World Health Organization
Centre for Health Development

WKC Policy Series on Long-Term Care No. 5:
Republic of Korea

Long-term care in the Republic of Korea: overcoming coordination challenges between health and social services to achieve universal coverage

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Context

Younger people pay contributions but their eligibility for benefits is restricted, and this has resulted in a large inter-generational transfer.

Long-term care insurance (LTCI) was introduced in 2008 in the Republic of Korea as the key institution for providing long-term care (LTC). LTCI is separate from national health insurance (NHI), although both are administered and managed by a single agency with two different funding pools.

LTCI in the Republic of Korea was introduced in the context of population ageing. As a result, people 65 years or older are eligible for all types of LTC, but eligibility of those under 65 is restricted to aged-related LTC needs. Younger people pay contributions but their eligibility for benefits is restricted, and this has resulted in a large inter-generational transfer and contributed to some extent to the financial sustainability of LTCI. As of December 2019, LTCI covered 9.5% of older people over 65. Since its inception, the number of LTCI beneficiaries 65 years and over has doubled.

After the introduction of LTCI, the number of LTC facilities rapidly expanded from 1700 to 5543 facilities/institutions and 6618 to 19 410 home-based care agencies from 2008 to 2019. The number of LTC hospital beds per 1000 persons aged 65 or older has increased from 5.9 in 2005 to more than 39 in 2019. This resulted in severe competition among LTC providers. The number of care workers and nurse aides increased dramatically, as the education and training requirements are lower than registered nurses.

Key findings

- LTCI is financed through contributions (60-65%), tax subsidies (20%), and user co-payments (20% for institutional services, 15% for home-based services, and 15% for welfare equipment).
- The LTCI contribution rate is 11.52% of health insurance premiums in 2021. As such, anyone who contributes to NHI also contributes to LTCI. In 2021, this amounted to approximately 0.79% of wages. Since 2017, LTCI has experienced an increasing deficit annually. As a result, the financial sustainability of LTCI is a serious concern.
- The NHIS implemented a quality evaluation system since 2009. The number of quality indicators varies by the type of service providers and grouped by five quality domains. The result of the quality evaluation score is publicly disseminated through an official LTCI website, and high-performance institutions receive incentives of 1-2% additional reimbursement. In addition, the NHIS gives 2% extra payment to the top decile of facilities and 1% extra payment to the next decile. Facilities that employ more human resources than required by law (social worker, nurse, night watch) also receive extra payments.
- LTCI is a centralized system with a single pool, which has the benefit of equity in financing and efficiency of risk pooling. However, there is a concern about lack of coordination between the NHIS and local governments regarding LTC delivery and quality. This coordination problem is prominent in the Republic of Korea, as the majority of LTC providers are private, and consumers are used to the freedom of choosing their providers.
- Poor coordination between the NHI and LTCI services is a serious problem, which has resulted in admissions of older people with lower medical care needs in LTC hospitals. In addition, a significant number of older people with clinical care needs stay in LTC facilities where health care provision is limited.
- Informal care is not covered by LTCI in principle. Recent surveys indicate that, among those who received some LTC, 19% relied on formal LTCI and 89% received some support from family members, mainly the spouse.
- The pricing of LTC is based on the costing of a standard practice model for each provider type based on the different number of personnel and include depreciation. Payment is based on one of five levels of severity considering resource needs including staff time and administrative costs. The LTC committee chaired by the Deputy Minister of Health makes final decisions on pricing and operational aspects of LTCI, including premiums, benefits, and pricing.
- In contrast to the national health insurance system, there is no price negotiation process under LTCI. This lack of negotiation may be related to the weak professional power of LTC providers relative to health care providers. In addition, LTC services rely heavily on direct labour input, with a much smaller number and type of simple homogeneous inputs and mostly a smaller scale of practice.

Best practices

Quality evaluation systems are in place for both institutional and home-based care.

- **Promoting community-based care.** The coinsurance rate for institutional care is higher than that for home-based care to promote de-institutionalization and community-based care.
- **The poor are exempt from contributions**. Co-payment is exempted for the beneficiaries of the Medical Aid programme, which is a public assistance programme for the poor. There is a 40% co-payment discount for those in the 25-50% income quartile and 60% discount for those in the lowest (0-25%) income quartile.
- **Quality evaluation systems are in place** for both institutional and home-based care, the results are publicly released, and additional reimbursements are provided for high-quality providers.
- **Pricing and price regulation** are key policy instruments for financial sustainability and affordability in LTCI.

Lessons for other settings

- **Coordination between health and LTC insurance needs to be considered in the design of LTC**. Long-standing coordination challenges started when the government introduced LTC hospitals and reimbursements under the NHI. There was no public funding for LTC initially and hospitals had lower requirements for medical personnel in comparison with acute care hospitals. As a result, social admissions were prevalent in LTC hospitals before LCTI was introduced, but inefficient social admissions continued even after the introduction of LTCI.
- **Factors inhibiting coordination between health and LTC include weak primary care, dominant private providers, and separate insurance systems and payments for health care and LTC**. Policy discussions include changing the co-payment exemptions for LTC hospitals especially for patients with low severity or those who can be transferred to LTC facilities, and discharge planning and patient assessment for LTC hospitals.
- **Linking payments to quality and performance.** Quality indicators for both institutional and home care are publicly disseminated, and quality is rewarded with financial incentives of 1-2% additional reimbursement. In addition, facilities that employ more human resources than required by law (social worker, nurse, night watch) also receive extra payments.
- **Promoting community-based care through co-payment discounts.** Given the importance of consumer choice, to promote de-institutionalization and community-based care, the LTCI offers a lower co-payment for community-based care.

The WKC and the OECD have produced a report summarizing key findings from nine country case studies on *"Pricing long-term care for older persons"*. The cases represent a range of health care systems and experiences in organizing and financing long-term care (LTC) for older persons. The report identifies best practices and policy lessons, which demonstrate the benefits of investing in quality LTC in the context of ageing populations. The summary report and case studies can be found here: https://extranet.who.int/kobe_centre/en/project-details/pricesetting2