Chapter 3

Social Protection in Korea- Current State and Challenges

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CHAPTER 3

Social Protection in Korea – Current State and Challenges

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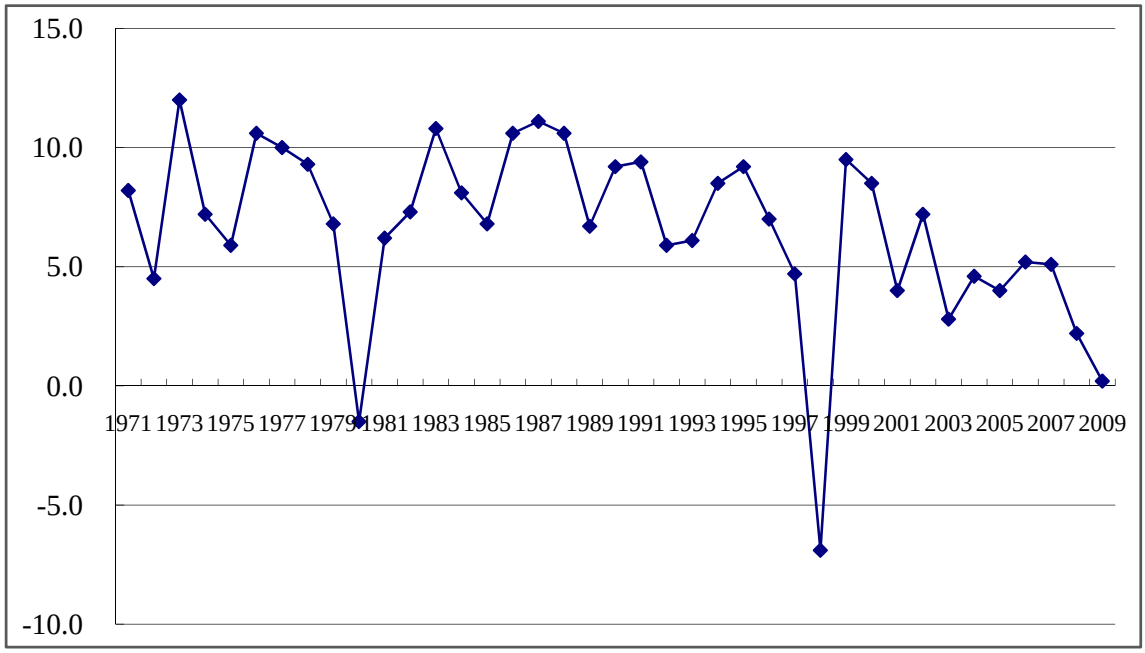
This research looks into social protection for the elderly in Korea, identifies critical challenges to it and seeks for possible solutions. The National Health Insurance was introduced in 1977 and expanded to universal coverage in 1989, protecting the elderly from the financial risk associated with acute illness. A new social insurance for long-term care was introduced in July 2008 to cover long-term care costs associated with aging-related chronic illness or disability. While the pension scheme was introduced in 1988 and then expanded to universal coverage in 1999, only 25% of the elderly were recipients of public pension schemes in 2008 because of its recent introduction. Additional Basic Age Pension was introduced in January 2008 and expanded in January 2009, providing 5% of the three-year average earnings of the national pension insured to the relatively poor 70% of the elderly.

Before they become mature enough to be efficient and effective in protecting the elderly, the social protection schemes face significant challenges ahead. First of all, financial sustainability should be enhanced by reducing their benefit levels and/or increasing contribution levels. With these changes, the inevitable challenge of inter-generational and intra-generational equity should be addressed carefully. Furthermore, coordination among the schemes will become more important over time. Especially, the National Pension Scheme should be coordinated with the newly introduced Basic Age Pension. Also, National Health Insurance should be coordinated with Long-term Care Insurance. Finally but most importantly, measures to help elderly people remain healthy and active in the labor market should be taken, while developing the social protection schemes for the vulnerable elderly.

1. Background and Objectives

The Korean economy experienced robust growth (except for 1980) until the mid-1990s. However, the economy plummeted with the Asian financial crisis, especially in 1998 as shown by the real GDP growth rate in Figure 1. The real GDP growth rate was -6.9 for the year 1998. Although it afterwards recovered, real GDP growth rate has been declining again with the current economic crisis.[1]

Figure 1. Real GDP Growth Rate (1971-2009)



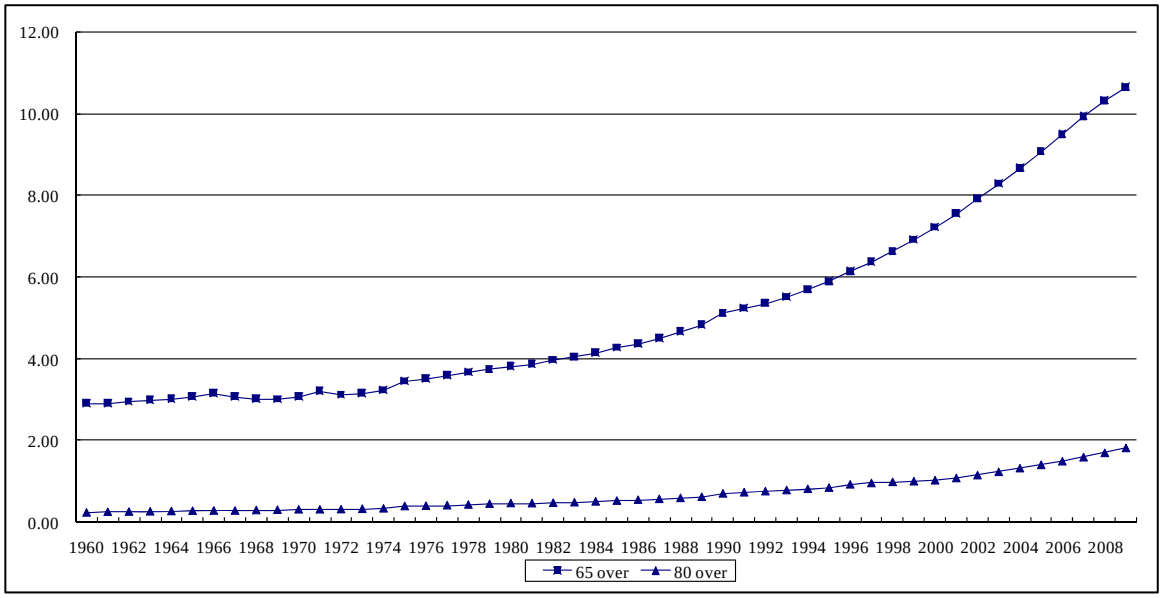
Source: Economic Statistics System (http://ecos.bok.or.kr), Bank of Korea, 2010.

Meanwhile, Korea's population has been aging rapidly. The share of those aged 65 and over in the total population increased significantly from 2.90% in 1960 to 10.65% in

[1] The real GDP growth rate was 0.2 in 2009. Data used in Figure 1 are presented in Table A-1.

2009 (See Figure 2.).[2] Korea is expected to become an aged society by 2018 when the share rises to 14 % or higher, and a super-aged society by 2026 when the share rises to 20% or higher. Similarly, the share of those aged 80 and over in the total population increased from 0.24 to 1.82 during the same period. Population aging in Korea is assessed to be more dramatic than in any other OECD country (OECD 2009).

Figure 2. Share of the Elderly in Population



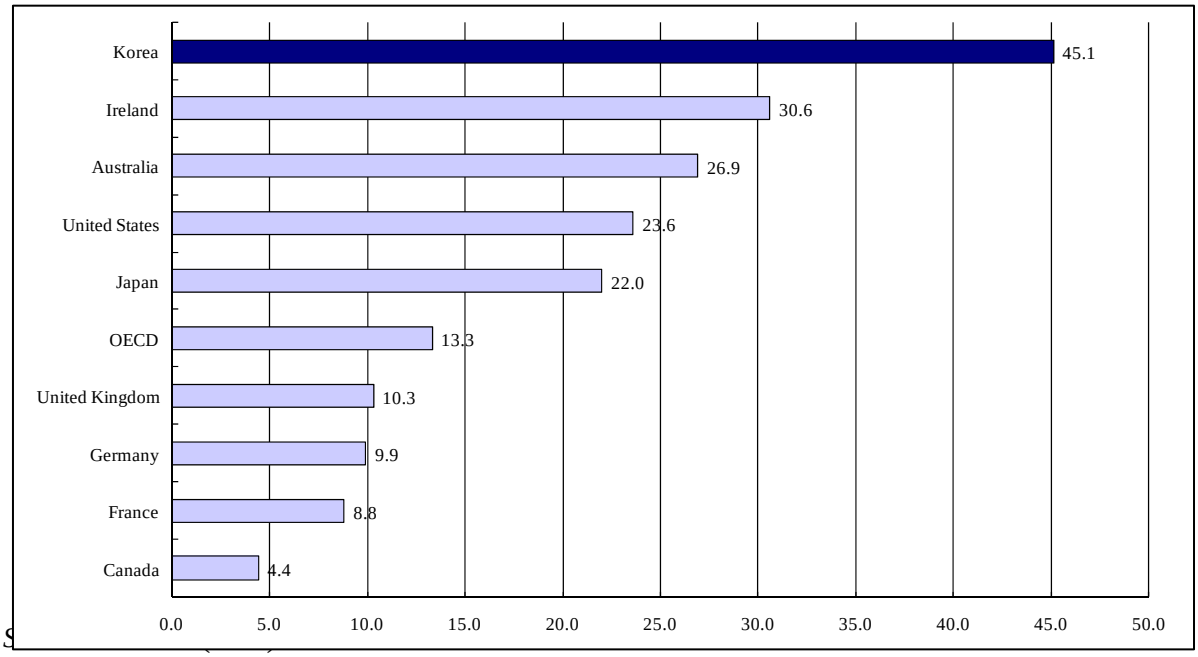
Source: Statistics Korea (http://kosis.kr), Population Projections for Korea 2006.

An aging population, especially during the current economic crisis, has been a growing concern for the social protection of the elderly. It is a fact that the elderly are more prone to illnesses and thus subject to poverty due to significantly high medical costs. The share of total national medical costs borne by those aged 65 and over has increased rapidly from 17.47% in 2000 to 30.79% in 2008. Thus, it may not be surprising that the elderly recipients of the National Basic Living Security (NBLS), the means-tested public

[2] Data used in Figure 2 are presented in Table A-2. Among those aged 65 and over, the male to female ratio increased from 0.597 in 1980 to 0.686 in 2009.

assistance program for the very poor, represented 26.5% (382,050 people) of NBLS recipients (1,444,010 people) in 2008. Furthermore, according to Figure 3, 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median in 2005, the highest old-age poverty rate among the 30 OECD countries (OECD, 2009)[3].

Figure 3. Poverty Rate of the Elderly



Source: OECD (2009).

This research looks into social protection for the elderly in Korea, driven by the high old-age poverty rate, and searches for measures for a sustainable social protection system in Korea. It is notable that the central government's spending for the welfare of the elderly has increased. The share of welfare spending for the old increased from 0.23% in 1999 to 1.59% in 2009. Above all, this study focuses on health insurance and pension systems in Korea. The former protects the elderly from the financial risks involved when

[3] Average for the 30 OECD countries is 13.3%.

they suffer from illnesses and have to bear their own medical costs. The latter directly supports the income of the elderly with pension benefits. In addition, this research introduces the newly initiated long-term care insurance of Korea.

Accordingly, the objective of this research is to review the current state of health insurance, long-term care insurance and pension systems in Korea. Furthermore, this research identifies critical challenges to those systems and seeks for possible solutions.

2. Current State of Social Protection

2. 1. National Pension Scheme (NPS)

2.1.1. Coverage

The pension scheme in Korea was introduced in 1988 and then expanded to universal coverage in 1999. The pension system is operated by the National Pension Service. All residents from 18 to 59 years of age, regardless of their income, are covered under the scheme. The insured persons under the scheme are divided into the mandatorily insured (major group) and the voluntarily insured (minor group). The mandatorily insured persons, who are not able to choose to participate in the scheme or withdraw from it, are further divided into workplace-based insured persons and individually insured persons.

All the employees and employers from 18 to 59 years of age at a workplace are covered by the National Pension Scheme as workplace-based insured persons.[4] Those under the age of 18 are covered by the pension scheme, subject to their employer's consent.

[4] Government employees, military personnel, and private school employees are covered by other public pensions, not the National Pension Scheme, specially designed for each group.

The very poor who are recipients of the National Basic Living Security are not covered by the scheme. Daily workers, casual workers employed for less than a month, or hourly workers working less than 80 hours in a month are not covered either. Meanwhile, individually insured persons are those who are self-employed, excluding non-income earners from 18 to 26 years of age who are studying or performing military service, and excluding also recipients of the National Basic Living Security.

The voluntarily insured persons are divided into two groups: those who are not eligible for the mandatory pension but want to participate in the pension, and those who reach age 60 before completion of the 20-year enrollment period and want to extend the enrollment period up to age 65 to become eligible for their pension (10 years minimum enrollment period is required) or more pension benefit. All foreigners residing in Korea are equally covered by the National Pension Scheme, based on individual qualifications except for foreign students, diplomats, etc.

As of November 2009, a total of 9,972,380 persons (53.27%) out of 18,721,200 insured persons were workplace-based insured persons, and 8,673,534 persons (46.33%) were individually insured persons. The rest were divided into 35,046 voluntarily insured persons (0.19%) and 40,240 voluntarily and continuously insured persons (0.21%) from age 60 to 65.

Among the old aged 65 and over, 25% were recipients of public pension schemes in 2008 (See Table 1). Of these, 22% were entitled to the National Pension, 2.6% to the public pension for government employees, and 0.4% to the public pension for private school employees, respectively. The number of recipients of the National Pension Scheme has increased from 283,179 persons (7.5% of the old) in 2002 to 1,103,007 persons (22%) in 2008. During the same period, the number of recipients of the public

pension for government employees has increased from 63,023 persons (1.7% of the old) to 131,482 persons (2.6%), and those of the public pension for private school employees from 7,421 (0.2%) to 17,663 persons (0.4%), respectively.

Table 1. Pension Coverage of the Elderly

		2002	2003	2004	2005	2006	2007	2008
National Pension Scheme	No. of Recipients	283,179	344,616	458,419	600,421	751,897	944,651	1,103,007
	Share (%)	7.5	8.7	11.0	13.7	16.4	19.6	22.0
Pension for Government Employees	No. of Recipients	63,023	73,439	83,658	93,468	104,942	118,503	131,482
	Share (%)	1.7	1.9	2.0	2.1	2.3	2.5	2.6
Pension for Private School Employees	No. of Recipients	7,421	9,551	8,877	10,298	13,658	15,800	17,663
	Share (%)	0.2	0.2	0.2	0.2	0.3	0.3	0.4
Total	No. of Recipients	353,623	427,606	550,954	704,187	870,497	1,078,954	1,252,152
	Share (%)	9.4	10.8	13.2	16.0	19.0	22.4	25.0

Source: Korea National Statistical Office (http://kostat.go.kr), Statistics for the Old, 2004~2009.

2.1.2. Contribution

The contributions of workplace-based insured persons are equally shared by the employer and the employee, while individually insured persons, including voluntarily insured persons, pay all their contributions themselves. All pension contributions are tax-exempt except for the contributions made by employers for the workplace-based insured persons.

The total contribution to the pension scheme by workplace-based insured persons is 9% of individual average monthly earnings (shared equally by employers and employees) with

a minimum cap of 0.22 million (KRW) and a maximum cap of 3.6 million (KRW) on the average monthly earnings.[5] The contribution rate was 3% between 1988 and 1992, 6% between 1993 and 1997, and 9% from 1999 onwards (See Table 2). It should be noted that Retirement Payment Reserve, money reserved for severance pay, was used for the contribution from 1993 to 1998. However, the use of Retirement Payment Reserve for the contribution was repealed in April 1999.

The contribution rate for individually insured persons was 3% from July 1995 to June 2000 but began to increase by 1% annually from July 2000 up to 9% in July 2005. Thereafter, the rate has remained at 9%. The income of individually insured persons is "any earned income". The contribution rate for voluntarily insured persons was 3% from 1988 to 1992, 6% from 1993 to 1997 and 9% from January 1998 to March 1999 following those for workplace-based insured persons. But, as the pension scheme in Korea was expanded to universal coverage in April 1999, the contribution rate for voluntarily insured persons was cut to 3% from April 1999 to June 2000 and increased by 1% annually from July 2000 up to 9% in July 2005. Thereafter, it remains at 9% following the contribution rate for the individually insured persons. The income for voluntarily insured persons is the higher of the median income of all workplace-based and individually insured persons or any reported income.

Financial support has been available to some workers in the agricultural and fishery sectors since July 1995. As of 2010, when their monthly income is less than 790,000 (KRW), half of the contribution is subsidized but when their monthly income is higher than 790,000 (KRW), the fixed amount of 35,550 (KRW) is subsidized for their pension contribution.

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[5] Amounts less than one thousand (KRW) in the monthly earning are rounded off.

When the contribution is not made by the due date, 3% of the contribution is additionally charged in arrears and an extra 1% for each additional month delayed is charged up to 9%. However, when the insured person is not able to make contribution due to job loss, business failure, etc. the person will be temporarily exempted from paying contribution. Accordingly, the unpaid period is not counted as an insured period but the person is able to increase his insured period by paying the delayed contribution afterwards. As of December 2008, the contribution collection rate is 96.7%. To illustrate, the rate turns out differently among the separately insured groups, for example 99.2% for workplace-based insured persons, 82.6% for individually insured persons and 100% for voluntarily insured persons.

Table 2. Contribution Rate

A. Workplace based Insured Persons

Year	1988-1992	1993-1997	1998	1999 ~
Total	3.0	6.0*	9.0*	9.0
Employee	1.5	2.0	3.0	4.5
Employer	1.5	2.0	3.0	4.5
Retirement Payment Reserve*		2.0	3.0	

*Retirement Payment Reserve is money reserved for severance pay. The use of Retirement Payment Reserve for the contribution was repealed in April 1999.

B. Individually Insured Persons

07.1995 ~ 06.2000	07.2000 ~ 06.2001	07.2001 ~ 06.2002	07.2002 ~ 06.2003	07.2003 ~ 06.2004	07.2004 ~ 06.2005	07.2005 ~
3	4	5	6	7	8	9

C. Voluntary Insured Persons

1988~1992	1993~1997	01.1998 ~ 03.1999	04.1999 ~ 06.2000	07.2000 ~ 06.2001	07.2001 ~ 06.2002	07.2002 ~ 06.2003	07.2003 ~ 06.2004	07.2004 ~ 06.2005	07.2005 ~
3	6	9	3	4	5	6	7	8	9

Source: National Pension Service (http://www.nps.or.kr), 2010.

2.1.3. Benefits

The National Pension Scheme (NPS) is designed as an appropriate income protection system against a wide range of social risks including old age, disability and death. The NPS is an income related scheme where benefits are based on both individual income and economy-wide average income. Pension benefits are calculated by C (A+B)*(1+0.05N), where C is a proportional constant designed for the desired income replacement rate of pension benefits, A is average monthly income of the pension insured over the previous three years, B is individual lifetime average monthly income, and N is the number of insured years in excess of 20 years (calculated by the number of insured months in excess of 20 years divided by 12).[6] The income replacement rate of pension benefits for 40 years of contribution was 70% from 1988 to 1998 and 60% from 1999 to 2007. This replacement rate was further reduced to 50% in 2008 and will be reduced by 0.5% per year to 40% in 2028.[7] However, the pension benefit cannot be higher than either individual lifetime average monthly income or average monthly income of the pension insured over the previous five years. This is intended to prevent economically viable people from retiring early.

Pension benefits (Basic Pension Amount, BPA) are available from age 60 (but this will be gradually increased to 65 by 2033), provided that the individual has contributed for ten years or more. Full benefit is available for those who have contributed to the pension scheme for twenty or more years. Reduced benefit is available, 5% lower for each year,

[6] The pension benefits formula is C (A+0.75B)*(1+0.05N) for the period from 1988 to 1998 but C (A+B)*(1+0.05N) for the period since 1999. Additional credits are available to those who give birth to more than 2 children or completed military service since 2008.

[7] Accordingly, C in the pension benefits formula is 2.4 from 1988 to 1998, 1.8 from 1999 to 2007, 1.5 and declines annually by 0.015 from 2008 to 2027. Afterwards it remains at 1.2.

for those who have contributed to the scheme for ten or more years but less than 20 years. Thus, the pension benefit for those who have contributed to the pension for 10 years alone is 50% of the benefit level for those who have contributed to the pension for 20 years or more, increasing by 5% for each additional contributory year (see Table 3).

Additionally, early pension benefit is available for those who are aged 55 and over (60 and over, when the normal pension age increases from 60 to 65) and economically inactive. Early pension benefit is lower by 6% for each year prior to age 60 when the pensioner begins to receive pension benefit. Thus, the pension benefit at the current early pension age of 55 is 70% of the benefit level at the normal pension age of 60, increasing by 6% for each deferred year of age up to age 60. When the current normal pension age increases from 60 to 65, the early pension age will increase as well from 55 to 60.

The pension benefit for those who are still working from age 60 to 65 (from 65 to 70 when the normal pension age increase from 60 to 65), whose yearly income is higher than the average monthly income of the pension insured over the previous three years (A in the pension benefits formula), is 50% of the full old age pension benefit level but increases by 10% for each deferred year of age up to age 65. However, if they have contributed to the pension for ten or more contributory years but less than 20 years, the pension benefit increases by an additional 5% for each additional contributory year. Since they are economically active, additional pension benefits for the dependents of pensioners are not available to them.

Additional pension benefits (Dependents' Pension Amount, DPA) are available to the dependents of pensioners such as spouse, children, and parents who are economically dependent upon the pensioners. The annual fixed amount (from April 2009 to March 2010) is 214,860 (KRW) for the spouse, 143,220 (KRW) for each child aged 18 and under

or severely disabled, and 143,220 (KRW) for each parent aged 60 and over or severely disabled. When a pensioner dies, 40 to 60% of the pension benefit (Survivor Pension) is available to the surviving dependents such as spouse, children, parents, and grandparents corresponding to the period during which contributions were made.

Table 3. Pension Benefits

Qualification	Benefits
Aged 60, contributed for more than 20 years	BPA+DPA
Aged 60, contributed for more than 10 years but less than 20 years	BPA(5% less for each contributory year lower than 20 years) +DPA
Aged 60 to 65, working	BPA(10% more for each deferred year of age to receive pension benefit up to age 65)
Aged 55 to 59, not working, contributed for more than 10 years	BPA(6% less for each earlier year of age to receive pension benefit than age 60 and 5% less for each contributory year lower than 20 years)+DPA
Divorced spouse, older than 60, married for more than 5 years during which contributions were made	Half of BPA corresponding to the married period during which contributions were made
Surviving dependents of pensioners	BPA(40% if the contributory years is less than 10 years, 50% if more than 10 years but less than 20 years, and 60% if more than 20 years)+DPA

Source: National Pension Service (http://www.nps.or.kr), 2010.

Meanwhile, some part of the pension benefit of a pensioner is available to his/her divorced spouse who is older than 60, if the couple were married for more than 5 years during which contributions were made. The benefit level to a divorced spouse is half the pension benefit corresponding to the married period during which contributions were made.

The number of pension beneficiaries (excluding lump-sum benefit recipients) increased from 292,976 in 1999 to 2,537,213 in 2008 (see Table 4). During this period, the overall cost of pension benefit increased from 1,326,036 million (KRW) to 27,414,488 million (KRW). When pension benefits are limited to old-age pension, excluding

disability pension and survivor pension, there were 2,064,198 beneficiaries of old-age pension and the cost of their pension benefit amounted to 427,860 million (KRW) in 2008.

Among the old-age pension beneficiaries, the majority group, categorized as special, is those who are too old to satisfy the minimum required contributory period of 10 years when the NPS was introduced and expanded, but who made contributions for more than 5 years. The basic pension amount (BPA) together with the dependents' pension amount (DPA), are available to them regardless of their working status. There were 1,673,576 beneficiaries and their pension benefits amounted to 16,181,115 million (KRW) in 2008 (see Table 5). Depending on the period of contributions, full benefit recipients numbered 12,798 and reduced benefit recipients numbered 216,084. Their pension benefits amounted to 49,586 and 2,659,399 million (KRW), respectively. The early pension benefit recipients numbered 159,202 and divided pension benefit recipients numbered 2,425. Their pension benefits amounted to 2,471,217 million (KRW) and 7,975 million (KRW), respectively.

Table 4. Pension Beneficiaries and Benefit Amount (1999-2008)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Beneficiaries	292,976	633,845	795,528	955,667	1,108,415	1,500,194	1,749,633	1,973,767	2,250,948	2,537,213
Amount	1,326,036	2,250,554	3,551,696	5,204,225	7,222,136	9,791,103	13,001,147	16,900,516	21,649,503	27,414,488

Source: National Pension Service (http://www.nps.or.kr), 2010.

Note : (million KRW, as of the end of each year).

Table 5. Pension Beneficiaries and Benefit Cost, 2008

	Total	Old-age Pension						Disability Pension	Survivor Pension
		Total	Special	Full	Reduced	Early	Divided		
Beneficiaries	2,537,213 (100.0)	2,064,085 (81.4)	1,673,576 (66)	12,798 (0.5)	216,084 (8.5)	159,202 (6.3)	2,425 (0.1)	100,776 (4)	372,352 (14.7)
Amount	27,414,488 (100.0)	21,369,292 (77.9)	16,181,115 (59)	49,586 (0.2)	2,659,399 (9.7)	2,471,217 (9)	7,975 (0.0)	1,633,932 (6)	4,411,264 (16.1)

Source: National Pension Service (http://www.nps.or.kr), 2010.

Note : (million KRW, %).

Pension benefits are taxable but pension income deduction applies with a graduated marginal deduction rate, [100% for 0~3.5 million (KRW), 40% for 3.5~7 million, 20% for 7~14 million, 10% for 14 million and over]. The maximum deduction is 9 million (KRW) per year.[8]

2.1.4. Basic Age Pension

However, because pension benefits are not sufficient to prevent 45.1% of those aged 65 and over from having (equivalent) incomes below half the population median, the highest old-age poverty rate among the OECD countries (OECD, 2009), the Basic Age Pension has been additionally introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured (A in the pension benefit formula above) to the relatively poor 60% aged 70 and over.

The coverage of Basic Age Pension has been expanded to the relatively poor 60% aged 65 and over in July 2008 and the relatively poor 70% aged 65 and over in January

[8] It should be noted that the old, aged 65 and over, receive an additional tax allowance of 1.5 million (KRW) on top of the standard tax allowance [1.5 million (KRW) for each tax payer and dependent] (OECD 2009).

2009. To be eligible in 2009, adjusted income, based on household income and assets, should be less than 680,000 (KRW) for the elderly living alone, and 1,088,000 (KRW) for the elderly living with his/her spouse.[9] The number of recipients has increased from 1,940,000 people in June 2008, to 3,585,000 people in September 2009. Simultaneously, the coverage rate has increased from 61% to 68.6%.

The benefit of Basic Age Pension is 5% of the three-year average earnings of the national pension insured (A in the pension benefit formula above). It will be increased to 10% by 2028. From 2008 to march 2009, the benefit was 84,000 (KRW) for the qualified elderly living alone and 134,000 (KRW) for the qualified elderly living with his/her spouse. From April 2009 to March 2010, the benefit was increased to 88,000 (KRW) and 140,800 (KRW), respectively. It has been financed by national and local taxes.

2. 2. National Health Insurance

2.2.1. Coverage

National Health Insurance in Korea was introduced in 1977 and expanded to universal coverage in 1989. Before being fully integrated into the National Health Insurance Corporation in 2000, there were three different categories of insurance societies, 139 insurance societies for employees (begun in 1977), an insurance society for government and private school employees (begun in 1977), and 227 insurance societies for the self-employed (begun in 1988 for those in rural area and in 1989 for those in urban area, respectively).[10]

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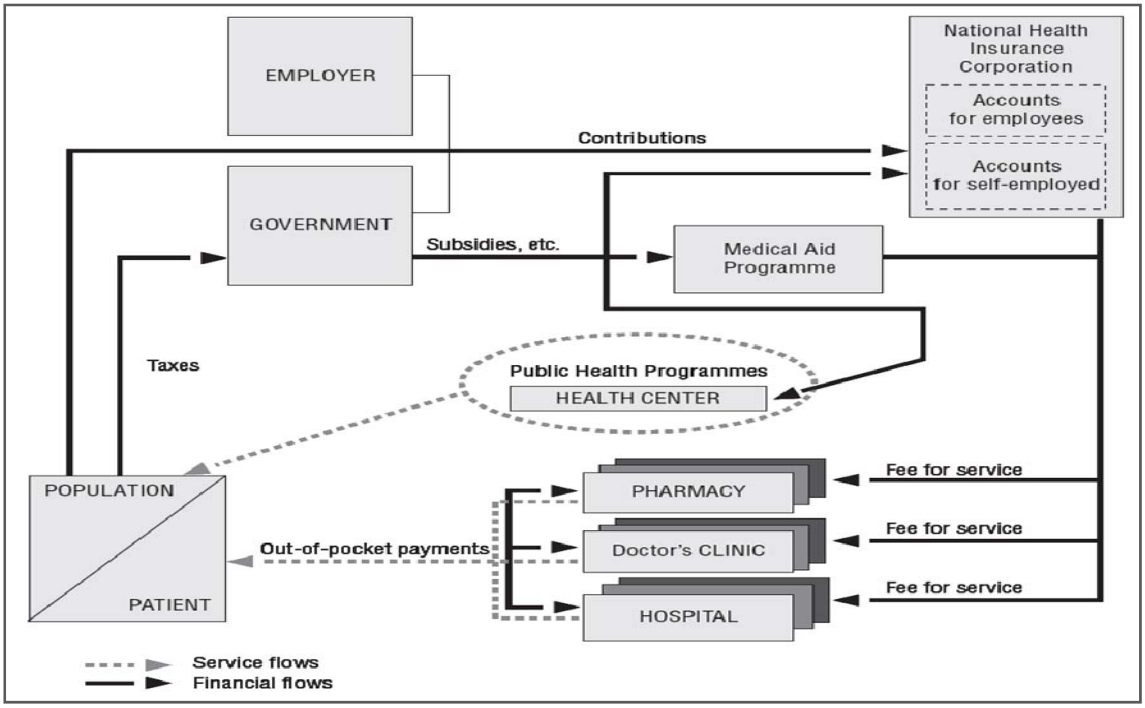
[9] The respective amounts were 400,000 (KRW) and 640,000 (KRW) in 2008.

[10] Before full integration in 2000, insurance societies for the self-employed and those employed in the government and private schools were integrated into the National Medical Insurance Corporation in October 1998.

Enrollment in National Health Insurance is mandatory for all Koreans, except for the poor who are eligible for the Medical Aid Program, which provides the same benefits as the National health insurance but subsidizes contribution and copayments. The number of people covered by the National Health Insurance as of 2008 was 48,159,718 people; with the employee insured comprising 63.2% and the self-employed insured 36.8%, respectively. The remaining 1,841,339 people were covered by the Medical Aid Program. Among the old, 4,599,562 people are covered by the National Health Insurance; with the employee insured (including the insured as dependents) comprising 66.4% and the self-employed insured 33.6%.

Figure 4. Operational Structure of National Health Insurance



Source: OECD (2003).

The operational structure of National Health Insurance is presented in Figure 4. The National Health Insurance Corporation (NHIC), a not-for-profit organization, is in charge

of administering the national health insurance program, collecting contributions and paying fees for services

2.2.2. Contribution

The contribution to the insurance is an amount calculated by multiplying the contribution rate by the average monthly salary for the employee insured, which is equally borne by both the employer and employee. The contribution rate has increased from 5.08% in 2008 and 2009 to 5.33% in 2010. There is a minimum cap of 0.28 million (KRW) and a maximum cap of 65.79 million (KRW) on average monthly earnings. Reduction of contribution by 50% is available to those living or employed on islands or in remote rural areas.

The contribution for the self-employed insured is calculated based on their income, assets, age, etc. Reduction of contribution for the self-employed insured is available by 50% to those living on islands or in remote rural areas, by 22% to those living in rural areas, by 28% to some workers in the agricultural and fishery sectors, by 20% to the very poor due to fire accident or bankruptcy etc., by 30% to those whose family member are all old and at least one member is older than 70, and by a maximum 30% depending on income or asset values to those who have a family member aged 65 or over or disabled.

2.2.3. Benefits

Benefits include all medical care covering diagnosis, tests, drugs, medical materials, treatments, surgery, preventive care, rehabilitation, hospitalization, nursing and transportation. Some cash benefits are available when copayment exceeds 1.2 million

(KRW) within 30 days, which amount to 50% of the excess amount.[11]

Co-payments are 20% of total cost for inpatient care and 30~60% for outpatient care. In the case of outpatient care, a lower rate for less expensive smaller-sized medical institutions applies, to incentivize more use of them, for example 30% for pharmacies and clinics, 40% of (treatment cost and per-visit consultation fee) for hospitals, 50% of (treatment cost and per-visit consultation fee) for general hospitals, and (per-visit consultation fee and 60% of treatment cost) for tertiary care hospital.[12] However, a copayment ceiling system was introduced in 2004. When copayment exceeds the ceiling any additional copayment for the services covered by the National Health Insurance will be exempted. The ceiling threshold is 2 million (KRW) for the 50% lowest contribution payers, 3 million (KRW) for the 30% medium contribution payers, and 4 million (KRW) for the 20% highest contribution payers.

Table 6. Copayments

Classification		Copayments
Inpatient		20% of total treatment cost
Outpatient	Tertiary care hospital	60% of (treatment cost) + per-visit consultation fee
	General hospital	50% of (treatment cost + per-visit consultation fee)
	Hospital	40% of (treatment cost + per-visit consultation fee)
	Clinic	30% of treatment cost
	Pharmacy	30% of total cost

Source: National Health Insurance Corporation (http://www.nhic.or.kr), 2010.

The balance of National Health Insurance is shown in Figure 5.[13] The revenue

[11] Additional cash benefits are available to the disabled, 80% of the expenses for wheelchairs, hearing aids, etc.

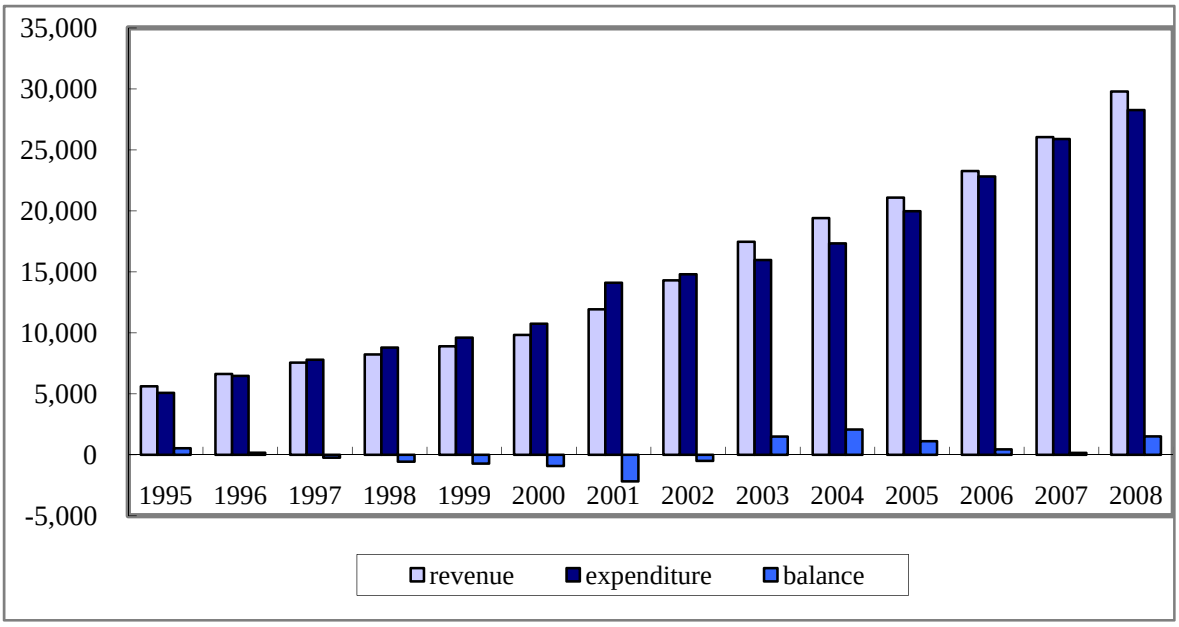
[12] The copayments are lower to those people living in town and township, 45% for general hospitals and 35% for hospitals, respectively.

[13] Data used in the Figure 5 is presented in Table A-3.

increased from 5,614 billion (KRW) in 1995 to 29,787 billion (KRW) in 2008. The main source of revenue was contributions, 24,973 billion (KRW), followed by government subsidies of 4,026 billion (KRW) and others of 787 billion (KRW) in 2008. Simultaneously, the expenditure increased from 5,076 billion (KRW) to 28,273 billion (KRW). The main expenditure was insurance benefits, 26,654 billion (KRW), followed by administrative cost 672 billion (KRW) and others 946 billion (KRW) in 2008. The balance (revenue – expenditure) was negative from 1997 to 2001 but became positive with the increase of government subsidy in 2002. Thereafter, the positive balance declined to 161 billion (KRW) in 2007 but jumped to 1,513 billion (KRW) in 2008 mainly due to the increase of contributions.

It is a fact that the elderly are more prone to illnesses and thus subject to poverty due to significantly high medical costs. According to Table 7, medical cost for the entire population increased by 2.7 times from 12,912 billion (KRW) in 2000 to 34,869 billion (KRW) in 2008. Simultaneously, that for the elderly increased by 4.76 times from 2,255 to 10,737 billion (KRW). Consequently, the share of medical costs borne by those aged 65 and over has increased rapidly from 17.47% in 2000 to 30.79% in 2008.

Figure 5. Balance of National Health Insurance.



Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Note: (billion KRW).

Table 7. Medical Cost by the Elderly

Total	2000	2001	2002	2003	2004	2005	2006	2007	2008
	12,912	17,843	18,832	20,742	22,506	24,862	28,410	32,389	34,869
Aged 65 and over	2,255	3,163	3,636	4,401	5,136	6,073	7,350	9,119	10,737
Ratio	17.47	17.73	19.31	21.22	22.82	24.43	25.87	28.15	30.79

Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2000-2008.

Note: (billion KRW).

2. 3. Long-term Care Insurance

A new social insurance for the long-term care was introduced in July 2008 in response to rapid population aging. While National Health Insurance covers the medical costs of acute illness, Long-term Care Insurance covers long-term care costs associated with aging-

related chronic illness or disability.[14] Enrollment in the Long-term Care Insurance is mandatory for all Koreans as it is for the National Health Insurance. Long-term care insurance is also operated by the Nation Health Insurance Corporation.

Only those with serious limitations in performing the activities of daily living (ADLs) are eligible for Long-term Care Insurance. The number of beneficiaries increased from 76,476 people in July 2008 to 202,492 people in May 2009. They represent 3.9% of 5,176,242 old people in May 2009. Since 259,456 people are eligible for the insurance, the number of beneficiaries accounts for 78% of those eligible in May 2009.

Currently, Long-term Care Insurance supplies two categories of service: institutional service and in-home services (home-visit care, home-visit bathing care, home-visit nursing, day and night care and respite care). Cash benefits are available only to those who are living in remote areas where long-term care services are not available or those who are not able to live with others due to mental problems etc. As of May 2009, 62,677 people (30.95% of the 202,492 recipients) are recipients of institutional service, 138,811 (68.55%) are recipients of in-home services, and 1,004 (0.50%) are recipients of cash benefits.

The insurance is financed by contribution, which is the contribution rate multiplied by the National Health Insurance contribution.[15] The contribution rates have increased from 4.05% in 2008 to 4.78% in 2009 and to 6.55% in 2010. The central government provides financial support of 20% of the expected long-term care insurance contribution. There is 20% copayment for institutional service users and 15% for in-home service users. This

[14] Further discussion on long-term care is available in Norton (2000).

[15] It should be noted that the National Health Insurance contribution is calculated by multiplying the National Health Insurance contribution rate with average monthly salary for the employee insured, which is equally borne by both the employer and employees. Therefore, the contribution to the Long-term Care Insurance is also equally borne by both the employer and employees for the employee insured.

copayment is reduced by half for the poor and even further to zero for the very poor, who are recipients of the National Basic Living Security.

For the year 2008, the revenue of the Long-term Care Insurance program was 868,974 million (KRW) and expenditure was 554,900 million (KRW). Thus, the balance (revenue – expenditure) was 314,074 million (KRW). The main source of revenue was contributions, 477,011 million (KRW), followed by (central and local) government subsidies of 386,883, million (KRW) and others of 5,079 million (KRW) in 2008. Meanwhile, the main expenditure was insurance benefits, 431,414 million (KRW), followed by administrative cost of 107,897 and others of 15,589 million (KRW) in 2008.

3. Challenges of Social Protection

3.1. National Pension Scheme (NPS)

The National Pension Scheme protects the old from poverty by supporting their income with pension benefits. However, the NPS was introduced and expanded to universal coverage by low contributions but generous benefits. Therefore, its financial sustainability was doomed to be fragile from the beginning. Furthermore, rapid population aging poses a serious challenge to the long-term financial sustainability of the National Pension Scheme. According to Moon (2008), the NPS fund was projected to be in deficit by 2035 and depleted by 2060 if the current contribution and benefit levels are maintained. Thus, to obtain a fiscal balance when the current partial prefunding method changes to the pay-as-you go method, the contribution rates to the NPS would have to rise to a 23.9% level in 2065.

Therefore, the financial sustainability of the NPS should be enhanced by reducing benefit levels and/or increasing contribution levels. This change will inevitably bring another challenge to the NPS: inter-generational and intra-generational equity issues. The policy of reducing pension benefits will have a greater influence on the current generation, while the increasing contribution levels will have a greater influence on the future generation. Depending on the relative changes and timing of those policies, inter-generational equity may improve or deteriorate. In the meantime, the intra-generational equity depends on the relative benefit-contribution ratio of the NPS across different income groups, designed to provide higher benefit-contribution ratios for the relatively poor. Thus, intra-generational equity may improve or deteriorate with changes in the relative benefit-contribution ratio of the NPS across different income groups.

An additional challenge to the NPS is the adequacy of pension benefits in financially supporting the elderly. As noted above, the elderly recipients of the National Basic Living Security, which is the means-tested public assistance program for the very poor, represented 26.5% (382,050 people) of all NPS recipients (1,444,010 people) in 2008. Furthermore, 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median, the highest old-age poverty rate among the 30 OECD countries (OECD, 2009). Since the NPS was introduced recently in Korea, this could be partly explained by the many people who are too old to satisfy the minimum required contributory period of 10 years to be eligible for a full or partial pension benefit. Basic Age Pension was introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured to the many poor among the old without the NPS benefits or with small benefits. Therefore, it will be necessary and important to coordinate the respective roles of the National Pension Scheme and Basic Age Pension

over time as the NPS matures in the future.

Finally, with the aging population and declining working population, it is necessary to increase the labor force participation of the old. Presently, early pension benefit is lower by 6% for each year of age prior to the normal pension age that benefits begin to be received. This will reduce the incentive to retire early. However, pension benefit for the old, who are still working after normal pension age and whose yearly income is higher than the average monthly income of the pension insured over the previous three years, is 50% of the full pension benefit level but increases by 10% for each deferred year of pension benefit. This will increase the incentive to retire at the normal pension age rather than remain active in the labor market past normal pension age.

3.2. National Health Insurance

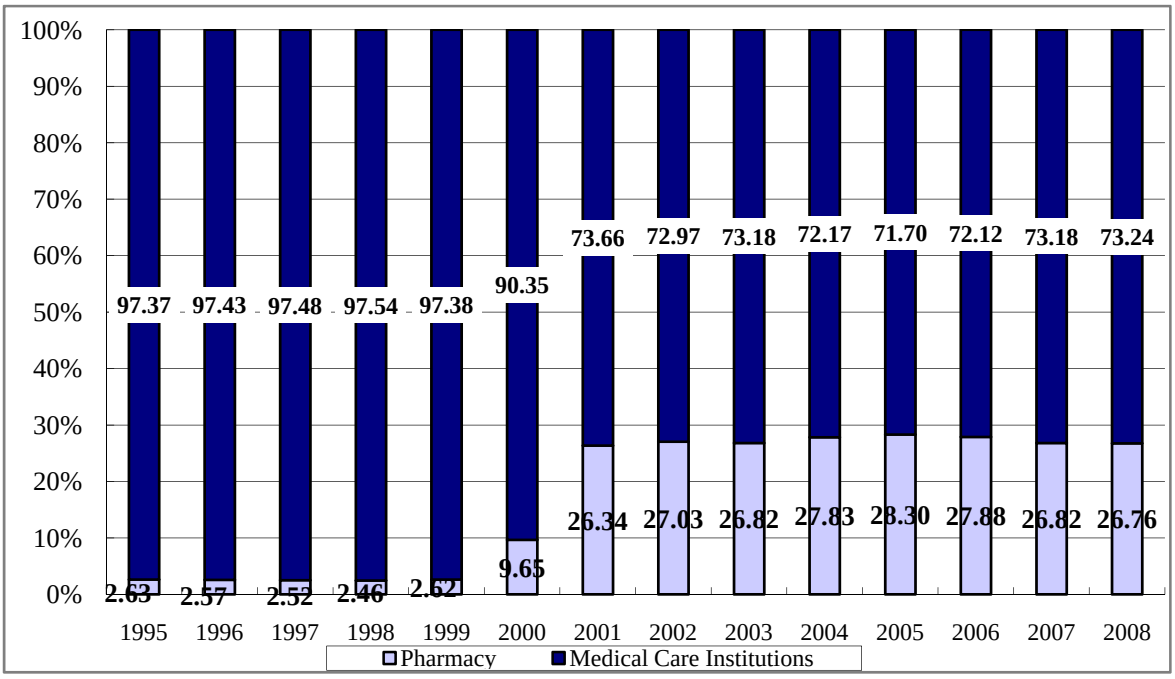
The National Health Insurance scheme was introduced in 1977 and expanded to universal coverage in 1989. This was achieved with low contributions and limited benefit coverage, and may have contributed to the improvement of population health together with other positive changes, for example rising income. Life expectancy at birth of 79.1 years and infant mortality rate of 4.1 (deaths per 1000 live births) in 2006 are significant achievements especially when considering the fact that medical spending remains at 6.3% of GDP in 2007 (OECD Health Data 2009), one of the lowest in the OECD countries. However, health spending has risen at a fast pace over time, challenging the financial stability of the National Health Insurance system as shown in Figure 5 above. Measures to increase revenue and/or to reduce expenditure are needed to ensure the insurance's financial stability.

One of the key stability measures should be a reduction in the spending on drugs.

Since the 2000 reform, which mandates the separation of drug prescribing and dispensing between physicians and pharmacists, the share of insurance spending on pharmacy costs has risen significantly. In 1995, the share was only 2.63% but jumped to 9.65% in 2000 and to 26.34% in 2001. It remains within a range between 26% and 28% (see Figure 6). This spending on drugs is significantly high even by OECD standards. Out of the spending on personal health care, the share of spending on pharmaceuticals and other medical non-durables for Korea is 24.7%, the third highest after the Slovak Republic (27.9%) and Hungary (31.2%) in 2007 (see Figure 7).

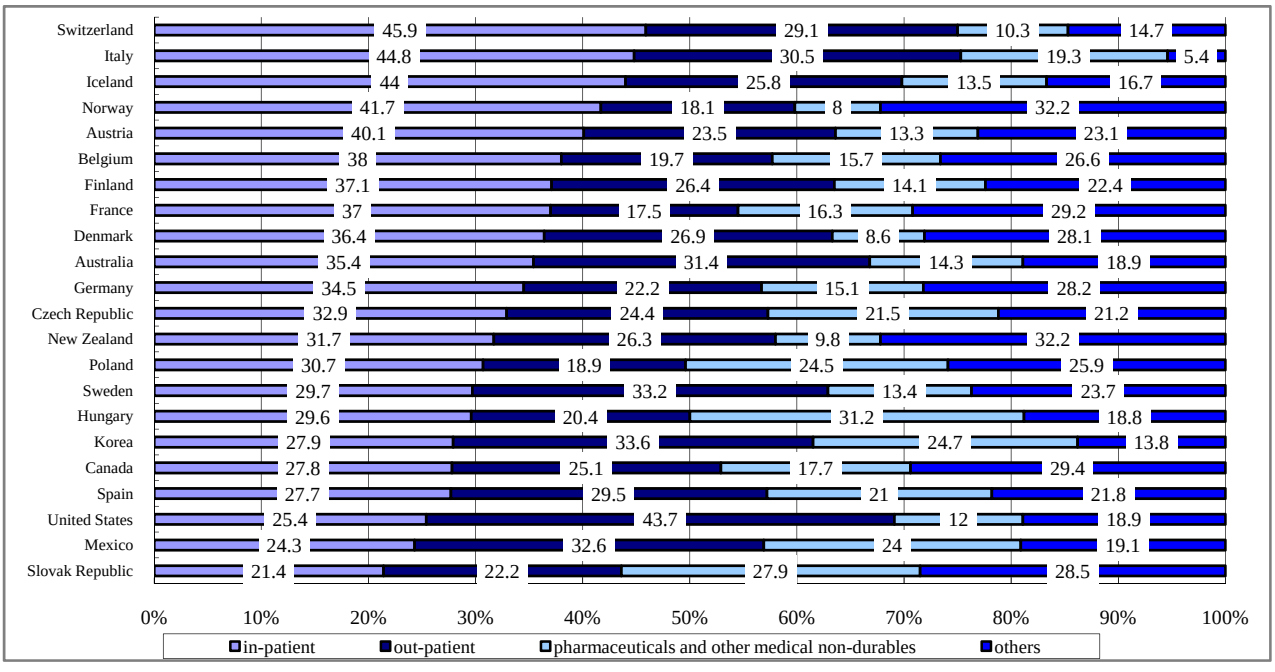
Another challenge to the National Health Insurance scheme is the (in) equity between the employee insured and the self-employed insured in sharing the financial burdens of the insurance. As explained above, contribution to the insurance scheme for the employee insured is the amount calculated by multiplying the contribution rate by average monthly salary; while for the self-employed insured it is calculated based on income, assets, age, etc. There is a potential for the self-employed to underreport their income or not to pay contributions. If anything, the benefit to contribution ratio for the employee insured as a whole increased from 89.73 to 131.52 in 2001 but declined to 76.95 in 2008 (see Figure 8). However, the ratio for the self-employed insured increased from 107.37 in 1995 to 139.10 in 2008.

Figure 6. Medical Spending by Type of Medical Institutions, 1995~2008



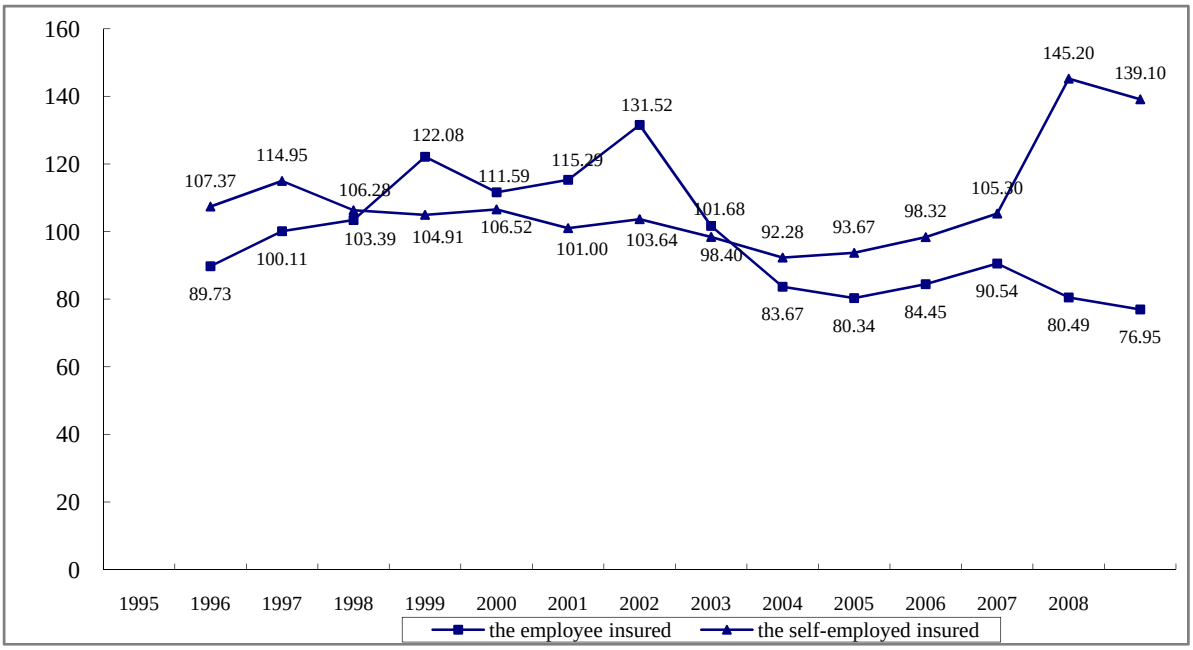
Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Figure 7. Medical Spending by Type of Medical Services, 2007



Source: OECD Health Data 2009.

Figure 8. Benefit to Contribution Ratio, 1995~2008



Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Furthermore, a greater attention to the quality of medical care is needed in the future. There should be efforts to enhance the quality of health professionals by licensure, and the quality of medical institutions by both evaluation and compensation based on evaluation results, in addition to increased competition among them.[16] Better education prior to licensure and continuing education to keep the license, will help improve the quality of health professionals. Meanwhile, periodic evaluation of medical institutions and compensation based on the evaluation outcome will help improve the quality of medical institutions.

Finally, access to medical care, especially by the poor old, is another great challenge considering the high copayments and many uninsured services by the National Health

[16] Further discussion on regulation in health care is available in Phelps (2009) and discussion on the entry regulations to the medical sector in Korea is available in Chung (2009).

Insurance. Due to high copayments and high fees of many uninsured services, private spending represents 45.1% in total medical spending in 2007, the third highest next to Mexico (54.8%) and the United States (54.6%), according to OECD Health data 2009. It is also notable that 32% of surveyed people in 2008 answered, "Being dissatisfied with medical treatment due to high medical fees," according to the Social Survey by the National Statistics Office. The answer recorded the highest percentage among other reasons for being dissatisfied with medical treatment, such as unsatisfactory treatment (20%), long waiting time (16.3%), unkindness (12%), etc.

3.3. Long-term Care Insurance

First, the Long-term Care Insurance program covers long-term care costs associated with aging-related chronic illness or disability. It is clear that long-term care costs will rise significantly over time with population ageing. The number of beneficiaries has been growing faster than expected. Contribution, copayment, eligibility criteria, etc., factors related to the revenue and expenditure of the insurance, should be streamlined to enhance the financial sustainability of the insurance.[17] Differential contribution rates across people with different risks of needing to use long-term care and measures to induce more use of less expensive in-home services rather than institutional service will be essential for the financial sustainability of the insurance.

Second, the Long-term Care Insurance scheme needs to improve the quality control of long-term care services. The quality of long-term care suppliers, facilities and workers, should be improved, subject to tight constraints on service fees. Better education of long-

[17] Issues on the long-term care insurance are discussed in OECD (2005) and OECD (2007), and those for the Korean long-term care insurance are discussed in Chung and Jin (2008).

term care workers and periodic evaluation of long-term care facilities and compensation based on the evaluation results will help improve the quality of services. It is, however, unquestionable that they will be constrained by the low wage for long-term care workers and tight control of service fees.

Third, the Long-term Care Insurance scheme needs to coordinate the respective roles of the National Health Insurance and Long-term Care Insurance schemes. While National Health Insurance covers medical costs due to acute illness, Long-term Care Insurance covers long-term care costs due to aging-related chronic illness or disability. Since the transfer of the elderly from hospitals to home or long-term care facilities can save the cost of the health insurance but increase the cost of the long-term care insurance, coordination of them is important alongside satisfying the respective needs of the elderly.

Lastly, inter-generational and intra-generational equity issues should be addressed. Contribution to the Long-term Care Insurance is calculated as the contribution rate multiplied by the National Health Insurance contribution. Therefore, the equity concern in the health insurance between the employee insured and the self-employed insured will be aggravated by Long-term Care Insurance. Furthermore, the relative benefit-contribution ratio of the insurance is largely dependent on the demographic structure of the population; for example, beneficiaries of the elderly and contributors of the working population. Therefore, inter-generational equity is another challenge to take on in the future.

4. Conclusion

An aging population, especially during the current economic crisis, has been a growing concern for the social protection of the elderly. It is a fact that the elderly are

more prone to illnesses and thus subject to poverty due to their significantly high medical costs. Notably, the elderly recipients of the National Basic Living Security, the means-tested public assistance program for the very poor in Korea, represent 26.5% of all pension recipients in 2008, and 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median in 2005 (OECD 2009).

The National Health Insurance scheme in Korea was introduced in 1977 and expanded to universal coverage in 1989. A new social insurance for long-term care was introduced in July 2008 in response to the rapid population aging. While National Health Insurance covers the medical costs of acute illness, Long-term Care Insurance covers long-term care costs associated with aging-related chronic illness or disability. Enrollment in both the National Health Insurance and Long-term Care Insurance is mandatory for all Koreans.

The pension scheme in Korea was introduced in 1988 and then expanded to universal coverage in 1999. However, only 25% of the elderly aged 65 and over are recipients of public pensions in 2008 because of it's the scheme's recent introduction. Additional Basic Age Pension was been introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured to the relatively poor 60% of those aged 70 and over. Its coverage was expanded to the relatively poor 70% of those aged 65 and over in January 2009.

Before they become mature enough to be efficient and effective in protecting the elderly, the social protection schemes face significant challenges ahead. First of all, financial sustainability should be enhanced by reducing their benefit levels and/or increasing contribution levels. With these changes, the inevitable challenge of inter-generational and intra-generational equity should be addressed carefully. Policies to reduce benefits will have a greater influence on the current generation, while policies to

increase contributions will have a greater influence on the future generation. Similarly, changes in the relative benefit-contribution ratios across different income groups and employment status groups will affect intra-generational equity.

Furthermore, coordination among the schemes will become more important over time. In particular, the National Pension Scheme should be coordinated with the newly introduced Basic Age Pension. National Health Insurance should be coordinated with Long-term Care Insurance. Finally but most importantly, measures to help elderly people remain healthy and active in the labor market should be taken, while developing the social protection schemes for the vulnerable elderly.

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Table A-1. Real GDP Growth Rate (1971~2009)

Year	Real Growth Rate	Year	Real Growth Rate
1971	8.2	1991	9.4
1972	4.5	1992	5.9
1973	12	1993	6.1
1974	7.2	1994	8.5
1975	5.9	1995	9.2
1976	10.6	1996	7
1977	10	1997	4.7
1978	9.3	1998	-6.9
1979	6.8	1999	9.5
1980	-1.5	2000	8.5
1981	6.2	2001	4.0
1982	7.3	2002	7.2
1983	10.8	2003	2.8
1984	8.1	2004	4.6
1985	6.8	2005	4.0
1986	10.6	2006	5.2
1987	11.1	2007	5.1
1988	10.6	2008	2.2
1989	6.7	2009	0.2
1990	9.2		

Source: Economic Statistics System (http://ecos.bok.or.kr), Bank of Korea, 2010.

Table A-2. Share of the Old (1960~2009)

Year	Aged 65 and over	Aged 80 and over	Year	Aged 65 and over	Aged 80 and over
1960	2.90	0.24	1985	4.27	0.53
1961	2.91	0.25	1986	4.37	0.55
1962	2.95	0.26	1987	4.51	0.57
1963	2.99	0.26	1988	4.67	0.60
1964	3.02	0.27	1989	4.84	0.62
1965	3.07	0.28	1990	5.12	0.71
1966	3.15	0.28	1991	5.23	0.73
1967	3.08	0.28	1992	5.36	0.76
1968	3.03	0.30	1993	5.51	0.79
1969	3.01	0.30	1994	5.70	0.82
1970	3.07	0.31	1995	5.89	0.85
1971	3.21	0.31	1996	6.14	0.93
1972	3.12	0.32	1997	6.37	0.96
1973	3.16	0.33	1998	6.63	0.99
1974	3.23	0.34	1999	6.92	1.00
1975	3.45	0.39	2000	7.22	1.03
1976	3.52	0.40	2001	7.56	1.08
1977	3.60	0.41	2002	7.92	1.15
1978	3.67	0.43	2003	8.29	1.23
1979	3.74	0.45	2004	8.67	1.32
1980	3.82	0.47	2005	9.07	1.40
1981	3.87	0.47	2006	9.49	1.50
1982	3.97	0.48	2007	9.93	1.59
1983	4.05	0.49	2008	10.32	1.70
1984	4.14	0.51	2009	10.65	1.82

Source: Statistics Korea (http://kosis.kr), Population Projections for Korea, 2006.

Table A-3. Balance of National Health Insurance (1990-2008)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Revenue	5,614	6,630	7,554	8,229	8,892	9,827	11,928	14,305	17,466	19,408	21,091	23,263	26,049	29,787
Expenditure	5,076	6,464	7,795	8,787	9,610	10,744	14,105	14,798	15,972	17,330	19,979	22,817	25,888	28,273
Balance	537	166	-241	-558	-718	-917	-2,178	-494	1,494	2,077	1,111	445	161	1,513

Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Note: (billion KRW).