CASE-STUDY REPUBLIC OF KOREA

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Republic of Korea

3 CASE-STUDY: REPUBLIC OF KOREA

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1 General background data

1.1 Preamble

Owing to continuous economic growth, a higher standard of living, and the advancement of medicine in Korea, the life expectancy of Koreans has increased from 69 in 1985 to 74.4 in 2000 (male: 70.5, female: 78.3). Now, Korea is on the verge of becoming an ageing society, and the speed of ageing is proceeding at a previously unparalleled rate. The proportion of people aged 65 years or older was 7.1% of the total population in 2000, and the projected percentage of elderly people will be 16.9% of the total population by 2025.

In addition to statistics that show that the rate of ageing is increasing, there is also data that indicate that chronic diseases are on the rise and that there is a change in the distribution and causes of disability (i.e. more people are developing disabilities and chronic conditions later in life as opposed to at birth).

Further, whereas family members had previously undertaken the primary caregiving responsibilities for the frail elderly in Korea (caretakers were usually wives, daughters, or daughters-in-law), realities are changing because of an increase in the number of nuclear families (79.8% in 1995), increasing urban migration and a growth in the number of economically active women (42.7% in 2000). In light of these developments, there is a need to re-examine the viability of this traditional support system for the future. Korea has thus an increasing need for professional care for people with dementia and chronic illness who previously would have been taken care of by family members.

Taken together, these trends indicate an urgent need for planning LTC services. While Korea has a well developed health and social system, better coordination of appropriate services for disabled populations with LTC needs remains a major challenge. Presented on the following pages are background data derived from international data bases.[1] These data concern demography, vital statistics and epidemiology, economic data, and health expenditure.

[1] For consistency reasons data used in this section are taken from international data sources:
UN, World Population Prospect, the 2000 revision (median variant);
US Bureau of the Census, International Data Base; WHO- World Health Report 2001;
World Bank, World Development Indicators Data Base;
ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

1.2 Background data from international data bases

Demography (year 2000)

Population (thousands)	46 740
Land area (sq km)	98 190
Population density (per sq km)	472
Population growth rate (% in 2000–2005)	1
Urban population (%)	82
Ethnic groups	
Homogeneous (except for approximately 20 000 Chinese)	
Religions (%)	
Christian	49
Buddhist	47
Other	4
Total adult literacy rate (% in 1997)	98
Age Structure (%):	
0–142	20.8
15–24	16.5
60+	11.0
65+	7.1
80+	1.0

[2] Elderly dependency ratio: the ratio of those age 65 and over per 100 persons age 20–64.

[3] Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.

Demography (continued)

Projections 65+ (%)

2025	16.9
2050	27.4

Sex ratio (males per female)

Total population	1.01
15–64	1.03
65+	0.63

Dependency Ratio:

Elderly dependency ratio in 2000[2]	1.1
Elderly dependency ratio in 2025	27.4
Parent support ratio in 2000[3]	7.2
Parent support ratio in 2005	14.5

Vital statistics and epidemiology

Crude birth rate (per 1000 population) (2000) 12.8

Crude death rate (per 1000 population) (2000) 5.9

Mortality under age 5 (per 1000 births) (2001)

males	8.0
females	8.0

Probability of dying between 15–59 (per 1000) (2001)

males	177
females	66

Vital statistics and epidemiology (continued)

Maternal mortality rate (per 100 000 live births) (1995)	20
Total fertility rate (children born/woman) (2001)	1.5
Estimated number of adults living with HIV/AIDS (2001)	4000
HIV/AIDS adult prevalence rate (%) (2001)	<0.1
Estimated number of children living with HIV/AIDS (2001)	<100
Estimated number of deaths due to AIDS (2001)	220
Life expectancy at birth (years) (2001)	
Total Population	74.9
Male	71.2
Female	78.7
Life expectancy at 60 (years) (2001)	
Total Population	20.0
Male	17.0
Female	22.0
Healthy life expectancy (HALE) at birth (years) (2001)	
Total Population	67.4
Male	64.5
Female	70.3
Healthy life expectancy (HALE) at 60 (years) (2001)	
Total Population	14.8
Male	12.9
Female	16.7

Economic data (year 2000)

GDP – composition by sector (%)	
Agricuture	6.0
Industry	41.0
Services	53.0
Gross nationaL Income (GNI) ($PPP)[4]	818 billion
GNI – per capita ($PPP)	17300
Gni – per capita (US$)	8901
GDP growth (annual %)	8.8
Labour Force Participation (% in 2000)	
Male	59.4
Female	42.7

Health Expenditure (Year 2000)

% of GDP	6
Health expenditure per capita ($PPP)	909
Health expenditure per capita (US$)	584

[4] PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.

2 General health and social system

2.1 Basic income maintenance programmes

These programmes are discussed under 'Social welfare system', section 2.3.

2.2 Organizational structure of decision-making

Health care can be divided into public and nongovernmental organizations. Nongovernmental health services make up the greater part of the Korean health care system.

Public health organizations include the Ministry of Health and Welfare (MOHW) at the central government level, and health centres, health sub-centres, and PHC (Primary Health Care) posts at the local government level. Nongovernmental health organizations can be classified as primary, secondary, and tertiary health care facilities based upon the scale and the level of specialization. The organizational structure of the health care system of the Republic of Korea is illustrated in Figure 1 on the following page.

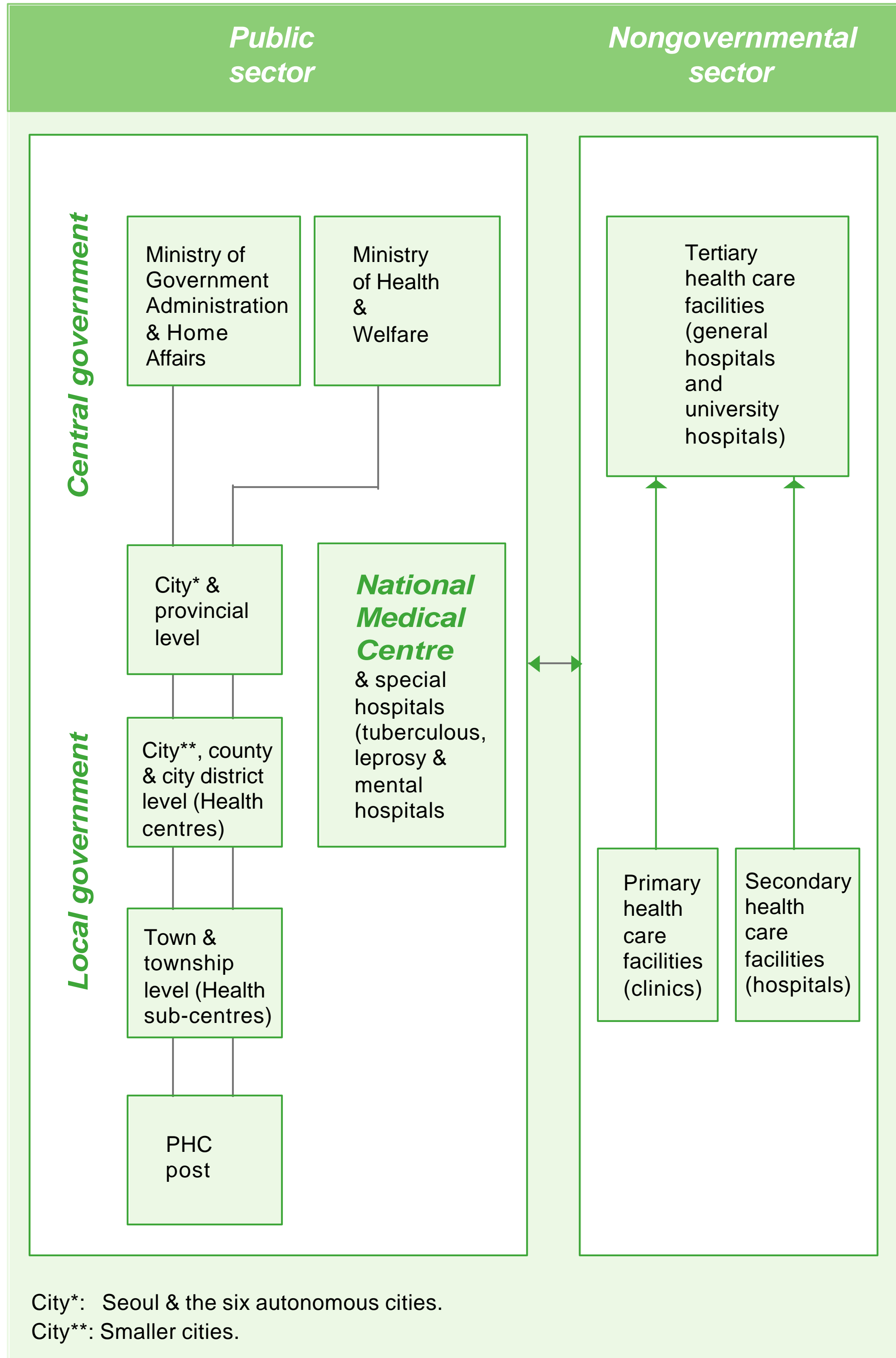
The MOHW is responsible for the maintenance and promotion of national health and social welfare. To carry out these functions, the MOHW is divided into two main areas of work: social welfare; and the planning and management of general health services.

2.2.1 Health care system

The MOHW is responsible for supervising, planning, personnel management, quality assurance, budget management, and service management of health care facilities. Seven metropolitan city health centers, nine provincial health centers, and 242 district health centres are responsible for maternal and child health in each community. They also supervise community health services such as communicable disease management, nutritional health services, and health education/promotion services.

Among the nongovernmental facilities, the majority of private facilities provide curative services, while public facilities provide preventive services. The MOHW controls licensing and the number of personnel, while the Ministry of Education (MOE) controls accreditation of medical and nursing schools.

Figure 1. Health care system of the Republic of Korea



City*: Seoul & the six autonomous cities.
City**: Smaller cities.

2.3 Social welfare system

The current social welfare system in Korea consists of three components:

- social insurance (health insurance, national pension, worker's compensation, unemployment relief);
- public assistance (livelihood protection, medical aid, veterans relief, disaster relief); and
- social welfare services (for people who are physically and/or mentally disabled, for elderly people, children, and women).

Social insurance programmes: the national health insurance scheme was launched on 1 July 1977, and 100% of the population has been covered since 1989. The public assistance programme, in accordance with the Livelihood Protection Act enacted in 1961, provides livelihood protection services to needy persons who have no physical ability and persons with low income.

Medical Aid has been operated separately under the Medical Aid Act since 1977, and now covers 1 740 000 persons, 3.8% of the total population. According to the Disaster Relief Act, the Government offers funeral costs, consolation money, livelihood subsidies and house reconstruction cost to victims of natural disasters. There is also the patriots' and veterans relief programme for those who were injured or killed in war and for their survivors.

The Government is striving to expand welfare institutions and improve the quality of their services, so that comprehensive protection for persons with severe and/or multiple disabilities can be provided. The Government is also expanding income maintenance programmes for persons with disabilities by providing welfare allowance and reducing taxes and fees.

Welfare policies for the disabled include:

- providing a welfare allowance for persons with severe and/or multiple disabilities;
- providing education aid for children of people with disabilities who are in the low-income brackets;

- supporting medical expenses for disabled persons with low incomes;
- providing loans for self-support;
- reducing economic burdens, such as deduction of tax, discount fees for public facilities; and
- the National Pension Scheme (NHS) which provides its members with protection against economic distress arising from disability.

Social welfare services for elderly people include:

- provision by the NHS of lifetime pensions for those aged 60 and over;
- provision of a ‘Non-contributory Old-age Pension benefit’ for elderly people in low-income brackets who are excluded from the national pension scheme;
- support of a part or the entirety of medical costs through the Medical Aid programme;
- reduction of economic burdens, such as deduction of tax and discount fees for public facilities; and
- provision of elderly people with an opportunity to earn money through job placement programmes such as the Aged Employment Services Centre for the Elderly, the Aged Workplace and Employment Promotion for the Elderly.

At the level of the central government, the MOHW is responsible for two major social security programmes; the National Health Insurance and the National Pension Scheme. It directly carries out social insurance programmes through related associations, such as the Korean Federation of Health Insurance and the National Pension Corporation. For public assistance and social welfare services, the MOHW is in charge of planning, coordinating, budgeting, and proposing the enactment or amendment of related law.

3 Financing of health services

3.1 General government finance

The health and welfare proportion of the total Government budget has been rapidly growing over recent years. This increase has resulted in strengthening various social security programmes, such as Health Insurance, National Pension, etc. The budget of the MOHW in the year 2000 amounted to 5310 billion won (approximately US$4.4 billion). This represented 5.98% of the total budget, an increase of 27.6% over that of 1999.

The breakdown of annual expenditure by programme is shown in Table 1.

Table 1. Budget of Ministry of Health and Welfare (millions of won)

Classification	Budget	(%)
Social Welfare	2 188 679	41
Health Care	236 088	5
Health Security	2 785 969	52
Fixed Expenditures	99 285	2

3.2 Government sponsored insurance with premiums

A major concern in the medical insurance scheme, like other kinds of insurance, is securing the financial resources for rendering effective benefits. The health insurance scheme in Korea is financed on the basis of 'social insurance', in which contributions are levied and collected in proportion to the income level of the insured.

Formerly, there were three forms of health insurance, employee health insurance, government and private school employee health insurance, and self-employed health insurance in Korea. Each insurance association was operated independently through a self-supporting system.

However, to achieve more efficiency in the operation of the insurance fund, to extend the benefit package, to meet the demand of the insured person, and to maintain equity and social solidarity among the insured, the Government passed a new National Health Insurance Act on 1July 2000. As a result, the three insurance associations merged into one organization called National Health Insurance.

Table 3. The health insurance financing system

Classification		EHI [1]	GHI [2]	SHI [3]
Share of contributions	Contributions by employers/employees	■ 2.8% of the monthly wages & salaries (50% of the premium) ■ Employers pay 50% of the premium	■ ***Government employees*** pay 3.4% (2.8% for servicemen) of the monthly wages & salaries (50% of the premium) ■ ***Private school employees*** pay 3.4% of the monthly wages & salaries (50% of the premium) ■ ***Employers*** pay 30% of the premium	■ Applies a flat sum system by grade (from 3 to 30 classifications according to income and assets)
	Government Subsidies	■ None	■ ***Government*** pays 20%-50% of the premium	■ Government subsidy covers about 36% of insurance funds
Benefit package		■ ***Non-cash benefits:*** health care benefits, maternity benefits, health examinations ■ ***Cash benefits:*** Maternity allowances, fixed amounts for funeral expenses ■ ***Co-payment*** • *Inpatient services*: 20% of total health care charges paid out-of-pocket. • *Outpatient medical services*: % paid out-of-pocket[4] in: General hospital: 55% of total charges Hospital: 40% of total charges Clinic: 30% of the total charges		

[1] EHI: Former Employee Health Insurance
[2] GHI: Former Government and Private Employee Health Insurance
[3] SHI: Former Self-employed Health Insurance
[4]Temporary Medical Aid recipients (numbering 760 000) are excluded.
[5] When the total charges do not exceed 12 000 won ($10.00), the patient pays 2200 Won ($2.00), or 2700 won ($2.50) at a dental clinic.

3.3 Private insurance with premiums

A limited number of people who are willing to pay the premium have private insurance such as life insurance or cancer insurance. Some kinds of life insurance cover fees for hospitalization with predetermined injuries or diseases. Likewise, cancer insurance pays its beneficiaries fees for cancer treatment and surgery.

Expenditure for insurance as a percentage of personal income, which represents insurance penetration, reached 11.3% in 1999.

3.4 Financing for the poor

3.4.1 Recipients

The Medical Aid Programme is designed to assist people with low incomes, those receiving livelihood assistance, and those who are unable to pay for health care. It provides the poor with health care services from the national budget.

Medical Aid, as a public assistance programme, is categorized into Class I and Class II. The total number of recipients was 2 128 000 in 1999.

Table 4. Share of medical costs (1999)

Classification	Outpatient services	Inpatient services	Remark
Class I	Free (Government pays all costs)	Free (Government pays all costs)	The range and level of medical services covered are equal to National Health Insurance policy holders.
Class II	1500 won ($1.25) per clinic visit	Recipient pays 20% of the total fees.	

4 Services delivery system and auspices of health service providers

4.1 Primary health care

The Government promulgated a special law for Primary Health Care (PHC) in Rural and Fishery Areas in 1981 for residents where accessibility to medical care was difficult. Primary Health Care Posts (PHP) were constructed, and in 1996 the number totaled 2034. PHPs were established in rural and fishery areas, with more than 500 inhabitants (more than 300 for the islands), and where medical facilities were located 30 minutes or more away by public transportation.

The major mission of the Community Health Practitioners (CHP) is to provide PHC including preventive health care and basic medical treatment. CHP services are covered by the National Insurance System. Each PHP is operated by a committee, which is formed by the community. The CHPs are qualified nurses or midwives who are deployed to a designated area after completing on the job training for 24 weeks. To improve the quality of service by the CHPs, an annual continuing education/training has been provided.

4.2 Types of health care facilities

Public health care facilities include health centres, health sub-centres, and PHC posts. National Special Hospitals such as tuberculous, leprosy and mental hospitals are included in the public health care institutions as well.

Non-governmental clinics and hospitals make up more than 91.0% of all medical facilities, employ 88.8% of physicians, and include 91.0% of total beds. Most nongovernmental facilities are concentrated in urban areas. In Korea, while about 69.9% of the population resides in urban areas, 92% of the physicians and 85.9% of hospital beds are concentrated in the cities. This situation makes it difficult for the rural population to have access to medical care.

Nongovernmental health care facilities (medical institutions) are classified as general hospitals, hospitals, dental hospitals, oriental medical hospitals, medical clinics, dental clinics, oriental medical clinics, and midwifery clinics.

General hospitals are medical institutions where doctors and dentists give medical treatment, and are equipped with more than 100 inpatient beds with specialty doctors and more than nine medical departments such as internal medicine, surgery, obstetrics and gynaecology, paediatrics, radiology, anaesthesiology, pathology and laboratory medicine, psychiatry, and dentistry.

Hospitals are medical institutions where doctors, dentists or oriental medical doctors give medical treatment, and are equipped with more than 30 inpatient beds. However, ***dental hospitals*** are not subject to the same requirements for facilities for inpatients. ***Clinics*** are medical institutions where doctors, dentists or oriental medical doctors give medical treatment, and which have facilities for medical examination and treatment.

Midwifery clinics are medical institutions where a midwife conducts child delivery, gives health education and cares for pregnant women, women in childbirth and newborn babies. The facilities are equipped for medical examination and treatment.

Table 5. Classification of medical institutions

Classification	Institution	Patient	Doctor
Primary health care facilities	Health centres Health subcentres PHC posts Clinics Special clinics	Outpatients residing in the area	General practitioners Medical specialists at special clinics
Secondary hospitals	Hospitals with 30–99 beds Hospitals with 100–699 beds	Outpatients & inpatients referred from PHC facilities	Medical specialists
Tertiary hospitals	Hospitals with 700 or more beds	Outpatients & inpatients referred from PHC facilities & secondary hospitals	Medical specialists in each field
Special hospitals	Psychiatric hospitals Rehabilitation centres Tuberculous hospitals Leprosy hospitals Cancer hospitals Communicable disease hospitals	Special disease patients	Medical specialists on specific diseases

Several NGOs such as The Korean Red Cross, The Planned Parenthood Federation of Korea, and religious organizations exist for persons who need help from others. These organizations are operated with a fund raised through fund-raising activities, donations from NGOs, and membership fees.

Other than these organizations, professional organizations such as academic societies and associations help to promote public health by providing continuing education for members, promoting the interest and rights of members, and establishing regulations defining duties of professionals.

4.3 Health care delivery and payment system

Selection of medical institutions is usually unrestricted. Patients who receive inpatient or outpatient treatment in medical facilities, and/or prescription drugs pay 20–65% of the total cost, out of pocket. The National Health Insurance Scheme pays the rest of the medical costs. The Medical Aid programme pays a part or the entire medical costs for the recipients. However, recipients of the Medical Aid programme are not free to select any medical institution but must use health centres and designated medical institutions.

In urban areas, most people use private clinics and walk-in clinics in hospitals, while people with low income and elderly people tend to use the health centres. In rural areas 30–40% of the population uses the health centers, while in remote areas, over 90% use the CHP for health care services.

The Livelihood Protection System (LPS), developed under the anti-poverty policies in Korea, provides protection for poor people who qualified as home care and institutional care recipients according to the Livelihood Protection Act. Livelihood aid of cash grants for staple foods (rice and barley), subsidiary dishes, clothing and other necessities of life are provided to home care and institutional care recipients. The benefit level varies according to the recipient's family income and the number of family members.

Educational aid offers educational fee assistance to school-aged children of families under the LPS. Medical aid is provided for Livelihood Protection recipients who are unable to pay for medical treatment from their own resources. Housing aid was designed to stabilize dwelling problems of low-income families. While emergency aid provides a livelihood allowance in urgent situations.

4.5 Human resources and training

According to the Medical Service Act, medical persons are defined as doctors, dentists, oriental medical doctors, midwives and nurses, who are licensed by the Ministry of Health and Welfare. Besides these, there are medical technicians, medical records officers, opticians described under the Medical Technician Act and under the Medical Service Act, nurse's aides, acupuncturists, moxibustionists and masseuses described as quasi-medical persons.

Because health related personnel are those who have special professions that deal with health, their qualifications are strictly prescribed by laws and the Government licenses only those who pass pertinent national examinations and only licensed persons can provide medical treatments and public health services. The qualification standard and licence conditions of these health related persons are determined by the degree of complexity in their services.

The number of health related personnel in Korea has increased rapidly in the last decade, but it is still comparatively low, compared to industrialized countries. The number of doctors per 10 000 persons is about 13, compared with 16–20 in industrialized countries. However, If we consider the medical demands and behaviour of people, the working hours of doctors, and the fact that there are 8714 oriental medical doctors, the above ratios seem satisfactory.

Specialists refer to those who take a training course of internship and residency at a hospital or medical institution designated by the Government after obtaining licences as a doctor or dentist. There were 26 specialties and 32 003 specialists in 1995. This represents an increase of 3.8 times the number of specialists compared to 1980.

Pharmacists and social workers are required to have four years of education after graduating from high school, and dental hygienists and physical therapists at least two years of education after high school.

Table 6. Number of health-related persons having registered licences (1999)

	Number	Educational requirements
Doctors	69 724	6 years after high school
Oriental medical doctors	11 109	6 years after high school
Dentists	17 193	6 years after high school
Nurses	150 067	3-4 years after high school
Midwives	8658	RN +1 year internship
Medical technicians	107 324	2 years after high school
Pharmacists	49 214	4 years after high school
Medical records officers	7060	4 years after high school plus 1 year internship

Social workers are classified as first, second, and third grade social workers, and the required education is different for each level.

Table 7. Number of social workers by level (2001.6)

	Number	Educational requirements
1st Grade	28 332	4 years after high school plus 3 years of field experiences after obtaining 2nd grade certification
2nd Grade	13 013	3 years of field experiences after obtaining 3rd grade certification
3rdGrade	9181	24 weeks education after high school
Total	50 526	

Table 8 shows the number of health care workers practising in public health care institutions. Table 9 lists the number of nurses working in the field.

Table 8. The mean number of public health care workers by institution (2001)

Classification	Health centre	Health subcentre	PHC post
Doctors	3.1	1.0	–
Oriental medical doctors	0.9	–	–
Dentists	0.9	0.5	–
Nurses	12.0	0.4	1.0
Pharmacists	0.9	–	–
Medical technicians	7.9	0.6	–
Nurse’s aides	5.3	1.9	–
Administrative workers	15.2	0.1	–
Total	45.0	4.5	1.0

Table 9. Number of nurses working in the field (1998)

Field	Number
Public health nurses	5436
Community health nurse practitioners	1947
School nurses	6156
Dispensary nurses*	1985
Nurses in Higher Education and Research	2001

* Number from 1994 data.

5 Summary of LTC provision

5.1 Long-term care services

Most LTC is still provided in the homes of the elderly, with most of the responsibilities falling on the eldest son. Professional LTC services can be illustrated in accordance with the type of caregivers as shown in Table 10.

Table 10. Elements of care for those in need of LTC

Elements	Home care at hospital	Visiting nurses at health centre	Home helper at home	Hospice at home
Assessment, monitoring and reassessment	■	■		■
Health promotion, health protection, disease prevention, and disability postponement		■		
Facilitation of self care, self-help, mutual aid and advocacy		■		■
General health care and management of chronic diseases			■	
Personal care, e.g. grooming, bathing, meals		■	■	■
Household assistance, e.g. cleaning, laundry, shopping			■	■
Physical adaptations of the home to meet the needs of disabled persons				
Referral and linking to community resources Community-based rehabilitation		■		■

Table 10. Elements of care for those in need of LTC (continued)

Elements	*Home care at hospital*	*Visiting nurses at health centre*	*Home helper at home*	*Hospice at home*
Provision of supplies (basic and specialized), assistive devices, equipment and drugs		■		■
Alternative therapies and traditional healing				
Specialized support (e.g. for incontinence, dementia, mental problems, substance abuse)				
Respite care (in-home or congregate)				
Palliative care, e.g. pain and other symptom management				■
Provision of information to patient, family and social networks		■		■
Counselling and emotional support		■		■
Facilitation of social interaction and development of informal networks		■		■
Development of volunteer capacity and provision of volunteer opportunities for clients	■		■	
Productive activities and recreation				
Opportunities for physical activities				
Education and training of clients, informal and formal caregivers		■		
Support for caregivers before, during,				

and after periods of caregiving

5.2 Forms of long-term care services

- ***Home care services***
  - Hospital-based home care
  - Visiting nurses at health centres
  - Welfare services for the aged at home
- ***Residential care***
  - Sanitarium
  - Geriatric hospitals
- ***Terminal care***
  - Hospice programme

5.3 Hospital-based home care

Targeting early discharge patients from hospitals, skilled nursing services are provided by nurses with certification in home care nursing, in consultation with the attending physicians.

- ***Introduction period***
  After completing demonstration projects started in 1994, home care services were disseminated nationally in January 2001.

- ***Background***
  As society has changed, traditional family support has been weakened and the number of elderly living alone has increased. The need for non-residential services for elderly people with restricted mobility, whether from chronic diseases or various kinds of accidents and disasters, has grown. Moreover, replacement services were required to decrease misuse of medical resources related to long-term and unnecessary hospitalization, and to increase efficiency of resource utilization.

- ***Target population and range of services***
  Basic nursing care, patient education, and consultation are provided in the homes of early discharge patients who have National Health Insurance. Laboratory tests, medication, injections, and other medical treatment can be provided by home care nurses with diagnosis and prescription from

physicians and oriental medicine doctors.

- ***Home care committee***
  Home care committees at central (The Ministry of Health and Welfare) and local (each hospital) levels of government are operated to provide support and consultation.

- ***Qualification***
  Home care nurses are certified by The Ministry of Health and Welfare after completing one year of training at an authorized institution.

- ***Service delivery system***
  Patients can be referred to outpatient departments of the hospital or other clinics and health care facilities if they need continuing medical supervision after completing home care services. A change in home care service institution can be achieved with a written request from the attending physician.

- ***Financing***
  Fees for home care services are reimbursed via a resource-based relative value scale (RBRVS).
  Fees for home care visits, transportation, and fees for services are included in the reimbursement.
  Co-payments are made at the time of services and the National Health Insurance Fund pays the rest.

- ***Coverage***
  Home care services are confined to National Health Insurance policyholders with Medical Aid and work accident compensation insurance being excluded.
  For hospital based home care, National Health Insurance covers up to eight home visits per month (service fee: 80% insurance vs. 20% self-paid; clients pay 100% of transportation fee). After eight home visits per month, clients are required to pay the whole service fee.
  Hospitals with extra beds for patients are not supportive of early discharge and home care services.

5.4 Visiting nurses at health centres

Nurses working at public health centres for disadvantaged persons in the community offer visiting nursing services. The disadvantaged populations served include elderly people, disabled people, and patients with chronic diseases.

- ***Introduction period***
  In 1956, initiated by government-centred public health services, visiting nursing services were introduced. Later in 1995, legislation was created for visiting nursing services.

- ***Background***
  To promote the health of the population, comprehensive services for prevention, treatment, rehabilitation, consultation, and health promotion are provided to the family as the unit of services in a cost-effective manner.

- ***Target population and range of services***
  Most health centers perform needs assessments through home visiting targeting Livelihood Protection recipients among the community residents. Frequently, two to three nurses are assigned to visiting nursing services, but in some health centres visiting nursing services have been activated and provide more comprehensive services.

- ***Service provider***
  When planning visiting nursing services, nurses request cooperation from other health workers within the health centre, support from the visiting nursing team, and utilization of assistant members in the community. Individual nurses constitute a support system around the team leader and services are provided using a team approach.

- ***Service delivery system***
  Clinics at health centres can refer to visiting nurses if the client needs home visiting; also, visiting nurses can refer clients to dentists, oriental doctors, physical therapists, and exercise therapists at the health centres if there is a need. Visiting nurses should implement services through team meetings including physicians and social workers. They also need to cooperate with and be connected to special programmes at health centers,

cooperate with administrative and other departments, and consult with physicians and other health professionals.

5.4 Visiting nurses at health centres *(continued)*

- ***Financing***
  Government supports all the expenses required.

- ***Coverage***
  The number of people covered in 1999 was 360 744 households, which is 2.4% of total households, and 16.1% of total low-income families in Korea.

Table 11. Comparison with home care and visiting nurses

Classification	Home care	Visiting nurses
Service provider	Qualified home care nurses	Visiting nurses
Service unit	Individual (family)	Family (individual)
Target population	Early discharge patients	Disadvantaged family
Approach	Home visiting	Home visiting
Services	Medical treatment and examination, medication etc.	Treatment, education, consultation, referral, and primary health care for prevention
Operation body	Hospitals/clinics	Health centres
Financing	National Health Insurance	Medical Aid National Health Insurance

Fees	Transportation + Basic fee + a	Free

5.5 Community-based welfare services for the eldeerly

Home help services, day care centres, and short-term care centres for elderly people are available.

- ***Background***
  As society has changed, traditional family support has been weakened and the number of the elderly people living alone has increased. The need for non-residential services for those elderly people who continue living in their own home has grown.

- ***Target population and range of services***

  - Home help services for low-income elderly people include homemaking services, meal services, bathing services, consultations, companion services, and visiting nursing care services. Services are performed mostly by volunteers, except for those rprovided for recipients who need professional care services.

  - Day care centre services are provided for elderly people who need help during the daytime because of the absence of family members to take care of them.

  - Short-term care facilities provide lodging, meals, physiotherapy and medical treatment for elderly people who need temporary hospitalization because of inadequate care by the family.

- ***Service provider***
  Home-helpers must be 20–65 years old with good health and need to have one week of training.

- ***Financing***
  The central government supports 88 home help services facilities, 57 day care centres, and 23 short-term care facilities. Other facilities are supported by local governments, individuals, and corporations.

- ***Coverage***
  A high percentage of welfare facilities (21.8%) for elderly people are concentrated around the Seoul area, while only 16.3% of elderly people reside in Seoul.

- ***Liaison System***
  Various facilities and programmes provide fragmented services,

and therefore need to have organizations which have the authority to coordinate those services.

Table 12. Community-based welfare services for the elderly (2000)

Service	Target population and duration of services	Number of facilities	Number of elderly per facility
Home help service	Elderly people at home (Livelihood Protection recipients)	109	2645
Day care centre service	Day-time (low income elderly persons)	107	1936
Short-term care facility	2–3, or 10–15 days (Livelihood Protection recipients)	36	4990

5.6 Residential care

There is a lack of long-term health care facilities for elderly people who need residential care and only 0.3% of the total population of elderly people enter residential care facilities. This represents only 61.4% of elderly people who need residential care.

Free facilities and low-price facilities are provided for Livelihood Protection recipients or low-income people over 65 years old. Fee-charging facilities are provided for individuals over 65 years with income.

Residential homes are provided for healthy elderly and nursing homes for elderly with less severe health problems. Special houses are expensive condominium facilities.

Table 13. Number of welfare institutions for the elderly (1999)

Total	Free facilities			Low-price facilities		Fee-charging facilities		
	Residential home	Nursing home	Nursing home for the severe illness	Residential home	Nursing home	Residential home	Nursing home	Special house
229	92	73	21	4	13	20	4	2

5.7 Terminal care: hospice

- ***Background***
  In Korea, the initial hospice programme was offered at a local clinic in 1965. As society has changed, traditional family support has been weakened and the number of elderly people and the number of patients with incurable cancers and AIDS has increased, and the need for terminal care has evolved.

- ***Forms of services***
  Sixty hospice programmes existed nationally in 1998. They are not yet approved by law as a part of the health care system.

- ***Service Provider***
  Tertiary health care facilities, hospitals, clinics, and other facilities.

- ***Personnel***
  Physicians, nurses, social workers, clergy, volunteers, nurse aides, pharmacists, nutritionists, and medical technicians.

- ***Financing***
  Donations, support from religious organizations, fees for

medical treatment, and funds from health care organizations.

5.8 Major educational/training needs for long-term care provision

Strategic planning and development for recruiting public health nurses for LTC institutions is needed. Each public health nurse covers about 10 000 people in urban areas and about 1000 people in rural areas. In order to provide comprehensive LTC in the community, more public health nurses should be recruited. Likewise, 7000 social workers are practising in the field of social welfare. Each social worker covers about 200 families in need of help.

Systems for recruiting volunteers are needed in the community. Currently, volunteers are recruited through NGOs and churches. However, due to a lack of systematic approaches to recruiting volunteers, many women who want to serve as volunteers are unaware of these opportunities to offer services for LTC patients.

A limited amount of education, which is focused on rehabilitation, has been provided to health care workers in the community. Thus, structured continuing education for nurses, home-helpers, volunteers, and social workers working in LTC institutions, as well as family caregivers, is required.

6 General questions pertinent to LTC Development

6.1 Present and future needs for long-term care and gaps between needs and provision of services

Indicators of the present needs for long-term care:

- ***An increasing population of elderly people***
  As was mentioned in the beginning of the paper, ageing in Korea is currently moving forward at unprecedented rate. Life expectancy has increased from 69 in 1985 to 75.5 in 2000. Additionally, the percentage of people aged 65 years or older was 7.1% of the total population in 2000, and the projected rate of elderly people will be 16.9% of the total population by 2025. The causes of this expected rise in life expectancy include better medical care and living environments.

- ***Distribution of the disabled***
  In Korea, there were 1.05 million disabled persons as of 1995, constituting 2.35% of the total population. However, the number of disabled persons registered was only 378 323, about 36% of the total population of disabled persons. Unlike in the past, the number of people born today with a disability has decreased, whereas the number of people with a disability due to car or industrial accidents and the number of elderly people who have become disabled due to age-related diseases are on the rise. Elderly disabled people comprise 44.1% of the total population of disabled persons.

- ***Increasing chronic illness***
  The Republic of Korea is now experiencing an epidemiological transition. During the last few decades, the incidence of infectious diseases has decreased, while the incidence of chronic degenerative diseases has been consistently increasing. As most chronic degenerative diseases need long-term care and have to be treated, the importance of prevention and health promotion is now being stressed. There is a distinct tendency for the mortality rates of communicable diseases to decrease, owing to improvement of the living environment and nutrition and to the development of treatment methods. However, the mortality rates of chronic diseases (or noncommunicable diseases) are rapidly increasing and it is anticipated that this tendency will be more pronounced because of the ageing of the population, changes in dietary habits, increase in smoking, and decrease in physical activity.

Table 14. Changes in morbidity rates of adult diseases (per 1000 persons)

Disease	1995	1999
Malignant neoplasm of stomach	0.66	0.85
Diabetes mellitus	16.10	22.38
Hypertensive disease	26.73	44.73
Cerebrovascular disease	5.73	6.48
Heart disease	11.55	18.29

Liver disease	11.95	17.04

The number and types of persons who need long-term care services are depicted in the following tables.

Table 15. The number of communicable disease cases among total population (42 million, 1995)

Disease	Cases
Tuberculosis	64 713
Leprosy	21 185
*AIDS**	4 000

*Estimated number of adults living with HIV/AIDS.

Table 16. Traffic accidents and deaths 1997–1999 (per 100 000 persons)

Year	Deaths	Injured
1997	25.2	746.1
1998	19.5	733.5
1999	20.0	859.1

Table 17. Estimated number of disabled persons according to type of disability (1995)

Type	Number	%
Physical	696 249	67.67
Visual	73 104	7.11
Auditory	153 444	14.91
Speech	36 371	3.54
Mental	69 669	6.77

Total	1 028 837	100.00

Table 18. Residents of institution for psychiatric patients (1999)

Number of Institutions	63
Number of Residents	12 962
Residents according to disease	
Schizophrenia	11 291
Melancholia	214
Epilepsy	254
Mental Retardation	476
Old age drug addiction, etc.	727

Table 19. Estimated number of elderly people with dementia (1995)

Number of elderly eeople (65+)	2 640 205
Number of elderly people with dementia	218 096
Mild	129 113
Moderate	59 322
Severe	29 661
Prevalence rate	8.3%

6.2 Changes in the ability of the family to provide care

As was mentioned in the beginning of the paper, whereas family members had previously undertaken the primary caregiving responsibilities for the frail elderly in Korea (caretakers were usually wives, daughters, or daughters-in-law), attitudes are changing because of an increase in the number of nuclear families (79.8% in 1995), increasing urban migration and growth in the number of economically active women (49.5% in 2000). Therefore, Korea has an increasing need for professional care for people

with dementia and chronic illness who previously would have been cared for by family members.

6.3 Main gaps between needs and present long-term care services

The Medical Aid programme is a government-funded programme designed to assist people with low income, those receiving livelihood assistance, and those who are unable to pay for medical care. It provides medical care services for the poor through the national budget.

The Mayor of each city or chief administrator of each county selects recipients through annual surveys of income and household assets. The criteria for selection are determined by the Ministry of Health and Welfare and may be subject to change yearly. In 1996, the recipients of the Medical Aid Programme numbered 1740 individuals and accounted for 3.8% of the population.

The greatest unmet needs for long term care service include the following:

- In Korea, there were 1.05 million disabled persons as of 1995, constituting 2.35% of the total population. However, the number of registered disabled people eligible for the Medical Aid Programme was only 378 323, about 36% of the total population of disabled persons in 1995.

- While only about 69.9% of the population resides in urban areas, 92% of the physicians and 85.9% of hospital beds are concentrated in the cities. This situation makes it difficult for the rural population to have access to medical care.

- At the district level, low-income LTC clients are placed in convalescent institutions, where district health centres and social welfare centers supervise LTC services. District health centres provide free nursing care services to low-income clients who need long-term care in their homes through visiting nurse programmes.

- Setting clear standards for selection of service recipients, as well as expansion of public LTC services to middle-income elderly people is required.

- Low-income frail and disabled elderly people who need help during the daytime because of the absence of family members have few supports from District Health Centres and Social Welfare Centres. Central and municipal government supports a fund needed for operating day care. Public health nurses, social workers, physical therapists, and nurse-aides staff this

service. The Government has a plan to expand day care.

- The convalescent institutions for mentally ill elderly people and elderly with dementia are sponsored publicly and privately by churches or NGOs. Provincial health departments control and regulate convalescent institutions within the province. Medical doctors, nurses, and helpers who provide personal care are employed in convalescent institutions. Geriatric hospitals and mental hospitals provide inpatient and outpatient care like general hospitals.

6.4 Major constraints on the development of health and long-term care

- ***Facilities***
  At present, it is so important to enhance the quality of service of welfare institutions, and to take care of elderly people who do not have the ability to pay. The government has provided mortgages to welfare foundations and charitable individuals to facilitate new construction of residential homes, nursing homes, and other LTC facilities.

- ***Surveillance system***
  The registration rate of LTC cases is low. A systematic surveillance system needs to be developed at the national and district level.

- ***Decreasing number of Community Health Posts***
  The Government promulgated a special law for Primary Health Care (PHC) in Rural and Fishery Areas in 1981. Primary Health Care Posts (PHP) were constructed, and in 1996 the number totaled 2034. Each PHP is operated by a committee, which is formed by the community. However, since the financial crisis and loans from the International Monetary Fund (IMF), the Government has decreased the number of Government workers. Among those, Community Health Practitioners were targeted to be decreased. Now, they have decreased from 2034 to 1750. This has affected LTC in rural areas.

6.5 Developments that will impact on LTC

- ***Financing health care for elderly people***
  Financing systems for health care for elderly people include government support such as Medical Aid and budgets for health care for elderly people, National Health Insurance, private insurance and out-of-pocket payments.

  The total health care budget is very limited and does not specify a separate budget line for elderly people. The national overall health care budget for elderly people was 481 billion won (US$400million) in 2000, 0.06% of the total government budget. However, most of it was used for welfare for elderly people rather than for health care. More funds are needed to support financing health care for elderly people.

- ***Health care system development for elderly people***
  To establish a health care delivery subsystem for elderly people, hospitals with 30-200 beds are encouraged to designate all or part of their beds to long-term care . Developing health care personnel for elderly people as well as reinforcing training and education for the existing health care workers is required. Utilization of existing primary health care workers through education and training is desirable.

- ***Development of comprehensive health care for elderly people***

  - ***Integrating acute and long-term care services***

  Provision of comprehensive health care and health promotion programmes; such as early detection and modification of risk factors, screening and early detection of diseases, prevention of complication and deformity and hospice care are required.

  - ***Integrating health and social care services***

  To integrate health and social care services, collaboration between health centers and social workers' office at local government level is required. Provision of comprehensive services through collaboration among health centers, health care facilities, and universities have been initiated. In order to provide culturally appropriate services, cooperation between local government and the private sector is

encouraged as well.

- ***Balancing the delivery of institutional and community-based care services***
  Most elderly people prefer community-based care services that reduce unnecessary use of medical resources by hospitalization. In order to provide quality community-based services, expansion of home-care services as well as strengthening of day-care centers, short-term care facilities and home-helper services are needed. More long-term care facilities are needed. Thus, growth in the number of long-term care facilities as well as balance between the delivery of institutional and community-based care needs to be monitored.

- ***Monitoring the quality of care***
  Establishment of inspection and evaluation systems are needed to increase quality of care and to reduce waste. These activities include:
  - Monitoring facilities and equipment
  - Monitoring quality and level of health professionals
  - Monitoring range of services and quality of care
  - Setting admission criteria
  - Evaluating results of services

■ ***Professional development***
Education and training programs for the development of health workers in this field such as geriatricians, home health aids, social workers for elderly people and case managers are needed.

6.6 Next LTC policy steps

As described earlier, family members have had the primary responsibilities for the care of frail elderly and disabled persons in Korea. The public and Government's expectations were that elderly persons would be cared for in the home, and families in the past faced criticism for placing a parent in a long-term care facility. Chronically-ill patients were able to stay for extended periods in the general hospital beds. Therefore, specialized nursing homes and other LTC facilities have been slow to develop.

However, attitudes are changing as the younger generation becomes conscious of alternatives that will lessen their burden. Likewise, increases in longevity

and chronic conditions have created a demand for more LTC facilities and services.
Better coordination of LTC facilities is required in order to avoid duplication of services between the public and private sector. Public LTC services have concentrated on low-income families. However, the selection criteria for low-income elderly persons and disabled elderly persons are vague.

Thus, setting clear standards for selection of service recipients, as well as expansion of public LTC services to middle-income elderly persons, are required. Quality of care of all services and facilities needs monitoring and continuous improvement.

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