ABSTRACT

A COMPARATIVE STUDY OF KOREA’S LONG-TERM CARE PROGRAM

By Haesang Jeon

In 1980 the proportion of the population in Korea aged 65 and over was only 3.0%. By 2000, that proportion had jumped to 7.2% and is expected to be 24.0% in the year 2030 (Korea National Statistical Office, 2002). The challenges of this demographic shift include the ability of the government to provide an adequate long-term care program for its disabled elders. This study explores the Korean long-term care program that will start in 2008. In order to better understand the Korean long-term care program, this study examines how three other nations (Germany, Japan and the United States) deliver long-term care services and compares the underlying policy models for all four nations. This study also critically analyzes the program theory and implications of the Korean long-term care program.
A COMPARATIVE STUDY OF KOREA’S LONG-TERM CARE PROGRAM

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In memory of my grandfather who passed away in the summer of 2006,
Mr. Sanghei Kim.
To you, I dedicate this thesis.
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Chapter 1
Long-Term Care Models

Introduction

As a result of major social, economic, and technical changes, the world’s older population has grown significantly in the last century. Although considerable variation in aging growth rates exists by country and geographic region, a majority of nations are now facing an increase in their older population. The net balance of the world’s older population has grown by more than 795,000 people each month since mid 1999. Projections to the year 2010 suggest that the net monthly gain will be on the average of 847,000 people (Kinsella & Velkoff, 2001). Furthermore, in 1990, 26 nations had older populations of at least two million; by 2000, 31 countries had reached the two million mark. By 2030, more than 60 countries will have two million citizens 60 years of age and older.

The combined effect of low fertility and improved health has resulted in an increase in the proportion of older population around the globe. Persistently low fertility rates since the late 1970s have led to a decline in the size of successive birth cohorts and a corresponding increase in the proportion of the older population relative to the younger population (Kinsella & Velkoff, 2001). As a result of improved medical treatments, a number of the diseases, which once led to death, are now treatable and this has led to major increases in life expectancy.

What makes the aging phenomenon even more interesting is the speed of growth, particularly in developing countries. As seen in figure 1, France took 115 years and Sweden took 85 years to become an aging society, having time to prepare for the aging population (Kinsella & Velkoff, 2001). However, for most of the developing countries, it will take only one-quarter of a century to become an aging society. Unlike developed countries, a majority of the developing countries face a sharp increase in elders before establishing an infrastructure of support, involving a long-term care program.
Figure 1

The Speed of Population Aging

(Number of years required or expected for percent of population aged 65 and over to rise from 7 percent to 14 percent)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>France (1865-1980)</td>
<td>115</td>
</tr>
<tr>
<td>Sweden (1890-1975)</td>
<td>85</td>
</tr>
<tr>
<td>Australia (1938-2011)</td>
<td>73</td>
</tr>
<tr>
<td>United States (1944-2013)</td>
<td>69</td>
</tr>
<tr>
<td>Germany (1932-1972)</td>
<td>40</td>
</tr>
<tr>
<td>Japan (1970-1994)</td>
<td>27</td>
</tr>
<tr>
<td>Sri Lanka (2004-2027)</td>
<td>23</td>
</tr>
<tr>
<td>Brazil (2011-2032)</td>
<td>21</td>
</tr>
<tr>
<td>Korea (2000-2018)</td>
<td>18</td>
</tr>
</tbody>
</table>


The demographic shift to an aging society also means an increase in social problems related to aging, including how to provide physical, mental and financial support to the growing aging population. Unfortunately, the current welfare system used in most countries is not designed to serve the increasing demands of the aging population. For example, most health care systems are based on the pay-as-you go design in which current working populations support the non-working group. However, due to the sharp drop in fertility, the number of workers available to support the cost of social health care system will shrink in size, thus bringing financial challenges to many governments. The challenges associated with these changing demographic patterns have been discussed widely in the area of pensions and health care, but the growing area of long-term care has received limited attention.

This study will examine the challenges associated with developing a comprehensive long-term care program to address these growing demographic changes. In response to these challenges of aging in Korea, the government developed a long-term care program which will be implemented in 2008. This study will describe the proposed plan, along with a critique and recommendations for reform of the program. To provide context for this review of Korea’s program, this paper will look at the long-term care program around the globe including Germany, Japan and the United States.
The Republic of Korea (hereafter referred to as Korea), which this paper will focus on, mirrors the global trend of an increased aging population among its citizens. Korea has the fastest growing aging population in the world. Its rapid increase is illustrated by the percentage of the very old (age 80 and older), which is projected to almost quadruple in the next 15 years (Heller, 2006). In addition, functionally dependent older people aged 65 and over are estimated to make up 15% of the total population, but only about 1% of older people can afford to use formal services (Sunwoo, 2004). In response to the increased burden of supporting a frail older population, the Korean government implemented a long-term care program in 2008.

In order to further understand how the new Korean long-term care program will work, it is necessary to examine long-term care programs around the globe. The focus of this chapter is to offer an understanding of how three selected countries (Germany, Japan and United States) organize their long-term care programs in order to cope with the increasing demand for long-term care. Germany was selected because it was the first country to adopt a universal long-term care program, doing so in 1995. Japan was used as a comparison because of its similarities in demographic patterns and the shared cultural norm of caring for its elders with Korea. Also, the Japanese long-term care system is most similar to the one that the Korean government is planning. Finally, the United States was selected as an example of a non-universal long-term care program. The United States does not offer universal long-term care insurance, but instead its state/federal governments cover long-term care in a fragmented way through two programs: Medicaid and Medicare.

Before examining long-term care for elders around the globe, it is necessary to define some of the essential terms that will be used. This is important because some terms might be understood differently for each nation, making it difficult to provide standardized information for this study.

Definition of Old Person

Although “old person” is a commonly used term, there is no general agreement on when a person becomes “old.” However, the UN agreed to refer to 60 and older as the “older population” and decided to categorize ages 15 to 64 as “working population” (World Health Organization, 2007). While the definition of old person is arbitrary, age 65 is a common
retirement age in most countries, including Korea. It is at this age that a person begins to receive their pension and is eligible to enroll in the long-term care program in Korea. For these reasons, this study will use age 65 and older to define old age.

Definition of Disability

The definition of “disability” varies by nation. In general, disability is based on either physical disability, mental disability, or both. Berkowitz and Fox (1989) note disability “represents a social judgment not an objective medical condition” and policies are formulated in response to this judgment. Therefore, an old person who is defined as ‘disabled’ in one country may not qualify to enroll in a long-term care program in another.

In addition, there is no uniform agreement on how long one has to be ill before being classified as a “disabled” person (Holdenriender, 2003). For example, ninety days is the number the U.S. Public Health Service uses to denote a “chronic condition.” Other countries, such as Japan, define 180 days as an acceptable period of time for consideration to receive long-term care services (Evashwick, 2005). However, all of the countries in this study use “Activities of Daily Living” (ADL) and “Instrumental Activities of Daily Living” (IADL), the most widely used method of defining “disability,” to explain eligibility criteria for long-term care benefits for elders. The “ADL” measure assesses an individual’s ability to complete a series of daily tasks including bathing, dressing, toileting, transferring, continence control, and eating (Katz et. al, 1963). “IADL” includes additional activities necessary for an individual to maintain independent living, such as shopping and housekeeping. Therefore, the definition of disabled in this study will be based on “ADL” and “IADL” measures of individuals.

Definition of Long-Term Care

There are differences in the services labeled as “long-term care” around the globe. Moreover, in a number of countries, there are services which are not described as “long-term care,” but which include similar tasks. Due to these difficulties, defining long-term care is a challenge. However, in order to reduce the complexity and to provide an international comparison of long-term care programs, it is necessary to provide, at least conceptually, an
overview of long-term care. Borrowing Evashwick’s (2005) definition, “long-term care is defined as a broad set of paid and unpaid health related services for people who have functional disabilities due to chronic illness or physical or mental disability over an extended period of time.”

The goal of long-term care is to enable a person to maintain the maximum level of functional independence. Unlike acute care, for which the goal is medical cure, long-term care recognizes that a person’s condition may be irreversible and may possibly deteriorate over time. This is the main characteristic that makes long-term care different from other health related services.

There are a variety of services identified as “long-term care.” For simplicity, this study will categorize benefits and services two ways: based on the place of care, as well as the kind of care a person receives. Institutional care is for people who are functionally disabled and thus require ongoing nursing and support services that are provided in a formal health care institution. Home care includes nursing and other support services that are provided to people at home. Home care programs range from formal organizations providing skilled nursing care to caring services such as housekeeping.

Because the focus of this study is public long-term care program, this study will examine long-term care services that are provided and financed by the government or an authorized public organization. However, in some countries long-term care is delivered through private providers and informal caregivers such as family and friends who are funded through the government. Therefore, the present study will expand the criteria for long-term care services to include private providers and informal caregivers, but the services must be controlled and subsidized by government authorities.

In addition, in an effort to expand home and community services for older people with disabilities, many countries, including Germany, Japan and several states in the United States, adopted consumer direction in their long-term care programs. Consumer direction is based on the assumption that individuals receiving services have the right and the ability to describe their own needs and to decide what services should be provided by who, and to assess the quality of the services they are receiving (Kunkel & Nelson, 2005). The purpose of the consumer directed program is to increase the quality of care by allowing consumers to have more voice and control over service delivery.
Theoretical Framework

Health and long-term care policies vary by country based on the history and culture of each nation. Following this line, Esping-Andersen (1990) said that when comparing international variations in social rights and welfare state stratification. Social rights refers to the extent to which a person can live without reliance on the market, while stratification of one’s system can be determined through corporatism, means-testing, universalism, and benefit equality of the welfare program (Powell & Barrientos, 2004). Furthermore, there are different arrangements between states, market, and the family. For these reasons, a broader theoretical framework is necessary to compare global long-term care programs.

This study will use the well known comparative social policy model of Esping-Andersen’s “Three Welfare Regimes” (Liberal, Corporatist and Social Democratic) from the book *The Three World of Welfare Capitalism* to illustrate how long-term care is managed and delivered in Germany, Japan, United States and Korea. This model identifies three main welfare approaches organized according to specific social risks, as well as the measure of social rights and stratification of the welfare program.

In the “liberal” welfare model, the state plays a restricted role of providing care based on the preference for market welfare production (Esping-Andersen, 1990). The state encourages market welfare by subsidizing private welfare, and the state will interfere only when market failure occurs. This model is supported by market optimists, who believe that economic development will improve the markets thus reducing market failure as well as the need for market intervention (Powell & Barrientos, 2004). According to this model, welfare programs are justified only when there are significant market failures, and those programs are more likely to be means-tested and social insurance benefits are modest (Myles & Quadagno, 2002). A great example of this model is the United States. The United States’ system assumes individuals to be primarily responsible for their long-term care, thus the government will only provide care when the individuals fail to look after themselves. As the “liberal” model would predict, the United States government does not provide a universal long-term care program, but instead the government provides limited long-term care for those who cannot afford the services.

The second welfare model is “corporatist” and it places family at the center of care provision. Social risks are defined as those affecting the family, and state's welfare program is
designed to respond only when a family failure occurs. The principle of ‘subsidiarity’ serves to emphasize that the state will only interfere when the family’s capacity to service its members is exhausted (Esping-Andersen, 1990). In this model, social spending is considerably higher than the previous liberal model; however, the government’s emphasis is on income transfers sufficient to cover the needs of the male breadwinner (Myles & Quadagno, 2002). Moreover, this model is based on gender and occupation. Therefore, daycare and similar family services are underdeveloped. Examples of this system are Germany and Japan.

The last model is a “social democratic” approach that is based on universalism to promote equality of highest standards, not an equality of minimal needs that was pursued in the previous models. Both “corporatist” and “social democratic” welfare states tend to spend a huge amount on social protection, but do so in fundamentally different ways (Myles & Quadagno, 2002). In “social democratic” model, the services are delivered not only to the low income groups but also to the middle class and upper groups directly by the state. In addition, the state plays a key role in providing welfare services over market and family, allowing women and parents to participate in the labor market. Sweden is a great example of the government playing a key role in delivering welfare services to citizens.

**Long-Term Care Models: A Comparison**

This section will offers an analysis of the long-term care program around the globe. More specifically, it will look at how three selected countries (Germany, Japan and United States) deliver long-term care services to their citizens. In this section a structured framework using four core questions will be applied to compare the programs across nations. The Esping-Andersen’s (1990) theoretical models will be used in analyzing each country’s long-term care program.

1. What is the historical background for implementing a long-term care system?
2. What is the eligibility criterion to enroll in a long-term care program?
3. What types of services are provided within a long-term care program?
4. How is a long-term care program financed?
GERMANY

Historical Background

Demographic change is the fundamental reason for the establishment of a long-term care system in most cases. In Germany, the population age 60 and older number around 19 million and in 2010 it is expected to increase to 21 million, comprising 26% of the total population. Conservative estimates expect the German long-term care population to grow from 1.5 million in 1993 to 2.0 million by 2010 and to 2.4 million by 2040 (Schneider, 1999).

Motivated by the demographic shift, the idea of creating a social long-term care program began in the early 1970’s. But it was the 1990’s when the need for long-term care was brought to the surface. Old age itself does not necessitate the need for caring. However, the increase in the number of older people means an increase of elders with diseases such as dementia, arthritis, and heart disease which lead to greater demand for long-term care services. While the need for long-term care has increased significantly, the base of caring services, family, has weakened due to the increase in older people living alone. Furthermore, the previous social insurance program was unable to handle the financial, mental and physical burden of primary caregivers. For example, traditional health care did not provide financial support for certain geriatric diseases increasing the financial burden to individuals and family. To solve this problem, the German government decided to input a new Social Dependency Insurance (SDI) program devoted to provide caring services for those who needed them.

The first step toward a Social Dependency Insurance scheme was taken in the 1988 Heath Reform Act. According to Shneider (1999), the “Health Reform Act entitled a small group of care clients to long-term care assistance to be paid for by the sickness funds and coverage was restricted to cases of severe dependency and to home care.” In 1995, the Dependency Insurance Act was introduced in the framework of Germany’s social insurance system and ever since about 90% of the German population has been covered by Social Dependency Insurance.

Esping-Andersen (1990) described Germany’s welfare system as an example of a “corporatist” model in which the state plays an active role in providing public services; hence, private insurance plays a marginal role in the welfare system. Since Germany’s long-term care program is both administered and delivered by the government, its welfare system contains
elements of the “corporatist” model. Furthermore, Germany also shows “social democratic” characteristics in its long-term care program. Esping-Andersen states that in the “social democratic” model, states’ grants are transferred directly to needy groups, in this case the aged, and the state takes direct responsibility of caring for them. Since Germany provides direct long-term care services, including cash allowances to individuals, it can be defined as an example of the “social democratic” model.

**Eligibility**

Social Dependency Insurance (SDI) provides long-term care coverage to clients regardless of age, financial need or the cause of dependency. Benefits are provided to persons who require a “substantial” degree of assistance in ADL at least two or more, and who need help in IADL tasks for more than six months (Shneider, 1999).

Based on the frequency of support and the time that is required for basic caring services, the law distinguishes three degrees of functional dependency: substantial, severe, and very severe, as illustrated in Table 1.

<table>
<thead>
<tr>
<th>Disability Level</th>
<th>Number of ADL/IADL deficiencies</th>
<th>Frequency of assistance with ADL</th>
<th>Frequency of assistance with IADL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Two or more ADL limitations and need for help with IADL</td>
<td>At least once a day</td>
<td>Several times a week</td>
</tr>
<tr>
<td>Medium</td>
<td>Two or more ADL limitations and need for help with IADL</td>
<td>At least three times daily and spread over the day</td>
<td>Several times a week</td>
</tr>
<tr>
<td>Severe</td>
<td>Two or more ADL limitations and need for help with IADL</td>
<td>Day and night</td>
<td>Several times a week</td>
</tr>
</tbody>
</table>

(Shneider, 1999)
Those enrolled in the mandatory health insurance program are also required to participate in SDI, including those who already have a private long-term care insurance program. The program provides long-term care services to people who live in Germany regardless of their nationality; allowing foreigners to participate as well.

The only exemption is made for people who exceed the monthly income determined by the government. These people are considered economically self-sufficient enough to take care of themselves without support; therefore they are excluded from mandatory SDI so they may either participate in SDI or choose private insurance.

Benefits

The Social Dependency Insurance (SDI) benefit is divided into home care services and institutional services. The kinds of service provided can be a cash allowance or caring services depending on the individual’s needs. Home care recipients have the choice of cash allowance and caring services. Institutional care recipients will receive services directly from facilities contracted by the government.

- Home Care

In Germany, most of older people live in the community and receive a home care service. Home care service providers help elders in a variety of ways, providing supportive services including delivering groceries, escorting elders to the hospital, housework, reading books and more. Additionally, if a person chooses professional home care, a nurse will visit occasionally and provide medical help.

The cash allowance is provided to support primary caregivers who are unable to continue working due to caring. Primary caregivers can be family members or neighbors who provide unpaid support at least 14 hours a week and who do not spend more than 30 hours a week in outside employment.

In case the primary caregiver is unable to provide help due to disease or travel, the care receiver can ask for a surrogate helper for up to 4 weeks per year. In this case, the care receiver
can chose anyone to be a short term caregiver or request professional help from a nurse. If neither option is available, the care receiver can stay in a short term shelter during this period.

- Institutional Care

Like other nations, Germany is trying to focus on home-care services and break from the traditional reliance on institutional care. However, if the home-care option is unavailable, institutional care is provided to individuals. Germany has several options for institutional care and care recipients can choose a place based on their needs and eligibility.

Independent Living
An independent living facility is for those who have the capability to maintain independent living and require only housekeeping services and other visiting services. Another difference from other institutional care is that this facility is usually an apartment or a house and individuals can bring their own furniture.

Nursing Home
Nursing Home care is for those who cannot maintain independent living and who require partial help on ADL tasks. The Nursing Home is usually run by the government, but there are several private facilities. Services include regular caregiving services and medical services. Doctor’s visits are done regularly.

Geriatric Care Facility
A Geriatric Care facility is for people who need constant care and are unable to maintain living without help. The Geriatric Care Facility is similar to the hospital but it normally is located within the Nursing Home facility.

General Facility
A General facility is a combination of the above three facilities. At least two doctors work in this facility and it requires regularly doctor’s visits by a specialist. This facility is funded by residents’ pension.
Considering the equity to others who do not use the institutional care, residents must pay board and lodging fees if these costs exceed the allowed payments. However, SDI will cover the extras for those who are unable to pay the cost due to their economic status.

Financing

The Social Dependency Insurance (SDI) is set up as a pay-as-you go system. A payroll tax is levied on wage-earners and the contribution is shared equally between employees and employers. The payroll tax is based on gross wages with an upper limit for the contribution. The limit is adjusted once every year. The contribution rate was 1.0% at the beginning of the program but was raised to the current 1.7% in 1996 (Shneider, 1999).

Retirees share premium payments equally with pension funds. Coverage is extended to spouses and children of enrollees without any additional premium payments (Shneider, 1999). Funds for building or remodeling the facility are supported by state. However, the federal government does not assume financial responsibility for any deficit run by SDI.

Japan

Historical Background

Japan shares the most similarities in long-term care with Korea. The two countries share cultural norms of taking care of elders and both nations face a rapid increase in the older population. Japan’s mandatory long-term care insurance started in April 1, 2000. This new program represents a reversal compared to the earlier governments’ attempt to support elders who needed long-term care. The program was designed to target older people and individuals age 40 and older with certain diseases. The Japanese government understood the burden of caregiving and took the responsibility of providing long-term care to all frail elders, regardless of the economic status of individuals.

Until now, the Japanese government has been hesitant to develop a long-term care program due to the fact that Japan has been well known for its traditional family caregiving. However in contemporary society, the percentage of elders who live with an offspring has dropped dramatically and the rapidly growing aging population has forced the Japanese
government to enact the long-term care program. Furthermore, the weakening of the traditional system of informal caregiving provided by family members played a major role in implementing a public long-term care program in Japan.

The first modern program for older people in Japan has a long history. In 1963 the Japanese government developed a program to help elders; but the major expansion came in 1973, when, in response to rising public concern medical care was made virtually free to people age seventy and older (Campbell & Ikegami, 2000). At that time social services, including nursing homes and home care, were still minimal and were not available to anyone who had family caregivers.

From 1963 to 1993 the number of hospitalized older people increased dramatically and disabled elders occupied nearly half of all hospital beds (Campbell & Ikegami, 2000). In response to the rapidly growing aging population, the ruling Liberal Democratic Party came up with the Golden Plan in December 1989. The Golden Plan, more formally called the “Ten-Year Strategy to Promote Health and Welfare for the Aged,” was developed to promote major changes in services, including: doubling the number of nursing home beds, tripling the number of home helpers, and building ten times the current number of adult day-care centers.

The Golden Plan was the first attempt by the government to be responsible for the care of frail elders, not just those who were poor or those without primary caregivers, but disabled elders in general (Campbell & Ikegami, 2000). The concept of the new long-term care plan was influenced by Germany’s social insurance model and brought up in 1995. Passage of the legislation took two years and an additional three years of intensive preparation prior to program implementation, which began in April 2000. In addition, the Japanese government plans to expand the new program gradually over ten years, leading to a major expansion of community-based care and a flexible approach to increase the choice of consumers.

Because the Japanese long-term care program is largely influenced by Germany’s social insurance model, it shares a similar underlying theoretical framework with Germany as well. Like Germany, the Japanese government plays an important role in providing long-term care services and it is also partly financed by general revenue, which is the characteristic of the “corporatist” and “social democratic” models.
Purpose

The new Long-term Care Plan was developed to:

1. Shift the major responsibility for caregiving from the family to the state.
2. Integrate medical care and social services via unified financing.
3. Enhance consumer choice and competition by allowing free choice of providers, including even for-profit companies.
4. Require older persons themselves to share the costs via insurance premiums as well as co-payments
5. Expand local government autonomy and management capacity in social policy.

Eligibility

According to the plan, a person who needs constant care with bathing, dressing and other daily living conditions for more than six months due to physical or mental disability is eligible for the long-term care program. Eligibility is strictly a matter of age and physical and mental condition; income and family relation are not considered.

In Japan, eligibility criteria are divided into two age groups, people age 65 and older, and those who are age 40 to 64. Individuals 65 and older are eligible to receive services without considering the diagnosis, however, for the younger group the service is limited to those with 15 age-related diseases such Alzheimer’s and stroke (Campbell & Ikegami, 2000). Eligibility for the younger group is designed to provide a tangible payoff so that all who must pay premiums have access to benefits.

Eligibility Assessment Procedure

Individuals or their families apply for long-term care through the municipal government. Assessments are usually made by a public health nurse or a social worker who are either employed through the municipality or through an independent organization (Ikegami, 2004). The assessment examines each applicant’s physical and mental status. The assessment form contains
79 items, each with a choice of three or four levels, additional space is provided for the descriptive statements on particular aspects of need. These items are then analyzed to classify each applicant into one of five levels or to reject.

The expert committee reviews the classification result and may make some changes according to additional written information or doctor’s comment (Ikegami, 2004). The expert committee is picked by the mayor but includes no municipal representatives; it usually has five members: two physicians, social workers, nurses, and others.

The Municipal government will inform the applicant about the eligibility decision within 30 days. Once accepted into the program, the applicant will be reevaluated every six months. The eligibility level is divided into five categories based on individuals’ conditions (Table 2).

Table 2

Japanese Long-Term Care Eligibility Levels

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Physical</th>
<th>Instability in standing and walking, need partial help with hygiene, bathing, and dressing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental</td>
<td>Often shows symptoms of dementia</td>
</tr>
<tr>
<td>Level 2</td>
<td>Physical</td>
<td>Impossible to stand or walk on their own and need help with hygiene, bathing and dressing</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Do not understand daily tasks and forget belongings</td>
</tr>
<tr>
<td>Level 3</td>
<td>Physical</td>
<td>Impossible to stand or walk on their own and need help with hygiene, bathing and dressing</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Do not care about the surroundings and often show resistance to caregiving</td>
</tr>
<tr>
<td>Level 4</td>
<td>Physical</td>
<td>The ability to carry ADL is very low and need partial help with eating</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Live day &amp; night oppositely and stray around. Shows resistance to caregiving</td>
</tr>
<tr>
<td>Level 5</td>
<td>Physical</td>
<td>Require constant caregiving on ADL &amp; IADL</td>
</tr>
<tr>
<td></td>
<td>Mental</td>
<td>Expressing their intention is impossible</td>
</tr>
</tbody>
</table>

(Lee, 2003)

After the eligibility level has been decided, care managers play an important role in the delivery of services. Care managers are people with a experience in the field, who pass an examination and have undergone training. The care manager develops the care plan based on the client’s need, and how much the client is able to pay. Once the plan is developed, the care manager needs an approval from the recipient or family member.
Benefits

Unlike Germany, a cash allowance is not included in the long-term care program in Japan. Campbell and Ikegami (2000) suggested three reasons for the rejection of the cash payment within the program. First, welfare professionals said that the top priority should be a rapid expansion of formal services, which would not occur unless demand was high. Second, feminists maintained that the allowance would just go into the household budget, and family caregivers would continue to be exploited. Third, policymakers worried that, even if the cash option were of less value than the services, everyone would take advantage of the benefit thus increasing the financial burden to the government.

As a result, the Japanese long-term care program does not provide cash allowance but delivers a variety of services based on the person’s needs and the place of service delivered. Long-term care benefits are divided in two categories: home care and institutional care.

- **Home Care**

  Home care includes services such as home-visit help for caring services, housekeeping, and other formal services such as visiting nurses, rehabilitation and in-home medical care management counseling is also included. Adult day care centers and short-term shelters are also included in in-home service; however short-term shelter recipients are only allowed to stay at these facilities for up to four weeks per year. Rental services for assistive devices, and allowances for modifying the home are also included in the home care benefit.

  A group home is a small unit house for elders with dementia. Depending on the size of a home, a group of older people live together and the home care services are delivered to them from local providers.

- **Institutional Care**

  Institutional care is divided into three categories depending on the place and types of services the facility provides: nursing home, health facility for the elders, and medical care facility.

  Nursing homes include regular caring services and the facility must provide professional caregivers authorized by the government. A Health facility is similar to a nursing home, but
provides more professional medical care by doctors and nurses. It also requires a medical office and physical therapy office inside the facility. A Medical care facility is a hospital with enhanced long-term care service provision for elders. It includes special units for patients with dementia.

Financing

The Long-Term Care Plan is funded through the use of insurance fees, general revenues, and a minimal contribution from individuals (Lee, 2003). Half of the long-term care budget is from the social insurance premiums and the other half comes from general revenues. Among general revenues, federal government funds half of the budget and the rest is funded by prefectures (State) and municipalities (Local) governments. Within the federal government’s budget, about 5% of the premiums are pooled at the national level and allocated to municipalities according to a formula based on demographics and income, and there is an additional fund to help states and localities with individuals with severe deficits (Campbell & Ikegami, 2000).

Table 3

Long-Term Care Financing

<table>
<thead>
<tr>
<th>Insurance (50%)</th>
<th>Age 65 and older 17%</th>
<th>Age 40 to 64 33%</th>
<th>The percentage is based on population rate of two age groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue (50%)</td>
<td>Federal government 25%</td>
<td>About 5% of the total is redistributed based on demographic pattern and income levels of states and locals.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prefectures (State) 12.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Municipalities (Local) 12.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Lee, 2003)

Insurance is funded by two premiums. First, the age 65 and older group will pay differently depending on their economic status within five income levels (See Table 3). The premium is also automatically deducted from the person’s public pension. The second premium is for the people age 40 to 64, who enroll in employee health insurance or local health insurance. For employees the premium is 0.9% of monthly income up to a ceiling, shared with the employer. In addition, the recipient has to cover 10% of the total cost as a co-payment. Individuals may purchase additional services if they wish to pay out-of-pocket.
United States

Historical Background

The older population in the United States is projected to grow dramatically during the coming decades, increasing from about 35 million in 2000 to more than 70 million by 2030 (Evashwick, 2005). This will dramatically increase the need and demand for long-term care services. In the United States, the government does not provide universal insurance program for long-term care, but there are two programs, Medicare and Medicaid, that provide limited long-term care coverage. Medicare was enacted in 1965 as Title 18 of the Social Security Act to help older people obtain and pay for medical care (Friedland, 2005). The primary purpose of the Medicare program has been to provide older citizens with protection from the high costs of acute medical illness, particularly costs associated with inpatient hospital care (Evashwick, 2005). Medicare is primarily intended to cover acute-care expenses such as hospital and physician care, but it does cover very limited long-term care services such as home health and nursing home care.

Medicaid was also introduced in 1965, as Title 19 of the Social Security Act, to assist states in paying for the healthcare of the very poor (Friedland, 2005). It is a means-tested program that provides health coverage to low income citizens serving as an important complement to Medicare. The most distinguishable benefit of Medicaid compared to Medicare is coverage of long-term care. Medicaid is a major financial source of long-term care providing 47% of total national long-term care expenditures (Feder, 2000).

Because the government does not have a universal long-term care program, private long-term care insurance also plays a role in the United States. Private long term care insurance is available for individuals who can afford this option. It became available in the 1980s, and accounts for about 8% of nursing home expenditures. In 2001, there were 3.3 million people covered through the use of such policies and the number of policies is growing. On average, 15% of people who are 65 and older with annual income of $20,000 or more have private long-term care insurance coverage (OECD, 2005).

Unlike Germany and Japan, the United States’ welfare system is close to the “liberal” model. According to Esping-Andersen (1990), “liberal” welfare state has modest universal transfers or modest social-insurance plans, and the benefits are mostly distributed to a clientele of low-income beneficiaries. Furthermore, the state guarantees only minimum benefits from the
public program, while encouraging the private market to play an active role in the welfare system. Since the United States does not have a universal long-term care program and the private insurance shares important status in providing long-term services, it can be defined as a “liberal” welfare state.

Eligibility

The primary beneficiary groups for Medicare are individuals who are over the age of 65 and have at least 40 quarters of Medicare covered employment. If people age 65 and older whose work histories do not qualify them to enroll in the program, they can participate in Medicare by paying a monthly premium. The program also covers workers who have received Social Security Disability benefits for at least two years. The eligibility criteria expanded in 1972 to other people under age 65 with end-stage renal disease requiring dialysis or a kidney transplant. In 1997, the program was further extended to cover people under age 65 with amyotrophic lateral sclerosis (Friedland, 2005). In 2005, there were about 42.5 million people covered through the use of Medicare. Among those most were age 65 and older, 35.8 million, and about 6.7 million were under the age of 65.

Unlike Medicare, each state operates a separate Medicaid program. Therefore, someone who is eligible for Medicaid in one state may not be eligible in another and the kinds of services one receives may vary from state to state. Even individuals in the same state with similar incomes may not be equally eligible for benefits, due to state’s welfare rules.

Despite the differences within the Medicaid program across states, generally eligibility criteria are considered based on one of the following: categorically needy, medically needy. Categorically needy is based on the level of income. Generally, Federal rules entitle elders and disabled people to Medicaid benefits if their incomes and assets are low enough to qualify them for the federal Supplemental Security Income cash assistance program.

The Medically Needy Category is for those who do not qualify based on income, but have extensive medical issues. In 2004, some 42.4 million people-more than one in seven Americans-were enrolled in Medicaid (Friedland, 2005).
Benefits

The Medicare program provides some limited long-term care coverage for home health and nursing home care without means testing. Despite recent growth in demand for long-term care services, much of the skilled nursing facility and home health services remain short-term rehabilitative care, often related to a hospital stay or outpatient procedure. Hospice care and other medical equipment are also supplied under Medicare program.

Skilled nursing facility care provides skilled nursing and rehabilitation services for the older population. Medicare covers 100 days of care in the skilled nursing facility. Medicare pays full coverage of the first 20 days in the facility, and the rest of the 80 days are covered through the use of Medicare and individuals’ insurance. Individuals are responsible for all charges after staying more than 100 days in the skilled nursing facility.

In home health care program, Medicare pays the full cost of home health care visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care and other therapeutic services. Medicare also pays for hospice care for those with a prognosis of six months life expectancy. Hospice is primarily a program of care provided in the individual’s home by a Medicare approved hospice and the service includes nursing care, medical appliances and supplies and more.

Because Medicaid was designed to act as an assistance program to the poor, covered services are similar in a number of ways with those in Medicare program (Evashwick, 2005). Medicaid covers a wide rage of medical services, including inpatient and outpatient hospital care, physician services, home health care, skilled nursing facility care and other medical services in need. A large portion of Medicaid funds go to the nursing home and essentially, Medicaid acts as a safety net for those entering nursing homes in the event that their personal resources are insufficient to pay for continuing care (Evashwick, 2005).

Medicaid also provides Home and Community-Based Services (HCBS) to elders who are functionally impaired and at risk of nursing home placement. The program is intended to assist older people in remaining in their own homes. In order to participate in the program, individuals must meet financial and physical eligibility requirements. Once a person is qualified, a case manager is assigned and services such as home delivered meals, personal care, non-medical day services, home-maker services, and respite care are arranged (Evashwick, 2005).
Financing

The Medicare program is financed through two trust funds: Hospital Insurance and Supplementary Medical Insurance. The Hospital Insurance trust fund is financed primarily through the use of payroll tax of 1.45% of all wages assessed on both employers and employees. Most of the annual trust fund income is used to fund current-year benefits (Friendland, 2005). The Supplementary Medical Insurance trust fund is primarily financed by premiums on beneficiaries of Medicare and general revenues of U.S. Treasury.

The Medicaid program is funded through federal and state funds. States receive federal matching funds for the services provided under their Medicaid programs. Federal funds may vary by state’s financial capacity, ranging from 83% for the poorest states to 50% for the richest ones (Evashwick, 2005).

Conclusion

This chapter has provided an overview of how long-term care is provided in Germany, Japan, and the United States. Each country’s long-term care programs were organized based on their historical background, eligibility, benefits and financing. Each nation shared similarities and differences within their programs. It used Esping-Andersen’s (1990) social policy model of “Three Welfare Regimes” to compare each nation’s long-term care programs. Both the Germany and Japan’s long-term care programs can be categorized as a mix of “corporatist” and “social democratic” models, while the United States long-term care system represents “liberal” welfare model.

Below is a brief summary of how long-term care programs are managed in Germany, Japan and the United States (See Table 4).
Table 4
Long-Term Care Programs in Germany, Japan, and the United States

<table>
<thead>
<tr>
<th>Program</th>
<th>Germany</th>
<th>Japan</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Dependency Insurance</td>
<td>Long-Term Care Insurance</td>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Universal Coverage</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Disabled (All ages)</td>
<td>Age 40-64: disabled by 15 aging-related diseases Age 65+: all disabilities</td>
<td>Medicare: disabled and age 65+ Medicaid: means-tested by income and medical needs.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Home care (services and cash) and institutional care</td>
<td>Home care (services only) and institutional care</td>
<td>Limited coverage of home care and institutional care</td>
</tr>
<tr>
<td>Financing</td>
<td>Payroll tax</td>
<td>General revenue, insurance premiums for age 40 and older, and 10% of individual co-payment</td>
<td>Medicare: payroll tax for limited coverage Medicaid: general revenue</td>
</tr>
</tbody>
</table>

Germany began the Social Dependency Insurance in 1995 to provide long-term care for elders and individuals with disability of all ages. This program is financed by the payroll tax and provides both home care and institutional care. The home care program in Germany provides a cash allowance for primary caregivers. Japan is one the first countries to enter the “aging society” in Asia. Japan modeled the Long-term Care Insurance based on Germany’s model. However, the eligibility group is limited to age 40 to 64 with 15 aging-related diseases and all disabilities for age 65 and older. The program is funded through general revenues and insurance premiums, and does not provide a cash allowance for informal caregivers such as family and friends. The United States is classified as taking the approach that the government will not intervene in the welfare market until people hit the poverty level, and as such the government does not have a universal long-term care program. Instead, it provides limited long-term care coverage through Medicare and Medicaid and unlike Germany and Japan, private long-term care insurance plays an important role in the society.

The next chapter will offer a detailed description of the Korean long-term program that will start in 2008. It will follow the same framework used in this chapter.
Chapter 2
Description of the Korean Long-Term Care Program

Introduction

The first chapter of this work provided an overview of the long-term care programs around the globe, including Germany, Japan and the United States. The analysis of global long-term care helped us to understand the important trends in global aging and how each government responds to the sharp increase in their older population. This process will allow further understanding of the Korean long-term care initiative that will be discussed later in this study.

Recently, the Korean government announced the Long-Term Care Program in order to meet the needs of the increasing older population. This new plan will start in July 2008 and will deliver a variety of services, including home and community based services and facility based services, for older people who require assistance in daily living. The focus of this chapter is to describe how the Korean government will organize and operate the long-term care program. Since, the long-term care program has not yet commenced the descriptions of the program will be based on the latest proposed bill. This study will use the report of the first pilot test completed in 2006 to compare the service utilization rate with the proposed long-term care program. This chapter will use the same structured framework that is used in the first chapter to examine long-term care programs in Germany, Japan, and the United States.

What is the historical background for implementing a long-term care system?
What are the eligibility criteria to enroll in a long-term care program?
What types of services are provided within a long-term care program?
How is the long-term care program financed?

Before examining the Korean long-term care program, this chapter will provide general information on the Republic of Korea in the following order: location, history, economy, and population. Then it will discuss the social and demographic reasons for implementing the long-term care program in Korea. Finally the increase in medical expenses will be explored, followed by the social change in the role of family caregiving.
General Background Information

Korea is located adjacent to China and Japan and is surrounded by the sea. The total area of Korea, including its 3000 islands, is estimated around 222,154 square kilometers, 45 percent of which belongs to South Korea (Korean Overseas Information Service, 2007). The combined territories of South and North Korea are similar to the size of Britain, with South Korea alone about the size of Hungary.

The history of Korea began in 2333 BC from its origin of the country of Gojoseon, literally meaning the “Land of the Morning Calm” (Korean Overseas Culture and Information Service, 1998) Later, Gojoseon was divided into three kingdoms: Goguryeo, Silla, and Baekje. In 676 AD, Silla united the three Kingdoms until the general Yi Seong-gye established the Joseon Dynasty in 1392. Korea was ruled by a single government and maintained political and cultural independence until 1910 when the Japanese government forced Korea to sign the Japan-Korea annexation. The brutal Japanese occupation continued until 1945. At the end of World War II, Korea was divided into two parts. The northern zone was occupied by the Soviet Union, and the southern zone was occupied by U.S. forces. In 1953, at the end of the Korean War, a new border was fixed and since then Korea has been divided into two countries: Democratic People’s Republic of Korea in the north and Republic of Korea in the south.

From an economic perspective, Korea was once known as one of the world’s poorest agrarian countries. However, since 1962, Korea has undertaken extensive economic development. In less than four decades, Korea has achieved strong economic development, which is known as the “Miracle on the Hangang River.” Korea’s Gross National Income (GNI) jumped from $2.3 billion in 1962, to $786.8 billion in 2005. The GNI per capita also increased from $87 in 1962 to $16,201 in 2005 (Korean Overseas Information Service, 2007).

The Korean population is composed of a highly homogeneous ethnic group, and the total population is around 48 million. The fast population growth was once a serious social problem in Korea, as in most other developing nations; however, due to successful family planning campaigns, the population growth has stabilized in recent years (Korean Overseas Information Service, 2007). A notable trend in the recent population structure is the increase of the older population. Compared to other age groups, the older population group has grown significantly,
bringing awareness of the aging issue as a social problem since the beginning of the 1970’s (Choi, 2000).

**Reasons for Implementing Long-term Care Program**

According to the Korean National Statistical Office (2005), the rate of aging in Korea is estimated to be faster than that of many other countries. For example, it will take only 18 years for the total older population to double from 7% to 14%. Compared to other industrialized countries such as France (115 years), Sweden (85 years) and Japan (24 years), the rate at which the aging population is increasing presents an important rationale for developing a universal long-term care program in Korea.

Since the early 1960s, when the Korean government launched a five-year economic development plan and adopted a family planning program as a national policy and mortality rates have continually declined (Choi, 2000). In addition to the increase in longevity, Korea has also seen a decrease in fertility rate and thus is showing a jump in the proportion of older people in the country.

![Figure 2](image)

*Figure 2*

*Proportion of Korean Population Age 65 and Over, Total and within Gender*

(Korea National Statistical Office, 2002)

As seen in figure 2, in 1980 the older population was only 3.0% of the total population; however, by 2000, it had jumped to 7.2%, indicating that Korea is becoming an aging society
In 2030, the older population is expected to be nearly one-quarter of the total population. Furthermore, the number of those aged 80 and over is expected to increase to about one million by 2010, with this figure doubling by 2020. Following this trend, the older population who require long-term care will jump from 650,000 in 2005, to 1.2 million by 2020 (Hong, 2005). Considering the rapid growth of the “oldest old,” who are both physically and mentally frail, the demand for long-term care is likely to explode in the near future.

Linked to the increase of the older population is a dramatic increase in the percentage of the older population’s medical expenses (National Health Insurance Corporation, 2004). In 1990, the older population’s medical expenses accounted for 8.0% of the total medical expenditures for the country; however, by 2004, that proportion had jumped to 23% (see Table 5). Medical expenses for older people are expected to be near 30% of total expenditures in 2010.

Table 5
Medical Expenses for Korea’s Older Population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical Expenses</td>
<td>2,219</td>
<td>5,977</td>
<td>12,912</td>
<td>22,355</td>
</tr>
<tr>
<td>Medical Expenses for Older Population</td>
<td>239</td>
<td>728</td>
<td>2,255</td>
<td>5,149</td>
</tr>
<tr>
<td>Percentages of Older Population By Total</td>
<td>8.2%</td>
<td>12.2%</td>
<td>17.5%</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

In addition, the sharp increase in medical expenses and the extended period of caregiving for the older population have become a financial, physical, and psychological challenge to both older individuals and their family caregivers. In Korea, due to the Confucian tradition of filial piety and the ideal of family members living together, family has been the core resource for caring for elders. However, the shift from the agricultural society to an industrial economy has brought major changes in traditional norms. The single generation family has increased and the tradition of caring for elders has become more difficult in modern society.

Although many older parents still live with their children, it is becoming increasingly difficult for them to be cared for by family members. According to the Korean Institute of Health and Social Affairs’ survey (2001), the proportions of the older population living alone or in
couples was 16.2% and 22.8% in 1994, and increased to 21.6% and 23.9% in 2001 (see Table 6). In particular, the percentage of elders living with their children is decreasing gradually, although this proportion is higher than many industrialized countries.

Table 6
Compositions of Elder Households, 1994 and 2001 (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Living Alone</th>
<th>Couples Only</th>
<th>Living with Their Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>16.2</td>
<td>22.8</td>
<td>55.9</td>
</tr>
<tr>
<td>2001</td>
<td>21.6</td>
<td>23.9</td>
<td>49.3</td>
</tr>
</tbody>
</table>

(Korean Institute of Health and Social Affairs, 2001)

Another challenge in caring for older parents at home is the increasing number of working women, who had been the primary caregiver in traditional society. More and more women are participating in the labor market, making caring at home more of a challenge (Sunwoo, 2004). Due to these challenges of supporting a frail older population, the Korean government decided to begin a universal long-term care program in 2008.

Korean Long-term Care Program

Historical Background

Despite the rapid increase of the older population and frail elders, the Korean government currently does not have a comprehensive long-term care program. As discussed in chapter two, the great majority of older people who need help with daily living are cared for by family members, with a small portion of elders receiving formal long-term care services (OECD, 2005). The current universal health care systems do provide limited long-term care services; however, since the focus is on acute care, it is not designed for those elders who have chronic conditions. In response to the growing long-term care needs, the government announced in 2004 that the new long-term care program would begin in 2008. Before implementing the long-term care program, the government conducted two pilot tests. The first pilot test started in July 2005 and finished in March 2006; the second pilot test began in April 2006 and will be completed in June 2007.
The history of the Korean long-term care program dates back to the 1950s when the government provided institutional care services for low income older people as part of a public assistance program (Sunwoo, 2004). However, functionally dependent older people with chronic diseases still lived together with healthy older people in people’s homes, not in nursing homes. When the Older Persons Welfare Act was enacted in June 1981, no-charge nursing homes were built for low income older groups who required long-term care. Later, part-charge nursing homes were added in order to protect those in low and middle income groups.

At present, most long-term care facilities are designed to provide services for beneficiaries of the National Basic Livelihood Security Scheme, which is similar to the Supplementary Security Income in the United States (Sunwoo, 2004). While there are several facilities for the middle class population, the costs for nursing homes are often too expensive for them. Following this line, those who need long term care services are estimated to make up about 15% of the total population, while only about 1% of them are able to afford such services (Sunwoo, 2004).

In 2003, the Ministry of Health and Welfare established a Planning Committee to develop a model for a public long-term care system. After two years of preparation, the first long-term care pilot test began in July 2005, and lasted until March 2006. The second pilot test began in April 2006 and is expected to be complete in June 2007. The proposed bill for a long-term care program was passed to the National Assembly, which is similar to Congress in the United States, in February 2006 and is still in the review process. Both the ruling party and the opposition party agree to implement the long-term care program; however, both parties hold different views on the program details, such as eligibility criteria, financing, and management. Such differences delay the passing of the bill. Therefore, the descriptions of the Korean long-term care program in this study are based on the latest proposed bill from the National Welfare Department.

In a theoretical analysis, the Korean long-term care program is closer to the “corporatist” model. Similar to Germany and Japan, the program is administered and financed by the government. It also contains “social democratic” elements in which the services are delivered directly to the elders who require long-term care.
**Purpose**

The Korean long-term care program was developed to:

1. Provide assistance to the elders with long-term care needs and to improve their quality of life.
2. Ease the persistent burden on family members.
3. Shift responsibility for caregiving from the family to the state based on social solidarity.

**Basic Principles**

The basic principles are to:

1. Establish a “consumer directed” long-term care system to enhance elders’ and their family members’ choice.
2. Encourage home and community based care over institutional care.
3. Provide universal coverage for long-term care services.
4. Provide additional medical services to keep elders’ health stable.

**Eligibility**

According to the Korean long term care program, people age 65 and older who need constant care with daily activities, along with age 64 and under with geriatric diseases, such as dementia, for longer than six months are eligible. In addition, eligibility is strictly a matter of age and physical and mental condition; income and family relations are not considered.

**Eligibility Assessment Procedure**

Elders and their primary caregivers may apply for the long-term care program by sending application forms with a medical referral to the National Health Insurance Cooperation (NHIC). If the elder already lives in a facility, the facility director could apply for the long-term care program. A medical referral is not necessary for those who are too severely disabled to visit the doctor.
Once the application is submitted, the NHIC assigns a nurse and a social worker to visit the elder’s home or the facility. If the applicant is in a remote location, the NHIC may request that the local government evaluate the applicant’s conditions. The assessment form contains two categories: ADL assessment and needs assessment. The ADL assessment includes 44 questions categorized by physical conditions, cognitive functions, medical needs, and a rehabilitation assessment. The computer program then analyzes the data by calculating the length of time per day that the elder requires long-term care services. The applicant’s assessment results and the medical referral are then forwarded to the local evaluation committee, where the final eligibility is decided. The evaluation committee members include nurses, doctors, and others who work in the medical field, along with social workers, a NIHC representative, and at least one person that either the mayor or the governor recommends. Overall, the committee will have an average of 15 members and the process must take no more than 30 days from the day the application is submitted.

Following the review process, The NHIC will then inform the applicant of the eligibility decision. Once accepted into the program, the applicant’s eligibility level is classified into three categories from level one to level three based on individuals’ conditions and the amount of time the services are needed. Level one is for elders with very severe conditions who require long-term care services for more than 90 minutes per day. Elders in level two have severe conditions and require 70 to 90 minutes of long-term care per day. Those in level three have moderate conditions and require 50 to 70 minutes of services per day (see Table 7).
Table 7
Korean Long-term Care Eligibility Levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Daily Required Service Time</th>
<th>Condition</th>
</tr>
</thead>
</table>
| Level 1     | More than 90 minutes       | - Immobile/bed-ridden.  
- Needs full assistance with eating, clothing, bathing, and other daily activities.  
- Severe dementia |
| Level 2     | Between 70 to 90 minutes   | - Assisted mobility.  
- Needs partial assistance with eating, clothing, bathing and other daily activities.  
- Early dementia. |
| Level 3     | Between 50 to 70 minutes   | - Needs partial assistance with eating, clothing, bathing and other daily activities.  
- Needs assistance in housekeeping and other activities outside the home. |

(National Health Insurance Cooperation, 2006)

After deciding the eligibility level, the applicant receives a handbook that explains the eligibility level and describes the long-term care services a person can receive. The NHIC also sends the “care plan” that is based on the applicant’s eligibility level and needs. The “Care plan” includes a description of the long-term care services and prices. The “care plan” is not mandatory; thus, a person can either accept the plan or choose other services within the content of their eligibility level.

In the first pilot test, the total percentage of elders who were eligible for the long-term care program was 6.7%, with 1.3% in level one, 1.8% in level two, and 3.6% in level three. Since the first pilot services were limited to elders of low income, the eligibility rate is higher than the national model. According to the first long-term care pilot test report (2006), on average, low income elders have worse health conditions than the middle and upper income groups, increasing the pilot test’s eligibility rate (see Table 8).
Table 8
Utilization Rates in Pilot Long-Term Care Program

<table>
<thead>
<tr>
<th>Level</th>
<th>First Pilot Test</th>
<th>National Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>1.3%</td>
<td>0.6 %</td>
</tr>
<tr>
<td>Level 2</td>
<td>1.8%</td>
<td>0.7 %</td>
</tr>
<tr>
<td>Level 3</td>
<td>3.6 %</td>
<td>1.9 %</td>
</tr>
<tr>
<td>Total</td>
<td>6.7%</td>
<td>3.2 %</td>
</tr>
</tbody>
</table>

(Sunwoo, 2006)

If an applicant does not agree with the eligibility result, the individual can file an appeal to the long-term care review committee within 90 days of receiving the results (Ministry of Health and Welfare, 2006). In the first pilot test, the total number of appeals was 59, or 1.6% of the total number of cases evaluated (Korean Institute of Health and Social Affairs and the Ministry of Health and Welfare, 2006). This rate is significantly lower than the appeal rate in Germany (6.7%). However, since the first pilot test was conducted using only the National Basic Livelihood Security beneficiaries, the participants received free services. As a result, they had less self-esteem as consumers in comparison to elders in general. This resulted in the lowered claim rates.

Benefits

The basic principle of the long-term care program is to deliver services based on the elders’ and family members’ needs and choices, in addition to the physical and psychological conditions of the individuals (Ministry of Health and Welfare, 2006). A good program should also include preventative care services by combining medical care with long-term care services.

The Korean long-term care program has two categories of service: home and community-based services and facility based services. For those interested in home care services a cash allowance is available under certain circumstances. Formal home and community-based services are the preferred care option.
Home and Community-based Services

a. Home-visiting/Care Service: This service includes bathing, toileting, and housekeeping.
b. Bathing Service: Service provider will visit elders’ home with equipment for bathing.
c. Visiting Nurse Service: Based on the doctor’s diagnosis, a nurse will visit the elder’s home and deliver medical services.
d. Daycare Service: This service provides daycare for elders, and while visiting the daycare center, elders receive rehabilitation services and more.
e. Short-Stay Service: Elders can live in the facility for a certain period; detailed amount of time has not yet been confirmed.
f. Rental Service for Care Equipment

Cash Allowance

a. Family Cash Allowance: Government will provide cash allowance to the family caregivers if the elder live in a remote location where formal service is difficult to reach. In addition, cash allowance will be provided if the local service provider is unable to deliver services due to a natural calamity. Furthermore, if the elder receives caregiving from family members based on a presidential decree of certain physical, or psychological conditions, long-term care programs offer cash allowance to the family caregiver.
b. Exemption Care Allowance: If an elder resides in a facility that is not part of the long-term care services, such as welfare facilities for disabled people, the government covers a portion of the service cost. The detailed coverage has not yet been confirmed.
c. Geriatric Hospital Allowance: If an elder enters a geriatric hospital, the government will cover a proportion of the total cost during the hospitalization based on the presidential degree.

Facility Based Service

Facility based services include skilled nursing facility and a group home. Similar to Japan’s group home service, it is a small unit house for elders with disabilities.
Depending on the size of a home, a group of elders live together and the home care services are delivered to them from local providers. Geriatric hospital services are excluded in the facility based service.

The first long-term care pilot test showed that elders prefer home and community-based service over facility based service (Sunwoo, 2006). Of the total 2,253 people who participated in the pilot test, 1,460 elders, (65%) of the total population received home and community-based service, while 753 elders (35.2%) of the population, received facility based services.

Within the home and community-based service, home visiting/care service utilization was higher than other services (Sunwoo, 2006). According to the first pilot test report, home visiting/care service utilization was the highest, accounting for 55.8% of the services received, followed by the combined home visiting/care service and visiting nurse service, which account for 32.9% of total utilization. Daycare services were 5.4%, and visiting nurse services alone was 4.7% of the total, and short-stay services utilization accounted for 1.2%.

**Financing**

The Korean long-term care program is funded through insurance, general revenue and a minimal contribution from the individual (Ministry of Health and Welfare, 2006). Half of the long-term care budget is funded by social insurance premiums. The premium is based on the individual’s income, and the insurance fee is linked to the cost of health insurance. Although the long-term care insurance payroll tax is combined with health insurance, the account will be managed separately. The remaining funds come from general revenues, which cover 30% of the total cost, and individuals, who pay 20% out of pocket. Individuals who receive the National Basic Livelihood Security benefit are exempted from the co-payment requirement. Older people in the low income group have a reduced co-payment rate of 10%.

The insurance premium rate has not been fixed; however, according to the Ministry of Health and Welfare report (2006), it is expected to be 3-4% in 2008 for first two years, and then will be raised to 5-6% in 2010. For instance, if a person pays roughly $60.00 a month for health insurance, the long-term care insurance will be about $2.10 in 2008, which will be raised to around $3.20 in 2010 (Ministry of Health and Welfare, 2006).
Conclusion

This chapter has provided an overview of Korea and the complex issues facing the aging population along with the description of the proposed long-term care program. It has emphasized that there has been a sharp increase in the aging population since the 1960’s, and it is expected to continue. The financial challenges as a result of increases in medical costs and nursing home costs also put pressure on both individuals and family members. Furthermore, the shift toward a modern society has influenced the traditional norms of filial piety. Due to the increase of elders living alone or in couples, and the growth of women in the labor force, it is becoming more difficult for family members to provide care at home. Fueled by the increase of the “oldest old” population, the growth in the proportion of the aging population is putting pressure on the government to assist with caring for elders. In response to these challenges, the Korean government has decided to launch a new long-term care program that will start in 2008.

The history of long-term care dates back to the 1950s when the Korean government first started to provide institutional care for low income older people. In 1981, based on the Older Persons Welfare Act, no-charge nursing homes were built to support low income older people who required long-term care. As the older population increased, part-charge and private nursing homes were added to serve middle and upper income groups. While individuals and their families with sufficient resources could afford nursing homes, most elders cannot. For these reasons, in 2003, the Planning Committee developed a model for a public long-term care system. After several years of preparation, the new long-term care program is waiting for the National Assembly to pass the bill to begin the program in 2008. This program is based on the “corporatist” model as well as some of the elements from “social democratic” model.

The eligibility of the program is anyone ages over 65 and those under 64 with certain geriatric disease. Eligibility is strictly a matter of age, physical and mental conditions, income and family relations are not considered. The benefit is divided by home and community based services and institutional services. The program is funded through insurance, general revenue and an individual co-payment.

The next chapter will describe the research method that will be used to analyze Korea’s long-term care program.
Chapter 3
Research Methods

Introduction

The goal of this work is to analyze the key elements of the Korean long-term care program. These findings are intended to answer how well the Korean long-term care program will meet the needs of an aging population. To address this question, this study will examine the proposed long-term care program in context of the two secondary data sets. The main data source for this study includes the “First Long-term Care Pilot Test” conducted in 2006. The main purpose of this pilot test survey was to simulate the instruments and the systems of the long-term care program before it comes into effect in 2008. This survey will help us to understand how the long-term care services were delivered and the service preferences of elders during the pilot test. Furthermore, this study will compare the proposed long-term care program with the “Needs Assessment of Korean Elders” report from 2004, in order to critically assess the quality of the program. Since raw data from the pilot test and the needs assessment were not publicly available, published reports were utilized for the analysis. Finally, the study will use cross-national comparisons to further analyze the goals and implementation of the Korean program.

First Long-term Care Pilot Test

Purpose

The purpose of the first long-term care pilot test was to simulate the assessment instruments and the service delivery systems of the long-term care program (Sunwoo, 2006). Furthermore, the first pilot test was designed to help develop eligibility criteria, care management guidelines and payment options before the long-term care program came into effect in 2008. In addition, the pilot test was conducted to publicize the long-term care program. The findings from the first pilot test will be used to develop a second pilot test, which will test the acceptability of the tools that are developed based on the results of the first pilot test with a larger sample.
Method

The first pilot test was performed from July 2005 to March 2006 by the Korean Institute of Health and Social Affairs and the Ministry of Health and Welfare. The sites for the first pilot test for the long-term care program were selected based on the capacity of the infrastructure for delivering long-term care. In order to have a representative national sample, the pilot test covered predominantly urban, predominantly rural, and the mix of both urban and rural areas. The selected areas included: Gwangju, Gangneung, Suwon, An-dong, Buyeo, and Jeju (Sunwoo, 2006).

The first pilot test participants were limited to a population age 65 and older in low income groups, who received the National Basic Livelihood Security Scheme benefit, which is similar to the Supplementary Security Income in the United States. The second survey that will be conducted from April 2006 to June 2007 will expand the sample size to elders in general, including middle and upper income groups.

The total number of participants who applied for the pilot was 12,414 and the number of people who received long-term care was 2,253. Once the application was submitted a team of a social worker and nurse visited the elder’s home or facility and conducted the needs assessment. The assessment questionnaire included an assessment of ADL, a cognitive assessment, a medical assessment, and a rehabilitation assessment (Sunwoo, 2006). The assessment result was then forwarded to the evaluation committee, where the final eligibility decision was made. Those who were eligible were then divided into five levels based on an individual’s conditions and the amount of time the services were needed. Unlike the proposed long-term care program, which delivers services to Level one (very severe) and Level two (severe) groups, pilot test services were provided to all five levels. Participants received either home and community based services or facility based services. Home and community based services include: home-visiting/ care services, visiting nurse service, day-care and short-stay service.
Needs Assessment of Korean Elders

Purpose

The purpose of the needs assessment of Korean elders was to provide a better understanding of elders and to collect data for developing a long-term care program (Hong et. al, 2005). The survey was designed by the Korean Institute of Gerontology to provide a needs assessment of the Korean older population. The first survey focused on elders in general and the second survey was completed on those who need long-term care services based on the first sample survey data.

Method

The first survey was conducted in May 2005 and the follow up survey was completed in June 2005 (Hong et. al, 2005). Respondents for the needs assessment survey were selected in order to have a representative national sample. The survey covered predominantly urban, predominantly rural, and a mix of both urban and rural areas. The selected areas include: Seoul, Cheongju and Gokseong. The sample was pulled from the Elder Honor Program participants list, which provides elders aged 65 and older, discounts on public transportation, discounted admission to public facilities such as parks and museums, along with limited monetary supplies for transportation (Choi, 2000). The survey was originally intended to have a sample of 3,000 per region; however the total number of people who participated in the survey was 5,281. The numbers of completed interviews were: Seoul 1,401, Cheongju 1,869 and Gokseong 2,011. The questionnaires include economic conditions, health conditions, and opinions on long-term care program. Both elders in general and those who require long-term care received the same survey, except that caregiving items were added to those with a disability.

Theoretical Analysis

In order to provide a critical analysis of the Korean long-term care program, this study will use the same theoretical framework that was used in the previous chapters. This analysis will be based on Esping-Andersen’s (1990) three welfare regimes: liberal, corporatist, and social
democratic, and will use comparative information from three other countries to review the Korean system.

In the next chapter, a critique of the proposed Korean long-term care program will be discussed. The first long-term care pilot test report and the needs assessment report will be analyzed to discuss whether the proposed program will be able to serve the needs of elders. The next chapter will also provide recommendations for program reform.
Chapter 4
Critical Analysis and Recommendations

Introduction

The proposed Korean long-term care program is in the final planning stage and will start in 2008. The objective of this program is to help older people live in the setting of their choice, as well as to maintain their dignity and independence throughout the aging process (Hong et. al, 2005). The goals of the program range from the enhancement of the life quality of elders and their family caregivers at the micro level, to a reinvigoration of the local economy at the macro level. At the individual level, the long-term care program is designed to stabilize the increase in long-term care costs and to reduce the family burden of caring for elders. Following this line, according to Kumamoto and colleagues (2006), the Japanese long-term care program effectively reduced stress among family caregivers. Furthermore, the Korean program will function as a safety-net for individuals. The professionally planned care and nursing services within the Korean program are expected to enhance the quality of life of disabled elders. At the macro level, the long-term care program will generate various jobs, including case managers, nurses, and personal aids and more. These labor opportunities are expected to increase employment opportunities, especially for women, thus creating more than one-hundred thousand jobs by the year 2013 (Hong et. al, 2005). In addition, the proposed long-term care program is designed to build infrastructure, such as nursing homes and local service agencies, which will help to revitalize the local economy.

Despite the positive effects of the proposed long-term care program, it faces several obstacles. This chapter will critique the proposed long-term care program and will provide recommendations for program reform. In the following of critical analysis and recommendations it will focus on two levels, one is the theoretical level in which discusses the ideological model of the program, and the other is the specific aspects of the program implementation.
Critical Analysis and Recommendations

Eligibility

Considering the high number of older population who will likely require assistance in daily living, the estimated number of long-term care beneficiaries seems very limited. Currently, about 720,000 elders, comprising 14.8% of the total older population, need long-term care (Hong, 2005). However, in the proposed long-term care program 1.7% of all elders are eligible to participate in 2008, and even when the government expands the eligibility in 2010 the number of eligible elders is limited to 3.2% of the total older population (Sunwoo et. al, 2006). In addition, according to the needs assessment survey (2004), among those elders who require long-term care, only 22% answered that they are independent in IADL tasks, while the majority of elders reported that they need assistance. These data raise questions about whether the proposed program will be effective, since such a small portion of elders are eligible to participate. This limited number of older people to be served raises questions since the public will be paying a high amount for the long-term care program while only a small portion of them will receive the actual long-term care benefits.

Based on Esping-Andersen’s (1990) welfare regimes, the long-term care program seems to follow the “corporatist” model as the government plays a more active role in providing care. Furthermore, the funding of the program is also similar to the “corporatist” model where the state shares more responsibility for providing care than in the “liberal” model, where individuals and the market are the key components in welfare services. The Korean long-term care program also provides services not only to low income individuals, but also to elders in general, including middle and high income groups, which is the main characteristic of “social democratic” model. However, due to the complicated eligibility criteria and the modest number of service beneficiaries of the program, it seems that practically speaking; the program is closer to the United States’ classified as the “liberal” model. Since the program has not yet started, the government should consider expanding the eligibility criteria to cover those who require long-term care, but have been excluded from the current proposal.

Second, local variations in program implementation could result in challenges about the objectivity of the program. For example, in the first long-term care pilot test (2006), Gwangju, which is considered predominantly urban, had a total of 25.9% of elders in level 1-2, compared
to Suwon, also a predominantly urban region, which had only 1.8%. Moreover, Gangneung, which is a predominantly rural area, had no one in level 1-2, while Buyeo also a predominantly urban region had 15.3% (see Table 9). The difference in the proportion of elders in each level indicates an implementation problem. This raises questions about the reliability and validity of the assessment measure and process (Jung, 2006).

<table>
<thead>
<tr>
<th></th>
<th>Gwangju</th>
<th>Suwon</th>
<th>Gangneung</th>
<th>Buyeo</th>
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<td>Level 1</td>
<td>18.5%</td>
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<td>Level 2</td>
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<td>0%</td>
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</tr>
<tr>
<td>Total</td>
<td>25.9%</td>
<td>1.8%</td>
<td>0%</td>
<td>15.3%</td>
</tr>
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</table>

(Sunwoo, 2006)

Japan, where the long-term program began in 2000, had a similar challenge in their initial implementation phase (Tsutsui & Muramatsu, 2005). In the Japanese long-term care program, powerful local leaders were able to raise applicants’ care-need levels in the past. Tsutsui and Muramatsu argue that such behaviors challenge the principle of objectivity and fairness of the overall program. To solve this problem, the Japanese Ministry of Health, Labor, and Welfare (MHLW) used a centralized computer system to identify individuals with high rates of disagreement between their initial and final assessment for further investigation. Learning from Japan, the Korean government should develop more objective tools to evaluate the applicant’s condition.

Third, the government must state the role of “case managers” in the long-term care program. The current program proposal does not mention the word “case manager” instead; it states that NHIC will assign a nurse and a social worker to evaluate the applicants’ conditions. Because the “care manager” plays an active role in other countries long-term care program in a purpose to make sure that consumers do not lack knowledge of local services, as well as to meet the variety of needs of elders, the Korean government should input the role of “care managers” in the bill.
Furthermore, the government should clarify the role of “home health aides” in the long-term program. The reputation of the home health aide remains fairly low in Korean society; therefore, the government should develop a better name for the home health aide, as well as, documenting the important role that these workers have in developing a high quality service.

**Benefits**

Once the long-term care program is launched in 2008, it will provide long-term care services to older people with disabilities and it is expected to raise the quality of life for both elders and caregivers. A recent study showed that the use of home and community based services under the Japanese long-term care insurance program effectively reduced feelings of burden to both disabled elders and their primary family caregivers (Kumamoto et. al, 2006). Thus, the proposed long-term care program is expected to result in positive outcomes, although questions remain about design and implementation.

First, the essential debate revolves around whether to provide cash allowances to the primary caregiver. There are various approaches to this issue across nations providing long-term care services. For instance, Germany includes cash allowances as an option to support primary caregivers who are unable to continue work due to caring, while the Japanese program excludes cash allowances. In Korea, the proposal states that the government will provide cash allowances, but only if the beneficiaries live in a remote place where formal service is difficult to reach. The cash benefit may reduce the financial cost of the program if the government provides 50% of the vendor service cost. A cash allowance can maximize consumer choice and reward the contribution of family caregivers, and can improve the quality of workers (Campbell & Ikegami, 2003). Furthermore, cash benefits can raise the standard of living for the entire family, particularly for low-income households (Ikegami & Campbell, 2002). In addition, according to Kunkel and Nelson (2006), the relationship between consumers and workers improved, and the majority of family workers said that it helped them be better caregivers.

On the other hand, a major drawback to the cash allowances is that the cash payments would be absorbed into family budgets with little real improvement in the situation of the older person and the family caregivers (Ikegami & Campbell, 2002). Accordingly, it is difficult for the government to track the quality of services provided by family caregivers. In response to this
problem, the Korean government limited the cash option to those who live in places where formal services are hard to reach. However, considering the fact that the proportion of elders living alone is higher in rural areas than urban, the effectiveness of the program remains in question. In this sense, cash allowances may improve the family relationships, but would neither relieve the actual burden of caregiving nor ensure high-quality care for elders (Ikegami & Campbell, 2002).

Cash allowance option is close to the “corporatist” model where family plays an important role in welfare program. Moreover, due to this reason that family, especially woman, may still be the primary caregiver despite the cash option it shows similarities with “corporatist” model. The Korean government’s basic stance in cash allowance is that it will provide this option only if the formal service is difficult to reach and will try to reduce this circumstances. In this sense, the Korean government follows the “social democratic” model, as the state plays a key role in providing welfare services over family, allowing women to participate in the labor market.

Second, in order to manage the program successfully, the government needs to develop a sound infrastructure. The Korean government is now trying to move away from traditional institutional care by promoting home and community based services. However, despite the effort to expand in-home services, according to the needs assessment (2004) data, 45.4% of elders preferred facility based care, while 44.2% preferred to receive in-home services for long-term care. The same question was asked to those elders who require long-term care and 48.5% answered they would choose institutional care over in-home services. This data indicates that the government should be prepared to provide various options to those in need of long-term care. Japan also faced the sharp increase of elders using facility based care after implementing the long-term care program (Shirasawa, 2004).

In Japan, there are long waiting lists of people who are seeking institutional care and in fact, the list is getting longer (Shirasawa, 2004). Shirasawa analyzed the cost structure and found that in-home service users often paid more than the institutional care receivers. For example, the in-home service beneficiaries must pay utilities, such as electricity and water, but facility recipients don’t. Furthermore, those living in the community setting will have more out-of-pocket expenses which may be increased by their care needs, indicating that there are still some incentives to institutional care over in-home services. To prevent the long waiting lists in the institutional care, the Korean government developed a plan in 2002 to fulfill the increasing
demands of institutional care (Hong, 2005). According to this plan, the government will build 100 institutional facilities and 50 home and community based facilities each year to match the demand by 2011.

Third, the government should enhance the consumer direction within the program. The proposed plan states that NHIC will send the “care plan” to the individuals who have been accepted to the program and indicate which services are available based upon the applicant’s eligibility level and needs. This procedure suggests that the program is emphasizing bureaucratic efficiency over the needs of the consumers due to the lack of consumer involvement in deciding the care plan. Furthermore, because the cash allowance that is utilized by several states in the United States to maximize the consumer choices is strictly limited in Korea, elders have a modest role in choosing the long-term care services. Despite the efforts of the Korean government to input the consumer direction in the program, the elders still play an inactive role in deciding which service to use. It would be beneficial for the elders to have more say in the long-term care services they are provided.

Lastly, the government should develop a system to ensure that services are delivered to the low income people. It may be more difficult for low income Koreans to gain access to the long-term care system. The majority of the benefits may be distributed to middle and upper class elders who have more access to information compared to those disabled elders in low income group. This oftentimes will mean that low income groups get excluded from participating in the program. The available long-term care report is limited to the first pilot test, which only included low income elders. This makes it difficult to compare the utilization rate among different income groups. However, since the long-term care program is available to disabled elders in general, the government should track their use of services. For this, the government should have a database of low-income elders before implementing the program, along with plans to publicize the program in order to prevent any person from being excluded from the program as a result of a lack of knowledge (Khoun, 2005).

Financing

In the proposed long-term care program, the individual co-payment is stated 20% of the total cost. This proportion appears to be too high considering the fact that individuals are already
responsible for food and extensive service cost. In Japan, the co-payment is 10%, thus, still this amount had made low income elders difficult to participate in the program. In this sense, the assumption that a 20% co-payment is needed in the Korean program will act as a barrier for individuals in utilizing the services. In response to this problem, the Korean government has proposed exemption of co-payment for low income individuals and suggests various co-payment rates depending on an individual’s ability to pay. Some critics have argued that, individual out-of-pocket costs are necessary to prevent excessive utilization and to provide a sense of responsibility to service beneficiaries. However, since the amount of the service benefit is already fixed based on one’s disability level, one cannot overuse the benefit, thus, the previous debate is irrational. Therefore, in order to provide long-term care services to elders in general, a reduction in the co-payment is important.

Conclusion

In hopes of increasing the quality of life of the disabled older population and to provide a safety net for health care costs, the new Korean long-term care program will be implemented in year 2008. The goals of the program include an enhancement of the life quality of individuals and once the program has been implemented successfully, it expects the reinvigoration of the local economy. However, despite the positive outcomes of the proposed program, several questions remain. Concerning eligibility, the proportion of the older population that will be eligible is small compared to the vast majority of elders who require long-term care. To create a universal program, the government should strongly consider broadening the eligibility criteria. Second, the government should develop an objective measure and process to evaluate the applicant’s conditions. Third, the government should also state the role of “case manager” in the long-term care program.

The issue of whether to provide a cash allowance to the primary caregiver is a challenging one. The proposal states that Korean government will only provide cash allowance if the beneficiary lives in a remote place where formal services are unavailable. However, the outcome of the cash option is still being debated. Second, the government should make sure to develop an infrastructure in order to successfully operate the program. Third, the government
must emphasize the consumer direction within the program. Lastly, the government should
develop a system to ensure that services are delivered to the low income people.

This study has used comparative data from three other countries and Esping-Andersen’s
(1990) three welfare regimes to critically analyze the long-term care program. It looked at
various elements of the program in a context of these welfare models. Contrary to the theoretical
typologies, the real world has hybrid models. For example, the overall picture of the Korean
long-term care program follows the “corporatist” model which the government plays an active
role of sharing both responsibility and financing of caring for elders. However, due to its limited
number of actual program participants, it contains similarities with the “liberal” model.

Korea today is a demographically young country; however by 2050 it may become the
oldest nation around the globe (Howe et.al, 2007). The nation will experience a dramatic
increase in the number of older people with disability creating enormous long-term care
challenges. The Korean long-term care plan is a significant attempt by the government to
address these issues and to create a system to share the responsibility with the individuals in
society. It is important for the government to examine these recommendations prior to
implementation, in order to create a sustainable and viable program.
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