# The Present situation and problems of the long-term care insurance in South Korea: from comparative perspectives between South Korea and Japan

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## Introduction

Japan introduced a long-term care insurance system in 2000 after the model of the German long-term care insurance system, and this system later began to be used widely with an increase in elderly people in need of long-term care. South Korea became an ageing society, too, in 2000, and the increasing needs for long-term care of the elderly was pointed out as social risks incurred with advancing population ageing. As part of the measures to cope with this problem, the South Korea government decided to create the long-term care insurance system by using the system in Germany and Japan for reference and also by adopting the country's original mechanisms. In this way, the South Korea established a long-term care insurance system for the elderly in July 2008.

The fact that Germany and Japan, both social insurance states, introduced a long-term care insurance system one after another as the policy for dealing with the need for long-term care, a new type of social risk, greatly affected South Korea in starting its own system for long-term care insurance. In particular, research papers on long term care and social protection for the elderly began to be published in the South Korea academic world in 1996, and these periods coincided with the time when Germany introduced and started to implement a long-term care insurance and when Social Security Advisory Council of the Cabinet Office of Japan advised the necessity for introducing the long-term care insurance. Then in 2000, Japan adopted the public long-term care insurance. In these situations, the South Korean government and policymakers began to have interest in a long term care system. As a result, the government established the policy committee for long term care and social protection policies for the elderly in the first half of 2000 and started preparations for creating a system for long-term care. The processes after that can be summarized as follows: a survey on needs for long term care and social protection for the elderly across the country conducted in 2001; the basic analyses of the survey outcome and estimation of the quantity of long term care services and infrastructure for such services in 2002; the development of a model of long term care insurance for the elderly in 2003–2004; the implementation of modeling work in selected districts and drafting and deliberations of the law in 2005–2007; and the enforcement of the long-term care insurance system in 2008.

It was the report on the survey on needs for long term care and social protection for the elderly in the country conducted in 2001 that first proposed the long term care and social protection ratio as one of the index for evaluation the performance of long-term care and welfare of the elderly, the problem on which discussions are continued even today. In those days, the ratio was calculated on the basis of ADL (IADL was excluded) and dementia and included those who had a low level of functional restrictions (e.g., the case where the person needs partial support in having a shower), and the estimated protection ratio was high. In short, it may be said that in those days, from which level the elderly should be covered by such a social assistance like long-term care was determined not theoretically but from policy standpoints.

Meanwhile, the South Korean society in 2000 and after was in a situation of rapid changes due to the relief financing from the IMF to overcome the foreign exchange crisis. In other words, it changed into a society where irregular workers and unstable employment and household economy increased and as a result the lowering of birthrates, leaving old parents without care and other similar phenomena were observed. In particular, because those eligible to receive public long term care service were limited to very low-income elderly persons, such as people on relief, other elderly persons in need of long-term care were left unattended although only part of them were able to use geriatric hospitals, fee-charging homes for the elderly or the like.

Therefore, many old people requiring long-term care were protected by their families or left without any help. In short, it can be said that owing to the debates about how to provide more employment opportunities and about conversion into more universal welfare, in addition to the social circumstances mentioned above, South Korea introduced by a government decision the long-term care insurance when the population ageing

rate was lower than that in Germany and Japan at the time when these countries started their own long-term care insurance system.

As stated above, the South Korean system is a long-term care insurance designed not merely for long-term care for the elderly but also for many other purposes, and will thus have a number of problems. In this paper, we will review the achievements and problems of the long-term care insurance system in South Korea based on the results achieved in the first three years and summarize desirable policy directions for the future and problems to be improved.

## II. Situations of the management of the long-term care insurance system for the elderly and its problems

### 1. Main results of the system and problems

#### *1) Increase in the number of persons recognized as eligible for long term care*

The standards for recognizing persons eligible for long term care in South Korea are based on the 52 items used to determine physical function, cognitive function measured by the ADLs and changes in behaviors as well as the need for rehabilitation steps. Of these items, the level of disabilities in physical function and cognitive function has a decisive effect on the recognition of the need for long term care. As a result of the survey for the recognition of the need for long term care, the need is classified into three grades, and the greater the need for care is, the more benefits are provided. Therefore, the providers of long-term care (or the managers of long-term care facilities) try to secure persons recognized as those having a great need for care because the differences in the quantity of care are not very large among the three grades.

The number of persons recognized as those in need of long term care in June 2011 was 320,261 [1], which was a little over twice as compared with the figure for July 2008 when the long-term care insurance system was started (Table 1). By the level of need for long-term care, an increase in those recognized as Grade 3 (by about 3.5 times) was worthy of note. On the other hand, the number of those recognized as Grade 1 was smaller than that in July 2008, and their percentage decreased, too. It has been pointed out that this is because in the early days of the system, applications for recognition were filed mostly by those living in care institutions and that many of Grade 1 people died or were hospitalized in the period from July 2008 to June 2011. Another factor is that the recognition standards for Grade 1 have become stricter so as to stabilize the insurance finance. As a result, as of June 2011, the ratio of the elderly recognized as requiring long term care was 5.4% of those of 65 and over, while the ratio of elderly persons was 11.4%.

**Table 1: International comparison of the gender gap in poverty rates (25 to 54 years only) Mid-2000s**

(Persons, %)

| | Total | Grade 1 (greatest need) | Grade 2 (great need) | Grade 3 (medium need) |
|---|---|---|---|---|
| July 2008 | 146,643 (100.0) | 50,209 (34.2) | 39,080 (26.7) | 57,354 (39.1) |
| June 2011 | 320,261 (100.0) | 42,611 (13.3) | 73,265 (22.9) | 204,385 (63.8) |
| Increase rate (%) | 118.4 | -15.1 | 87.5 | 256.4 |

Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

One of the factor contributing to the great increase in Grade 3 persons in June 2011 is this: in the grading system, the grade was determined on the basis of the number of points of the need for long-term care [2], and those who were not recognized as Grade 3 because the number of points they had was only a little fewer than the minimum number of points necessary for the recognition complained loudly; in an attempt to address these complaints, the Committee for Recognition of Long term care Needs made adjustments at the secondary judgment stage [3]. As a consequence, a considerable part of elderly people with dementia who still had motor function was recognized as Grade 3 persons. However, there has been the tendency toward those elderly people showing symptoms of dementia irregularly from time to time not recognized even as Grade 3.

In the South Korean long-term care system, those of 20 and up are defined as the insured persons of the long-term care insurance, but people with disabilities are excluded. However at beginning in October 2011, these disabled people can receive long term care service from another system for supporting their activities. This settled the problem of excluding people with disabilities for the time being, but discussions about the development of a method for checking the physical and cognitive function and the level of care more precisely, including whether the items for recognition

are appropriate or not, have been continued.

### *2) Rapid increase in the users of long-term care service*

The South Korean system approves not only benefits in kind provided as institutional care and home care service [4] but also cash benefits only for elderly people living in specified districts or having a mental disease. Thus, it defines cash benefits as only exceptional measures rather than universal benefits.

The category and quantity of benefits are restricted according to the need for long term care (long-term care grades). First, those recognized as Grade 1 or 2 indicating a relatively greater need can select either institutional care service or home care service, while Grade 3 persons [5] can receive home care service only. Behind this was the fact that because the ratio of entering stay facilities was high in South Korean society, it was supposed that the number of these facilities estimated immediately before the introduction of the long-term care insurance system might be too small to meet the demand. Second, the upper limit to the monthly benefits that allow the use of home care service is fixed for each of the three grades of long-term care needs. The upper limit is set in consideration of the amount of institutional benefits. In other words, the upper limit can make the two types of service, home care service and institutional care service, fair because people can receive the level of service equal to service at institutions even at home, and can also contribute to prevention of thoughtless entering into care institutions.

The ratio of those recognized as in need of long-term care who actually used long term care service was 65.6% on average in December 2008 in the initial period of the system but reached about 90% by June 2011. The ratio of use of the service tends to rise more when the level of needs for long-term care is higher and the income level is lower (Table 2). The factor behind the fact that the differences between the ratios of use are very small among the grades but are greater among the income levels is probably the cost of long term care (co-payment) that the user must bear [6]. In other words, it can be supposed that the greater difference in the ratio of use in terms of income levels arose because the recipients of basic livelihood protection benefits (public assistance recipients) have not to bear any cost and low-income earners are given reductions in the amount of the legal cost-sharing. Therefore, it has often been pointed out that the system has tended to encourage people provided with basic livelihood protection benefits and those with low income to use the long term care service.

As for home care service, no official data about how much of the upper limit to the monthly benefits was used have been published. But it has been estimated that the ratio of use of home care service is a little less than 90% on average by making use of monthly statistical data.

**Table 2: Change in the ratio of use of long-term health care service of people of 65 and over (ratios to the total number of people recognized as requiring long-term health care)**

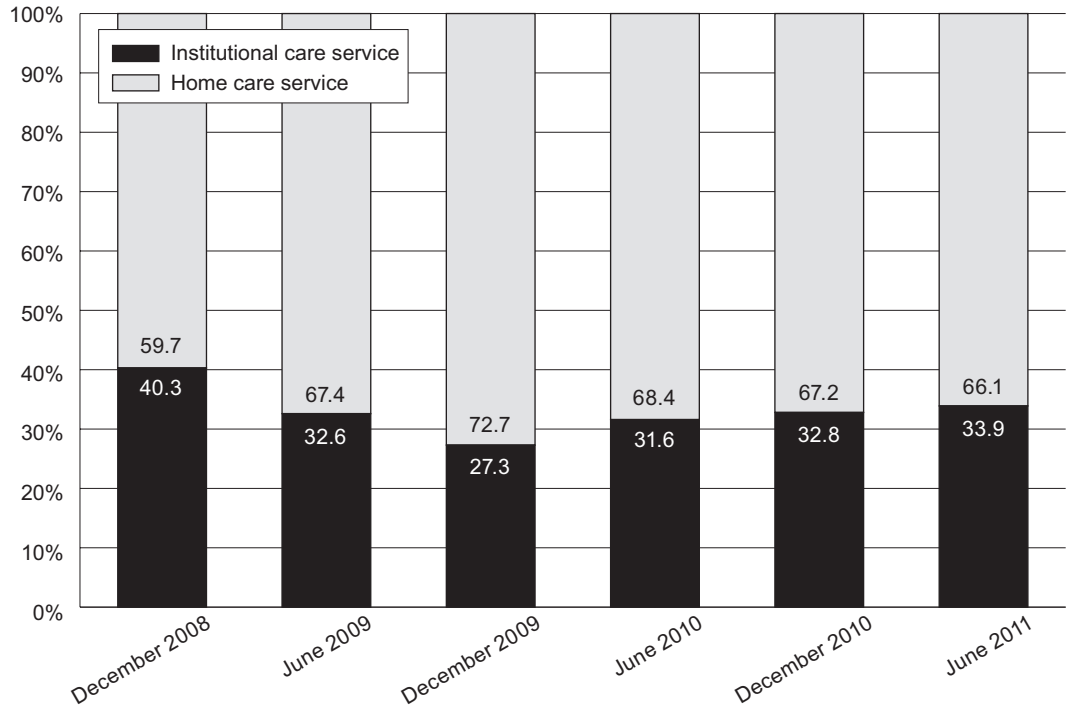
(%)

| | | December 2008 | June 2009 | December 2009 | June 2010 | December 2010 | June 2011 |
|---|---|---|---|---|---|---|---|
| Grade | Grade 1 | 68.1 | 66.6 | 82.6 | 86.7 | 90.9 | 90.4 |
| | Grade 2 | 65.9 | 63.9 | 82.8 | 86.5 | 90.7 | 89.4 |
| | Grade 3 | 64.5 | 57.9 | 82.5 | 85.2 | 89.9 | 89.2 |
| Income level | Recipients of basic livelihood protection benefits | 86 | 83.8 | 93.7 | 93.7 | 98 | 97.2 |
| | Low-income earners | – | 68.7 | 83.3 | 87.6 | 94.1 | 91.3 |
| | General persons | 59.5 | 65.1 | 79.5 | 83.7 | 87.9 | 87.3 |
| | (Average ratio) | 65.6 | 69 | 82 | 85.5 | 89.9 | 89.1 |

Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

The ratio of the number of users of institutional care service to that of home care service users was 4:6 in the initial period of the system but has been roughly 3:7 in recent years. This is because Grade 3 people (persons having medium needs for long-term care) whose use of institutional care service is restricted have increased rapidly. In fact, the number of persons who entered care institutions has continued increasing. The problem to be pointed out here is the fact that persons of Grade 3 who were unable to enter any care institution but were unable to have protection from the family either were sent to hospital for the elderly [7] or short-stay facilities [8].

**Figure 1: Change in the ratio of use of long-term care by the type of service (Based on the actual number of users) (%)**




Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

One reason for the rapid increase in the users of long term care service in South Korea is the fact that most of patients hospitalized in hospitals for the elderly for long term care before the establishment of the system were removed to long-term care facilities. But the patients now in hospitals for the elderly are those receiving long term care whose need for medical treatment is high or whose level of need for long term care is low. It is said that there are still a large number of hospitals for the elderly operated for patients for long term care whose level of need for long term care is low. The background of this kind of situation is that, in many cases, these patients with a low-level need for long term care have been hospitalized at the request of their family although it is possible to give care to them at home.

### *3) Inefficient patterns of use of long term care service at home*

The patterns of use of long term care service may be affected not only by the wishes of the users but also by the management policy of the suppliers (care providers) and the government. But at present, the intention of users and suppliers is mainly reflected on the patterns. In other words, while users tend to buy service considering the accessibility and convenience of the service, suppliers have no alternative but to attach greater importance to profitability.

The price of long term care service (remuneration for long-term care), the matter in which care providers are deeply interested, is calculated by the fixed amount per day for each grade of needs for long term care for institutional care service but by the hours of home-care types of service (care and nursing service) provided for home care service. In other words, in this calculation method, the more the hours of service provided increase, the higher the income the supplier earns becomes. Therefore users hope that the home care worker will give them care as long as possible, and providers also hope that they can give service to users as long as possible because they can earn the same amount of profits by visiting users the smaller number of time.

As for home care (home care worker) service, the service most popular among users, the cases of this service provided for four hours (240 minutes) or more per visit accounted for a little less than 30% of all the cases of this service, but in more than a half of the cases, the service hours were three hours (180 minutes) or more (Table 3). While the tendency toward long-hour home care like these cases has declined as compared with the initial years of the introduction of the system, such

cases still have a high ratio even today. The pattern of using home care (home care worker) service mainly has led to the problem of users losing the chance to use other types of home care service, and the problem of no cooperation with medical staff being gained has been pointed out especially as to home-visit nursing. In addition, it is more desirable for users and their families to use day-care centers than long-hour care service at home, but at present there are no sufficient day-care centers and there are problems about the system for transporting residents to and from day-care centers and about the way of the family to handle these residents.

**Table 3: Change in the pattern of using home health care (home care worker) service**

(No. of service provided, %)

| | 30–less than 60 minutes | 60–less than 90 minutes | 90–less than 120 minutes | 120–less than 150 minutes | 150–less than 180 minutes | 180–less than 210 minutes | 210–less than 240 minutes | 240 minutes or more | Total |
|---|---|---|---|---|---|---|---|---|---|
| December 2008 | 4,594 | 13,504 | 108,664 | 120,693 | 132,541 | 183,571 | 135,497 | 304,159 | 1,003,223 |
| | -0.5 | -1.3 | -10.8 | -12 | -13.2 | -18.3 | -13.5 | -30.3 | -100 |
| December 2009 | 6,652 | 35,104 | 754,926 | 218,540 | 110,969 | 521,721 | 169,232 | 965,823 | 2,782,968 |
| | -0.2 | -1.3 | -27.1 | -7.9 | -4 | -18.7 | -6.1 | -34.7 | -100 |
| December 2010 | 8,085 | 44,062 | 1,305,417 | 226,621 | 121,860 | 633,480 | 226,031 | 1,085,041 | 3,650,597 |
| | -0.2 | -1.2 | -35.8 | -6.2 | -3.3 | -17.4 | -6.2 | -29.7 | -100 |
| July 2011 | 5,871 | 42,795 | 1,301,6 | 230,859 | 127,518 | 636,739 | 217,832 | 1,064,5 | 3,627,799 |
| | -0.2 | -1.2 | -35.9 | -6.4 | -3.5 | -17.6 | -6 | -29.3 | -100 |

Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

The family members having a home care worker's license (also called licensed family-member home care workers) can give home care (home care worker) service to their parents receiving long term care, too. But this service is restricted to 90 minutes per time per day. One problem posed at present is that family members with a home care worker's license give little service to their parents. It is said that in many cases, those family members having the license who do not live together with their parents give no care to their parent consequently.

### *4) Inadequate management systems of people with a low-level need for long term care*

As stated in the previous section, those with a low level of need for long term care are not provided with insurance benefits in South Korea, which is the problem giving trouble to the government. These people with a low-level need for long term care are subdivided into Grade A, B and C according to the level of need and Grade A persons have the highest level of need of the three grades. Nominally, local governments should, on their responsibility, provide persons having a low-level need with care and regional health and welfare service by government budget (state and local government expenditure). The situation of the provision of service to people with a low-level need shows that the total amount of service provided has continued increasing year after year (Table 4). Because the figures include the people who used regional health and welfare service only once, too, it is said that the effect of service, etc. can not be evaluated by looking at this total amount of the services provided.

**Table 4: Situation of provision of service to people with a low-level need for long-term health care**

(Persons, %)

| Year | Total number of people with a low-level need (Grades A, B and C) | Total number of users of service | (Ratio of use) |
|---|---|---|---|
| January–June 2010 | 1,264,976 | 909,578 | (71.9) |
| July–December 2010 | 1,400,183 | 1,114,651 | (79.6) |
| January–June 2011 | 1,510,512 | 1,235,546 | (81.8) |

Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

Problems at present are that due to the insufficient budget of local governments, those provided with service are limited to low-income earners only and that the type of service does not meet users' needs and does not include preventive service, such as rehabilitation and improvement in bodily function. Because of this, there are many cases where Grade A persons file an application for re-recognition of care needs repeatedly. In particular, elderly people with dementia whose level of need for long term care is low are rated Grade A in most cases because they still have ADL abilities; it is said that if they apply for re-recognition repeatedly, they may be rated Grade 3 in the need for long term care.

***5) Increasing expenditure of the insurance finance***

Financial resources for the South Korean system are composed of, in principle, premiums [a little more than 60% of all], the state liability from the government [20%] and users' cost sharing [in other words, co-payment or user charge) [a little less than 20%]. The balance of the insurance finance has been favorable from 2008 to recent years (Table 5).

Because premiums are calculated by multiplying the health insurance premium of participants (insured persons) by the rate of long term care premium, the amount of premiums changes according to change in the health insurance premium and the rate of long term care premium (Table 6). Since the system was established, the premium rate has been raised at the end of each year so as to avoid the insurance from suffering red figures in the following year.

If it is simply supposed that the financial expenditure is determined by the number of service recipients and the cost per recipient, the most important factor contributing to increasing expenditure will be an increase in the number of users. This can be seen from the fact that since the introduction of the system, raises in the price of long term care service (remuneration for long-term care) have been controlled while the number of people recognized as in need of long term care and service users increased beyond all expectations.

**Table 5: Change in the revenue and expenditure of financing long-term care insurance**

(100 million won)

| | July–December 2008 | 2009 | 2010 |
|---|---|---|---|
| Revenue | 8,690 | 20,849 | 28,777 |
| Expenditure | 5,549 | 19,085 | 25,891 |
| Balance | 3,141 (63.86) | 1,765 (91.54) | 2,886 (89.97) |
| Accumulated reserves | 230 | 1,054 | 3,082 |

Note: Figures in parentheses are the ratios of income to expenditure (income/expenditure x 100).
Source: National Health Insurance Corporation, "Statistical Annual of the Long-term Health Care Insurance for the Elderly, 2011."

**Table 6: Change in the premium rates of the Health Insurance and the Long-term Health Care Insurance**

(%)

| | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| Health Insurance | 5.08 | 5.08 | 5.33 | 5.64 |
| Long-term Health Care Insurance | 4.05 | 4.78 | 6.55 | 6.55 |

Source: National Health Insurance Corporation.

## 2. Situation of infrastructure for long term care and problems

***1) Rapid increase in the total number of facilities and strict competition among institutions***

In South Korea, not merely non-profit organizations but also commercial businesses may establish long-stay facilities by permission of the authorities. This aimed at encouraging competition among facilities and realizing better service quality and more efficient management by opening social welfare service business, which had been conducted mainly by non-profit social welfare corporations just before the establishment of the system, to commercial businesses, too.

**Table 7: Increase in institutions for long-term health care**

(Number of institutions, persons)

| | December 2008 | June 2009 | December 2009 | June 2010 | December 2010 | June 2011 |
|---|---|---|---|---|---|---|
| Stay facilities | 1,717 | 2,114 | 2,629 | 3,442 | 3,751 | 3,963 |
| | (68525) | (77919) | (88196) | (108996) | (116782) | (123047) |
| Home health care establishments | 4,362 | 6,404 | 8,446 | 9,136 | 9,164 | 9,094 |
| | (20.3) | (23.8) | (29.4) | (29.3) | (29.0) | (28.4) |
| Home bathing establishments | 3,006 | 4,539 | 6,279 | 7,100 | 7,294 | 7,361 |
| | (14.0) | (16.9) | (21.9) | (22.7) | (23.1) | (23.0) |
| Home-visit nursing establishments | 626 | 719 | 787 | 774 | 739 | 714 |
| | (2.9) | (2.7) | (2.7) | (2.5) | (2.3) | (2.2) |
| Day care establishments | 806 | 951 | 1,106 | 1,247 | 739 | 1,312 |
| | (3.8) | (3.5) | (3.9) | (4.0) | (2.3) | (4.1) |
| Short-stay establishments | 691 | 1,112 | 1,368 | 205 | 204 | 214 |
| | (3.2) | (4.1) | (4.8) | (0.7) | (0.6) | (0.7) |
| Welfare equipment establishments | 733 | 914 | 1,086 | 1,212 | 1,278 | 1,322 |
| | (3.4) | (3.4) | (3.8) | (3.9) | (4.0) | (4.1) |

Note: Figures in parentheses for "Stay facilities" are the capacity of residents, and those for home care service establishments show the number of establishments per 1,000 persons recognized as requiring long-term health care.

Source: National Health Insurance Corporation, "Statistical Monthly of the Long-term Health Care Insurance for the Elderly."

As a result, the number of long term care institutions increased beyond all expectations for some types of service (Table 7). For example, stay facilities continuously increased from 1,717 at the end of 2008 to 3,963 as of June 2011. The capacity of these stay facilities in June 2011 was 2.2% of the total population of the elderly. By the category of management bodies of stay facilities, public institutions are 111 (2.9%), institutions of various corporations are 1,377 (35.6%), individually managed profit institutions are 2,367 (61.3%) and others are 9 (0.2%). In other words, about two-thirds are facilities for commercial purposes. Another characteristic is that 83.1% of individually operated facilities are small-scale ones having 30 beds or less and a half of them are group homes with 5 to 9 beds.

As for home care service providers, there are many providers of home care and home bathing services but the number of those of other types of service is relatively small. This is because it is easier to establish facilities, and people in need of long-term care have greater need for the two services as compared with other services. In the case of short-stay facilities, the number decreased sharply because most of these facilities were politically converted into small-scale long-term care facilities for the elderly in 2010. It is said that short-stay facilities are now used as institutions for elderly people waiting for admission to long-term care facilities for the elderly.

***2) Lowering remuneration for care workers***

When the long-term care insurance system was established, a system of specialized care workers was newly introduced, too. These care workers are officially called licensed home care workers and take charge of the provision of long term care service at institutions and at home. Figure 2 shows an outline of the process for acquiring home care worker's licenses. In South Korea, the education for home care workers is provided not at universities but at educational institutions for home care workers, a kind of cramming school. Even the person who had education on long-term care (care welfare) at a university and acquired a social worker's license (Grade 1 or 2)[9] has to receive some education at a home care worker's educational institution so as to become a home care worker. The number of hours of education at a home care worker's school is 240 hours in total, consisting of 80 hours of theoretical education, 80 hours of practical training and 80 hours of practice at a long term care institution. Those who have completed training at a home care worker's institution must then receive a state examination[10] and will be given a license if they succeed in the exam.

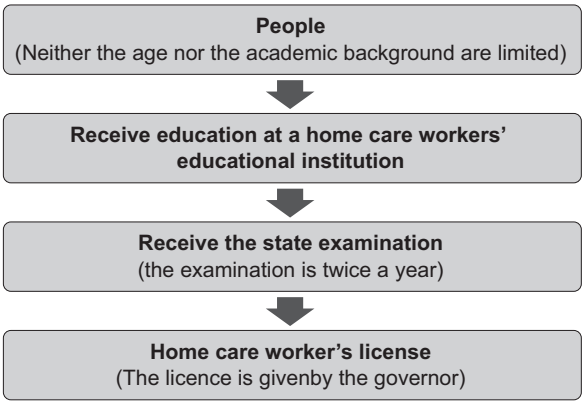
Until the first half of 2010 the number of educational institutions for home care workers continued increasing but decreased in 2011 because the requirements for establishing the institution were changed from a reporting system into a designation system. On the other hand, the number of licensed home care workers continued to rise and exceeded one million persons by 2011(See Year 2011.5 of Table 8), although the increase rate has declined since the state examination was adopted. The ratio

of licensed home care workers actually working at long-stay facilities or home care service establishments is 23% or so.

Problems regarding licensed home care workers at present include bad working environments, low wages and a lack of understanding of these workers among people. First, according to the wage level survey in 2011, while the ratio of the licensed home care workers paid less than one million won a month was 72% of all, that of those paid two million won or more a month[11] was only 0.2%. These figures include those of non-regular and part-time workers, and the average wage of even regular workers was estimated at about 60–70% of the average wage of all regular workers in South Korea.

The result of the questionnaire conducted in 2010 by the Research Institute of Health & Welfare Resources shows that licensed home care workers considered the labor intensity of their physical care service very great and said that a lack of understanding of users and their families about the task of licensed home care workers caused mental stress to them. In particular, the people's poor understanding and low wages accounted for 77.2% of the answers of the licensed home care worker respondents. The investigation by the insurer (National Health Insurance Corporation) brought about a similar outcome, too.

**Figure 2: Process of acquiring a home care worker's license**




Source: the author's tabulation

**Table 8: Increase in the number of licensed home care workers**

| | No. of educational institutions (institutions) | No. of persons acquiring a license (persons) | No of licensed home care workers working at home care facilities (persons, %) |
|---|---|---|---|
| 2008.12 | 1,080 | 339,197 | 84,412 (24.9) |
| 2009. 6 | 1,162 | 518,806 | 129,205 (24.9) |
| 2009. 12 | 1,308 | 692,138 | 175,441 (25.4) |
| 2010. 4 | 1,407 | 813,215 | 206,888 (25.4) |
| 2011. 5 | 1,004 | 1,027,898 | 237,256 (23.1) |

Note: Figures in parentheses for "No. of licensed home care workers working at home care facilities" are the ratios to persons acquiring a home care worker's license.
Source: In-house data of the National Health Insurance Corporation and the Ministry of Health & Welfare.

In short, it indicated that the satisfaction of licensed home care workers with their work was not so great because of low wages, poor working environments and trouble with users. In addition, excessive demand for service caused by a lack of understanding about the work of care workers was most of complaints from them. The quality of service has been inferior because of the problems mentioned above, and the job of licensed home care workers has not been considered as any good specialist one.

## III. Analysis of the achievements of the long-term care insurance system

According to the report that analyzed the achievements expected from the introduction of the long-term care insurance system, the government concluded that the system achieved fairly good results. This analysis was made on the basis of clinical effects, economic effects and social effects. The analysis of clinical effects adopted as the criterion how the state of users changed as they used the service. When the effects were analyzed based on the ADL scores (Table 9), it was found that the physical functions were maintained or improved among not only home care service users but also institutional service users.

The analysis of economic effects assessed to what extent the long-term care insurance system affected the national economy sector on the basis of the effect of creating employment opportunities and value added and the degree of change in fiscal expenditure for health insurance (Table 10). First, the number of employees increased by about eight times in the 2008–2011 period from 20,916 persons to 165,051 persons (the figure for 2011 is a provisional one), and value added also went up by 8.4 times in the same period from 826.6 billion won to 6,903.3 billion won (provisional figure).

**Table 9: Change in the physical functions (ADL scores) of long-term health care service users by year**

| | 2008 (m±SD) | 2008 (m±SD) | 2008 (m±SD) |
|---|---|---|---|
| Home care service users | 24.44±6.18 | 23.81±6.73 | 23.76±6.53 |
| Institutional care service users | 28.95±6.72 | 28.93±7.11 | 27.67±6.86 |
| Users of both home care service and institutional care service | 24.83±7.29 | 26.83±7.06 | 26.26±7.04 |
| All users | 25.85±7.00 | 26.26±7.27 | 25.75±6.99 |

Note: The lower the score is, the better the physical functions of the user are.
Source: The report of the Korean Tax Research Institute in 2011.

**Table 10: Effects of the long-term care insurance system of inducing employment opportunities and value added**

| | Value added (100 million won) | No. of employees (persons): long-term health care segment | No. of employees (persons): long-term health care-related segment |
|---|---|---|---|
| 2008 | 8,266 | 20,916 | 2,597 |
| 2009 | 33,975 | 83,606 | 10,369 |
| 2010 | 43,400 | 103,760 | 12,869 |
| 2011 (provisional figures) | 69,033 | 165,051 | 20,471 |

Source: The report of the Korean Tax Research Institute in 2011.

On the other hand, the short-term effect the long-term care insurance had on health insurance expenditure in 2009 was shown in the fact that an increase in medical cost was smaller among the group of service users than among the non-user group. By making use of the result of change in medical cost for the service users of this sample analysis, it was estimated that benefits provision expenditure was reduced by about 423.4 – 449.7 billion won, and for the user group as a whole, the expenditure cut down was estimated at about 895.4 – 994.2 billion won. [12)]

The analysis of social effects was made about to what extent the long-term care insurance system affected the sense of physical and mental burdens of family care givers for people requiring long term care and the social activities of these family care givers and user satisfaction with service (Korean Tax Research Institute, 2011). The result of the 2011 analysis indicated that 86% of family care givers felt their physical burdens decreased, while 90.3% of them increased their social activities. In the analysis of user satisfaction with service, it was found that 86.9% of users were satisfied with service and the degree of satisfaction was the highest among institutional care service users.

## IV. Improvements in the long-term care insurance system for the elderly thus far and government plans for the future

Since the introduction of the long-term care insurance system, South Korea has partly improved the system thus far (Table 11). A number of problems that had not been expected in the model project period before the system's introduction (July 2005 to June 2008) came up in the past three years. Among other things, a rapid increase in small-scale long-term care facilities for the elderly and home care (home care worker) service establishments and an artificial rise in persons recognized as in need of long term care raised serious issues. In other words, it is said that supplier-induced demand was created to some extent.

Examples of this include the fact that while those eligible for entry into long-stay facilities were limited to persons of Grade 1 or 2, even those of Grade 3 with low-level needs for long-term care to whom family members could give care were allowed to enter such a facility if they had dementia and that because the management of the system laid emphasis on those in serious conditions and the number of persons for home care service was fewer than that of home care service establishments, those recognized as having medium need for care were increased on the pretext of reinforcing the protection of these people. In addition, there was the case where the existing home care service users were encouraged to use the service up to the monthly limit and where family care givers were persuaded to get a home care worker's license and earn wages for service for their own parents.

**Table 11: Main improvements in the long-term care insurance system**

| Sector | Improvements |
|---|---|
| Recognition/ service user support | * While the minimum score required for recognition (55 or more) was not changed, the system was changed so that those with dementia might be recognized as those of the lowest grade (Grade 3) even if their score are less than 55.<br>* The application of the standard plan to use long-term health care was made compulsory for recipients of basic livelihood protection benefits (public assistant recipients). |
| Benefits provision | * The entry into health care facilities, which had been limited to Grade 1 and 2 persons, was permitted to those of Grade 3 having dementia, too.<br>* The legal hours of family care for family members with a home care worker's license were reduced.<br>* The insurance benefits provision period was shortened for short-stay facilities, too (from 180 days a year to 15 days a month).<br>* The legal price of long-term health care service (remuneration for long-term care) was adjusted each year (A partial price adjustment system was introduced).<br>* Those eligible for the lending of welfare equipment were restricted, and the types of welfare equipment for lending were increased. |
| Evaluation system of service quality | * In 2009, the evaluation of the quality of stay facilities was made.<br>* In 2010, the evaluation of the quality of home care service establishments was made. |
| Securing of revenue sources | * The premiums for the long-term care insurance system were raised each year (4.05%−4.78%−6.55%) |
| Facility infrastructure | * The standard for the legal number of licensed home care workers at home health care (home care worker) service facilities was raised. |
| Care workers | * The state examination system was introduced for home care workers.<br>* The procedures for establishing training institutions for home care workers were changed from a reporting system into a licensing system. |
| Other improvements | * The system for supporting the activities of people with disabilities (also known as the system for supporting long-term health care service for people with disabilities) was established (October 2011). |

Source: the author's tabulation

Because fiscal expenditure increased because of the phenomena mentioned above, premiums of the long-term care insurance, the main revenue sources, have been raised each year. In the present system, when the premiums for the health insurance are raised, those for the long-term care insurance are increased automatically, and thus the mechanism where the premiums for the long-term care insurance system are raised although there is no need to do so will create a problem.

Meanwhile, the South Korean government has adopted the policy of reducing wasteful or inefficient services in an effort to control its fiscal expenditure. It has carried out such measures as the compulsory implementation of care plans, restrictions on the provision of home care benefits

to family care givers, reduction in the benefits provision period at short-stay facilities, introduction of the system for adjusting the price of long term care service according to differences in the environment of facilities and evaluation of service quality.

**Conclusion: Subjects for future improvements and government programs**

It may be said that since the introduction of the long-term care insurance system, the South Korean government has improved the system in an attempt to meet users' needs. But because it is stipulated by law that it should draw up a basic long term care plan every five years, it has drafted a basic plan to be carried out from 2013. This system follows the example of Japan that had reformed its own long-term care insurance system every fifth year.

The South Korean government aims at reinforcing the security of long term care and improving the quality of long term care service according to the policy of building up a sustainable system. The subjects of discussion about the security of long term care include guaranteeing the better life of those with low-level needs for long-term care for whom it is considered have relatively high needs for long term care and securing the life of people receiving home care service by supporting the households lacking in family care ability. As for improvement in the quality of long term care service, there have been debates about the fact that the wage of care givers and the quality of service have been lowered when the supply of facilities is excessive as compared with the demand and about the need to adopt the policy of paying subsidies to good-quality facilities to support their management.

Finally, the authors' views about the problems to be considered to improve the system in the future are summarized below:

First, there should be a system for cooperation between the long-term care insurance system and the health and welfare system for the elderly. At present, people with severe disabilities rely on the long-term care insurance system, while those having small needs for long-term care use the service of the health and welfare system for the elderly, but because service is provided without regard to the level of vital functions, persons with slight disabilities do not use welfare service for the elderly very much. This has caused the number of recipients of the long-term care insurance benefits to increase. In particular, the health and welfare service for the elderly for those having slight disabilities takes their income levels into consideration, and thus general people other than public assistance recipients want very much to be recognized as those eligible for insurance benefits.

Second, there is the need to build up a system for supporting the use of long term care service. Because no care management system has been established, it is supposed that the effective or efficient service is not always selected and used. In particular, public assistance recipients are exempted from cost-sharing (co-payment) and are persuaded to use service up to the monthly limit. As a result, the finance of the local governments that have to cover the cost-sharing expenditure has become heavier.

Third, a system for controlling the supply of long-term care facilities should be created. As stated above, there is no mechanism for forcing the supply to become appropriate for demand at present. In particular, there are great regional differences in the supply of facilities, which has caused unfairness in the use of service. On the other hand, because profit-making enterprises are allowed to take part in the market of both institutional and home care service, competition is keep among establishments. To continue a stable management, facilities must cut down their expenditure as much as possible, and because the greater part of facilities choose the method of reducing personnel expenses, which account for over a half of expenditure, strong competition among long-term care businesses has ultimately been causing wage cuts to care workers.

Finally, there is the need to create a comprehensive regional care system. This means, similar to the concept emphasized now in Japan, comprehensive assistance in each region, ranging from care prevention to welfare at home. This is an idea that even those in a care need condition are given care in the community and house where they used to live in and thus this new idea for the care of the elderly is considered to be a desirable method.

The pace of population ageing is expected to be quicker than that in Japan, and the financial pressure of social security will come soon. In particular, the number of young people who bear the finance is decreasing, and so there may arise serious imbalances among generations. Therefore, South Korea is now required to adopt a better policy for long term care and more broadly, healthy ageing philosophy for policies for the elderly.

**Acknowledgement:** The author is grateful for the valuable comments provided by the participants of the workshop held at National Institute of Population and Social Security Research (IPSS) in February 2012. This workshop was supported by Health Labor Sciences Research Grant (Research

on Policy Planning and Evaluation), Grant Number: H22-seisaku-ippan-018.

**Notes**

1) In the South Korean system, those younger than 65 suffering from a senile disease may be recognized as those requiring long term care, and these people accounted for 7.4% of the persons so recognized as of June 2011.
2) The number of points required for recognition of the need for long-term care is 95 or more for Grade 1, 75 to 94 for Grade 2 and 55 to 74 for Grade 3.
3) As a result, the ratio of those recognized as in need of long-term care, which had been estimated at 3.2% of the elderly population, became higher than the expected one.
4) Long term care institutions providing institutional benefits are divided into long-term care facilities for the elderly (capacity: 10 persons or more) and community life home facilities for long-term care for the elderly (capacity: 5–9 persons). The types of in-home benefits include home long-term care (home care worker) service, home bathing, home-visit nursing, day care, short stay and lending of welfare equipment.
5) But elderly people with dementia can receive institutional care service; this is based on the opinion that the care burdens of the family are heavier for elderly persons with slight dementia who have a higher level of bodily function.
6) The legal cost-sharing ratio is 20% of the medical costs for institutional care service and 15% for home care service, and this ratio is reduced to a half respectively for low-income earners. Living expenses, food costs, etc. at the institutions are borne by the user because these are not included in the categories of insurance benefits.
7) In South Korea, hospitals for the elderly are named hospitals for long-term care by law but are not recognized as institutions for long term care.
8) Long-term care facilities for the elderly in South Korea have not only beds for short stay but also short-stay facilities. But the number of days covered by insurance benefits for these facilities is up to 15 days a month.
9) Those having a social worker's license have only to receive 50 hours of education, registered nurses, 40 hours, and nursing assistants, 50 hours.
10) Initially, those receiving 240 hours of education were automatically given a license but in August 2010, the state examination system was introduced.
11) The average monthly wage of regular workers in South Korea in 2010 was 2,304,176 won.
12) This is equivalent to 3.1–3.4% of the total benefits provision expenditure of the health insurance in 2009.

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