



Population Aging and Long-term Care Insurance in Korea

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ROAD MAP

I. Backgrounds

Demographic and social change, Aging and health expenditure, Policy process

II. Structure of Long-term Care Insurance

Population coverage, Assessment, Level of benefits, Type of benefits

III. Future Challenges

I. Background

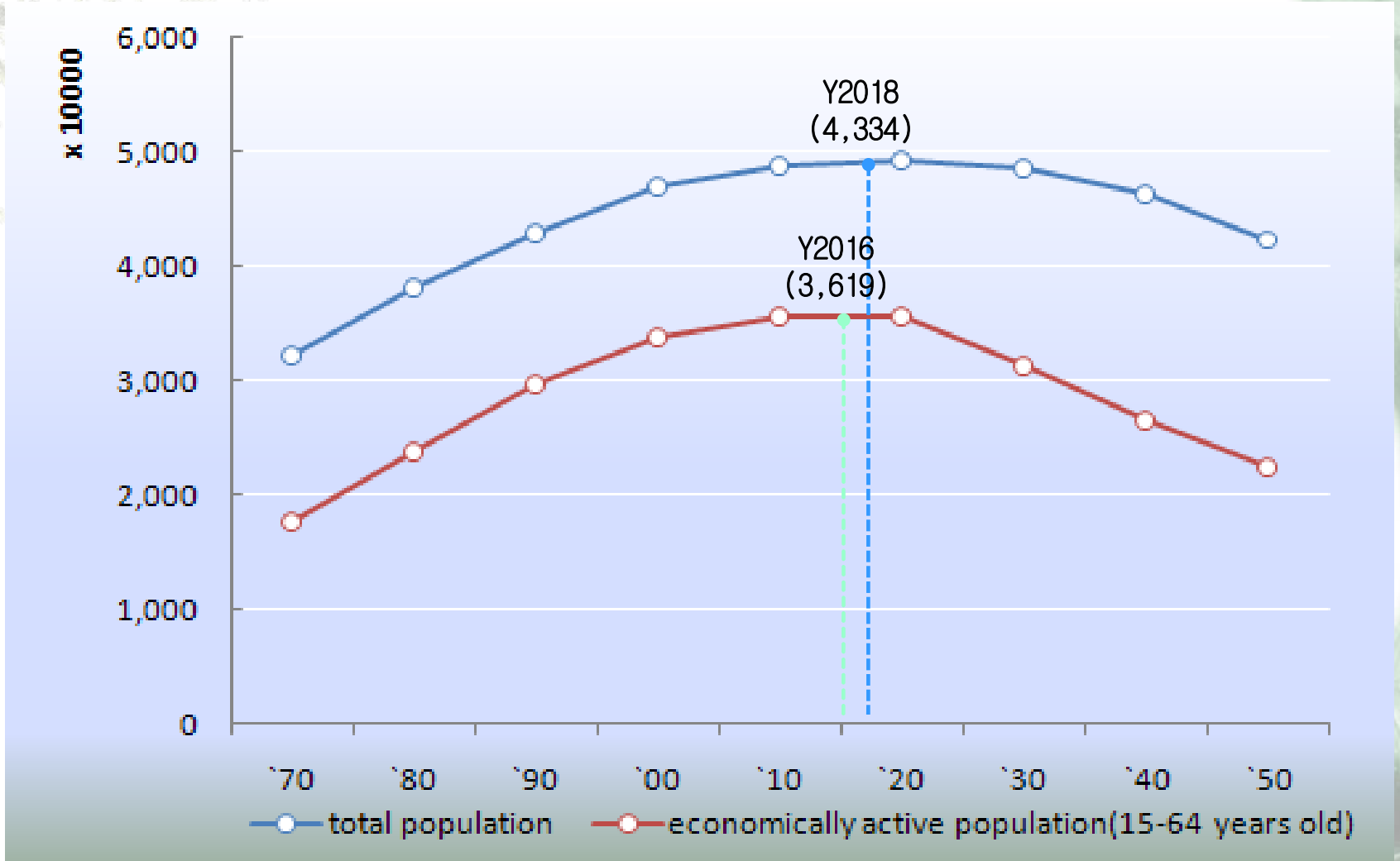
1. Demographic and Social Changes

- a. Population aging: increase in life expectancy, sharp decline in fertility
- b. Change in family structure:
decrease in cohabitation with adult children (38% in 2004)
- c. Increase in women's labor participation, change in attitude for care giving
(care giving: 36% by the spouse)

Total Fertility Rate



Total Population



Speed of Aging

(Unit: No. of Years)

	7% ➔ 14%	14% ➔ 20%	7% ➔ 20%
Korea	18	8	26 <2026>
Germany	40	37	77 <2009>
France	115	39	154 <2036>
USA	73	21	94 <2036>
Japan	24	12	36 <2006>

❖ Numbers in angle brackets are the year, in which post-aged society begins.

Low Level of Income of the Elderly

- Nature of employment status: predominantly self-employed (agriculture/fishery) or informal-sector workers
- Limited pension or welfare program: as of 2008, only 21.9% of the elderly are recipients of public pension
- Family-based welfare (transfer) is still a major source of income
- Elderly single as the most financially vulnerable group

44.7% of the elderly: Household income is less than 150% of minimum cost of living (Ku and Sohn, 2005)

Gini Coefficient

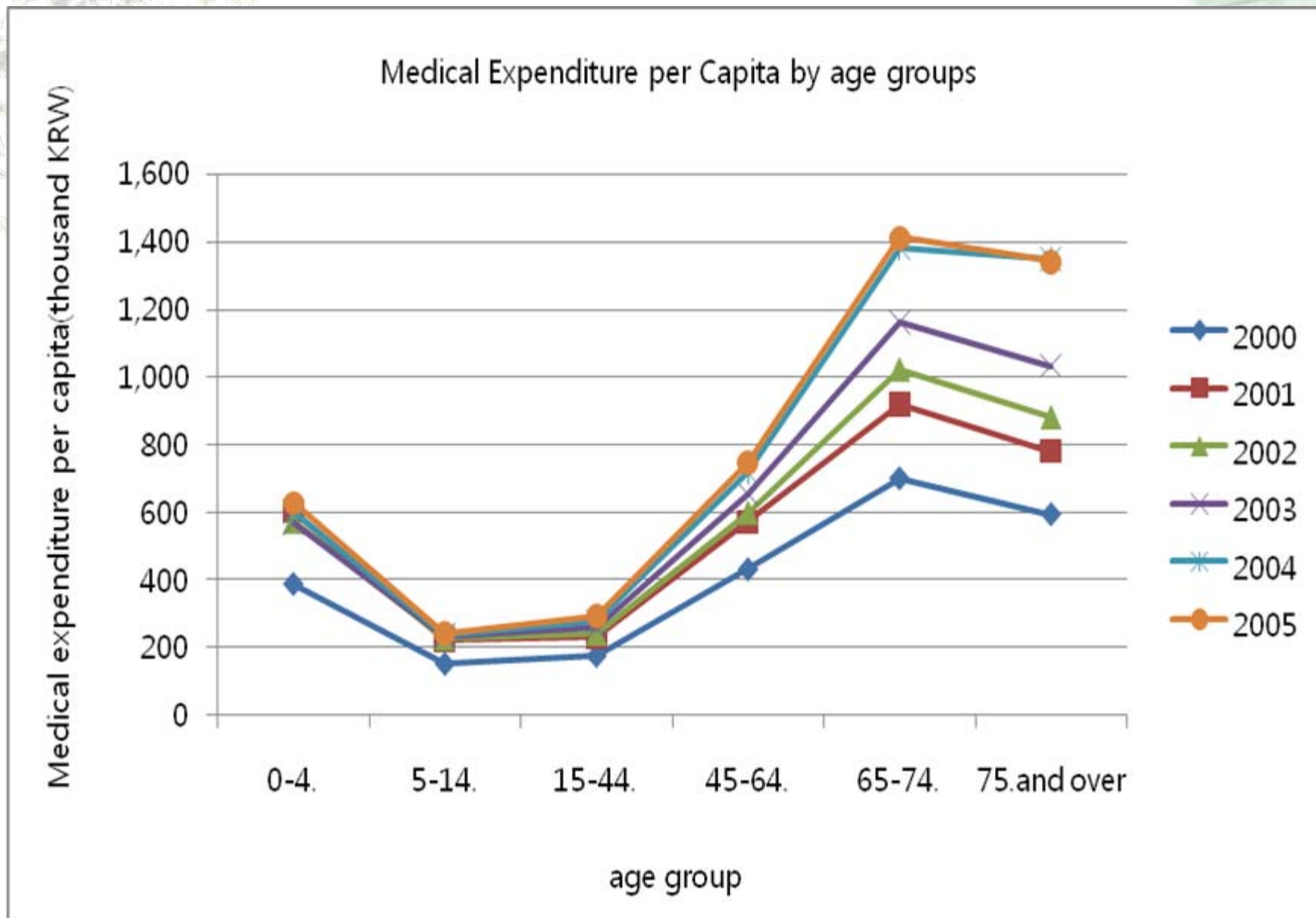


2. Aging and Health Expenditure

Trend in Per capita Health Spending

- Increase with age: U shape
- Increase over time for all age groups, but faster for the elderly
- Per capita health spending of the very old (+75) is lower than that of 65-75 years old in Korea
 - > die home (not in hospitals), access problem (financial barrier for the elderly), non-intensive care at the end stage of life (cultural)
- > *Policy implication* for **long-term care system**

Medical Expenditure per capita by age groups



3. Policy Process of Long-term Care Insurance

Unclear policy goal

- Ease the financial burden of the elderly with universalism?
- Reduce the financial burden of health insurance by reducing social admissions?
- Enhance employment by extending social service such as LT care

Government reluctance to expand public assistance for long-term care of the (poor) elderly

- > Stick to health insurance model from the beginning

3. Policy Process (continued)

Urgency (taking into account the proportion of the elderly) or timing of the introduction of LTC insurance?

Proposed and implemented by progressive governments with the expansion of the welfare state (presidents Kim DJ and Rho MH)

Bureaucrats-driven policy in alliance with academics

Little role of civic groups and feminists:

e.g., exclusion of LT care related to disability,
no cash benefit, no voice of women groups
demanding socialization of care

National Health Insurance Corporation (NHIC):
opportunity to extend its operation and mitigate the
pressure of downsizing/employment adjustment

II. Structure of LT Care Insurance

1. Social Insurance for LT Care

- a. Insurer (National Health Insurance Corporation): can use the existing administrative structure of health insurance
(e.g., sickness funds in Germany,
Local governments in Japan)
- b. Financing mix: mixed model (with tax subsidy) as in health insurance, rather than pure social insurance (e.g., Germany)
- c. Path dependency, institutional stickiness

2. Policy Priority over Health Care vs Long-term Care

a. Difference in Nature

- Life and death vs. quality of life
- Predictability and degree of catastrophic expense: inter-temporal (self) risk pooling can be more feasible in LTC than in HC
- Possibility of spending down/reverse mortgage by the elderly

b. Need to balance the benefits (or OOP payment) between HI and LTCI -> Most countries provide more extensive coverage for HC than for LTC

3. Population Coverage

Coverage of 3-4% of the elderly: unmet LTC needs?

- a. Long-term care for the elderly (+65), and
- b. Age-related long-term care of the younger (<65 years)
-> will be very few

Political compromise: Everybody should pay contribution, and everybody is eligible when he/she has LT care needs due to age-related health problems

Mix of German and Japanese model

- Germany: all types of disability regardless of age
- Japan: long-term care of the elderly (+65) and age-related LT care for 40-64 years old

4. Assessment

3 levels of functional status (3-4% of the elderly)

Visiting team from NHIC branch offices, Annual assessment, 56 evaluation items

Assessment committee in the regional offices of National Health Insurance Corporation:
less than 15 members including social worker, and medical doctor (or traditional medical doctor)

Decision of the committee is based on

- Assessment (ADL) made by a visit team, using algorithms
- Doctor's report

5. Level of Benefits

Contribution rate: 4.7% of health insurance contribution

Financing mix

- Government: 20%
- Copayment: 20% (institution), 15% (home-based)
 - > exemption or discount for the poor
- Contribution: 60-65%

Meals, private rooms are not covered by LT care insurance

6. Type of Benefits

Service benefit in principle, cash benefit in exceptional cases (e.g., no service providers in the region)

Payment to providers

- pay per hour: visiting care
- pay per visit: visiting nursing, visiting bath
- pay per day: institutional care, day/evening care

Ceiling on benefit coverage for non-institutional care:
for three levels of functional status

6. Type of Benefits (continued)

Role of cash benefits needs to be considered

a. Pros

- Preserving the role of family
- Consumer choice (competition among formal and informal care givers)
- Potential cost savings (level of cash benefits lower than service-in-kind)

b. Cons

- Potential abuse, low quality of care, gender perspective?
- Against the philosophy of socialization of care

III. Future Challenges

1. Supply of LT care institutions and providers

- as of the end of 2006, there are 815 LTC institutions (covering about 41,000), and 1,045 home-based care providers (covering about 51,000)
- variation across localities: 92 out of 232 localities have less than half of the number (capacity) of LTC institutions that they need
 - > NIMBY?, lack of budgets?
- Training and supply of LTC workers is also of concern

2. Role of local governments

- Only in the area of regulation and certification of LT care institutions, and financing for LT care expenditure of the poor
- Potential problems in coordination between LT care and welfare service
- Reluctance to empower local governments in LTC insurance system: concern on equity across localities, history of the merger of multiple insurance societies?

3. Coordination between health insurance and LT care insurance

- Coordination between health care and long-term care: medical care as a prevention of LT care
- Relative generosity of benefits for patients in LT care hospitals (covered by health insurance) and those in LT care institutions (covered by LT care insurance)
- Relative level of fees for LT care hospitals and LT care institutions

4. Delivery of LT care

Coordination between institutional care and home-based care

Quality of care issues

- Broad spectrum in quality of care across LTC institutions
- Need fee based on structural measures (facility, personnel) or service evaluation
- Need to monitor the quality of care of home-based care

Appeal of those who do not accept the outcome of assessment

THANK YOU !!!



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