Long-term Care Insurance in South Korea

Help Age meeting in Hangzhou
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I. Key Features of LTC Insurance (LTCI)

1. Structure

Public insurance for long-term care (LTC), separate from health insurance
- Higher willingness to pay for a separate LTCI?
- **Same insurer for HC and LTC** with **different funds**:
  Save administrative cost
  -> NHIS (National Health Insurance Service) manages both Health insurance and LTC insurance
- Coordination problem between health care and LT care?

Little role of **local governments**:
Problem of coordination between long-term care and (community) welfare services for older people

2. Population Coverage

The insured of the LTCI is the same as those of NHI
 a. **Long-term care** for the elderly (+65), and
 b. **Age-related long-term care** of the younger (<65 years)
   -> Mix of German and Japanese model

Younger population pay contribution for LTCI, but their eligibility for LTCI benefits is limited: **inter-generational cross subsidy**
-> Political acceptability/sustainability in the long run?

Number of beneficiaries as % of those +65: 8.4% (2018) -> 9.6% (2019) -> 10.1% (2020) -> 10.2% (2022) -> 10.8% (2024)

Lower than < 20% (Germany), 18% (Japan)

3. Assessment

Need assessment of **physical and cognitive functioning/disability** to be eligible for LTCI
- difference between health insurance and LTCI

Visiting team from NHIS branch offices

Annual assessment

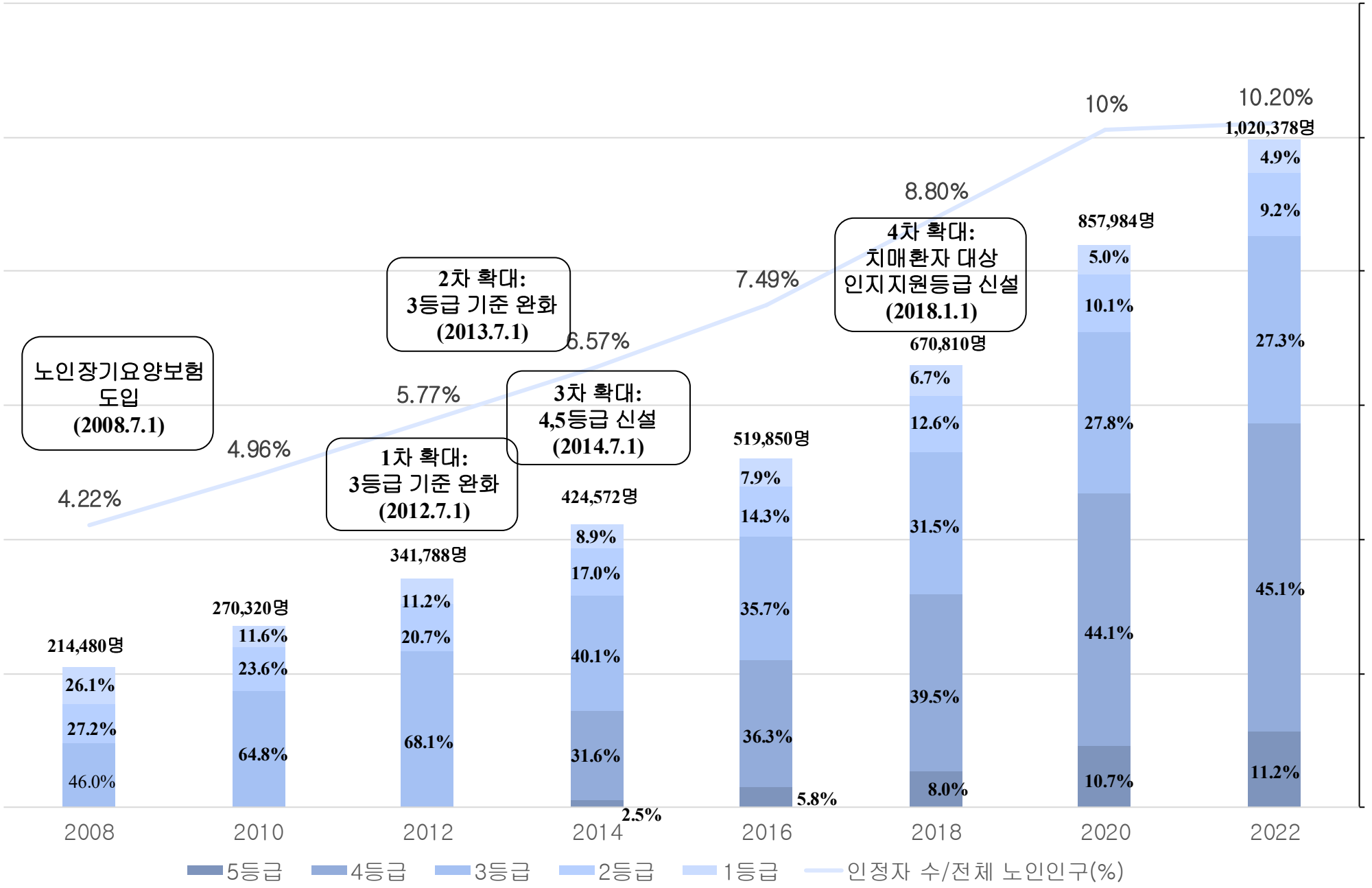
Assessment committee in the regional offices of National Health Insurance Service:
less than 15 members, including social worker and medical doctor (or traditional medical doctor)

Assessment

Eligibility is determined by **needs certification** using a standardized 52-item functional assessment tool

- Originally a 3-level system and expanded to a **five-level** system from Level 1 (completely dependent) to Level 4 (moderately dependent) followed by Level 5 (a special level for people with dementia with a lighter physical dependency) in 2014

- In 2018, another special level (Level 6), called the "cognition support" level, was introduced, for people with dementia



Source: Long term care insurance statistical yearbook 2008~2022.

Distribution of LTC Grades/Levels

(Unit: thousand persons, %)

	2008	2010	2012	2014	2016	2018	2020	2022	2024
Grade I	57 (26.8)	31 (11.6)	38 (11.2)	38 (8.9)	41 (7.9)	45 (6.7)	43 (5.0)	50 (4.9)	55 (4.7)
Grade II	58 (27.2)	64 (23.6)	71 (20.7)	72 (17.0)	74 (14.3)	85 (12.6)	87 (10.1)	94 (9.2)	99 (8.5)
Grade III	99 (46.0)	175 (64.8)	233 (68.1)	170 (40.1)	186 (35.7)	211 (31.5)	238 (27.8)	279 (27.4)	311 (26.7)
Grade IV	-	-	-	134 (31.6)	189 (36.3)	265 (39.5)	378 (44.2)	459 (45)	536 (46.0)
Grade V	-	-	-	10 (2.5)	30 (5.8)	54 (8.0)	92 (10.7)	114 (11.2)	135 (11.6)
Grade for cognitive support	-	-	-	-	-	11(1.7)	19(2.2)	23(2.3)	28(2.4)
Total	214 (100)	270 (100)	342 (100)	425 (100)	520 (100)	671 (100)	857 (100)	1,019 (100)	1,165 (100)

Source: NHiS

4. Contribution and Funding

Contribution rate:

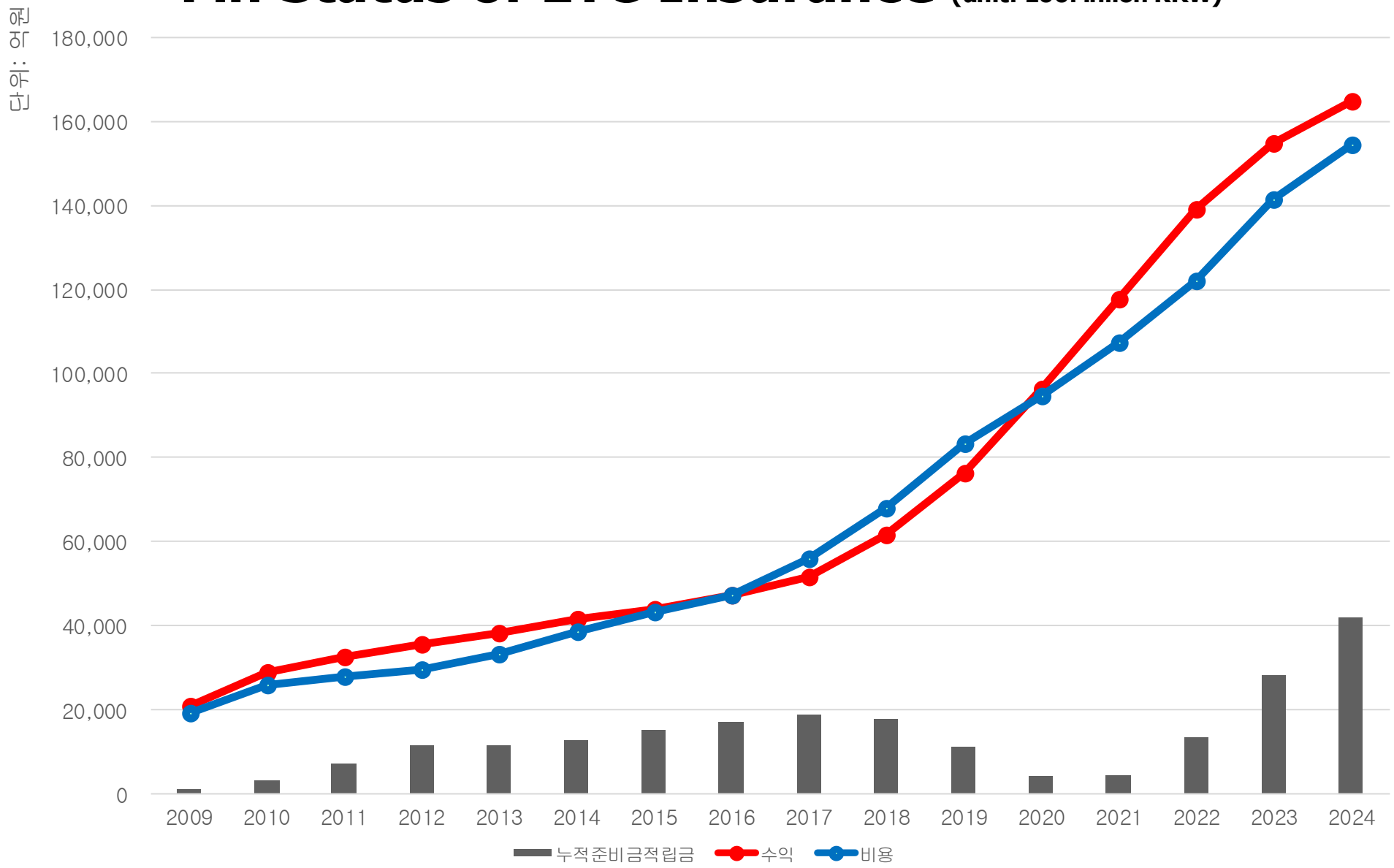
4.05% of health insurance contribution (2008)
-> 4.78% (2009) -> 6.55% (**2010-17**) -> 7.38% (2018)
-> 8.51% (2019) -> 10.25% (2020) -> 11.52% (2021)
-> 12.27% (2022) -> 12.81% (2023) -> 12.95% (2024)

Financing mix

- Contribution: 60-65%
- Government subsidy: 20%
- Copayment: 20% (LTC institutions), 15% (home-based care provided by LTC providers) -> exemption or discount for the poor

Meals, private rooms in LTC institutions are not covered

Fin Status of LTC Insurance (unit: 100Million KRW)



원출처: 국민건강보험공단. 장기요양보험통계연보.

자료출처: 통계청(KOSIS). 노인장기요양보험통계. https://kosis.kr/statHtml/statHtml.do?orgId=350&tblId=DT_35006_N023&conn_path=I3 (접근일: 2026.05.17.)

LTCI Expenditure by Service Types

(Unit: billion Korean won, %)

	2012	2014	2016	2018	2020	2022	2024
Total LTCI Expenditure (Unit: billion Korean won, %)	2718	3498	4418	6299	8882	11444	14767
	(100%)	**(100%)**	**(100%)**	**(100%)**	**(100%)**	**(100%)**	**(100%)**
Institutional care	**(51.1%)**	**(52.1%)**	**(50.7%)**	**(45.5%)**	**(41.1%)**	**(38%)**	**(37%)**
Home-based care	**(48.9%)**	**(47.9%)**	**(49.3%)**	**(54.5%)**	**(58.9%)**	**(62%)**	**(63%)**
Within home-based care (%)							
Home-visit care	80.6	78.3	73.8	70.9	68.6	67.8	66.9
Home-visit bathing	5.3	4.2	3.5	2.9	2.6	2.7	3.1
Home-visit nursing	0.5	0.5	0.4	0.5	0.5	0.5	0.6
Day and night care	7.2	10.4	16.6	21.4	24.3	25.1	28.9
Short-term care	0.7	1.0	0.6	0.4	0.2	0.1	0.1
Welfare equipment	5.7	5.6	5.2	3.8	3.8	3.8	5.9

Source: 노인장기요양보험 통계연보(2024)

5. Type of Benefits

Service benefit (provided by certified long-term care providers) in principle, cash benefit in exceptional cases (e.g., when no service providers in the district)

Payment to LTC providers

- pay per hour: visiting care, visiting nursing
- pay per visit: visiting bath
- pay per day: institutional care, day/evening care

Ceiling on benefit coverage for non-institutional care: depending on the levels of functional status

6. Governance of Policy Making of LTCI: National LTC Committee

Major decisions on contribution, benefits, payment, etc.

Tripartite committee: representatives of
payers, providers, and public interest

- Total number of members: 22 (7+7+7+1), including the Vice Minister of Health and Welfare as the Chair
- One of expert group members is the vice chair of the committee and also the chair of the subcommittee on technical discussions
- Public interest consists of MoHW, MoF, NHIS, 4 experts

II. Challenges for LTC Insurance

1. Key Challenges

Population coverage adequate?: financial protection for older people and family vs. financial sustainability of LTCI

Benefit packages need to be diversified, tailored, and better coordinated for person-centered LTC delivery

Health care services, provided by professional workforce, such as registered nurses, need to be strengthened

Over-supply of providers: Private provision and severe competition

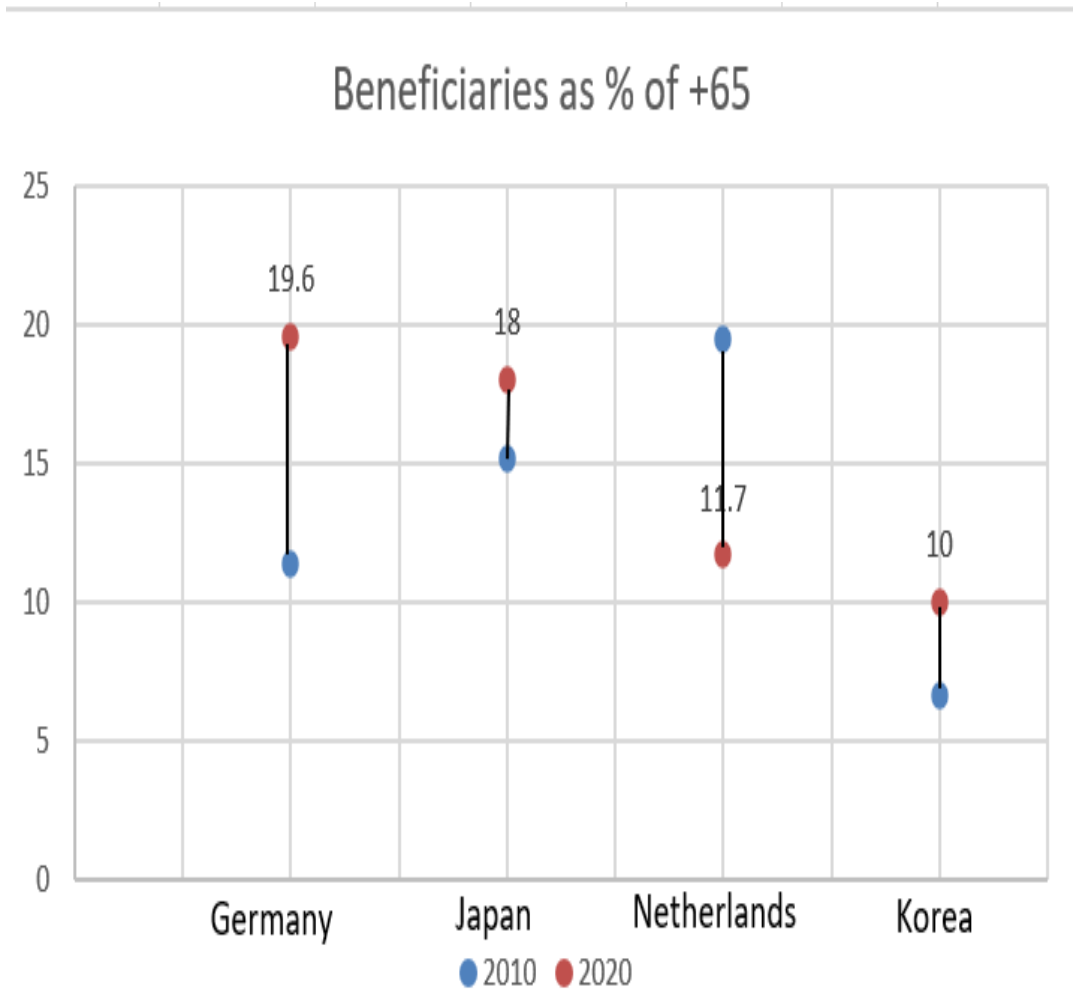
Care workers: High turnover and low pay, Import of workers is opposed by labor union

Comparative Needs Assessment and Eligibility

- Germany: 19.6%
- Japan: 18%
- Netherlands: 11.7%
- Korea: 10%

-> stage of population ageing, stringency of population coverage

(source: Morikawa, 2014; Okamoto, 2022; OECD, 2021;OECD, 2022)



LTC Providers

Institutions (number)	2008	2010	2012	2014	2016	2018	2022
a. HCBS (Home- and Community-based Service)	6,618	11,228	10,730	11,672	14,211	15,970	18,272
b. Facility	1,700	3,751	4,326	4,871	5,187	5,320	6,150
b-1. Aged Care Facility	1,379	2,408	2,588	2,714	3,137	3,389	4,372
b-2. Senior Congregate Housing	321	1,343	1,739	2,157	2,050	1,931	1,778

2. Coordination of NHI and LTCI

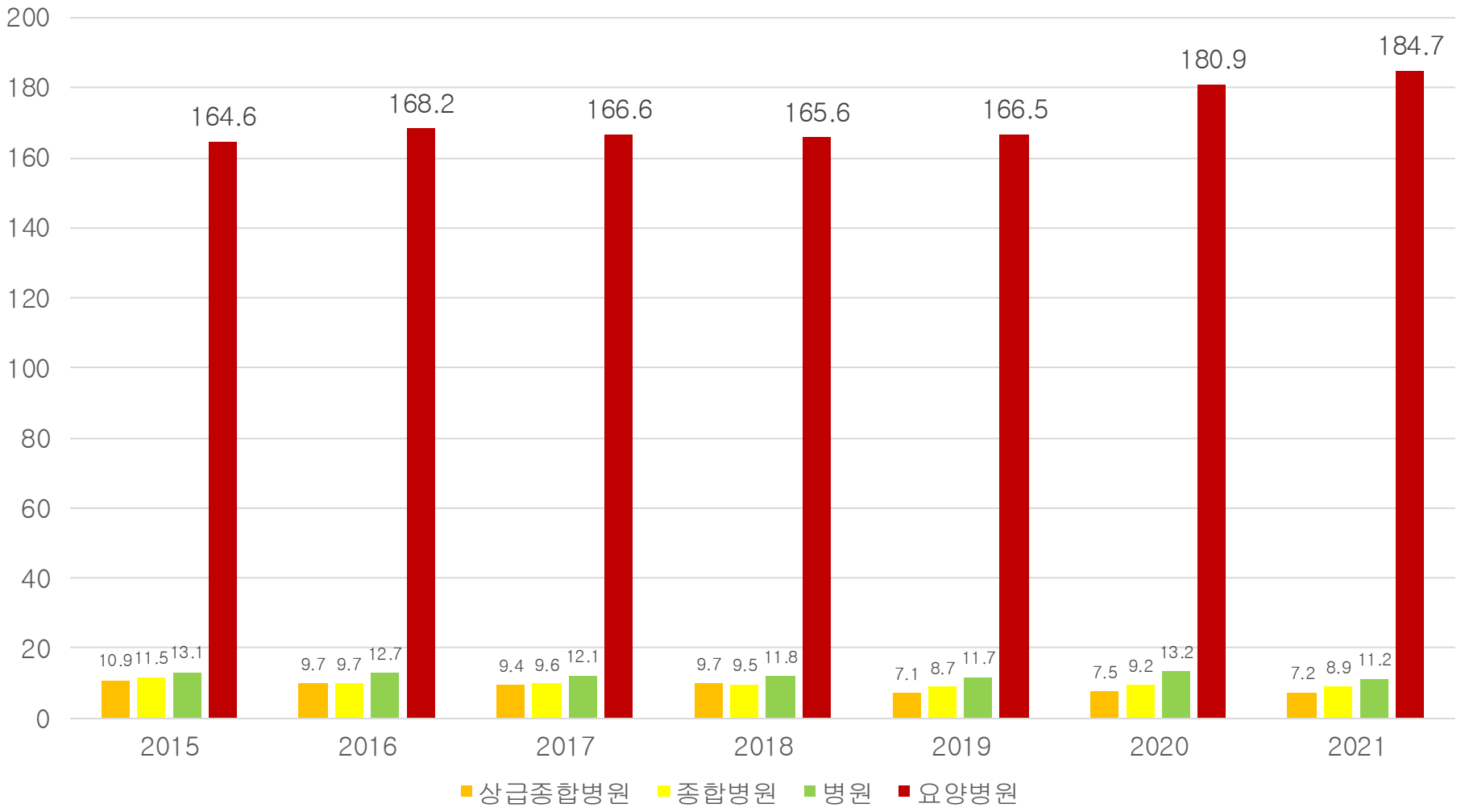
Coordination between health insurance (NHI) and long-term insurance (LTCI)

- **LTC hospitals** covered by health insurance and **LTC institutions (residential care)** covered by LTC insurance
- Relative generosity of benefits for patients in LT care hospitals (covered by HI) and those in LT care institutions (covered by LTCI)

Social admissions persist after the introduction of LTCI

- **for-profit nature** of providers and oversupply of LTC hospitals and LTC facilities: LTC hospitals and LTC institutions compete for the elderly

Average LOS in LTC Hospitals



- About 47% of older patients (+65 years) in LTC hospitals stay more than 180 days
  (https://www.msn.com/ko-kr/news/national/불필요한-요양병원-장기입원시-비용-부담↑…병원도-패널티/ar-AAAItCW)

S Kwon: LTC Insurance Korea

Source : 보건의료빅데이터개방시스템(http://opendata.hira.or.kr)

3. Governance

Centralized nation-wide LTCI has the advantage of efficient risk pooling and equitable benefits packages
-However, centralized system may not be effective toward building **community-based** integrated LTC systems, responding to local needs

Under the national LTCI, **local governments** currently have limited roles, mostly administrative support for the designation of LTC institutions
-> Need to empower local governments for **coordination between LTC and (community) welfare services**

Coordination of Health care, Long-term Care and Community social services toward person-centered integrated care system
<- How to overcome the fragmentation in funding (NHI, LTCI, budget) and responsible agencies, Private sector domination?