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

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Outline

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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

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I. Health and Care Needs: Changes and Their Contexts

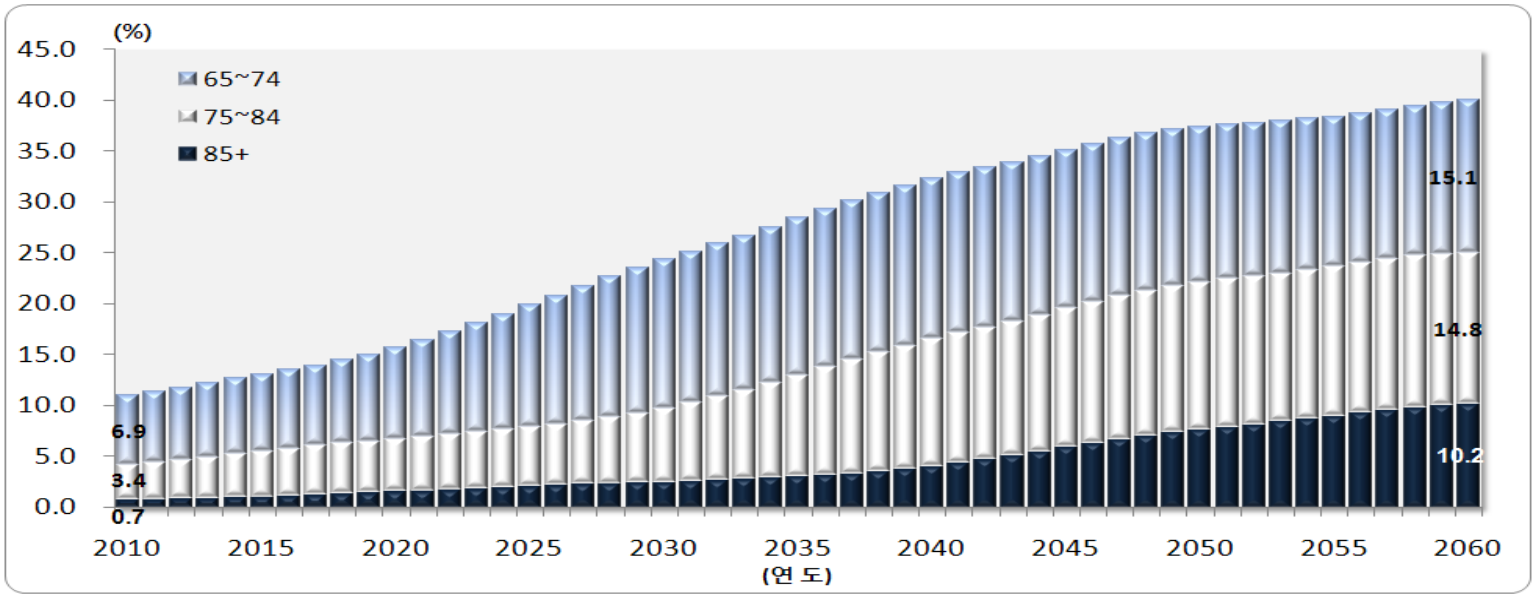
1. Demographic Changes

- **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

KOSTAT (2011)

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.

	Aged Dependency Ratio	Aging Index
1990	7.4	20.0
2000	10.1	34.3
2015	17.9	94.1
2030	38.6	193.0
2040	57.2	288.6
2060	80.6	394.0

- Aged dependency ratio = (population aged 65+/ population aged 15-64) *100

* Aging index = (population aged 65+/ population aged 0-14) * 100

Aged Statistics (2015)

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

2. Health and Well-Being of Older Adults

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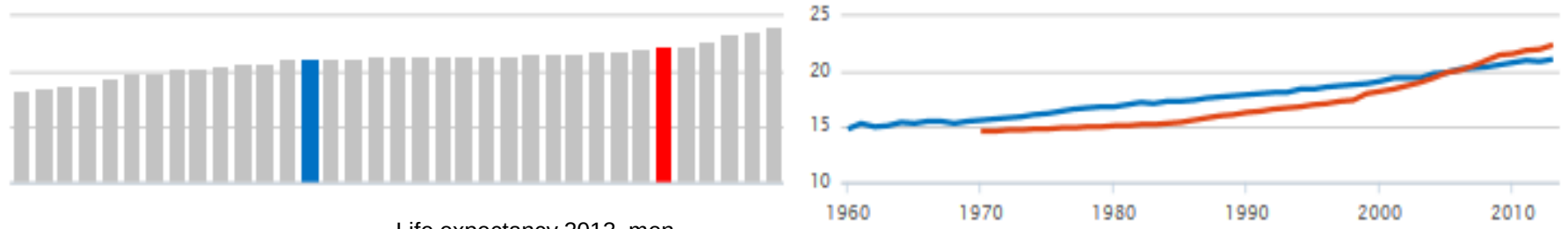
- **Life expectancy at 65**

- Rapid increase in **life expectancy** of Koreans over the last 40-50 years

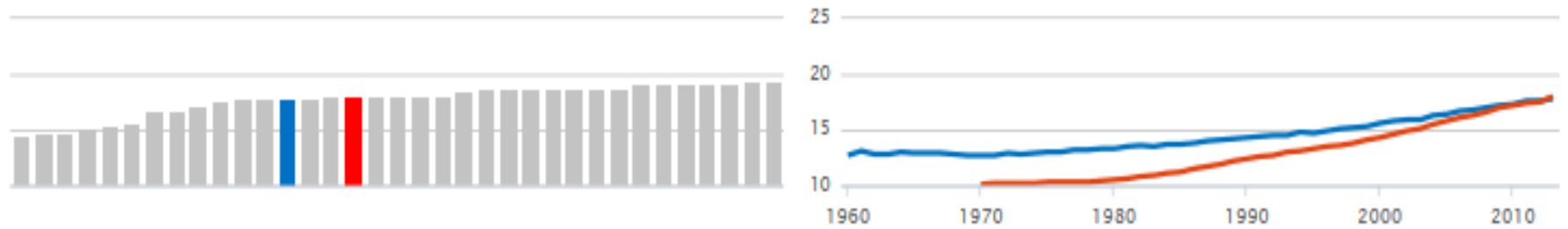
- 18.0(M) & 22.4(F) yrs. in Korea vs. 17.8(M) & 18.0(F) yrs. of OECD avg. in 2013

- Yet **disability-free life expectancy** is much lower: 15.2(M) & 18.2(F) at 60 in Korea

Life expectancy 2013, women
OECD : 21.1 years
Korea: 22.4 years



Life expectancy 2013, men
OECD: 17.8 years
Korea: 18.0 years



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OECD Health Data (2015)

2. Health and Well-Being of Older Adults

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- **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

Aged Statistics (2015); KIHASA (2014)

3. Increasing Long-Term Needs

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- **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%)

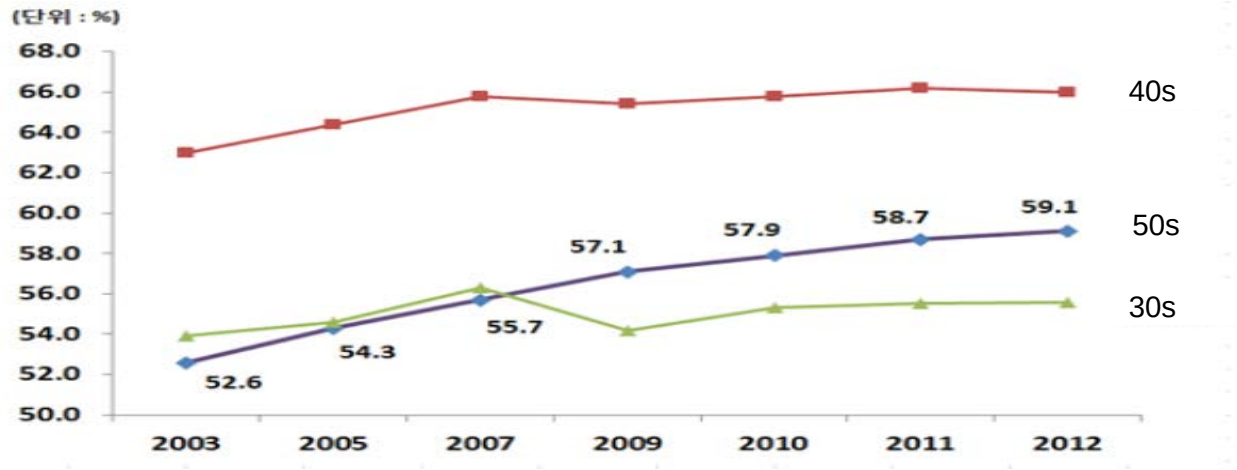
OECD (2012); OECD stats (2015); KMHW (2015)

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

Women's economic activity participation rate



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KOSTAT (2012, 2015)

II. Community-Based Care Within the National Context

1. Context for Community-Based Care

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- 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 Heath 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

1. Context for Community-Based Care

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- 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.

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

III. Key Policies and Programs for Community-Based Long-Term Care

1. Community-Based Long-Term Care in Korea

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- **HCBS under the NLTCI (National)**

  Home and community-based services (HCBS) covered by the NLTCI, a nation-wide 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**]

Level 1	Level 2	Level 3	Level 4	Extra Level A Level 5	Extra Level B & C
95	75	60	51	45	B (40-45), C(<40)

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

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2. Key Aspects of the NLTCI

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- 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)

2. Key Aspects of the NLTCI

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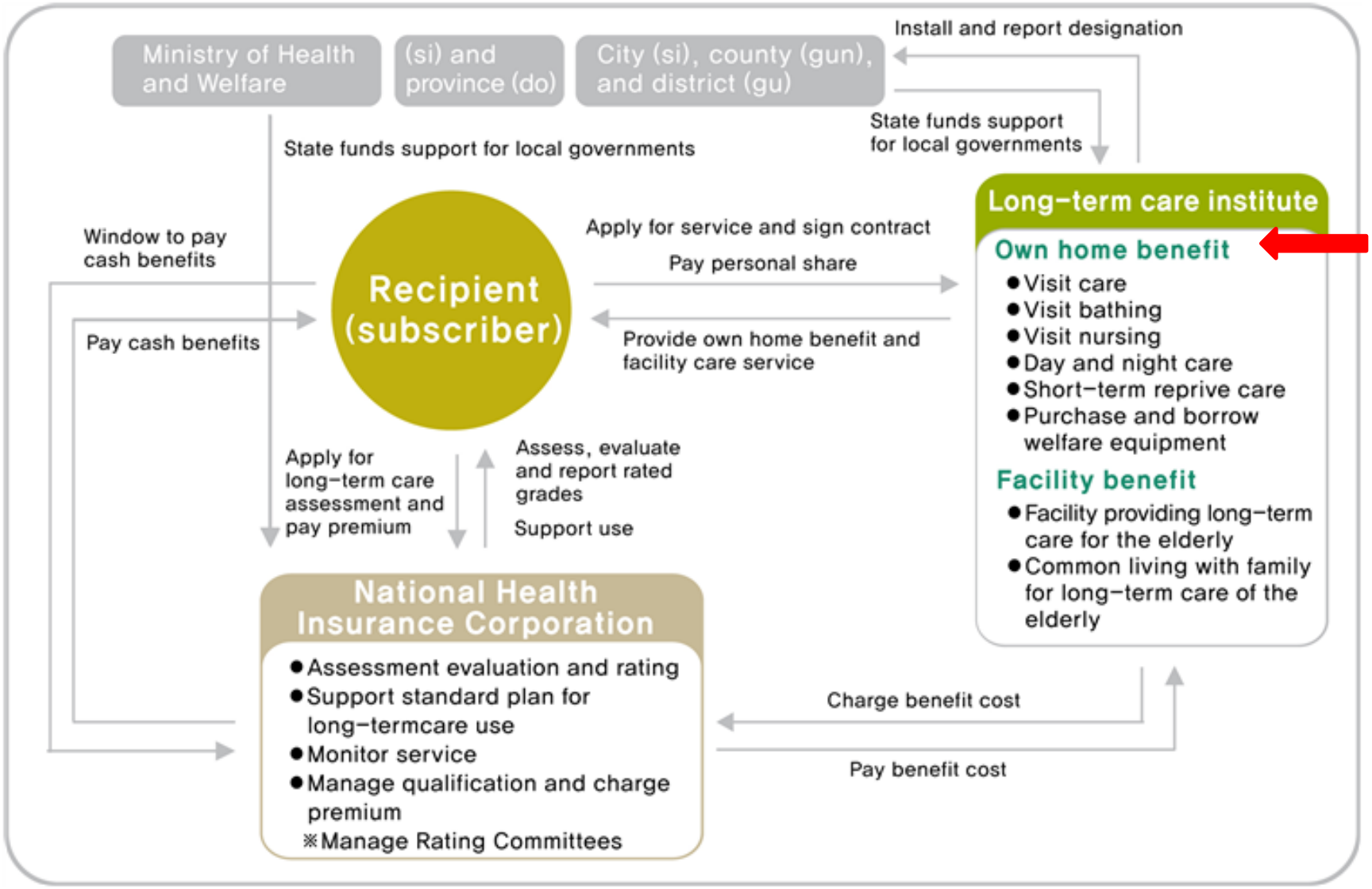
- **Population coverage/eligibility**
  - Adults aged 65+ or those below 65 with an age-related disease
  - **And** those past certain thresholds of care needs defined by the nationally standardized care-need certification (CNC) system based on 5 functional levels: Level I (wholly dependent) through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

Roles/Collaborations Between MHW, NHIC, and Local Governments in NLTCI Operations



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NHIS LTC (2015)

Benefits: The HCBS under the NLTCI

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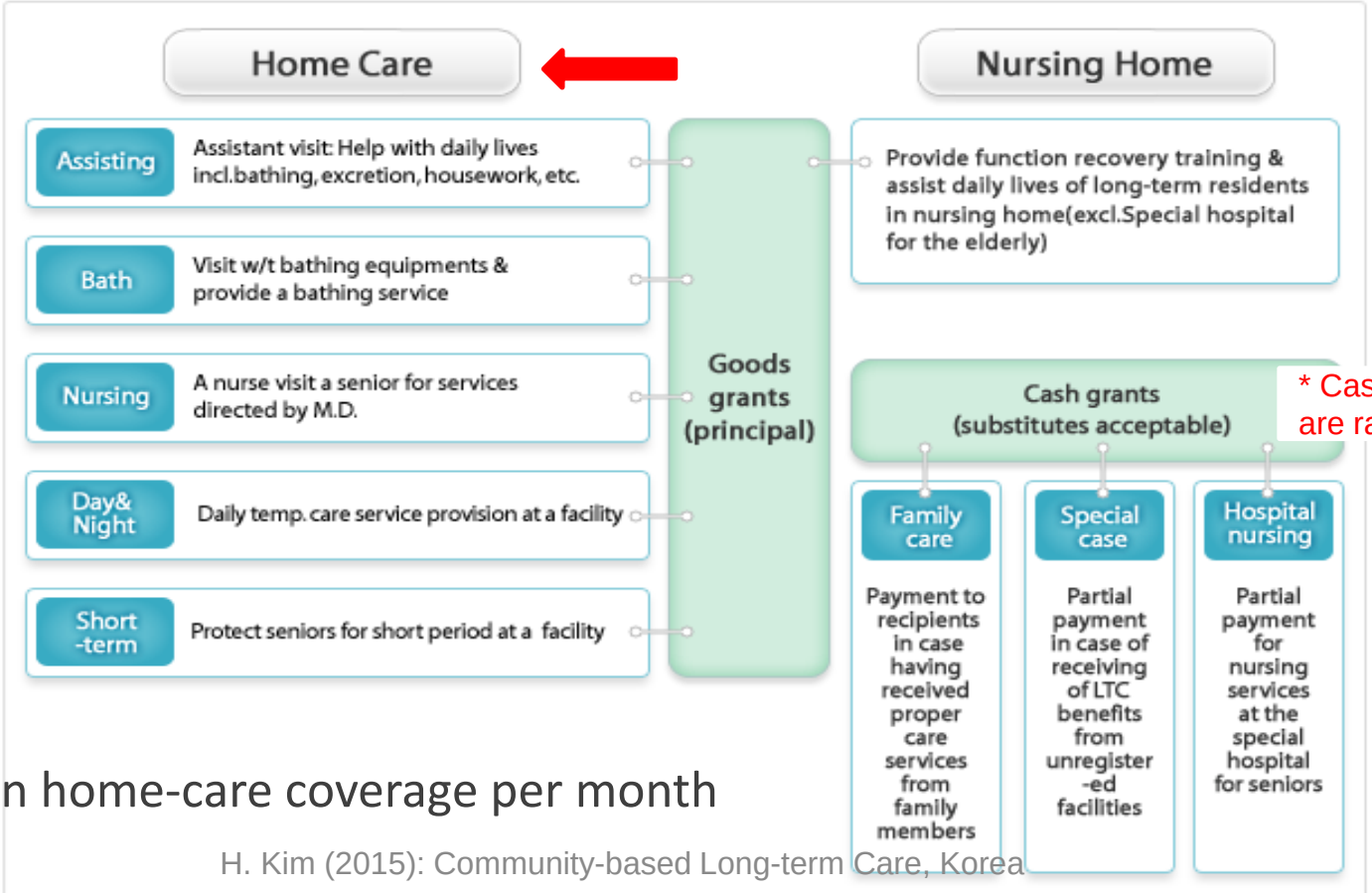
Payment schemes

- 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

NLTCI Trends:
Coverage Expansion & Home vs. Institutional Care

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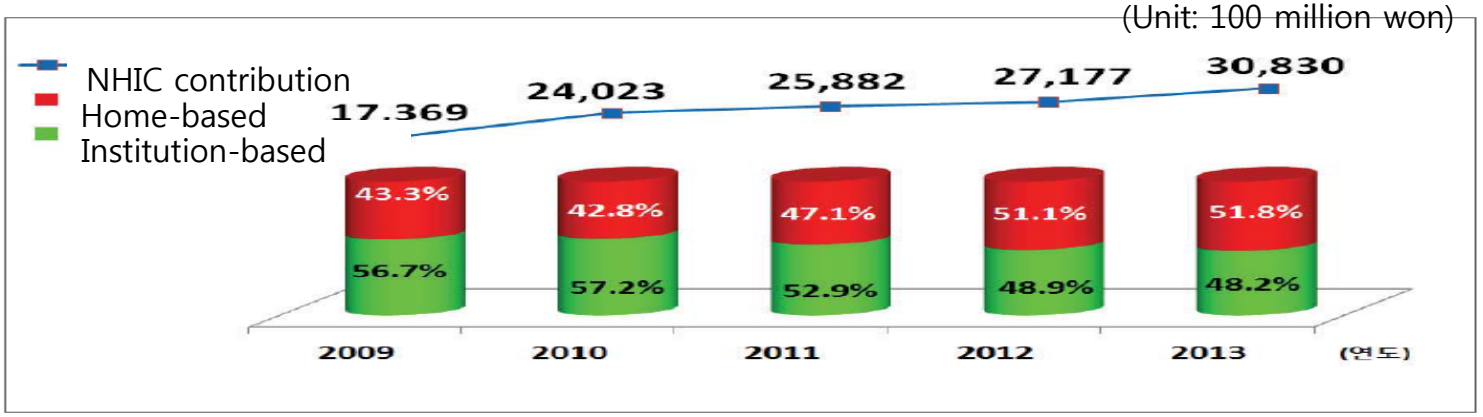
Trends in eligible population

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



NHIS LTC (2013)

NLTCI Trends:
HCBS Provision under the NLTCI

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	2010	2011	2012	2013	2014
Home-visit care	9,164	8,709	8,500	8,620	9,073
Home-visit bathing	7,294	7,162	7,028	7,146	7,479
Home-visit nursing	739	692	626	597	586
Day and night care	1,273	1,321	1,331	1,427	1,688
Shot-term care	199	234	257	368	322
Welfare kit	1,278	1,387	1,498	1,574	1,599
(unit: number)					

NHIS LTC(2014)

3. Community Long-Term Social and Health Care Programs by Local Gov'ts.

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- 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

3. Community Social and Health Care Programs

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

KMHW (2015)

3. Community Social and Health Care Programs

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	Comprehensive Elder-Care Services[1]	Visiting Health-Management Services
Services provided	-**Home care** (27 or 36 hrs/month) Basic ADL supports and household chores/errands -**Day care** (9 or 12 days/month; hours a re the same as home care) -**Dementia family-support services** (6 d ays/year) - **Short-term household chores service** (24 hrs/month)	-**Frailty prevention services** including exercise, nutrition, oral care, urinary incontinence care, mental health promotion, cognition, fall prevention, etc. - **Chronic-disease management** - **Dementia screening service**

[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

KMHW (2014, 2015)

Key Issues and Research/Policy Agenda

1. Population Coverage

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- 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

2. Service Coverage, Quality, and Coordination

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- 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

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- 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

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- 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.

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Thank You
Q & A

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