and supervision is necessary
- Current nursing staffing standard in Korean nursing homes (personal care assistant [PCA] to resident ratio = 1:2.5)
- Concerns about the lack of supply of direct-care workforce at the beginning of LTCI program, July 2008
- Issuance of personal care assistant (PCA) certification program, resulting in over-supply of PCAs

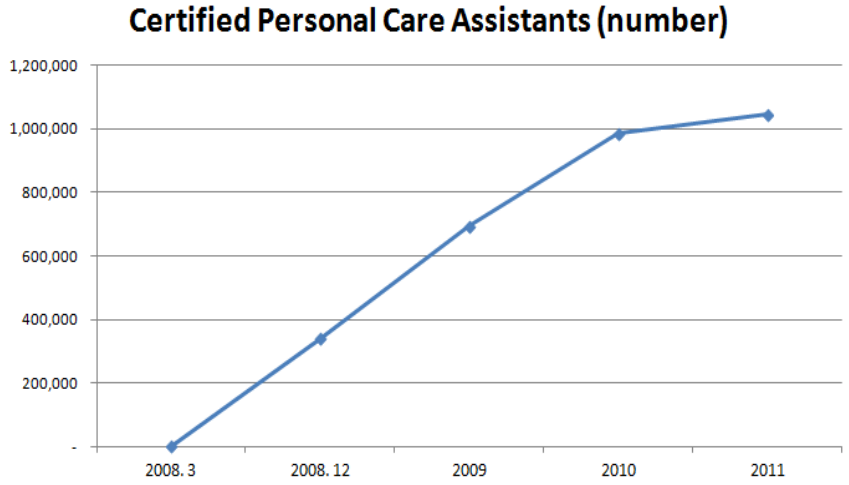
- Anecdotal evidence:

  Lack of competencies

  Poor work conditions

  High turnover

- POLICY CHANGE (April 2010)

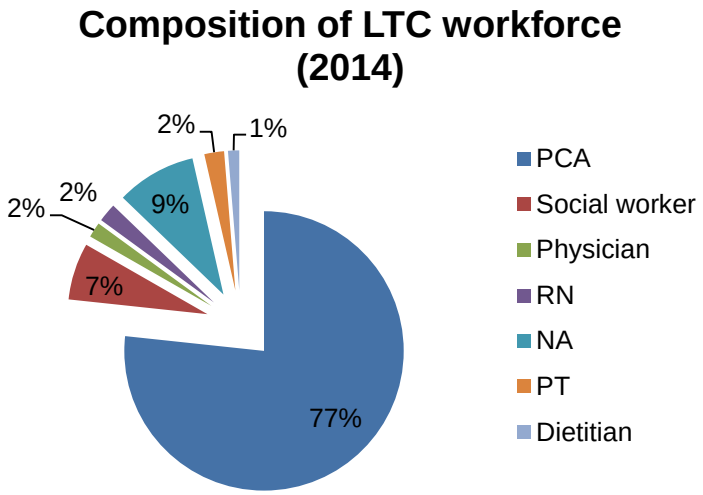


- Required to pass a national PCA certification examination

5. LTC Workforce (2)

- **Currently, PCAs compose 77% of total LTC workforce**

- Implies services are mainly functional assistance
- This may meet a main goal of the introduction of LTCI: a decrease in the burden of family caregiving
- Is this the only goal? Maybe not.
- Also, does this match with the needs of current and future (possibly extended) LTC clients/users?



- Should give attention to complex health conditions, which cause functional dependence
- Need for provision of workforce to promote secondary/tertiary prevention for LTC residents; a key mechanism to decrease health care costs and improve QoL of residents, according to the experience of other countries

6. Quality Monitoring/Assurance System (1)

- 1st LTC institution survey, Sept.-Nov. 2009
- Voluntary
- More than 80% of LTC institutions participated
- A total of 106 quality items, mostly yes/no questions
- Open to the public: the list of institutions in the top 10%
- In 2010, it became a mandatory evaluation by NHIC every other year for all nursing homes & home-care agencies
- Concerns for quality of quality monitoring program
- Mainly structure aspect of care; Lack of quality monitoring on care quality itself
- Needed are stronger clinical tools for ongoing resident assessment and care planning that can promote quality of care

Yoo, A. & Kim, H. (2016). Factors associated with physical restraints use of older adults in nursing homes and long-term care hospitals. *Korean Journal of Health Economics and Policy. 22*(1), 39-58.

<Abstract>

Physical restraints use and associated factors among older adults in nursing homes

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Purpose: This study aims to examine the extent of physical restraint use and associated patient- and facility-level factors among older adults in nursing homes in Korea. Method: The sample includes 307 randomly selected older residents in 10 nursing homes. Data on the functional status of these older adults and the services they received were collected using the Korean version of interRAI LTCF. Data on facility characteristics including staffing level were also collected through chart review and confirmed by staff. As physical restraints, full-side bed rails, trunk restraints, and chairs preventing rising were observed in this study. Multi-level, multivariate analyses were conducted. Results: About 78.2% of older residents in the sample were restrained by full-side bed rails and 31.9% by trunk restraints and/or chairs preventing rising. Restraint use was associated with several patient (cognition, ADL, and dependence in moving around) and also facility (size, ownership, type, staffing level) characteristics. Conclusion: This is the first empirical study on physical restraint use among older adults in nursing homes in Korea. Physical restraint use was prevalent, and several patient- and facility-level factors were simultaneously associated. Needed are facility-level strategies to decrease physical restraints and policies to promote such strategies.

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METHODOLOGICAL REPORT: EPIDEMIOLOGY, CLINICAL PRACTICE AND HEALTH

Reliability of the interRAI Long Term Care Facilities (LTCF) and interRAI Home Care (HC)

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Aim: Sharing clinical information across care settings is a cornerstone to providing quality care to older people with complex conditions. The purpose of the present study was to examine the reliability of the interRAI Long Term Care Facilities (interRAI LTCF) and the interRAI Home Care (interRAI HC), comprehensive and integrated assessment instruments with common core items, in Korea, an Asian county where comprehensive geriatric assessment is not widely used in long-term care.

Methods: The Korean version of the instruments was developed through field tests, as well as multiple iterations of translations, back-translations and expert reviews. For the reliability test, a random sample of 908 older people in 27 long-term care hospitals or nursing homes, or at home with home care, were assessed by regular staff, among which a subsample of 534 people were dually assessed. The Cronbach's alphas of seven major composite scales in the instruments were examined for internal consistency. Interrater reliability was tested using agreement, kappa coefficients and interclass correlation coefficients.

Results: The internal consistencies of all key measures were adequate (Cronbach's alpha ≥0.75). The overall mean kappa statistics of the items in the interRAI LTCF and those in the interRAI HC were 0.78 and 0.89, respectively. All key common items in the interRAI LTCF and the interRAI HC had almost perfect ($\kappa \geq 0.81$) or substantial ($0.61 \leq \kappa \leq 0.80$) interrater reliability.

Conclusions: The findings show the interRAI LTCF and the interRAI HC have adequate reliability for assessing the function and health of frail older adults across various long-term settings, which can promote continuity of care for the aged. **Geriatr Gerontol Int 2015; 15: 220–228.**

Keywords: continuity of care, geriatric assessment, long-term care, reliability.

Future Agenda

Summary of Key Achievements

- South Korea does now have a public-funded comprehensive LTCI program with universal coverage;
  - Before the LTCI implementation, only about 1 percent poor older people received benefits of public LTC services.

- The LTCI program
  - has been operating for over 9 years without a catastrophic event
  - provides benefits to the frailest older people; opens a channel to decreasing the burden of family caregiving (high satisfaction (89.1%) of users in 2014)
  - Universal coverage through subsidy for the poor to enroll “the social LTCI”

- Rapid development of the infrastructure for LTC delivery (e.g., LTC institutions and direct-care workforce have been strengthened, at least in number)

Choi (2015); MOHW (2014)

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재가 장기요양 서비스 이용과 노인 가족돌봄제공자의 돌봄 스트레스: 방문간호 서비스의 영향

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Effects of Home Care Services Use by Older Adults on Family Caregiver Distress

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Purpose: The purpose of this study was to examine the association between utilization of home care services under the national long-term care insurance system and family caregiver distress. **Methods:** A secondary data analysis was conducted in this study using data collected in 2011 and 2012 from the Korean version of International Resident Assessment Instrument (interRAI) Home Care assessment system. The study sample included 228 clients receiving community based home care and their family caregivers in Korea. Descriptive statistics, χ^2 test, t-test, and Heckman selection model analysis were conducted using SAS 9.3. **Results:** Presence of family caregiver distress was significantly associated with days of nurse visits (ß=-.89, p=<.001) and home helper visits (ß=-.53, p=.014). Level of caregiver distress was also significantly associated with days of nurse visits (ß=-.66, p=.028). Other factors which were significantly associated with caregiver distress were depression, cognitive function, inadequate pain control, social support for older adult, and caregiver relationship to the older adult. **Conclusion:** The results of this study show that visiting nurse service and appropriate support programs for Older Adults and family caregivers experiencing caregiver distress should be developed and provided to families based on the health care needs of older adults and their family caregivers for effective and sustainable home care.

Agenda: 1. Population Coverage

- Financial sustainability of the NLTCI was a core policy agenda at the inception of the program; its downside is limits in population and service coverage.

- Limited population coverage of the NLTCI: has increased from 3.3% in 2008 to 7.2% of people aged 65+ in 2016 (LTC expenditure: 0.6% of the GDP in 2012)
  - Germany: 14.1% (1.8% of GDP), Japan: 18.3% (1.0% of GDP)
  - Need to refine the current care-needs assessment system in terms of scope and methods

- Limited population coverage of LTC by local government: mainly targeting the very poor population

* Limited financial protection, especially for those who have a relatively low income but are not below the poverty line

Kim, H. & Kwon, S. (2012). Projection of demand and expenditure for services under long-term care insurance for the elderly in Korea. *The Korean Journal of Health Economics and Policy, 18*(3), 29-51.

<Abstract>

Projection of demand and expenditure for services under long-term care insurance for the elderly in Korea

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Korea's national long-term care insurance (LTCI) was introduced in 2008, aiming to meet the increasing long-term care (LTC) needs of an aging population. The purpose of this study is to project demand and expenditure for services under LTCI to 2050 as well as develop a projection model. The analytic dataset was developed by merging 2006 population projection data, 2010 health insurance claims data, 2010 LTCI claims data and care needs certification data. The data includes a 5% random sample of all people aged 65 or older. Guided by the U.K. PSSRU's projection model of LTC demand, the projection model of this study was a cell-based model that included a total of 160 cells categorized by sex, age, having one or more chronic conditions, living arrangement, and income. The number of service users was projected by multiplying the estimated probabilities of home and institutional LTC utilization among the population in each cell by the projected population. Total expenditure was projected by multiplying the projected number of users by the average service expenditure in 2010. Sensitivity analyses and scenario analyses were conducted. The findings show service users under LTCI will increase from 5.79% of Korean people aged 65 or older in 2010 to 9.29% in 2050. The projected expenditure in 2050 ranges from 0.37% to 0.97% of GDP. Policy implications as well as a comparison of study findings with existing studies are discussed.

Agenda: 2. Service Coverage, Quality, & Coordination

- Challenges in meeting health care needs of NLTCI beneficiaries
  - NLTCI was designed to focus on the social aspect of LTC, but beneficiaries have higher and more complex health care needs
  - Difficulties in the coordination of health care covered by NHI with LTC covered by NLTCI
- Service range and mix
  - HCBS in the NLTCI were mainly basic ADL and daily-living support and also delivered in a fragmentary way
- Fragmentations within and between service deliveries in community-based LTC under NLTCI and local gov’ts
- Limited channels for input from older people and family: no person-level assessment of quality of care and quality of life beyond an eligibility test with 51 items only

Agenda: 3. Roles & Responsibilities of Local Governments

- Need to refine the roles and responsibilities of local gov’ts to promote community-based LTC
- Under the NLTCI, local gov’ts have roles limited to Levels 1-5 in the certification and regulation of LTC institutions, but they are responsible for delivery to and partial financing for people with Extra Levels A & B.
- Lack of financial and human resources for LTC provision by local gov’ts; potential tensions in roles and responsibilities between local LTC systems and the MHW/NHIS
- Policy efforts are needed to build better partnerships between local gov’ts and MHW/NHIS in order to increase access to and enhance quality and continuity of LTC.

Agenda: 4. Integrated Community-Based LTC Systems

- Need to build well coordinated, integrated community-based LTC systems
- Relatively low HCBS use (47.9%, vs. 52.1% institutional care in 2014) compared to other OECD countries
- Higher use of institutional care and lower family burden; limited policies and family support programs
- Aging in place is regarded as an ultimate goal, but a wide range of drastic system reforms along with strong financial and political investments will also be needed. Are we ready?

  - May not be cost-effective, and would involve more family involvement, potential role conflicts/tensions between professions and institutions

- Ideal LTC models in Asia considering our social and economic context? Further research is needed.

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Universal Long-Term Care Insurance Program: South Korea's Experience

Thank You
Q & A?

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