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SNU Health
Graduate School of Public Health

Korean Experience of Public Long-term Care Insurance

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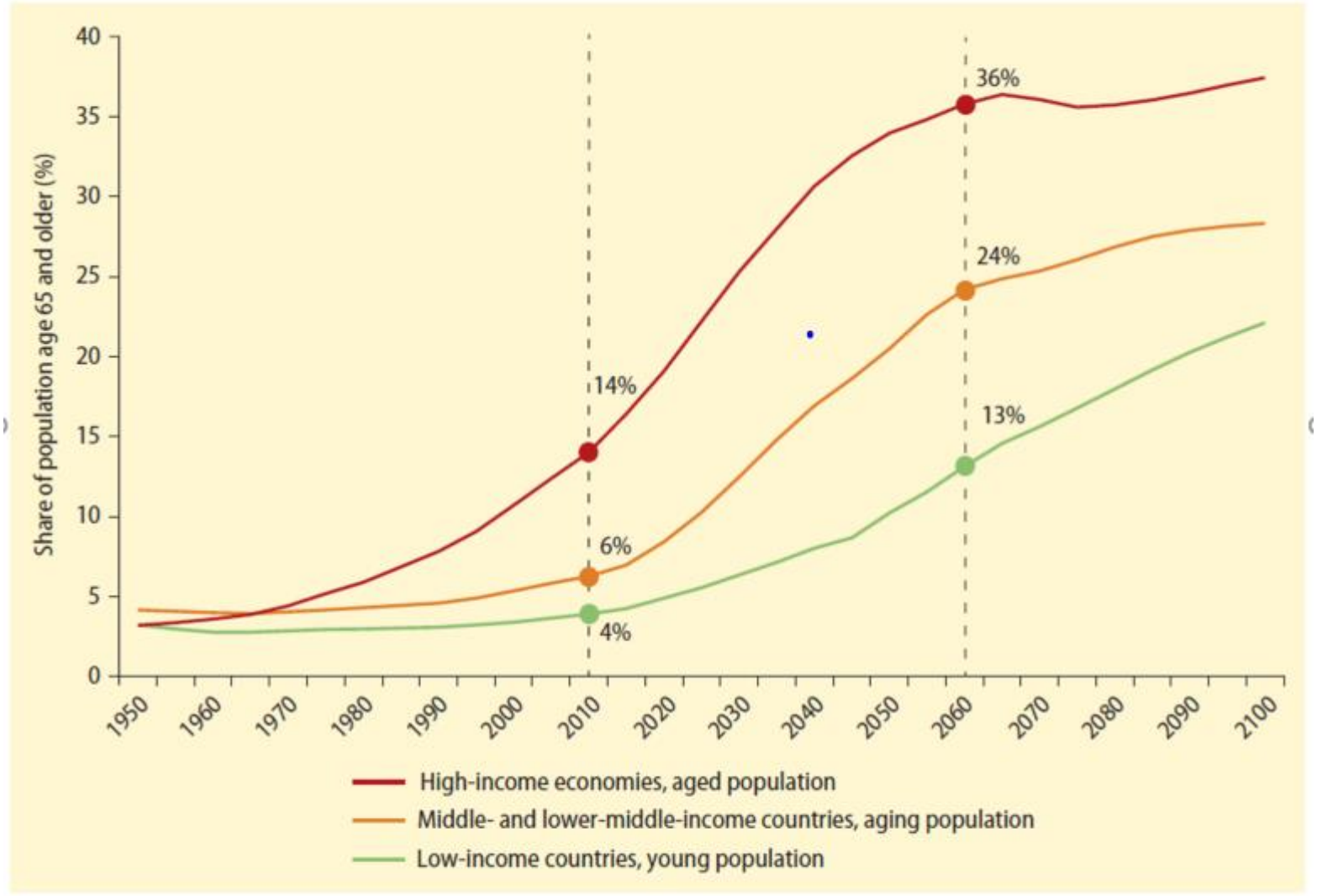
Contents

I. Background

Population Aging in East Asia



Source: World Bank estimates based on data from UN 2013.

World Bank (2016)

Trends and prospects of old-age dependency ratio

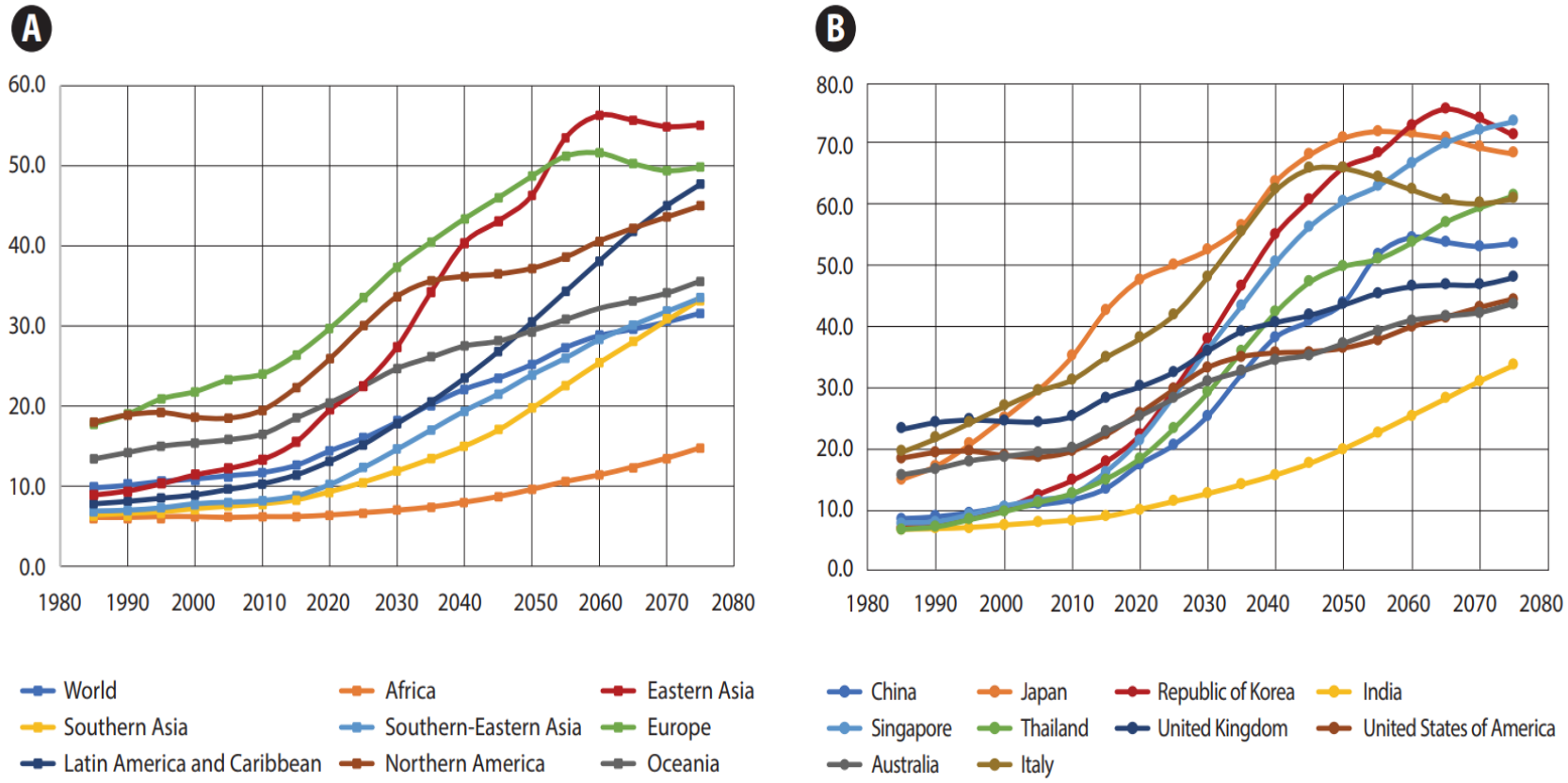
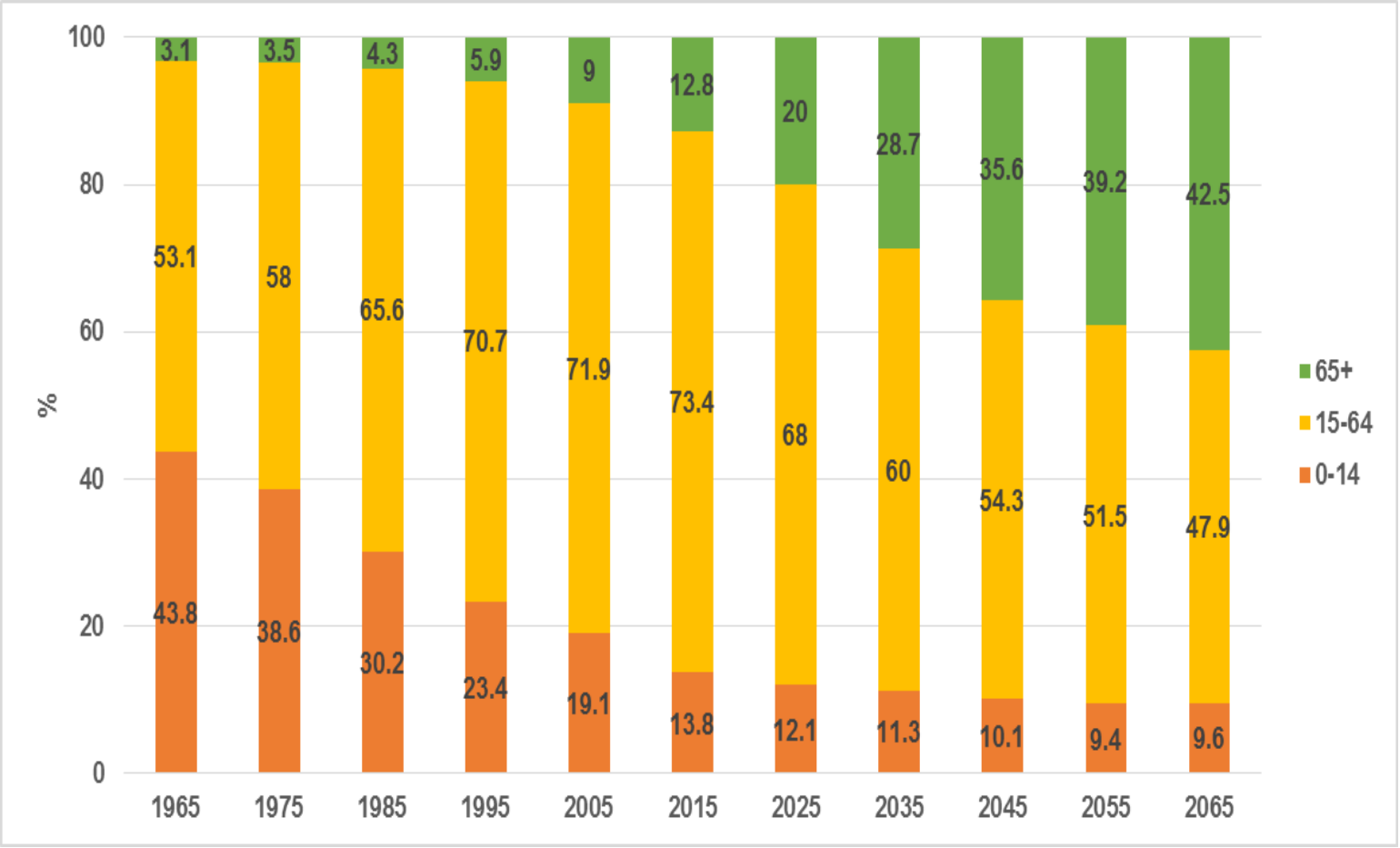


Fig. 1. Trends and prospects of old-age dependency ratio (ratio of population aged ≥65 years per 100 population aged 15–64). (A) Comparison by continents. (B) Comparison by countries. Custom data were acquired from World Population Prospects 2017, Population Division, ©(2017) United Nations ([cited 2017 Oct 16]. Available from: https://esa.un.org/unpd/wpp/DataQuery/). Reprinted with the permission of the United Nations.

Population Trends by Age Group in Korea (1965-2065)



Future Population Projections (KOSTAT, 2016)

Shifts in demography and healthcare needs

- Population aging and increased life expectancy
  - 42.5% over the age of 65 in 2065, median age 58.7 y/o (KOSIS, 2016)
  - Average life expectancy of girls born in 2030 is 91, and 84 for boys (Kontis et al., Lancet, 2017)
- Changes in healthcare needs
  - Increased prevalence of multimorbidity (69.7%, ,avg 2.6 comorbidities); increase in functional limitations including frailty, geriatric syndrome, and sensory impairment; elderly with ADL & IADL limitations(18.2%) (The survey of living conditions and welfare needs of Korean older persons, 2014)
  - Compression of morbidity? Uncertain
- Increase in social responsibility
  - 47.7% Proportion of elderly household in 2045; proportion living with elderly parents (34.1%); introduction of the elderly long-term care insurance in 2008
  - Of those under the national basic livelihood security in 2016, 27.3% were 65+
  - Elderly public pension recipients 44.6%(2016); avg. amount received monthly among 55-79 via pension was 520,000 won (KOSIS, 2016)

Change in needs and impact on current HC system and budget

- Current Healthcare System (OECD, 2015' * OECD avg)
  - No. of beds per 1,000 pop (11.0 vs. 4.8*); avg LOS (16.5 vs. 8.1*)
  - No. of physicians: generalist (23%) vs. specialist (73%) in 2013
  - No. of nurses per 1,000 pop : 5.2 (vs. 9.1*) per 1000 population
  - Proportion of nurses in primary care vs. hospitals (13.3% vs. 72.0%)
- Impact of Population Aging
  - Increase in HC utilization of elderly amidst slow economic growth (HIRA, 2017)
    - In 2016, avg HC costs per elderly was 3,811,000 won (total avg 1,274,000won)
    - The elderly, which account for 13.8% of population utilized 38.0% of HC costs; 15% increase from prv. year (due to expansion in public coverage)
    - Red-herring effects? Perhaps due to chronic conditions, and end-of-life HC costs rather than age (Zweifel et al., 1999; Choe et al. 2010)
  - Aging effect: Decrease in working population -> decrease in premium vs. Possibility of working in old age
  - Short term solutions: re-evaluation of flay payment system for outpatient; Quality assessment for inpatient and reducing LOS (건보공단 용역연구, 2017)
  - Elderly-focused cost-saving policy: unclear results; do not change demand of care (Boult et al., 2009; Taylor et al., 2011)

Needs for health and care system reforms for aging society

- Need to design a new healthcare/long-term care system to meet the needs of a super-aged society
- Improve quality of care to address the complex health and care needs of elderly
- Fundamental change is needed in how we design health systems: a move toward a **person-centered, integrated (coordinated) care system** is needed (WHO, 2015)
- **Need for a comprehensive public health response** to population aging (Beard & Bloom, 2015)
- Public health framework for healthy aging: Strategic Priority Areas (WHO, 2015)
  - Commit to action
  - Aligning health systems to the needs of the older populations they now serve (Health systems that meet the needs of Older People)
  - **Developing systems for providing long-term care (Long-term care Systems)**
  - Creating age-friendly environments
  - Improving measurement, monitoring and understanding (Data & Research)

II. The Public LTCI Program in Korea: Key Features & Development

Purpose of the Public LTCI

- **Implemented in July 2008**
- **Purpose**

  - To support activities of daily living and/or housework for elderly people who have difficulty taking care of themselves due to old age or geriatric diseases

  - To 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 on LTCI for Senior Citizens)

Population Coverage

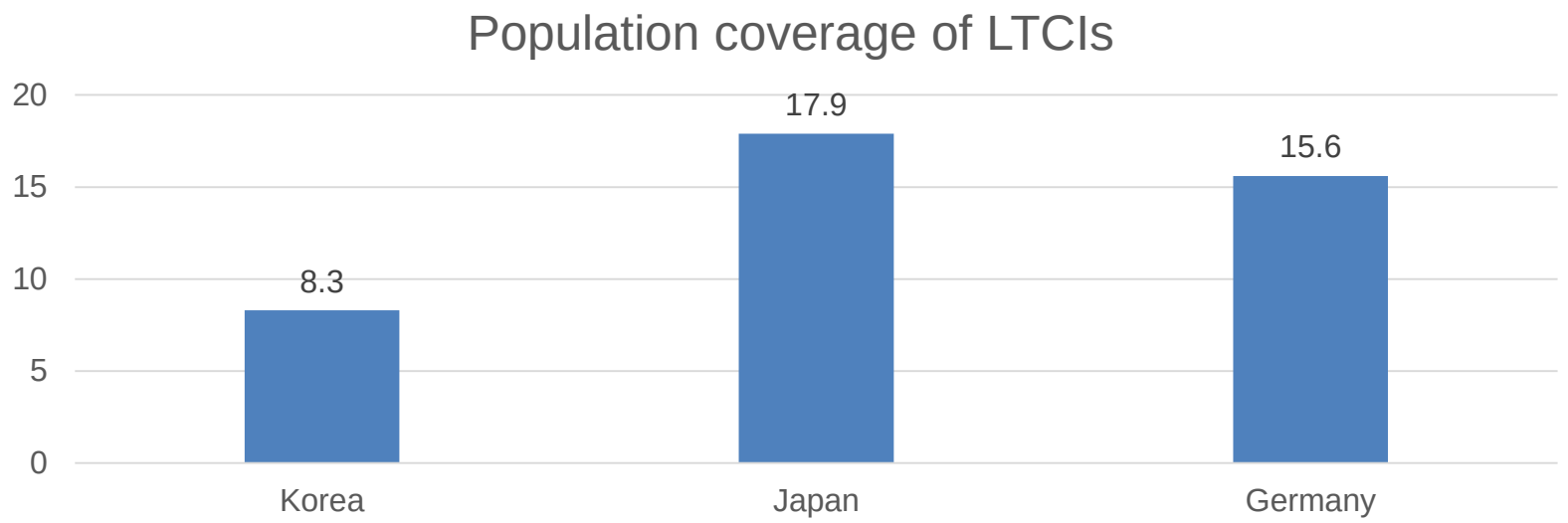
- **Population coverage/eligibility**
  - Adults aged 65+ or those below 65 with an age-related disease
  - **And** those past certain thresholds of care needs defined by the nationally standardized care-need certification (CNC) system
    - Originally a 3-level system; expanded it continuously

Level 1 (wholly dependent)	Level 2	Level 3	Level 4	Level 5	Cognition support grade
95	75	60	51	45 & dementia	<45 & dementia

The Care-Need Certification (CNC) System in the Public LTCI

- No coverage for people with disability-related needs

Population Coverage



Trends in population eligible for the Public LTCI in Korea

	2008	2014	2016	2018	2019	2020
Population aged 65+	5,086,195	6,462,740	6,940,396	7,611,770	8,003,418	8,480,208
Certified (Levels 1-5) *Cognitive support grade included from 2018	214,480	424,572	519,850	670,810	772,206	857,984
Population coverage d/a ** 100 (%)	**4.2%**	**6.6%**	**7.5%**	**8.8%**	**9.6%**	**10.1%**

Japan MoH (2015), NHIS LTCI (2020), OECD (2019)

Financing

- A social insurance scheme
- Contribution-based social insurance financing system (vs. tax-based)
- LTC insurance & National health insurance
  - Shared governance and administrative bodies
    - The Ministry of Health & Welfare (MOHW)
    - The National Health Insurance Corporation (NHIC)
  - But separate financing schemes
    - Several reasons including: Increase of public acceptance for new social insurance (LTCI; WTP); Concerns for medicalization, etc.
    - Has caused issues in coordinating health care (including long-term care hospital care) under HI and long-term care under LTCI

Financing

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
    - 11.52% of the NHI contribution in 2021 (vs. 4.05% in 2008)
      a fixed rate of NIH contribution
- 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

Means Tests Are Not Needed

- Universal coverage regardless of income or existence of family support

Countries that apply asset tests when determining social protection for home care and institutional care

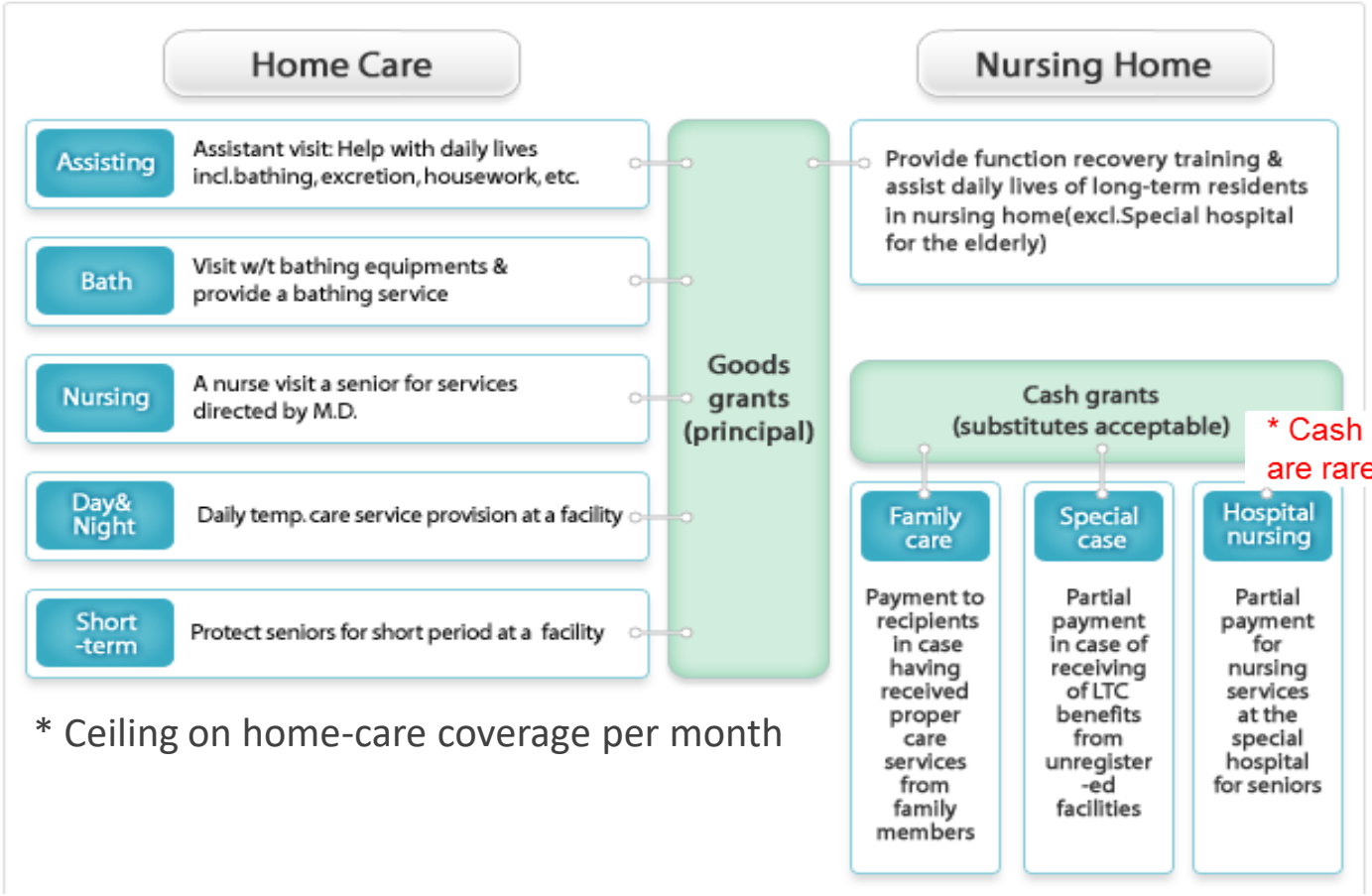
	Home care	Institutional care
Belgium	O	O
Canada: Nova Scotia and Ontario		
Croatia	O	O
Czech Republic		
England	O	O
France		O
Iceland		
Israel		O
Japan		O
Korea		
Netherlands	O	O
Slovenia		
Sweden		
United States: California and Illinois	O	O
	"5/14"	"8/14"

Muir (2017)

Service Coverage: LTCI Benefits

Payment schemes

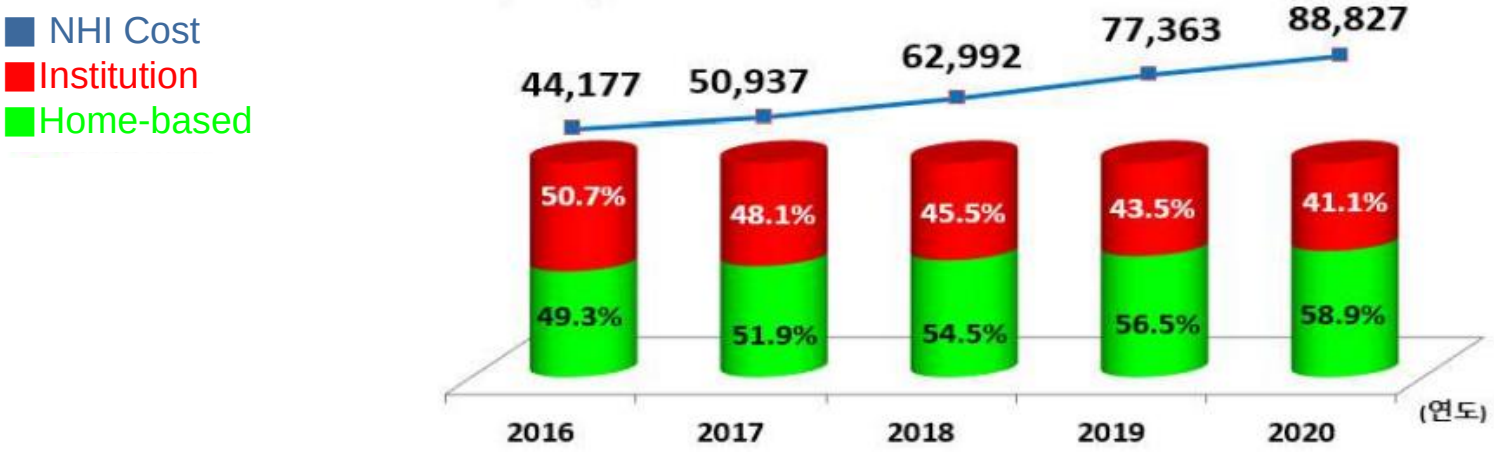
- Pay-per-day: day & night, short-term, & nursing home care
- Pay-per-hour: assistance & nursing at home
- Pay-per-visit: bathing



* Ceiling on home-care coverage per month

Trends in LTCI Benefits in Korea

Trends in annual contributions of the NHI



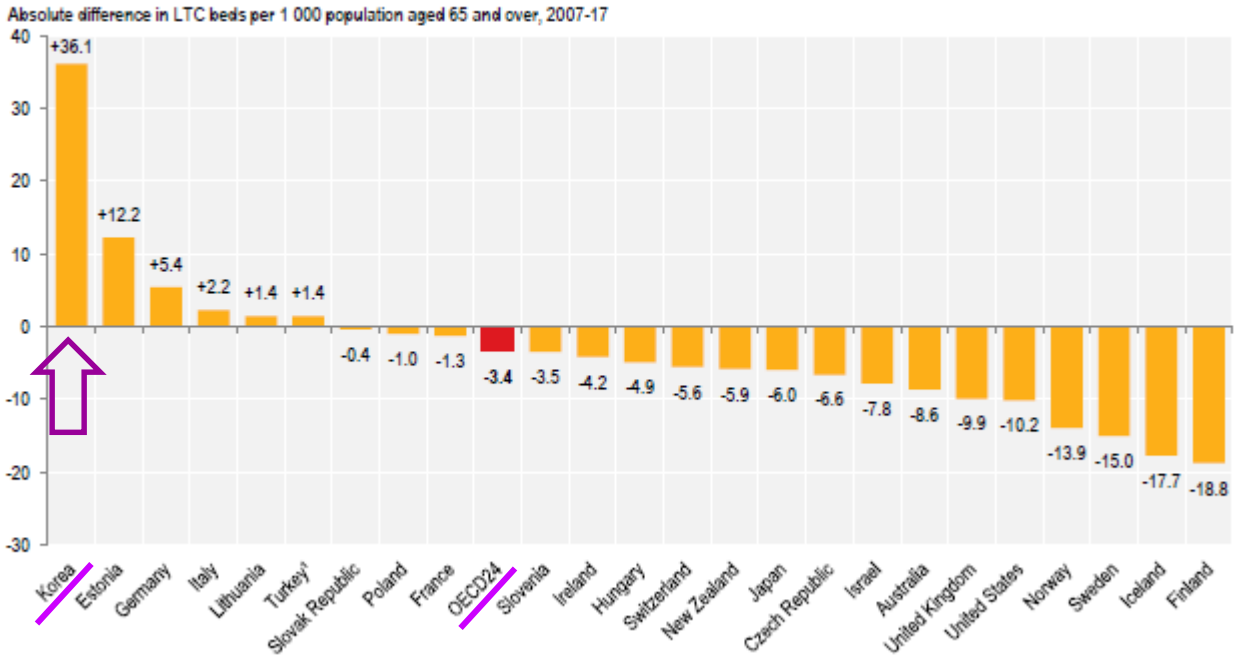
The LTCI Statistic Books (NHIS, each year)

Home-based benefits	2014	2015	2016	2017	2018	2019	2020
Home-visit care	9,073	10,077	11,072	11,662	12,335	15,305	15,412
Home-visit bathing	7,479	8,235	8,957	9,357	9,665	11,121	11,086
Home-visit nursing	586	574	598	650	682	795	774
Day and night care	1,688	2,018	2,410	2,795	3,211	4,179	4,587
Short-term care	322	299	267	218	179	162	148
Welfare kit	1,599	1,700	1,823	1,892	1,920	1,975	1,941

Trends in LTC Benefits

- LTC hospital services are not a benefit of the public LTC insurance but that of the national health insurance
  - Substitute rather than complementary
  - Coordination issues

Figure 11.27. **Trends in long-term care beds in facilities and hospitals, 2007-17 (or nearest year)**



OECD (2019)

Trends in LTC Institutions and Workforce

Table 2
Long-term care institutions and workforce under the public LTCI in South Korea.

	2008	2009	2010	2012	2014	2016	2018	Average % change per year (2009–2018) [1]
Institution (ownership type)								
Individual	4,856	10,135	11,113	11,080	12,569	15,401	17,254	6.1
Corporate	3,054	3,889	3,585	3,695	3,667	3,704	3,708	−0.5
Local government	182	227	215	203	228	213	245	0.9
Other	226	309	66	78	79	80	83	−13.6
Institution (number)								
Home- and community-based services (HCBS)[2]	6,618	11,931	11,228	10,729	11,672	14,211	15,970	3.3
Facility	1,700	2,629	3,751	4,327	4,871	5,187	5,320	8.1
- Aged care facility	1,379	1,695	2,408	2,588	2,714	3,137	3,389	8.0
- Senior congregate housing	321	934	1,343	1,739	2,157	2,050	1,931	8.4
Workforce (number)								
Social welfare worker	4,195	6,313	7,136	6,751	11,298	14,682	22,305	15.1
Registered nurse	2,951	3,617	3,370	2,735	2,683	2,675	2,999	−2.1
Nurse aide	2,373	4,379	5,500	6,560	8,241	9,080	10,726	10.5
Care helper	102,456	330,220	454,921	233,459	266,538	313,013	379,822	1.6

Source: The long-term care insurance (LTCI) statistics year books (National Health Insurance Services [NHIS], each year)

[1] The LTCI was implemented in July 2008, so the statistics from 2008 are only for half the year; this statistic was computed between 2009 and 2018 as follows: Compound Annual Growth Rate (CAGR) = $\left(\frac{Ending\ Value\ (year\ 2018)}{Beginning\ Value\ (year\ 2009)}\right)^{\frac{1}{n}} - 1$ (n: number of years).

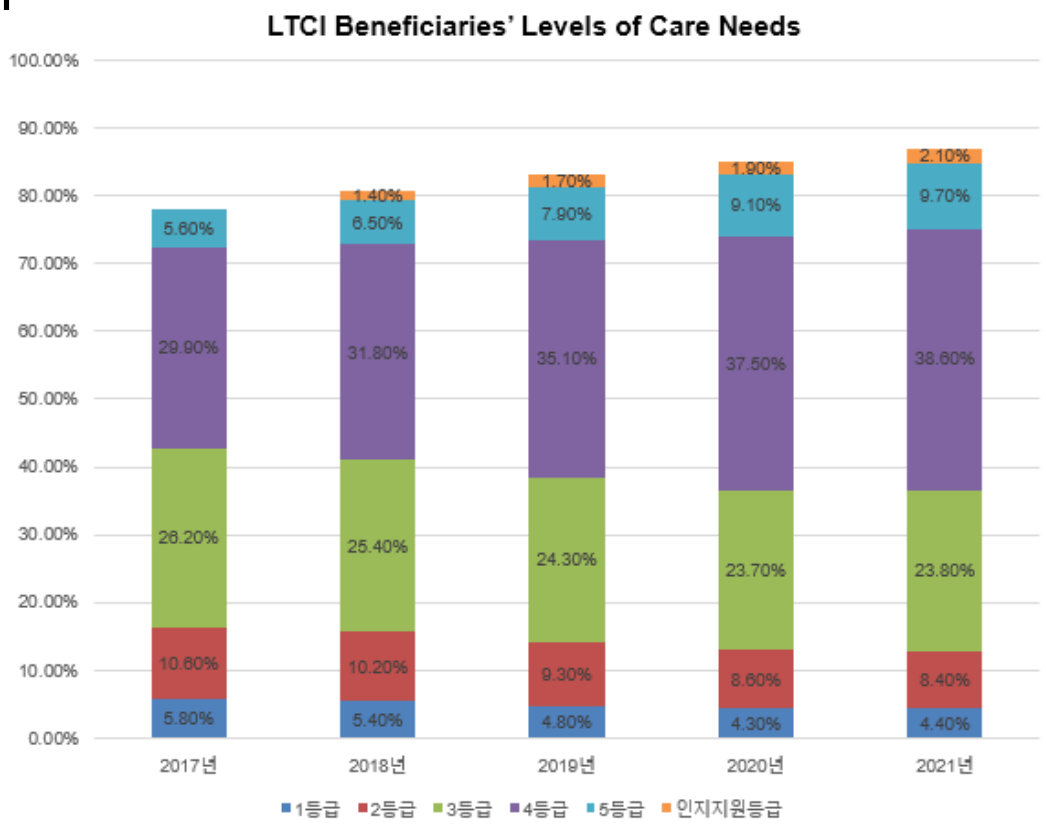
[2] The HCBS (benefits) currently provided under the public LTCI are listed in Fig. 1.

IV. Recent Reforms & Policy Efforts

Reforms: 1. Expansion of Population Coverage

- The financial sustainability of the public LTCI was a core policy agenda at the inception of the program, so the initial coverage rate was 3.3% in 2008 (vs. 10.1% in 2020)

- Who was and will be additionally covered?
  - Expansion to people with relatively lower dependency
  - Expansion of coverage for people with dementia



Reforms: 2. Key Policy Efforts to Improve Quality of Care

- **Increased staffing level and capacity for LTC facilities (MoH, 2016)**
  - Strengthening the contracted physician programs
  - Requirement for staffing during night shift for resident safety
  - Payment incentives to hire registered nurses instead of nurse assistants as nursing care personnel
- **Integrated home-care service demonstration program (NHIS, 2016-)**
  - By SW-RN(NA)-PCA team
  - A series of pilots for coordination with home and community –based benefits Care management program (care managers: SWs and/or RNs)
  - Aim to strengthen health monitoring (RN-PCA)
- **Heighten barriers to entry for LTC providers (MoHW, 2019)**
  - Designation of providers based on history of sanctions received, salary provision for employees, operation plan, etc. for new entrants
  - Able to deny license to applicants with history of sanctions due to unfair claims, elder abuse, or otherwise determined to be unable to provide high quality services

Reforms: 3. Key Policy Efforts to Service Coverage & Quality

- **Family caregiver support program (Han et al., 2015)**
  - Strengthening the contracted physician programs
  - Family counseling demonstration program (2015-2016)
  - Short respite-care programs for families caring at home for people with dementia

- **Strengthening the beneficiary support program (Han et al., 2012)**
  - Consistent efforts to increase the effectiveness of the program by NHIS
  - A kind of substitute care-management program that does not exist yet
  - Updates the contents of the standardized utilization plans
  - Training program for planners

- **Home-based medical care pilot program (2022. 12- ; expected)**
  - Aim to strengthening health care services in LTCI
  - Services provided by a multidisciplinary team including a medical doctor, a nurse, and a social worker (minimum staffing requirement)
  - Including comprehensive geriatric assessment, care planning, team care conference
  - Will evaluate its impact on quality, cost, and experience of older people/family

Reforms: 4. Promoting Integrated HCBS* Delivery

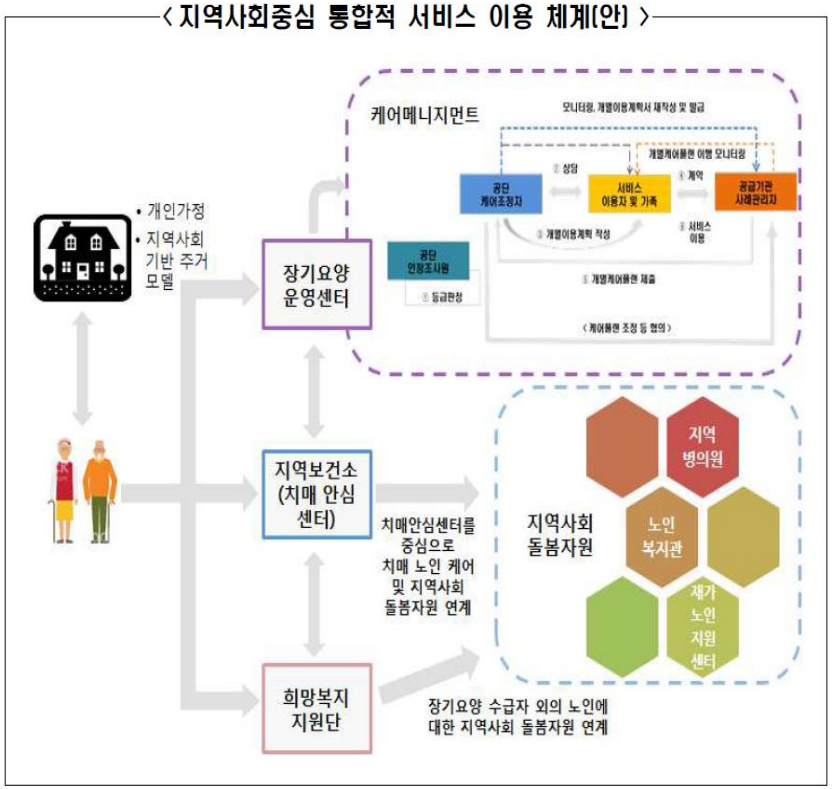
* HCBS: Home and Community-Based Care

The 2nd National LTC Plan (2018-2022)

- ❖ Vision: securing dignity in old age through care in the community
- ❖ Policy goals 2: strengthen community care to secure user's QOL

- Introduce Korean version of care management to support aging in place
- **Comprehensive Home Care Benefits**
  - Team of social worker, nurse, and care worker
- **Distinguish Health and Care**
  - Plan to distinguish functions of LTCH and LTCF ('18.8)
- **Connecting Hospital-Facility-Home**
  - Focus on LTCH patients requiring treatment; prevent long-term stay
  - Create special care rooms in LTCF

Aligned with the nationwide community-based integrated care initiatives led by the Ministry of Health since 2018



MOHW (2017)

IV. Success, Key Future Agenda, & Lessons for Other Aging Countries

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 10 years without a catastrophic event
  - provides benefits to the frailest older people; opens a channel to decreasing the burden of family caregiving (high satisfaction (91.6%) of family(proxy) vs. work satisfaction (62.8%) by LTC care workers in 2021)
  - 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)

Agenda 1: Coordination of Care Under HI and LTCI

Health Policy 119 (2015) 1330–1337

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Health Policy

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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.

Agenda: 2. Financial Sustainability of the LTCI

- The expenditure is expected to increase due to the increasing eligible population and planned expansions in service coverage, which will result in a threat to the financial sustainability of the public LTCI in Korea.

(Unit: USD, %)

	2008	2009	2011	2013	2015	2017	2019	2020
Total Revenue (USD)	868,974	2,084,929	3,263,144	3,831,212	4,388,391	5,142,991	7,620,331	9,613,843
Total Expenditure (USD)	554,900	1,908,462	2,787,757	3,317,961	4,313,950	5,589,091	8,314,938	9,469,503
Total Expenditure to Revenue	64	92	85	87	98	109	109	98
Balance	314,074	176,466	475,387	513,251	74,441	-446,099	-694,607	-144,340

*Note: Exchange rate is based on 1 USD = 1,000 Korean won

The LTCI Statistic Book (NHIS, each year)

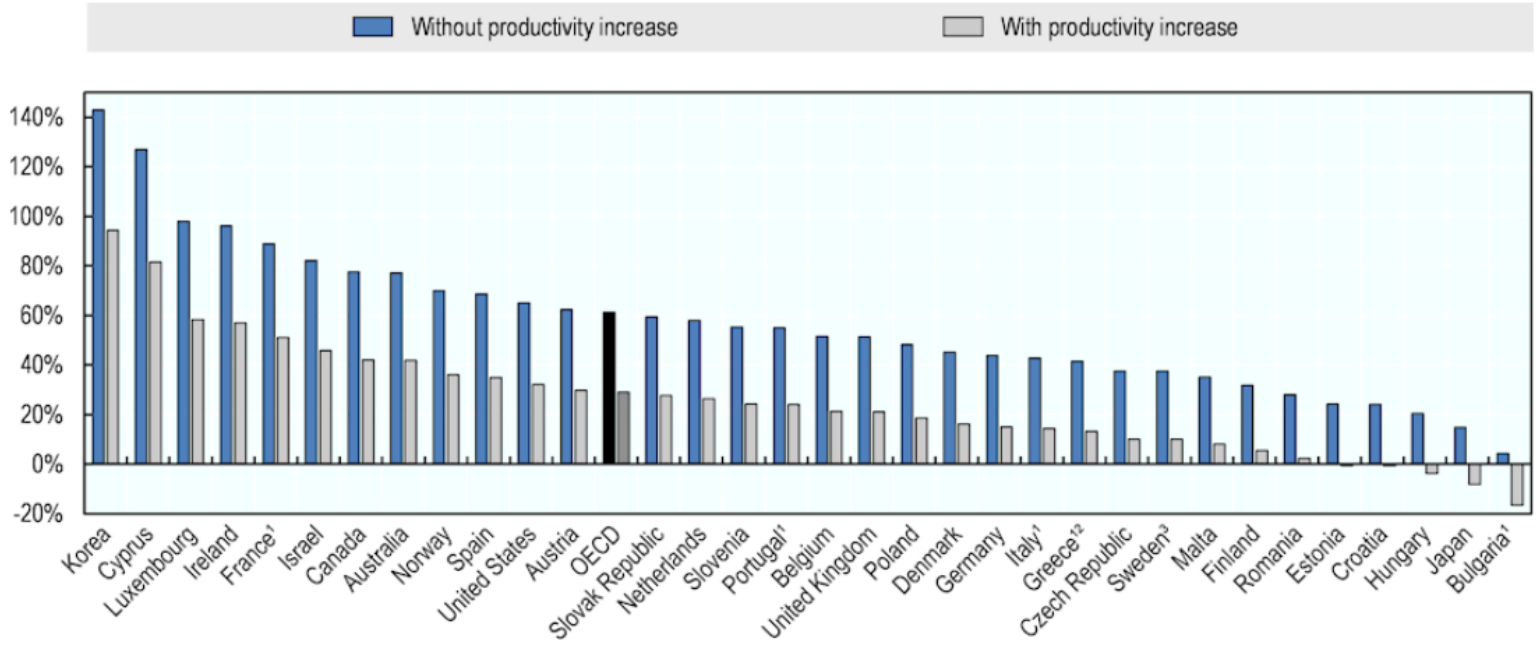
Agenda: 3. Roles & Responsibilities of Local Governments

- 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 NLTCI under central gov’t (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. Quality LTC workforce Preparation

Figure 1.5. **An additional 60% LTC workers are needed by 2040**

Number of additional LTC workers needed by 2040 to keep the ratio constant as a share of the total number of workers in 2016



Note: OECD is the unweighted average of the 28 OECD countries shown in the chart.

1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. Data refer only to the public sector.

Source: EU-Labour Force Survey and OECD Health Statistics 2018, with the exception of the Quarterly Labour Force Survey for the United Kingdom and ASEC-CPS for the United States; Eurostat Database for population demographics (data refer to 2016 or nearest year).

OECD (2020) Who Cares? Attracting and Retaining Care Workers for the Elderly

Agenda 5. Needs for Innovation

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OXFORD

Intervention Research

Effectiveness of a Technology-Enhanced Integrated Care Model for Frail Older People: A Stepped-Wedge Cluster Randomized Trial in Nursing Homes

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Decision Editor: Suzanne Meeks, PhD, FGSA

Abstract

Background and Objectives: The objective of this study was to evaluate the impact of an information and communication technologies (ICT)-enhanced, multidisciplinary integrated care model, called Systems for Person-centered Elder Care (SPEC), on frail older adults at nursing homes.

Research Design and Methods: SPEC was implemented at 10 nursing homes in South Korea in random order using a stepped-wedge design. Data were collected on all participating older residents in the homes before the first implementation and until 6 months after the last implementation. The 21-month SPEC intervention guided by the chronic care model (CCM) consists of 5 strategies: comprehensive geriatric assessment, care planning, optional interdisciplinary case conferences, care coordination, and a cloud-based ICT tool along with a free messaging app. The primary outcome was quality of care measured by a composite quality indicator (QI) from the interRAI assessment system. Usual care continued over the control periods. Nursing home staff were not blinded to the intervention.

Results: There were a total of 482 older nursing home residents included in the analysis. Overall quality of care measured by the composite QI was significantly improved (adjusted mean difference: −0.025 [95% CI: −0.037 to −0.014, $p < .0001$]). The intervention effect was consistent in the subgroup analysis by cognition and activities of daily living. There were no important adverse events or side effects.

Discussion and Implications: The SPEC, a CCM-guided, ICT-supported, multidisciplinary integrated care management intervention, can improve the quality of care measured by health and functional outcomes for frail older persons residing in nursing homes with limited health care provision.

Clinical Trials Registration Number: ISRCTN11972147

Keywords: Asia, Evaluation, Geriatric care model, Implementation science, Long-term care

Agenda 6. Need for Advanced Institutional Performance Monitoring

Kim and Jeon *Health Research Policy and Systems* (2020) 18:27
https://doi.org/10.1186/s12961-020-0529-8

Health Research Policy and Systems

RESEARCH Open Access

Developing a framework for performance assessment of the public long-term care system in Korea: methodological and policy lessons

Hongsoo Kim[1*] and Boyoung Jeon[2]

Abstract

Background: Limited evidence exists on how to assess long-term care system performance. This study aims to report on the process and results of developing a performance assessment framework to evaluate the long-term care system financed by the public long-term care insurance in South Korea.

Methods: The framework was developed through a six-step approach, including setting the goals and scope of performance assessment in the given policy context, reviewing existing performance frameworks, developing a framework with a wide range of potential indicators, refining the framework through a series of Delphi surveys and expert meetings, examining the feasibility of generated indicators through a pilot test, receiving the comments of stakeholders, and finalising the performance framework.

Results: The finalised framework has 4 domains – coverage, quality of care, quality of life and system sustainability – and 28 indicators, including 10 core indicators to monitor long-term care system performance. Usability and feasibility along with policy relevance were important criteria in selecting these indicators. The proposed framework can be used to assess the performance of the long-term care system in Korea, and the framework and its methodological approach can be benchmarks for other countries developing their own framework.

Conclusions: It is critical to reconcile and prioritise various stakeholders' views and information needs as well as to balance methodological rigor with practical usefulness and feasibility in the development and implementation of a long-term care performance monitoring system.

Keywords: Long-term care systems, performance measurement, social long-term care insurance

Lessons for Aging Countries

- The experiences of the Korean LTCI can provide a few lessons for institutional design and policy implementation of LTC financing

- Having an LTCI separate from the NHI
  - benefit of potential de-medicalization of LTC/social care
  - vs. challenges in the alignment of the two funding mechanisms and the coordination of health care and LTC.

- The governance of the LTCI

- A tradeoff between population coverage, benefits/cost coverage, and fiscal sustainability

Health Policy 125 (2021) 22–26

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Health Reform Monitor

A decade of public long-term care insurance in South Korea: Policy lessons for aging countries

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ABSTRACT

South Korea proactively introduced public long-term care insurance (LTCI) in 2008 when older people were only about one-tenth of the total population. At that time, Korea switched from a tax-based, local-government-operated LTC program targeting low-income older people to the current universal public LTCI run by the National Health Insurance Service, the single public insurer. The LTCI program provides a comprehensive package of home- and institution-based care mainly targeting older people who need assistance in daily living. Over the past decade, the program has continued to expand its population and service coverage: older people in high need have been covered, and an infrastructure for service provision has been established. Future agendas include financial sustainability, care coordination, and the role of local governments. Korea's experiences suggest having an LTCI separate from the NHI has the benefit of potential de-medicalization of LTC, which, in turn, creates challenges for the coordination of health care and LTC. A centralized LTCI system with a single payer has the benefit of bigger risk-pooling, but this may become a barrier to designing integrated community care systems at the local level. There is a tradeoff between population coverage, benefits/cost coverage, and fiscal sustainability.

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Same same but different? Comparing institutional performance in the long-term care systems of Japan and South Korea

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Abstract

Responding to a rapidly aging population, Japan and South Korea introduced social insurance-based long-term care systems (LTCSs) in 2000 and 2008, respectively. Korea studied and took up key features of Japan's system while evolving along its own trajectory in line with its healthcare system. The aim of the present study is to unpack the broad category of 'social insurance' to explore how distinct system inputs and designs in Korea and Japan related to outcomes in performance measured in terms of coverage, quality of care, and sustainability. In doing so, the study serves as an important starting point for advancing a new stream of social policy research on the comparative performance of LTCSs. Our findings demonstrate that despite adopting a common system type, differences in implementation of the social insurance model (particularly in terms of financing and governance) contributed to divergent performance, with Japan outperforming Korea on most indicators during the observed period. This bears contrary implications for policymaking in the two countries: Whereas Japanese policymakers are faced with the challenge of promoting quality while containing spending, in Korea greater investment is required to strengthen the workforce and build up community care.

KEYWORDS
Asia, long-term care, social insurance, system performance

* Benefits from cross-national research & learning

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Korean Experience of Public Long-term Care Insurance

Thank you

Q&A?

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