Part 1-CHAPTER 4

Policy Issues of Long-term Care for Older People in the Republic of Korea

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CHAPTER 4

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1. Population Ageing

Population ageing in Korea is projected to be the most rapid amongst Organisation for Economic Co-operation and Development (OECD) countries between 2000 and 2050. The population will peak at 50 million in 2020 and then decline about 15% by mid-century, even as the proportion of the older population grows. The median age, 20 years in 1960, reached 38 in 2010 and is likely to be nearly 50 in 2030, suggesting fundamental changes in the country's socio-economic structure. The proportion aged 65 and older doubled from 7% in 2000 to 14% by 2018; in contrast, this transition is projected to take 71 years in the United States and took 115 years in France. In only 8 more years (compared with up to 40 years in major European countries), by 2026, the proportion of the elderly in Korea will increase from 14% to 20%.

The 'compressed population ageing' in Korea has been driven by increasing life expectancy and falling fertility. Life expectancy increased by 26 years from 55 in 1960 to 81 in 2020. A more important factor is the fall in the fertility rate, from 6.0 in 1960 to 1.5 in 2000 and 0.90 in 2020, the lowest in OECD countries. This dramatic decline may have resulted from heightened economic uncertainty in the wake of the 1997 Asian financial crisis and the 2008 global financial crisis.

1.1. Long-term Care System

In July 2008, Korea introduced a long-term care insurance (LTCI) system to provide security to older people who cannot take care of themselves due to physical weakness or geriatric diseases and to reduce the burden on their families. In addition to demographic changes, family structures and attitudes towards care for older people have changed during the last decades. As female labour participation increased, families became smaller, and informal caregivers became less available.

Table 4.1. Population Ageing in the Republic of Korea

	Population (millions)	Growth rate (%)[a]	Fertility rate [b]	Life expectancy (years)	Median age (years)	Proportion of elderly (%)[c]
1960	25.0	2.3	6.0	55.3	19.9	2.9
1970	31.5	1.8	4.5	63.2	19.0	3.1
1980	37.4	1.5	2.7	65.8	22.2	3.8
1990	43.4	0.6	1.6	71.3	27.0	5.1
2000	46.1	0.6	1.5	75.9	31.8	7.3
2010	49.2	0.1	1.2	79.1	37.9	10.9
2020	50.0	-0.1	1.2	81.0	43.7	15.7
2030	49.3	-0.5	1.3	81.9	49.0	24.1
2040	46.7	-0.5	1.3	82.6	53.1	32.0
2050	42.3	...	1.3	83.3	56.2	37.3

[a] The annual average growth rate for the decade in the row for 1960, for example, shows the rate for the decade 1960–1970.

[b] The average number of children that a woman can expect to bear during her lifetime.

[c] The number of persons over the age of 65 as a percentage of the total population.

Source: Korea National Statistical Office. Projections for 2005–2050.

There were some debates on whether Korea, whose proportion of older people was still lower than that in OECD countries, should have a mandatory and universal LTCI. A progressive government played a key role in introducing universal LTCI to cover all older people who need LTC. Kim Dae Jung, who became president in early 1998, had a strong interest in progressive welfare state policies. Formal discussion of LTCI started in 2000 when the Ministry of Health and Welfare appointed the Planning Committee for Elderly Long-term Care. The provision of LTC to expand care for older people had broad appeal and did not encounter political opposition (Jeon and Kwon, 2017).

Financing

The contribution rate is 6.55% of health insurance premiums; in other words, anyone who contributes to health insurance also contributes to LTCI. The financing mix is composed of contributions (60%–65%), tax subsidies (20%), and co-payment by service users, which is 20% for institutional services and 15% for home-based services.

Administration

Funding of LTCI is separate from that of the National Health Insurance (NHI), but both are administered by the NHI Service (NHIS) to reduce administrative costs.

Eligibility

To use LTC services, individuals must pass a needs assessment to determine the functional status of physical, cognitive, behaviour, nursing care, and rehabilitative characteristics, using 52 items. The eligible group was classified into five levels for those with dementia. The population coverage of LTCI was increased from 3.1% to 10.1% of older people from 2008 to 2019.

Benefits

LTCI provides institutional and home-based care and cash benefits. Home-based care consists of bathing, nursing, day and night care, short-term care, and assistive devices (e.g., walker or cane, wheelchairs, pressure relief mattresses). Cash benefits are available only in exceptional cases, for example, when no service providers are accessible in the region. The amount of benefits depends on the eligibility level, and the ceiling on benefit coverage differs by level. Utilisation of home-based care increased from 61.4% in 2008 to 67.92% in 2016.

Table 4.2. Long-term Care Institutions and Home-Based Care

- 97% are private agencies (56% individuals, 41% private organisations)
- 18% newly opened, 12% closed in 2014
- 82% occupation rate due to competition with long-term care hospitals

	2010	2012	2014
Institutions (no.)	3,751	4,331	4,875
Beds (no.)	116,782	131,761	150,579
Occupied beds (no.)	88,832	107,615	123,814
Occupancy (%)	76.1	81.7	82.2

- 99% are private agencies (84% individuals, 15% private organisations)
- Small number of elderly (26) cared for by one home-based care agency
- 30% newly opened, 19% closed in 2014

	2010	2012	2014
Home-visit care	20.7	22.3	25.0
Home-visit bathing	9.2	9.9	10.2
Home-visit nursing	11.8	13.7	15.0
Day and night care	10.9	12.7	15.3
Short-term care	7.2	9.0	10.1

Sources: Author.

1.2. Long-term Care Service Delivery

Long-term care providers

After the introduction of LTCI, the number of LTC providers rapidly expanded from 6,618 in 2008 to 14,211 in 2016, and from 1,700 home-based care agencies in 2008 to 5,187 in 2016. Whilst the utilisation rate of institutional care decreased from 38.6% in 2008 to 32.03% in 2016, the utilisation rate of home-based care increased from 61.4% in 2008 to 67.92% in 2016.

The oversupply of LTC providers has led to problems. The number of providers exceeds demand and there is intense competition amongst them to recruit beneficiaries. One common strategy used by providers is to offer beneficiaries reduced co-payment, which has resulted in reduced quality of care.

Long-term care workers

The oversupply of LTC providers also led to the oversupply of service workers, who include care workers (90.1%), social workers (4.1%), and nurses (3.5%). The number of care workers rapidly increased from 176,500 in 2008 to 301,700 (almost double) in 2016 and the number of nurse aides increased from 4,200 to 9,770, whilst the number of registered nurses decreased from 3,400 to 2,800.

Quality evaluation system

To assure LTC quality LTC, NHIS implemented a quality evaluation system in 2009. The number of quality indicators varies by type of service provider: for example, 88 items for institutional care and 32–59 items for home-based care are grouped under five domains of quality measurement: management of institutions, environment and safety, rights and responsibilities, process of services, and outcome of services.

1.3. Policy issues of the Long-term Care Insurance system

Lack of coordination between healthcare and long-term care

Lengthy hospitalisation (often social admissions who do not require medical care) is due to limited coordination with LTCI. NHI's benefits package is more generous than LTCI's. The cost of hospital stay is much higher than that of LTC institutions, increasing healthcare expenditures. LTC institutions (covered by LTCI) and LTC hospitals (covered by NHI) have overlapping services for older people with similar health and functional status, which resulted in persistent social admissions in LTC hospitals amongst older people with lower medical care needs. A significant proportion of older people with clinical care needs, however, stay in LTC institutions where healthcare services are not provided (Jeon and Kwon, 2017).

Primary care providers should play a key role in prevention and in promotion of health and in overcoming the inefficiencies of hospital-centric care. If home-based care services can be linked with community-based primary care, the health and functional status of older people will improve and expensive acute hospitalisation and institutional care use be reduced. Service programs in day-care centres and home-visit nursing, in collaboration with primary-care doctors, are needed.

Oversupply of long-term care providers

The number of beds in LTC institutions almost tripled from 58,000 in 2008 to 168,000 in 2016 and the number of beds in LTC hospitals more than quadrupled from 60,000 in 2008 to 255,000 in 2016 (more than quadrupled). Several institutional factors contribute to persistent social admissions in LTC hospitals. Most LTC hospitals and LTC institutions are private, and more patients and residents means profits. The competition between LTC hospitals and LTC institutions has been fierce. Of LTC institutions, 97% are private agencies (56% owned by individuals and 41% owned by private organisations). In 2014, 18% were newly opened and 12% were closed. The occupancy rate is 82% due to competition with LTC hospitals. In case of home-based care agencies, 99% are private (84% owned by individuals and 15% owned by private organisations). An average of 26 elderly were cared for by one home-based care agency. In 2014, 30% of LTC institutions were newly opened and 19% closed.

Low qualification of service workers

The LTC workforce has basic quality issues. Those who want to become care workers must complete a 240-hour training course and pass the national qualification examination. The increase in quasi-professional staffing may be due to the small size of institutions. One of the main problems related to care workers is poor working conditions, resulting in low job satisfaction, high turnover rates, and low quality of care.

Most LTC providers are small private for-profit entities that invest minimally in infrastructure and are not financially stable. The rapid increase in LTC providers and service workers was not accompanied by improved quality of care or equitable distribution by region. More than 90% of providers and service workers are from the private sector, and most home-care providers are in urban areas.

Inadequate cooperation between local government and the National Health Insurance System

Although the LTC quality evaluation system was initiated to improve the quality of care, there are still several limitations. The gap between real quality of care and evaluation results exists due to the insufficient number of outcome-based indicators. Inadequate cooperation between local governments and NHIS has been criticised because local governments are not active in controlling the quality of LTC institutions, even though they have the authority to approve or close them.

Concerns about sustainability of financing

Concerns have been raised about the sustainability of the health and LTCI system because of rapidly growing demand and expenditure for geriatric and personal care. Reducing social admissions and strengthening policies for prevention and for health promotion amongst older people might directly or potentially result in financial savings. There is also a trade-off between population coverage and the LTC system's financial sustainability. A strict assessment for eligibility can improve financial sustainability, but the resultant low coverage of the population can limit the capacity of the LTC system to meet the LTC needs of older people. The LTCI covers about 8.7% of older people, which is significantly lower than in OECD countries (average more than 10%).

2. Conclusion

In 2018, the government announced comprehensive community care for older people as a future direction for improving LTC services, based on supporting ageing in place; integrating healthcare, LTC, and welfare services; adopting a care-manager system as service planner, coordinator, and supervisor; establishing community networks; and encouraging community residents' participation. Ageing in place is the ability to remain in one's own home or community despite potential changes in health and functioning in later life. Older residents need to be able to access community support and services, whether by leaving their homes and venturing out or by bringing support and services into their own homes. Older adults' needs can be met through public, non-profit, for-profit, and informal organisations within the community. Whilst research is limited in terms of documenting the direct relationship between these community characteristics and ageing in place, there is evidence that these characteristics can promote the physical, mental, social, and economic health and well-being of older adults, which, in turn, can help them age in place.

Introducing LTCI achieved a great deal. The proportion of older people who benefit from LTC services has increased substantially. Early evaluation studies on LTCI show that it significantly reduced family caregivers' burden, including psychological and financial stress.

LTCI created a framework to provide universal coverage for all older people who require LTC, regardless of income. Rapid population ageing is expected to increase public expenditure on LTC. Korea now confronts difficult challenges in seeking to secure financial stability and quality of care for older people in need of LTC services.

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