Health Policy xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Delivery of institutional long-term care under two social insurances: Lessons from the Korean experience

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ARTICLE INFO

Article history:
Received 3 March 2015
Received in revised form 24 July 2015
Accepted 27 July 2015

Keywords:
Long-term care policy
Coordination of care
Social insurance
Older people

ABSTRACT

Little is known about health and social care provision for people with long-term care (LTC) needs under multiple insurances. The aim of this study is to compare the profile, case-mix, and service provision to older people at long-term care hospitals (LTCHs) covered by the national health insurance (NHI) with those of older people at long-term care facilities (LTCFs) covered by the public long-term care insurance (LTCI) in Korea. A national LTC survey using common functional measures and a case-mix classification system was conducted with a nationally representative sample of older people at LTCFs and LTCHs in 2013. The majority of older people in both settings were female and frail, with complex chronic diseases. About one fourth were a low-income population with Medical-Aid. The key functional status was similar between the two groups. As for case-mix, more than half of the LTCH population were categorized as having lower medical care needs, while more than one fourth of the LTCF residents had moderate or higher medical care needs. Those with high medical care needs at LTCFs were significantly more likely to be admitted to acute-care hospitals than their counterparts at LTCHs. The current delivery of institutional LTC under the two insurances in Korea is not coordinated well. It is necessary to redefine the roles of LTCHs and strengthen health care in LTCFs. A systems approach is critical to establish person-centered, integrated LTC delivery across different financial sources.

1. Introduction

Building sustainable long-term care (LTC) systems and quality LTC provision are a shared health policy agenda in many developed countries experiencing an aging population. Institutional LTC is a key component of the continuum of LTC in most developed countries, and aims to maintain the health and well-being of the frailest older population [1]. Institutional LTC is the most expensive form of LTC, so LTC reforms often target deinstitutionalization and promote community-based LTC, but institutional care is still an essential service for older people with complex medical conditions and severe functional limitations [1,2]. The most common institutional LTC settings are long-term care hospitals (LTCHs) and long-term care facilities (LTCFs), but their roles and the coordination of care across the two settings vary across countries, according to health and LTC delivery models and financial schemes [1,2].

In Korea, which has the most rapidly aging population in the world, the provision of LTCH and LTCF services is financed by two distinct social insurances: LTCH services are covered by the National Health Insurance (NHI), and LTCF services are covered by Long-Term Care Insurance for the Elderly (LTCI) [3,4]. The separation of the two types of service funded by the respective insurances is rooted in a broader health and social care context. First, LTCHs under

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http://dx.doi.org/10.1016/j.healthpol.2015.07.009
0168-8510/

NHI were introduced to control the provision of acute-care hospital beds. Korea has the second-highest number of acute-care hospital beds among OECD countries; more than 90% of the beds are supplied by private institutions [5,6], and policies to control bed size have not been successful. LTCHs, first introduced in 1993 [7], are an alternative type of hospital for acute-care services. In the early 2000s, small- and medium-size hospitals were oversupplied, many of which had financial struggles due to their lower competitiveness compared with larger hospitals with more skilled medical staff and more advanced medical technology. To address these conditions, the Korean government encouraged less competitive, non-general hospitals to switch from acute care hospitals to LTCHs [8,9], demand for which was expected to increase due to the rapid population aging. Some financial support was provided to hospitals electing to switch; barriers to enter the LTCH market were set low; and the workforce and facility requirements for being certified as a LTCH were less strict than those for being an acute-care hospital [8].

The populations to be served by the LTCHs were broadly defined by medical law as people who mainly needed care for geriatric or chronic diseases, or those in a recovery period after surgery or injury [10]. The number of LTCHs doubled over five years, from 639 in 2008 to 1356 in 2013 [11], and the number of beds increased by about 20% on average per year, from 66,727 in 2007 to 161,054 in 2012 [6]. Before the introduction of LTCI, social admissions in LTCHs were inevitable because there was no public financing available once older people were discharged from LTCHs.

In contrast, LTCF care in Korea targets the beneficiaries of the public LTCI implemented as a separate social insurance scheme in July 2008 [1], partially due to path dependency created by Korea's running the NHI as a social insurance for 30 years. Similar to the NHI, LTCI was operationalized by the National Health Insurance Services (NHIS), the centralized, single insurer of the public LTCI [4,12]; but financially, the two social insurances were designed to be separate, and the benefits under the two insurances were designed not to overlap. Because LTCFs were established under the welfare act for the aged, LTCF service has several unique characteristics [4,12,13]. First, the majority of LTCF residents covered by LTCI are people aged 65 or older who have passed a certain threshold of functional limitation set by the standardized, national care-need certification system. Second, LTCFs are not health care organizations but entities providing social care services; LTCFs primarily offer non-medical care, mainly support for the daily living of older people with functional limitations. Thus, more than 70% of the current workforce in LTC institutions are also personal care assistants, and the nursing staff requirement is only 1 per 25 residents. Nursing staff do not need to be registered nurses (RNs), and no in-house medical staff is mandated. Rather, a community doctor with an LTCF contract is supposed to visit the facility once every two weeks for general check-ups and to update prescriptions, etc. LTCF residents are supposed to visit outpatient clinics or be transferred to hospitals when they have health and medical care needs beyond a general check-up.

There were several advantages to introducing LTCI and LTCFs separately from existing LTCH services under the NHI. First, it could help prevent the medicalization of LTC. Adding LTC services to the existing health care benefits package of the NHI could have resulted in a rapid increase in health care utilization by older people with complex health and social care needs. Politically, introducing a brand-new social insurance including new benefits to support the frail elderly and decrease family burden was likely to be more attractive to the public, who would have to pay more for another mandatory social insurance. In addition, administratively, it would be easier to make and manage a financial account for LTCI separate from the NHI; financial sustainability was at the top of the agenda in designing LTCI.

Seven years has passed since LTCI was introduced in 2008, and it has had several early successes. About 6.1% (n = 378,493) of Korean people aged 65 or older with the most severe functional limitations were the beneficiaries of LTCI at the end of 2013, almost 1.5 times higher than the 4.2% at the end of 2008 [14,15]. About 71.0% of the public is aware of LTCI, and more than 88.6% is willing to use the service, showing high acceptance of the new insurance by the public [16]. The family members of LTCI beneficiaries have reported satisfaction with the services their older relatives have received and the decreased burden of family caregiving [16]. As for the number of institutions, more than 4648 LTCFs provide institutional LTC services that are reimbursed by the public LTCI [14].

In contrast to such success, the health- and care-service delivery across LTCHs and LTCFs under the two insurances is not organized well. LTCH patients and their length of stay (LOS) rapidly increased between 2008 and 2013: the number of patients rose by 78.9% (from 185,464 to 331,919 patients) and the average LOS rose by 28.9% (from 127.8 to 164.7 days) [17]. Social readmissions with a long LOS are still a policy concern, although the government in 2009 implemented a policy to increase copayments for light care from 20% to 40% [18]. A recent study reported one third of older LTCH patients had a low need for medical and nursing treatment, although it used a relatively small and convenient sample [3]. The same study also reported complex conditions and unmet health care needs in older LTCF residents.

Some overlap between LTCH and LTCF services is inevitable and even maybe necessary, but the current mixed roles of LTCHs and LTCFs under the two insurances could make health and LTC systems in Korea inefficient, ineffective, and unsafe. Policy interventions are necessary, but no empirical evidence except Roh et al.'s study [3] exists on the care needs and service use of older people in the two LTC settings. Based on our assessment of the current situation, as described above, we hypothesized that the care needs of people in LTCHs and LTCFs would be alike, but that service utilization would be affected by the type of institution, even in similar case-mix groups. The purpose of this study was to examine the profile of people in LTCFs under LTCI and LTCHs under NHI in Korea; in particular, we compared the key functional status, case-mix, and service utilization of older people in the two settings using psychometrically sound common measures.

Please cite this article in press as: Kim H, et al. Delivery of institutional long-term care under two social insurances: Lessons from the Korean experience. Health Policy (2015), http://dx.doi.org/10.1016/j.healthpol.2015.07.009