Community-Based Long-Term Care in Korea: Current Status and Future Agenda

Hongsoo Kim, PhD, MPH
Associate Professor
Dept. of Health Care Management and Policy
Graduate School of Public Health
Seoul National University
Outline

I. Changes in Health and Care Needs of Korean Older People

II. Community-Based LTC Within the National Context

III. Provision of Community-Based LTC: Key Policies and Programs
   - National long-term care insurance for the elderly
   - Community social care and health care programs at a local level for elderly people with long-term care needs

IV. Issues and Future Agenda
I. Health and Care Needs: Changes and Their Contexts

H. Kim (2015): Community-based Long-term Care, Korea
1. Demographic Changes

- Populating aging
  - Ratio of 65+ to total population: 13.1% in 2015 -> 40.1% in 2060.
  - Rapid increase of the oldest old (85+): 0.7% (370,000) in 2010 -> 10.2% (1,762,000) in 2060
  - Sharp increase of the older population due to the entry of baby boomers (1955-1963): 65-74 yrs. in 2020, 75-84 yrs. in 2023, & 85+ in 2024

Age-categorized population ratio of elderly to total population, 2010-2060

H. Kim (2015): Community-based Long-term Care, Korea
1. Demographic Changes

- **Increase in dependency ratio**
  - The *age dependency ratio* will double (17.9 to 38.6) between 2015 and 2030 and double again (38.6 to 80.6) between 2030 and 2060.
  
  - The *aging index* is expected to increase almost twenty times (20 to 394.0) over the 70-year period due mainly to low fertility rates along with increasing life expectancy.
  
  - The *working-age population* is also expected to dramatically decrease.

<table>
<thead>
<tr>
<th>Year</th>
<th>Aged Dependency Ratio</th>
<th>Aging Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>7.4</td>
<td>20.0</td>
</tr>
<tr>
<td>2000</td>
<td>10.1</td>
<td>34.3</td>
</tr>
<tr>
<td>2015</td>
<td>17.9</td>
<td>94.1</td>
</tr>
<tr>
<td>2030</td>
<td>38.6</td>
<td>193.0</td>
</tr>
<tr>
<td>2040</td>
<td>57.2</td>
<td>288.6</td>
</tr>
<tr>
<td>2060</td>
<td>80.6</td>
<td>394.0</td>
</tr>
</tbody>
</table>

• Aged dependency ratio = \( \frac{\text{population aged 65+}}{\text{population aged 15-64}} \) * 100

• Aging index = \( \frac{\text{population aged 65+}}{\text{population aged 0-14}} \) * 100

H. Kim (2015): Community-based Long-term Care, Korea
2. Health and Well-Being of Older Adults

- **Life expectancy at 65**
  - Rapid increase in life expectancy of Koreans over the last 40-50 years
  - 18.0(M) & 22.4(F) yrs. in Korea vs. 17.8(M) & 18.0(F) yrs. of OECD avg. in 2013
  - Yet disability-free life expectancy is much lower: 15.2(M) & 18.2(F) at 60 in Korea

H. Kim (2015): Community-based Long-term Care, Korea

OECD Health Data (2015)
2. Health and Well-Being of Older Adults

- **Top 5 reasons for death** of people 65+ are non-communicable diseases (NCDs): cancer, heart diseases, cerebrovascular diseases, pneumonia, and diabetes

- **Health care utilizations**: 35.1% of NHI expenditure for people aged 65+ (13.1% of total pop.); trend is a consistent increase

- **Self-reported health**: poor, by 48.7% of older people (M: 38.5, F: 54.4)

- **Suicide death rate**: 55 per 100,000 persons; #1 among OECD countries

- **Poverty rate**: 12.6%, #1 among OECD countries
3. Increasing Long-Term Needs

- **The world’s most rapidly aging country**
  - The proportion of 65+ 7% → 14%: 18 years in Korea
  - USA: 73 years, France: 115 years

- **Prolonged life expectancy**
  - Life expectancy in Korea (at birth): 81.8
  - OECD average: 79.8; Japan: 83.4

- **Older people with chronic diseases**
  - Older people with one or more chronic diseases: 89.2%

- **Limitations in ADL and IADL**
  - People who have limitations in IADL: 18.2%
    - (IADL limitations only: 11.3%; IADL & ADL limitations: 6.9%)

H. Kim (2015): Community-based Long-term Care, Korea

OECD (2012); OECD stats (2015); KMHW (2015)
3. Increasing Long-Term Needs

- Changes in family structure and values
  - The head of one in five households is aged 65+
  - Living alone or with spouse only: 14.2% in 2015; will be double (28.5%) in 2035.
  - Expecting to live with children in the future: 27.6%
  - Increased women’s social participation

![Graph showing women's economic activity participation rate](image)

H. Kim (2015): Community-based Long-term Care, Korea

KOSTAT (2012, 2015)
II. Community-Based Care Within the National Context
1. Context for Community-Based Care

• Basic design of health and care systems in Korea
  - Two social insurances for health and care, respectively: the national health insurance (NHI) and the national long-term care insurance (NLTCI)
  - Both NHI and NLTCI are shared the central governance system: overseen by the Ministry of Health and Welfare (MHW) and operationalized by the National Health Insurance Services (NHIS)
  - Korea is second among OECD countries in number of acute-care beds; private, specialized-care dominant delivery under fee-for-service with tight fee control

H. Kim (2015): Community-based Long-term Care, Korea
1. Context for Community-Based Care

- Population aging, a key driver to health reforms to promote community-based care
  - Chronic care management, health promotion, and social care services for older populations in local communities
- Policies directions: toward strengthening community-based care by local gov’ts
  - Subsidizing, extending, and/or coordinating with NHI and NLTCI, rather than the decentralization of these national programs;
- Tensions between central and local gov’ts in policy and program priorities and implementations may also exist.
- The national programs may prevent local gov’ts from further investment in and commitment to their own community-based care policies and programs.

H. Kim (2015): Community-based Long-term Care, Korea
2. Community-Based Care for Older Populations

- Consensus exists on the importance of community-based care for older people due to complex, long-term health and care needs.
- Emphasis on community-based care for older populations in two ways: non-institutionalized care vs. tailoring care to meet local needs.
- Basic principles of the provision of LTC benefits (Article 3 in Act on LTCI for Senior Citizens, 2007)
  - Appropriateness; home-/community-based care first (rather than institutional care); coordination between LTC with medical services.
- Building community-based care systems is still patchwork; large variations exist in quality and quantity of care due to differences in local needs and also financial/political contexts.

H. Kim (2015): Community-based Long-term Care, Korea
III. Key Policies and Programs for Community-Based Long-Term Care
1. Community-Based Long-Term Care in Korea

- **HCBS under the NLTCI (National)**
  Home and community-based services (HCBS) covered by the NLTCI, a nationwide mandatory social insurance program; services delivered at local level in collaboration with local gov’ts; target the disabled elderly [Levels 1-5 in the NLTCI-CNC system]

- **Community Social Care Programs for the Elderly (Local)**
  Local government-funded social welfare services; target the frail/pre-frail elderly [Extra Levels A & B] with low income

- **Community Health Care Programs for the Elderly (Local)**
  Chronic care management services at community health centers (CHCs); local government-funded programs; programs vary across CHCs; target the frail/pre-frail elderly [Extra Levels A-C]

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Extra Level A</th>
<th>Extra Level B &amp; C</th>
</tr>
</thead>
<tbody>
<tr>
<td>95</td>
<td>75</td>
<td>60</td>
<td>51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**The Care-Need Certification (CNC) System in the NLTCI**

H. Kim (2015): Community-based Long-term Care, Korea
2. Key Aspects of the NLTCI

• Implemented in 2008

• Purpose
  - To support physical activity or housework for elderly people who have difficulty taking care of themselves due to old age or geriatric diseases
  - To promote senior citizens’ health and life stabilization as well as improve the quality of people’s lives by mitigating the burden of care on family members
  
  (Article 1 of the Act on LTCI for Senior Citizens)

• Finance
  - Contribution-based social insurance financing system (vs. tax-based)
  - Universal coverage regardless of income or existence of family support
  - Financial schemes: contributions (60-65%), government subsidy (approx. 20%), & copayment (discounted or cost-exempted for low-income populations)

H. Kim (2015): Community-based Long-term Care, Korea
2. Key Aspects of the NLTCI

• Population coverage/eligibility
  - Adults aged 65+ or those below 65 with an age-related disease
  - And those past certain thresholds of care needs defined by the nationally standardized care-need certification (CNC) system based on 5 functional levels: Level I (wholly dependent) through Level 5 (special level for mild dementia); Extra Levels A, B, C; & No Level. Final decision made by local/community LTCI expert committee

H. Kim (2015): Community-based Long-term Care, Korea
Roles/Collaborations Between MHW, NHIC, and Local Governments in NLTCI Operations

H. Kim (2015): Community-based Long-term Care, Korea
Benefits: The HCBS under the NLTCl

Payment schemes
- Pay-per-day: day & night, short-term, & nursing-home care
- Pay-per-hour: assistance & nursing
- Pay-per-visit: bathing
- Copayments: home care (15%) vs. nursing homes (20%)

* Ceiling on home-care coverage per month

H. Kim (2015): Community-based Long-term Care, Korea
## NLTCI Trends:
### Coverage Expansion & Home vs. Institutional Care

#### Trends in eligible population

<table>
<thead>
<tr>
<th>Care Level</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Population aged 65+</td>
<td>5,286,383</td>
<td>5,448,984</td>
<td>5,644,758</td>
<td>5,921,977</td>
<td>6,192,762</td>
</tr>
<tr>
<td>b. Applicants</td>
<td>522,293</td>
<td>622,346</td>
<td>617,081</td>
<td>643,409</td>
<td>685,852</td>
</tr>
<tr>
<td>c. Certified (Levels 1-3)</td>
<td>390,530</td>
<td>465,777</td>
<td>478,446</td>
<td>495,445</td>
<td>535,328</td>
</tr>
<tr>
<td>&amp; Extra Levels A, B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Certified (Levels 1-3)</td>
<td>286,907</td>
<td>315,994</td>
<td>324,412</td>
<td>341,788</td>
<td>378,493</td>
</tr>
<tr>
<td>d/c * 100 (%)</td>
<td>73.4</td>
<td>67.8</td>
<td>67.8</td>
<td>69.0</td>
<td>70.7</td>
</tr>
<tr>
<td><strong>Population coverage</strong></td>
<td><strong>5.4 %</strong></td>
<td><strong>5.8 %</strong></td>
<td><strong>5.7 %</strong></td>
<td><strong>5.8 %</strong></td>
<td><strong>6.1 %</strong></td>
</tr>
<tr>
<td>(d/a * 100 %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NHIS LTC (2013)

- **Institution-based**
- **Home-based**
- **NHIC contribution**

(Unit: 100 million won)

H. Kim (2015): Community-based Long-term Care, Korea
## NLTCI Trends: HCBS Provision under the NLTCI

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-visit care</td>
<td>9,164</td>
<td>8,709</td>
<td>8,500</td>
<td>8,620</td>
<td>9,073</td>
</tr>
<tr>
<td>Home-visit bathing</td>
<td>7,294</td>
<td>7,162</td>
<td>7,028</td>
<td>7,146</td>
<td>7,479</td>
</tr>
<tr>
<td>Home-visit nursing</td>
<td>739</td>
<td>692</td>
<td>626</td>
<td>597</td>
<td>586</td>
</tr>
<tr>
<td>Day and night care</td>
<td>1,273</td>
<td>1,321</td>
<td>1,331</td>
<td>1,427</td>
<td>1,688</td>
</tr>
<tr>
<td>Shot-term care</td>
<td>199</td>
<td>234</td>
<td>257</td>
<td>368</td>
<td>322</td>
</tr>
<tr>
<td>Welfare kit</td>
<td>1,278</td>
<td>1,387</td>
<td>1,498</td>
<td>1,574</td>
<td>1,599</td>
</tr>
</tbody>
</table>

(unit: number)

H. Kim (2015): Community-based Long-term Care, Korea
• Targeting non-beneficiaries of NLTCI, older adults with Extra Levels A, B, (C)
  - Referral from the National Health Insurance Services (NHIS) to local governments’ Dept. of Elderly Welfare or community health centers
  - Potential coordination and priority issues; budget and human resource limits

• Programs
  - Social care programs; comprehensive elder-care services
  - Health care programs; visiting health-management service

* vs. Preventive health programs at local branches of NHIS, the insurer of NLTCI: intensive case management (3-6 months) and health education for people with chronic diseases (e.g., DM, HT); health-promotion programs

H. Kim (2015): Community-based Long-term Care, Korea
### 3. Community Social and Health Care Programs

<table>
<thead>
<tr>
<th>Type</th>
<th>Comprehensive Elder-Care Services</th>
<th>Visiting Health-Management Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Extra Levels A &amp; B from the NLTCI-CNC system, &amp; 150% below national average income</td>
<td>Extra Levels A &amp; B as well as people with other health risks in the community, regardless of income level, but with priority to socio-economically vulnerable pop.</td>
</tr>
<tr>
<td>Financial Schemes</td>
<td>Taxes (nat’l. and local gov’t matching programs); voucher program</td>
<td>Taxes (nat’l. and local gov’t matching programs); copayment</td>
</tr>
<tr>
<td>Provider</td>
<td>Home-care facilities designated by local gov’t</td>
<td>Community health centers; provided by multidisciplinary visiting team with nurses, physical therapists, nutritionists</td>
</tr>
</tbody>
</table>

H. Kim (2015): Community-based Long-term Care, Korea

KMHW (2015)
3. Community Social and Health Care Programs

<table>
<thead>
<tr>
<th>Services provided</th>
<th>Comprehensive Elder-Care Services¹</th>
<th>Visiting Health-Management Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Home care</strong> (27 or 36 hrs/month) Basic ADL supports and household chores/errands</td>
<td><strong>Frailty prevention services</strong> including exercise, nutrition, oral care, urinary incontinence care, mental health promotion, cognition, fall prevention, etc.</td>
</tr>
<tr>
<td></td>
<td><strong>Day care</strong> (9 or 12 days/month; hours are the same as home care)</td>
<td>- <strong>Chronic-disease management</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Dementia family-support services</strong> (6 days/year)</td>
<td>- <strong>Dementia screening service</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Short-term household chores service</strong> (24 hrs/month)</td>
<td></td>
</tr>
</tbody>
</table>

¹ vs. basic elder-care services, lighter social services for those living alone

* Special dementia benefit (Level 5) within the NLTCI

- Newly designated in July 2014;
- Aimed to increase access of older people with mild dementia to LTC
- Benefits: mainly cognitive training (home-visit care), medication management (home-visit nursing), counseling with family caregivers at home or day care centers

H. Kim (2015): Community-based Long-term Care, Korea
Key Issues and Research/Policy Agenda

H. Kim (2015): Community-based Long-term Care, Korea
1. Population Coverage

• Financial sustainability of the NLTCI was a core policy agenda at the inception of the program; its downside is limits in population and service coverage.

• Limited population coverage of the NLTCI: has increased from 3.3% in 2008 to 6.6% of people aged 65+ in 2014 (LTC expenditure: 0.6% of the GDP in 2012)
  - Germany: 14.1% (1.8% of GDP), Japan: 18.3% (1.0% of GDP)
  - Need to refine the current care needs assessment system in terms of scope and methods

• Limited population coverage of LTC by local government: mainly targeting the very poor population
  * Limited financial protection, especially for those who have a relatively low income, but are not below the poverty line

H. Kim (2015): Community-based Long-term Care, Korea
2. Service Coverage, Quality, and Coordination

- Challenges in meeting health care needs of NLTCI beneficiaries
  - NLTCI was designed to focus on the social aspect of LTC, but beneficiaries have higher and more complex health care needs
  - Difficulties in the coordination of health care covered by NHI with LTC covered by NLTCI
- Service range and mix
  - HCBS in the NLTCI were mainly basic ADL and daily-living support and also delivered in a fragmentary way
- Fragmentations within and between service deliveries in community-based LTC under NLTCI and local gov’ts
- Limited channels for input from older people and family: no person-level assessment of quality of care and quality of life beyond the eligibility test with 51 items only
3. Roles and Responsibilities of Local Gov’ts

- Need to refine the roles and responsibilities of local gov’ts to promote community-based LTC
- Under the NLTCI, local gov’ts have only limited roles for Levels 1-5 in the certification and regulations of LTC institutions, but they are responsible for the delivery and partial financing for people with Extra Levels A & B.
- Lack of financial and human resources for LTC provision by local gov’ts; potential tensions in roles and responsibilities between local LTC systems and the MHW/NHIS
- Policy efforts are needed to build better partnerships between local gov’ts and MHW/NHIS in order to increase access to and enhance quality and continuity of LTC
4. Integrated Community-Based LTC Systems

- Need to build well coordinated, integrated community-based LTC systems
- Relatively low HCBS use (47.9% vs. 52.1% institutional care in 2014) compared to other OECD countries
- Higher use of institutional care and lower family burden; limited policies and family support programs
- Aging in place is regarded as an ultimate goal, but a wide range of drastic system reforms along with strong financial and political investment will also be needed. Are we ready?
  - May not be cost-effective, and would involve more family involvement, potential role conflicts/tensions between professions and institutions
- Ideal LTC models in Asia considering our social and economic context? Further research is needed.

H. Kim (2015): Community-based Long-term Care, Korea
Thank You
Q & A

Hongsoo Kim
hk65@snu.ac.kr