# The National Policy of Health and Social Services for Older Persons in the Republic of Korea

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# FOREWORD

The present paper provides information on the status of health and social services needs of the elderly in Korea and suggests policy options, along with analysing a variety of data on elderly Koreans.

The ongoing, inevitable process of population aging in Korea is largely due to extension of life expectancy at birth and the continuous decline in birth rate. The process of aging is unprecedently fast, and it will take only 22 years for older persons aged 65 and over to be doubled in moving from 7% of total population to 14% compared to the industrialized OECD countries(40~110 years).

The importance of maintaining and improving elderly health through better health care services higher retirement incomes and more aged-friendly jobs cannot be overemphasized. As older persons or their family care givers becomes more productive in terms of participation in and contribution to regional development, the process of population ageing can be conducive to increasing social wellbeing.

To accomplish these objectives, the Government has taken a number of progressive initiatives concerning the diverse needs of elderly Koreans. The expansion of free community hall-based wheels-on-meals implemented in 1998 and the efforts to expand institutional/home elderly care services since 1987 and the establishment of tentative long-term care service plan in 2000 are among the examples in point.

The present report provides readers interested in the health and social services with rich information germane to income

support, health care, institutional and home care systems for elderly Koreans.

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# Chapter Ⅰ. Introduction

The Republic of Korea is an urbanized country with about a half of its population—47.3 million in 2000—concentrated in Seoul and six other cities. The crude birth rate and the crude death rate for Korea in 2000 were 14.8 and 5.7 respectively. The Total Fertility Rate has been declining since 1980, reaching 1.4 in 1999.

Korea's social security system began with economic development policy implemented in 1962 under the Five-Year Economic Development Plans. During the First(1962～66) to Fourth Plans(1977～81) the government concentrated on introducing social insurance schemes as industrial accident compensation insurance(1963), health insurance scheme(1977) and private school employee pension insurance(1975). From the Fifth Plan(or the Five-Year Economic & Social Development Plan, 1982～86) the government began to concentrate on extending the then-existing social insurance and to introduce new social insurances including national pension scheme(1988) and employment insurance scheme(1995) that have been providing health and social services to the disadvantaged.

The continuing development of health and social services for the elderly in Korea can be divided into four stages: (1) before the enactment of the *Older Persons Welfare Act* in 1981; (2) from the enactment in 1981 to the first amendment to the Act in 1989; (3) from 1989 to the whole amendment to the Act in 1997; and (4) after 1997.

Social welfare policies for older Koreans in the 1960s and 1970s were focused on giving livelihood protection benefits mainly to indigent people under Livelihood Protection Act. In particular, with the momentum of the 1981 *Older Persons*

*Welfare Act*, asylums for the aged began to be differentiated from nursing homes and, with the whole amendment to the Act, various facilities were implemented to provide quality services to the elderly.

This report consists of 9 chapters including the introduction (Chapter Ⅰ) and conclusion(Chapter Ⅸ). Chapter Ⅱ examines changes in the numbers elderly persons and their households. Chapter Ⅲ explains the level of health among elderly individuals, reviewing life expectancy, self-rated health status, prevalence of chronic diseases and dementia, activities of daily living, etc. Chapter Ⅳ is devoted to get a general grip on the current health care policies and arrangements for the elderly, which include health examination services, community nurse visiting services, medical treatment services and long-term care services. Current income support policies for the elderly—including public old-age pension and old-age allowance, livelihood protection, and employment promotion—are being reviewed in Chapter Ⅴ. Chapter Ⅵ offers a snapshot of social welfare policies for the elderly, with a view to grasping the current status of elderly activities, informal helpers, senior home care and institutional care services. Chapter Ⅶ addresses expenditures on elderly care, health care and government welfare services that have been expanded to provide broader coverage for the elderly in Korea. The main objective of Chapter Ⅷ is to identify some of important policy issues to grapple with in making efforts to improve health and social services for elderly Koreans.

# Chapter Ⅱ. Aging in Korea

## 2.1 Increase in the Elderly Population

The primary source of demographic data on Korean population is the *Census of Population and Housing* conducted every five years by the National Statistical Office(NSO).

The number of the elderly aged 65 and over in 2000 was 3,371 thousand (7.1% of the total population of 47,275 thousand). The elderly aged 80 and over, or the oldest old, as a percentage of the total elderly population (aged 65 and over) stood at 14%.

The proportion of women in the elderly population was 62% (2,075 thousand). However, the percentage of women tends to increase as the age group gets older. To be more specific, 57% of the 65~69 age group were women and, in the case of those aged 80 and over, 72% were women (see Table 2.1).

Korea as whole can be seen as an increasingly aging society. One of the findings from the calculation of annual rates of population increase for the period 1970~2030 is that the elderly population growth has been, and will be, outpacing the national average. The very old population, in particular, is increasing at an accelerating rate. As the age structure of the elderly population changes, the demand for proper policies on health and long-term care services increases.

*Table 2.1 Number of Persons Aged 65 and over, 2000*

(unit: 1,000 persons, %)

| Sex | 65~69 | 70~79 | 80 and over | Total |
|---|---|---|---|---|
| Males | 593.7 (17.6) | 567.1 (16.8) | 134.6 ( 4.0) | 1,295.4 ( 38.4) |
| Females | 772.5 (22.9) | 957.8 (28.4) | 344.9 (10.2) | 2,075.2 ( 61.6) |
| Total | 1,366.2 (40.5) | 1,524.9 (45.2) | 479.5 (14.2) | 3,370.6 (100.0) |

Source: National Statistical Office, *The Future Estimated Population*, 1996.
(Author's calculations on the basis of this source)

The annual average rate of growth in the elderly population aged 65 and over was 4.10% for the period 1980~1990 and 4.54% for the period 1990～2000 and is expected to decrease for the next two decades (4.09% for the 2000～2010 and 3.21% for the 2010～2020. However, the projection shows that the rate will reach its peak (3.95% per annum) during the period 2020~2030 as members of the Korean baby boomer generation reach retirement age.

The rate of growth in population for both age groups (65 and over and 80 and over) was found to be higher for women than for men throughout 1980～2030 (see Table 2.2). However, the oldest old (those aged 80 and over) group is expected to follow a different trend, showing an average growth rate as low as 2.88% for the period 2020～2030, a result assumed to be stemming from the excessively mortality during the Second World War (1940s) and the Korean War (1950s).

Meanwhile, the relative and absolute sizes of the elderly population in Korea are continuously increasing. In 1980, those aged 65 and over occupied 3.8% of the total population. The proportion of the same group has increased to 7.1% in 2000 and is expected to reach 14%[1)] in 2022 (see Table 2.3).

1) It will take 22 years for the proportion of the elderly population to increase from 7% (aging society) to 14% (aged society).

*Table 2.2 Annual Rate of Increase, 1970~2030*

(unit: %)

| | Males | | | Females | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | 65+ | 80+ | All ages | 65+ | 80+ | All ages | 65+ | 80+ | All ages |
| 1970~1980 | 3.09 | 2.08 | 1.74 | 3.52 | 5.00 | 1.77 | 3.36 | 4.18 | 1.75 |
| 1980~1990 | 4.16 | 5.57 | 1.51 | 4.07 | 5.32 | 1.48 | 4.10 | 5.38 | 1.49 |
| 1990~2000 | 4.80 | 6.21 | 0.91 | 4.38 | 4.80 | 0.81 | 4.54 | 5.17 | 0.86 |
| 2000~2010 | 4.97 | 6.15 | 0.69 | 3.50 | 4.94 | 0.68 | 4.09 | 5.29 | 0.69 |
| 2010~2020 | 3.68 | 6.97 | 0.33 | 2.85 | 4.36 | 0.35 | 3.21 | 5.22 | 0.34 |
| 2020~2030 | 4.18 | 3.66 | 0.04 | 3.77 | 2.43 | 0.11 | 3.95 | 2.88 | 0.07 |

Source: National Statistical Office, *The Future Estimated Population*, 1996. (Author's calculation on the basis of the above sources)

The age structure of the elderly population has also changed. Those aged 80 and over as a percentage of the elderly population was 11.9% in 1980 and 14.2% in 2000. This figure is expected to increase to 19.4% by 2020. The absolute size of those aged 80 and over has increased from 171 thousand in 1980 to 480 thousand in 2000, and will further increase to 803 thousand in 2010 and 1 million by 2020.

While the proportion of elderly people living in metropolitan cities including Seoul stands at under 7% of the regional population, the proportion of the elderly living in most rural areas is much more than 7% and, for some areas, even goes beyond 20% due to a sharp increase in migration of younger generation to urban areas.

All these are likely to result in a bewildering array of problems related to the elderly population at least for two decades to come.

*Table 2.3 Resident and Projected Populations for Persons Aged 65 and over, 1980~2030*

(Unit: person, %)

| | 1980 | 1990 | 2000 |
|---|---|---|---|
| Males | | | |
| 65+ | 539,481 ( 1.4) | 810,656 ( 1.9) | 1,295,337 ( 2.7) |
| 80+ | 42,842 ( 0.1) | 73,691 ( 0.2) | 134,561 ( 0.3) |
| All ages | 18,749,306 ( 50.1) | 21,770,919 ( 50.2) | 23,831,316 ( 50.4) |
| Females | | | |
| 65+ | 906,633 ( 2.4) | 1,351,583 (3.1) | 2,075,231 ( 4.4) |
| 80+ | 128,607 ( 0.3) | 215,947 (0.5) | 344,978 ( 0.7) |
| All ages | 18,657,509 ( 49.9) | 21,619,455 (49.8) | 23,443,227 ( 49.6) |
| Total | | | |
| 65+ | 1,446,114 ( 3.8) | 2,162,239 (5.0) | 3,370,568 ( 7.1) |
| 80+ | 171,449 ( 0.4) | 289,638 (0.7) | 479,539 ( 1.0) |
| All ages | 37,436,315 (100.0) | 43,410,899 (100.0) | 47,274,543 (100.0) |

| | 2010 | 2020 | 2030 |
|---|---|---|---|
| Males | | | |
| 65+ | 2,104,583 ( 4.2) | 3,021,341 ( 5.8) | 4,551,251 ( 8.6) |
| 80+ | 244,381 ( 0.5) | 479,449 ( 0.9) | 686,749 ( 1.3) |
| All ages | 25,536,492 ( 50.4) | 26,384,054 ( 50.4) | 26,491,907 ( 50.2) |
| Females | | | |
| 65+ | 2,927,563 ( 5.8) | 3,877,928 ( 7.4) | 5,613,581 ( 10.6) |
| 80+ | 558,631 ( 1.1) | 856,024 ( 1.6) | 1,087,840 ( 2.1) |
| All ages | 25,081,260 ( 49.6) | 25,974,273 ( 49.6) | 26,251,701 ( 49.8) |
| Total | | | |
| 65+ | 5,032,146 ( 10.0) | 6,899,269 ( 13.2) | 10,164,832 ( 19.2) |
| 80+ | 803,012 ( 1.6) | 1,335,473 ( 2.5) | 1,774.589 ( 3.4) |
| All ages | 50,617,752 (100.0) | 52,358,327 (100.0) | 52,743,608 (100.0) |

Source: National Statistical Office, *Future Population Projection*, 1996. (Author's calculation on the basis the above source)

## 2.2 Increase in the Number of Elderly Households

Many people believe that families constitute the most reliable source of emotional, practical and financial support in society (Gibson, et al., 1999). Such support in Korea is provided primarily on a non-paid, voluntary basis. It should be recognized, however, that informal care services can be provided to frail/ disabled elderly persons by non co-resident family members, as experiences of many industrialized countries show. The high percentage of informal elderly care in these industrialized countries, despite the increasing proportion of elderly living alone, is a result of frequent contacts made with non co-resident family members.

Of those aged 65 and over living in private households (excluding health/welfare institutions), 69.9% were living in either other elderly households[2] or non-elderly households while 13.7% lived alone. The proportion of older persons living alone in private households decreased to 10.7% for those aged 80 and over, compared to 13.3% of 65~69 age group. It was found that the frail older elderly who had disability and therefore needed help from others were likely to be cared by family members or institutionalized in health/welfare facilities.

Women in general have greater longevity than men, and therefore tend to live alone for a longer period of time. Among those aged 80 and over, 25.7% of men living in private households were living with a spouse, while only 2.3% of women in the same age group lived with a spouse. Women aged 80 and over were twice as likely as men in the same age group to live alone (12.5% of women aged 80 and over residing in a private household were living alone while only 5.8% of men were living alone) (see Table 2.4).

With the increasingly aging Korean population, the rate of older persons living alone has increased from 16.2% in 1994 to 20.1% in 1998, according to the *1994* and *1998 survey of Living*

2) Other elderly household means household headed by non-spouse elderly person aged 65 and over.

*Profile & Welfare Service Needs of Older Persons* conducted by KIHASA.

In particular, as older persons have a tendency to be alienated from community life, the demand for home visit based emotional support services is increasing.

*Table 2.4 Types of Private Dwellings among Older Persons, 1995*

(unit: %)

| | Elderly Household | | | | Non Elderly Household |
|---|---|---|---|---|---|
| | Elderly Only | Elderly Couple | Other | Total | |
| Males | | | | | |
| 65~69 | 4.3 | 11.4 | 0.3 | 16.0 | 84.0 |
| 70~79 | 5.4 | 30.3 | 0.2 | 64.0 | 36.0 |
| 80+ | 5.8 | 25.7 | 0.5 | 31.9 | 68.1 |
| 65+ | 5.0 | 21.7 | 0.3 | 26.9 | 73.1 |
| Females | | | | | |
| 65~69 | 19.7 | 20.5 | 0.6 | 40.7 | 59.3 |
| 70~79 | 20.7 | 11.2 | 0.5 | 32.5 | 67.5 |
| 80+ | 12.5 | 2.3 | 1.4 | 16.2 | 83.8 |
| 65+ | 19.0 | 13.2 | 0.7 | 32.8 | 67.2 |
| Total | | | | | |
| 65~69 | 13.3 | 16.7 | 0.5 | 30.5 | 69.5 |
| 70~79 | 14.9 | 18.5 | 0.4 | 33.8 | 66.2 |
| 80+ | 10.7 | 8.6 | 1.2 | 20.5 | 79.5 |
| 65+ | 13.7 | 16.4 | 0.5 | 30.6 | 69.4 |

Source: National Statistical Office, *1995 Population & Housing Census*, 1996.

## 2.3 Implications

There are two salient phenomena related to the elderly in Korean. First, the rate in growth of the elderly population aged 80 and over is remarkably high. Second, there is a continuous growth in the proportion of older persons (including very old persons) living alone, a majority of whom are very old women.

The first is an inevitable outcome stemming from the process of aging in Korea, and the more the number of elderly persons aged 80 and over, the higher the demand for elderly care services becomes. The second outcome, controllable to some extent, can be mitigated by promoting changes in social norms in Korea, where rampant individualism of younger generation is increasingly prevalent.

Another characteristics associated with the elderly population in Korean is that the rate of co-residency with children is higher for the for the older elderly than for the younger elderly.

These suggest that welfare policies for the elderly population should be directed toward developing and improving a benefit system (either cash or in-kind, or both) that would support elderly people in the context of co-residency and family, rather than toward for providing individual-based benefits to the elderly.

# Chapter Ⅲ. Health Status of Elderly People

## 3.1 Trends in Life Expectancy at Birth

Life expectancies for men and women at birth in Korea have risen continuously to 70.6 years and 78.1 years respectively in 1997. These are estimated to rise further to reach 73 years for men and 81 years for women by the year 2010. Life expectancy at age 65 years also has risen from 10.2 years for men and 14.6 years for women in 1971 to 13.6 years and 17.3 years in 1997 (see Table 3.1). Disability-Free-Life Expectancy (DFLE) at birth in Korea was estimated to be 63.3 years for men and 65.4 years for women in 1998(KIHASA, 1999).

The increases in life expectancy in Korea resulted largely from the combination of rapid declines in infant and maternal mortality led by advanced medical technology and the improvement of public health and good nutrition.

An international comparison of life expectancies at age 65 for Korea and other selected OECD countries for the year 1996 is shown in the following table. Korean women and men aged 65 years have the lowest life expectancy among OECD countries. There is a gap of 3-4 years between Korean women aged 65 years and their counterparts in Japan, France, Switzerland and Canada (see Table 3.2).

*Table 3.1 Life Expectancy at Birth and at Age 65*

(Unit: year)

| Year | At Birth | | | Age 65 Years | | |
|---|---|---|---|---|---|---|
| | Average | Males | Females | Average | Males | Females |
| 1971 | 62.3 | 59.0 | 66.1 | 12.5 | 10.2 | 14.6 |
| 1975 | 63.8 | 60.2 | 67.9 | 12.6 | 10.3 | 14.9 |
| 1979 | 65.2 | 61.3 | 69.5 | 12.8 | 10.4 | 15.1 |
| 1983 | 67.1 | 63.2 | 71.5 | 13.2 | 10.9 | 15.2 |
| 1987 | 70.0 | 65.8 | 74.0 | 13.9 | 11.7 | 15.8 |
| 1991 | 71.7 | 67.7 | 75.9 | 14.7 | 12.6 | 16.4 |
| 1995 | 73.5 | 69.6 | 77.4 | 15.4 | 13.3 | 17.0 |
| 1997 | 74.4 | 70.6 | 78.1 | 15.8 | 13.6 | 17.3 |

Source: Ministry of Health and Welfare(2000). (Adapted from internal administration data)

*Table 3.2 Life Expectancy at Age 65 in OECD Countries, 1996*

(Unit: year)

| Country | Males | Females | Country | Males | Females |
|---|---|---|---|---|---|
| Japan | 16.9 | 21.5 | Austria | 15.3 | 18.8 |
| France | 16.1 | 20.6 | Finland | 14.6 | 18.7 |
| Switzerland | 16.3 | 20.3 | Greece | 16.1 | 18.6 |
| Canada | 16.3 | 20.2 | Germany | 14.9 | 18.6 |
| Spain | 15.8 | 19.8 | Netherlands | 14.4 | 18.6 |
| Sweden | 16.1 | 19.7 | Luxembourg(1993) | 14.2 | 18.5 |
| Belgium | 15.3 | 19.7 | UK | 14.7 | 18.4 |
| Australia | 15.8 | 19.6 | Portugal | 14.3 | 17.7 |
| Italy | 15.7 | 19.6 | Denmark | 14.2 | 17.7 |
| Norway | 15.5 | 19.5 | Korea(1997) | 13.6 | 17.3 |
| Iceland | 16.2 | 19.1 | Ireland(1993) | 13.5 | 17.1 |
| New Zealand | 15.5 | 19.0 | Poland | 13.0 | 16.8 |
| USA | 15.7 | 18.9 | Czech Republic | 12.9 | 16.5 |
| Mexico | 15.5 | 18.8 | Hungary | 12.1 | 15.9 |

Source: OECD, *Health Data 98*, 1999.

The low life expectancy for women may be traceable to the poor level of health in Korea in comparison with the more advanced OECD countries[3)].

## 3.2 Self—rated Health Status

The majority (75.4%) of older Koreans rated their health as either ‘fair', 'poor' or 'very poor’, and only about a quarter (24.6%) of elderly Koreans reported their health as either ‘good' or 'very good’, according to the *1998 Survey of Living Profile & Welfare Service Needs of Older Persons* conducted by KIHASA (see Table 3.3).

This pattern, however, is not constant throughout different age groups in the elderly population. Those reported their health as either 'poor' or 'very poor' in the 65～69 age group occupied 56.6%, while 60.7% of the 70~74 age group made the same responses. Meanwhile, those aged 75 and over were more likely to report their health as ‘good or very good’ compared to the 70~74 age group. This rather counter-intuitive result from the oldest group may be attributable in part to the sampling bias associated with selecting people who living through old age with good health.

Overall, it was revealed that the self-rated health status for men was higher than that for women. Gender variations in self-rated health may reflect differences in experiencing chronic morbidity (77.2% for men and 92.2% for women). The evidence suggests that self-rated health is a reliable and easily administered indicator of health status, principally defined by severe illness and disability and it also may reflect psychological wellbeing, aspects of health behaviour, social support and self-efficacy(Gibson, et al., 1999).

According to the above mentioned 1998 survey data, the pattern of oral health also continues to change through old age. Over 20% of the 65~69 age group reported their oral health

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3) Disability-Free-Life Expectancy at birth in Japan is higher than any other country (73 years for men and 78 years for women), compared to Gremany (69 and 74 years), UK (59 and 62 years), or Canada (61 and 64 years) (OECD, *Health Data*, 1998).

measured by level of chewing status as 'good or very good', compared to 9.9% of older persons aged 75 and over. Meanwhile, 62.5% of elderly people reported their health measured by level of hearing ability 'good or very good' and 24.9% elderly people reported their health measured by level of seeing ability 'good or very good'. It should be recognized that the oral health problem of elderly people is serious in the case of Korea.

One of the main findings is that elderly Koreans tend to report their health as either 'poor or very poor' if they have chronic diseases (see Table 3.4). But it should be recognized that 18% of elderly people reported their health as either 'good or very good', although they had chronic diseases of one kind or another[4].

The reason for the low self-rated health among these elderly people is a result of the high prevalence of minor old age pains with no direct cause of impeding activities of daily living. It is necessary, therefore, to promote their positive health attitudes toward themselves.

*Table 3.3 Self-rated Health Status by Sex and Age, 1998*

(unit: %, person)

| Category | Very good | Good | Fair | Poor | Very poor | Total(N) |
|---|---|---|---|---|---|---|
| Sex | | | | | | |
| Males | 9.9 | 26.7 | 17.4 | 27.1 | 18.9 | 822 |
| Female | 2.1 | 15.5 | 16.0 | 40.1 | 26.3 | 1,396 |
| Age Group | | | | | | |
| 65~69 | 5.4 | 21.0 | 17.0 | 33.4 | 23.2 | 882 |
| 70~74 | 4.8 | 17.6 | 16.9 | 35.1 | 25.6 | 669 |
| 75+ | 4.7 | 19.7 | 15.4 | 38.1 | 22.1 | 666 |
| Average | 5.0 | 19.6 | 16.5 | 35.3 | 23.6 | 2,218 |

Source: Chung, et al. (1998)

4) Older Koreans don't tend to regard arthritis as a disease, that is, they take it for granted that older persons suffer from arthritis as they age. Therefore, the result may reflect the above phenomenon.

*Table 3.4 Self-rated Health Status by Existence of Chronic Diseases, 1998*

(unit: %, person)

| Category | Very good | Good | Fair | Poor | Very poor | Total(N) |
|---|---|---|---|---|---|---|
| With chronic disease | 18.1 | 49.5 | 20.8 | 8.8 | 2.9 | 100.0 |
| Without chronic disease | 3.0 | 15.1 | 15.8 | 39.3 | 26.7 | 100.0 |

Source: Chung, et al. (1998)

## 3.3 Prevalence of Chronic Diseases

According to the *1998 National Health & Nutrition Survey* co-conducted by MOHW & KIHASA, 81.6% of elderly people aged 65 and over and living in private households reported that they had at least one chronic disease[5] (see Table 3.5).

*Table 3.5 Prevalence of Chronic Diseases at Age 65 and over, 1998*

(unit: %)

| Age Group | Total | Acute and chronic diseases | Chronic disease only | Acute disease only |
|---|---|---|---|---|
| 0~ 6 | 60.5 | 10.6 | 10.1 | 39.8 |
| 7~18 | 43.1 | 7.6 | 17.2 | 18.2 |
| 19~44 | 47.0 | 8.7 | 27.4 | 10.9 |
| 45~64 | 70.1 | 14.8 | 48.7 | 6.5 |
| 65+ | 84.4 | 15.6 | 66.1 | 2.8 |

Source: MOHW & KIHASA, The 1998 survey data of *National Health & Nutrition,* 1999.12.

5) According to the *1998 Survey of Living Profile & Welfare Service Needs of Older Persons* conducted by KIHASA, the prevalence of chronic diseases was 86.7% of total older persons.

Also, the *1998 Survey of Living Profile & Welfare Needs of Older Persons* conducted by KIHASA revealed that the major self-reported chronic diseases with the highest number of new cases were arthritis/rheumatism (43.4%), non-arthritic back problems (29.2%) and hypertensive diseases (23.5%). Women, in comparison with men, reported higher prevalence rates of these diseases. Some 9% of elderly Koreans aged 65 and over reported having diabetes that had been diagnosed by a health professional. There were no substantial differences in the prevalence of diabetes between both sexes (see Table 3.6).

*Table 3.6 Prevalence of Chronic Diseases at Age 65 and over, by Type, 1998*

(unit: %)

| Category | Prevalence | | | Restriction in Daily Livings | | |
|---|---|---|---|---|---|---|
| | Average | Males | Females | Average | Males | Females |
| Malignant neoplasms | 0.9 | 1.7 | 0.5 | 70.3 | 64.8 | 81.4 |
| Arthritis | 43.4 | 26.6 | 53.3 | 84.4 | 76.1 | 86.8 |
| Lame back | 29.2 | 15.9 | 37.1 | 88.2 | 83.8 | 89.3 |
| Disk | 5.4 | 4.9 | 5.6 | 87.0 | 76.0 | 92.7 |
| Gastric ulcer | 15.9 | 11.7 | 18.3 | 63.5 | 58.0 | 65.5 |
| Hepatitis, Liver cirrhosis | 1.6 | 3.3 | 0.7 | 65.7 | 60.7 | 80.4 |
| Diabetes mellitus | 9.0 | 8.6 | 9.2 | 62.9 | 50.6 | 69.7 |
| Thyroid | 1.3 | 0.6 | 1.6 | 64.4 | 73.4 | 62.5 |
| Hypertensive diseases | 23.5 | 17.5 | 27.0 | 55.7 | 45.3 | 59.6 |
| Stroke | 4.4 | 4.5 | 4.3 | 82.9 | 81.8 | 83.6 |
| Angina pectoris | 5.1 | 4.7 | 5.3 | 74.9 | 66.7 | 79.1 |
| Tuberculosis | 0.5 | 1.1 | 0.1 | 58.0 | 49.3 | 100.0 |
| Chronic Bronchitis | 6.3 | 9.1 | 4.7 | 66.2 | 58.6 | 74.9 |
| Asthma | 5.1 | 6.2 | 4.5 | 72.4 | 66.4 | 77.2 |
| Cataracts | 10.6 | 6.0 | 13.4 | 74.3 | 61.3 | 77.7 |
| Chronic otitis media | 1.0 | 1.3 | 0.8 | 83.5 | 94.6 | 73.7 |
| Chronic kidney diseases | 1.1 | 0.4 | 1.5 | 88.6 | 35.0 | 96.4 |
| Sequela of bone fracture | 5.4 | 6.6 | 4.7 | 89.6 | 92.5 | 87.3 |
| (Average) | (86.7) | (77.4) | (92.2) | | | |

Source: Chung, et al. (1998)

Arthritis/rheumatism and non-arthritic back problems were cited as main causes of restricted daily living. Nearly 90% of elderly people reported having these diseases. While prevalence rates of stroke, chronic otitis media and chronic kidney disease were low, the level of restricted daily living owing to the those chronic diseases was revealed high.

Despite the high prevalence of chronic diseases among elderly Koreans, the national chronic disease management system is far from reaching full development.

## 3.4 Prevalence of Dementia

The number of elderly people with dementia continues to increase in Korea as the number of the oldest old increases[6]. Dementia is known to be characterized initially by the development of difficulties with everyday tasks of daily living, by changes in personality and by a later progression to the loss of the capacity to act independently (Gibson, et al., 1999). Although the proportion of dementia vary depending on definition of the measurement index, the number of persons with dementia in Korea in 1997 was estimated at 241,900 (8.3% of the elderly population aged 65 and over. This estimate includes persons with very mild dementia) (see Table 3.7).

Against the backdrop of these bleak statistics, the Government implemented the first 10 Year Plan for Senile Dementia, which consists of construction of dementia-specific nursing homes and geriatric hospitals, and pilot projects on remote clinics. The Government is also operating dementia-specific counselling centers established in public health centers since 1993. However, there still remain series of problems to be tackled,

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6) As older Koreans age, the number of patients with Alzheimer's dementia are increases at a higher rate than the number of patients with cerebrovascular dementia.

including the shortage of specialized counselling nurses and of other services linked with counselling.

*Table 3.7 Prevalence of Dementia, 1997~2020*

(unit: person, %)

| Age Group | 1997 | 2000 | 2005 | 2010 | 2015 | 2020 |
|---|---|---|---|---|---|---|
| 65～69 | 26,143 | 30,299 | 36,606 | 38,161 | 43,413 | 53,400 |
| 70～74 | 37,632 | 42,241 | 54,274 | 65,977 | 69,023 | 78,892 |
| 75～79 | 69,718 | 83,331 | 100,328 | 128,396 | 155,367 | 162,292 |
| 80+ | 108,396 | 121,877 | 159,817 | 201,383 | 259,264 | 324,547 |
| Total | 241,889 | 277,748 | 351,025 | 433,918 | 527,068 | 619,132 |
| Prevalence | 8.3 | 8.2 | 8.3 | 8.6 | 9.0 | 9.0 |

Source: Byun, et al. (1997)

## 3.5 Diseases as Major Causes of Death

In the case of older Koreans aged 60 and over, cerebrovascular diseases, heart diseases and diabetes mellitus constitute are major causes of death in 1999 (see Table 3.8). The disease responsible for the largest percentage of disease-induced deaths among the elderly population was cerebrovascular disease (265.2 per 100,000 persons for the 60~69 age group and 1,098.8 per 100,000 persons for those aged 70 and over). These numbers respectively represent four times and fifteen times the average which is 4 or 15 times the average for all age groups.

Cerebrovascular and heart diseases involve ischemic heart disease, acute myocardinal infarction or heart attack and stroke. Diabetes is the third leading cause of death after age 60 in 1999. Stomach cancer, the most common form of malignant neoplasm, is the fifth cause of deaths among elderly Koreans.

Cardiovascular disease is also a major cause of mortality and morbidity among persons who are older than 65 years of age. However, cardiovascular mortality the elderly and the middle-aged

population is declining. Risk factors which influence the occurrence of cardiovascular disease among older persons are much the same as those which operate for other age groups (Kannel, 1997).

*Table 3.8 Major Causes of Death, by Ranking, 1999*

(unit: per 100,000 persons)

| Rank | All ages | 60~69 | 70+ |
|---|---|---|---|
| 1 | Cerebrovascular disease (72.9) | Cerebrovascular disease (265.2) | Cerebrovascular disease (1,098.8) |
| 2 | Heart diseases (39.1) | Heart diseases (131.1) | Heart diseases (501.2) |
| 3 | Unintentional accidents (26.3) | Trachea cancer (124.4) | Diabetes mellitus (274.3) |
| 4 | Stomach cancer (24.0) | Stomach cancer (114.0) | Chronic lower respiratory diseases (256.8) |
| 5 | Liver diseases (23.5) | Diabetes mellitus (101.4) | Stomach cancer (235.0) |

Source: National Statistical Office, *Cause of Death Statistics*, 1999.

## 3.6 Dependency Levels by ADLs and Instrumental ADLs

The national survey data on the dependency levels of older Koreans can be obtained from the *1998 Survey of Living Profile & Welfare Service Needs of Older Persons* conducted by KIHASA. In this national survey, dependency is measured in terms of restricted activities of daily living (ADL) and instrumental activities of daily living[7] (instrumental ADL).

For the purpose of understanding dependency levels among older persons, the instrumental ADL category functions as a useful indicator of low levels of dependency, while the ADL

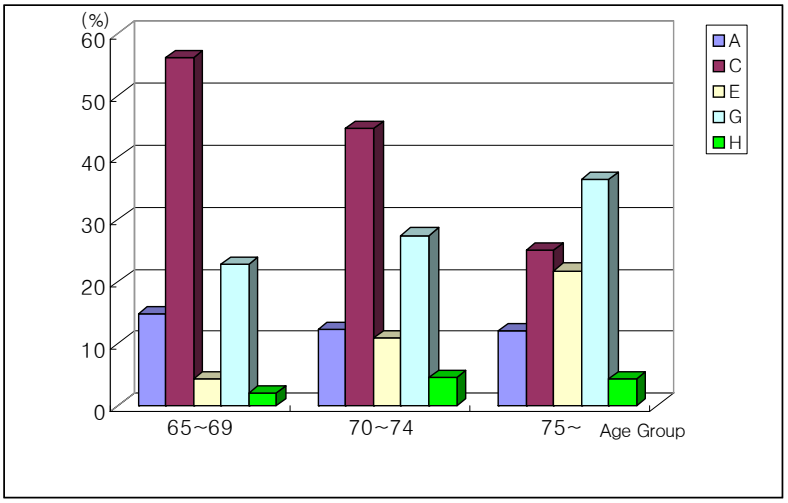
7) ADL category includes bathing, changing clothes, eating, sitting, walking, and toilet using. Instrumental category includes buying living goods, telephone using, use of public transportation and cleaning & laundry.

category is the best indicator of higher levels of dependency. According to the 1998 survey, 11.5% of elderly persons had a mild activity restriction, an estimated 31.9% of whom reported having a profound or severe activity restriction. In the case of the oldest elderly aged 75 and over, the numbers respectively increase to 21.8% and 40.9% (see Figure 3.1).

*Figure 3.1 Dependency Levels among Older Koreans, 1998*

〈all elderly people aged 65 and over〉

<table>
<tr><td rowspan="3">13.3%<br>(A)</td><td colspan="3">86.7%(B)</td></tr>
<tr><td rowspan="2">43.4%(C)</td><td colspan="2">43.3%(D)</td></tr>
<tr><td rowspan="2">11.5%<br>(E)</td><td>31.9%(F)</td></tr>
<tr><td>28.4%(G)</td><td>3.5%(H)</td></tr>
</table>




Note: A: healthy and independent elderly persons without chronic diseases
B: unhealthy elderly persons with chronic diseases
C: independent elderly persons with chronic diseases
D: elderly persons with restricted instrumental ADLs
E: elderly persons with restricted instrumental ADLs only, not ADLs
F: elderly persons with at least one restricted ADLs
G: elderly persons with restrictions in 1-5 ADLs
H: elderly persons with restrictions in all ADLs

Source: Author's bar diagram based on Chung, et al. (1998)

According to *National Long-Term Care Strategy for Older Persons* published in 2000, the category profound or severe activity restriction is deeply related to need for assistance and therefore demand for long-term care services among older persons.

Among elderly Koreans having activity restriction in only 1 ADL, the proportion of those having restriction in only 'walking' category is 43.2% and the proportions of restriction in 'transferring', 'bathing', 'toileting' and 'feeding' are 36.3%, 18.9%, 1.8% and 0.6% respectively (see Table 3.9). The high percentage of those suffering from walking restriction may be associated with the high prevalence of chronic diseases like arthritis and rheumatism among elderly Koreans.

Table 3.10 shows dependency ratio among older Koreans having simultaneous restriction in 2 ADLs and more. The proportion of elderly persons having simultaneous restriction in 2 ADLs of 'walking' and 'transferring' categories is 75.6%. The proportion of elderly persons having simultaneous restriction in 3 ADLs of 'walking' and 'transferring' and 'toiletting' categories is 51.5%. The proportion of elderly persons having simultaneous restriction in 4 ADLs of 'walking' and 'transferring' and 'toiletting' and 'bathing' categories is 76.4%. The proportion of older persons having simultaneous restriction in 5 ADLs of 'walking' and 'transferring' and 'toiletting' and 'bathing' and 'dressing' categories is 92.9%.

*Table 3.9 Dependency Ratio among Older Koreans Having only 1 ADL, by Category, 1998*

(unit: %)

| | Walking | Transferring | Bathing | Toiletting | Dressing | Feeding |
|---|---|---|---|---|---|---|
| Percentage | 43.2 | 36.3 | 18.9 | 1.8 | - | 0.6 |
| Number of respondents | (169) | (169) | (169) | (169) | (169) | (169) |

Source: SunWoo, et al. (2000)

*Table 3.10 Dependency Ratio among Older Koreans Having Two or More Simultaneous Restrictions in ADLs, 1998*

(unit: %)

| No. of ADLs | Category of ADLs | Proportion | No. of respondants |
|---|---|---|---|
| 2 | Walking+Transferring | 75.6 | (193) |
| 3 | Walking+Transferring+Toiletting | 51.5 | (131) |
| 4 | Walking+Transferring+Toiletting+bathing | 76.4 | ( 71) |
| 5 | Walking+Transferring+Toiletting+bathing+dressing | 92.9 | ( 69) |

Source: SunWoo, et al. (2000)

## 3.7 Implications

The health level of elderly Koreans, based on life expectancy or self-report, is among the lower ranks in OECD countries. This calls for more efforts to increase health level of the elderly population in Korea.

Along with joining into the worldwide process of population aging, Korea is becoming increasingly similar to more advanced countries in that cerebrovascular and cardiovascular diseases have emerged as leading causes of death among its elderly population. Also, the high prevalence of Alzheimer's dementia can be regarded as one of the symptoms of the ongoing population aging.

All these would require the Government to earmark more funds for the development of lifelong health management and chronic disease management systems, placing priority on improving both preventive and curative treatments for strokes and heart diseases with in-depth reviews of the precedent experiences of other countries.

# Chapter Ⅳ. Health Care Policy for the Elderly

## 4.1 Health Examination Services

Mandatory health examination services for older persons are being provided in Korea under two Acts based on income level. The first type of health examination services are under the *Older Persons Welfare Act*, targeting those with lower incomes, namely, recipients of National Basic Livelihood Security. Elderly persons suspected of having and suffering from one disease or another after the first screening test may take further examinations.

However, the number of persons who had received health examination services remained as low as 30,000 as of 1999, occupying only 12% of the total elderly recipients of Livelihood Protection Scheme, largely due to the limited government budget. Statistics revealed that almost a half (44.2%) of the elderly persons who took the first examination were ill-healthy (see Table 4.1). This number gives some explanation as to why mandatory health examination services are being provided mainly to elderly individuals who are regarded as unhealthy or very old.

These first health examination services, consisting of measurement of blood pressure and urine/blood tests, are provided through public health centers(SunWoo, et al., 2000).

The second type of health examination services target those who are eligible among higher income/wage earners and their dependents to provide them with regular medical check ups every two years under the National Health Insurance Act. To be eligible for these in-kind benefits according to the Act, one must be aged 40 and over. For example, in the case of elderly dependents

(aged 65 and over) of government employees, the rate of receiving examination was 31% in 1997.

Meanwhile, the simple health check services for elderly persons living in private dwellings are provided under the *Community Health Care Act* mainly by community visiting nurses working at public health centers, or by voluntary nurses working at community welfare centers. These centers focus on providing blood pressure measurement and, in some cases, urine and blood tests(SunWoo, et al., 2000).

*Table 4.1 Health Examination Services for Livelihood Protection Older Recipients Aged 65 and over*

(unit: person, %)

| | First examination | | | Second examination | | |
|---|---|---|---|---|---|---|
| | Total | Healthy | Suspected of being ill-healthy | Total | Healthy | Suspected of being ill-healthy[1)] |
| 1990 | 169,520 | 121,470 (71.7) | 48,050 | 16,778 | 6,352 | 10,426 (6.2) |
| 1991 | 170,839 | 124,000 (72.6) | 46,839 | 18,490 | 7,436 | 11,054 (6.5) |
| 1992 | 121,534 | 83,878 (69.0) | 37,656 | 17,342 | 7,091 | 10,251 (8.4) |
| 1993 | 126,058 | 83,073 (65.9) | 42,985 | 19,188 | 6,849 | 12,339 (9.8) |
| 1994 | 117,722 | 77,412 (65.8) | 40,310 | 20,942 | 7,910 | 13,032 (11.1) |
| 1995 | 76,969 | 40,866 (53.1) | 36,103 | 14,547 | 3,716 | 10,831 (14.1) |
| 1996 | 27,443 | 14,144 (51.5) | 13,299 | 6,284 | 1,986 | 4,298 (15.7) |
| 1997 | 24,382 | 12,354 (50.7) | 12,028 | 6,036 | 1,784 | 4,252 (17.4) |
| 1998 | 24,734 | 11,666 (47.2) | 13,068 | 6,429 | 1,742 | 4,687 (18.9) |
| 1999 | 26,428 | 11,685 (44.2) | 14,743 | 7,233 | 1,791 | 5,442 (20.6) |

Note: 1) The statistics in parenthesis is percentage of first check recipients.

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics*, 1998.

## 4.2 Community Visiting Nurse Services

There are two types of community visiting nurse (CVN) services for elderly persons in Korea. One is CVN services that are provided under the *Community Health Care Act* by nurses working at public health centers. These public health centers are being operated by corresponding local governments—Si (cities), Gun (counties), Gu (districts)—scattered throughout the country. There were 243 public health centers and 1,270 public health clinics as of September 1999. Medical services provided on a free of charge basis by these public facilities are mainly targeted at low income groups.

The role of community visiting nurses at public health centers had been largely confined to providing simple or routine health care services such as bathing/dressing patients and providing health checks. But recently, more sophisticated medical care services, including ulcer treatments, are being delivered.

The other type of CVN services are services delivered under the *Medical Care Act* by home visiting nurses working at hospitals[8]. As of 2000, 45 hospitals were providing these services. The target group consists of early discharged patients, those who have experienced inpatient (or outpatient or emergent patient) treatments and needs re-admission to hospital, patients with chronic diseases or cerebrovascular diseases, women who are delivering a child, new born babies, etc. Costs of those services are paid through health insurance and co-payment by patients.

Hospital-based community visiting nurse services were delivered by 4 general hospitals in the country on a time-limited basis (22 month) beginning in 1994 under the name of the First Pilot Project, forging the model for visiting nurse services. The Second Pilot Project was implemented in 1997 and operated through 1999 to establish a legal foothold for systematizing hospital-based visiting nurse service. A total of 45 hospitals have participated in the Second Pilot Project.

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8) Those services can be provided through medical facilities having 2 and more home nurses.

## 4.3 Medical Care Services

Medical care services are delivered through national health insurance and medical aid scheme[9]. These services are targeted at all Korean citizens living in Korea including insured employees, the insured self-employed, and dependents of the insured. The total number of the insured under the national health insurance reached 45.2 million in 1999, of whom 21.7 million were insured employees (48%) and the remaining 23.5 million (52%) were the insured self-employed.

On the other hand, low income elderly people receiving livelihood assistance benefits from the Livelihood Protection Scheme are covered by the medical aid scheme (3.0% of total population).

Patients are responsible to pay 20% of the total medical care charges for inpatient services provided at hospitals. Co-payment rate for outpatient services vary according to hospital size and amount of medical fee. In the case of outpatient services, for example, the patient is responsible to pay 2,200 won for a total medical fee less than or equal to 12,000 Won and 30% of a total fee exceeding 12,000 won. For medical services at a hospital and teaching hospital, the patient should repay 40% and 55% of the total fee.

The current patient charge for elderly patients aged 65 and over is as low as 1,200 Won per outpatient visit. But this is limited only to clinic services[10]. Elderly persons who needs

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9) Unlike the United States (Medicare) and Japan (ro-zin-ho-ken-sei-do), Korea does not have a special elderly medical scheme.

10) Older patients can receive no-charge outpatient services at public health centers. The government is planning to extend no-charge services for the elderly to include (within the scope of health insurance coverage) hearing aids and artificial teeth necessary to perform activities of daily livings.

hospital-based medical treatments are bearing heavy burden of paying for high medical cost, let alone the risk of receiving belated treatments.

## 4.4 Long-Term Care Services

Long-term care service for frail elderly persons in Korea was mainly concentrated on institutionization until the middle of 1990s. There were only two no-charge nursing homes as long-term care facility with a total of 108 occupants in 1983. Currently there are 128 nursing homes operation on a no-charge, part charge or full charge basis (see Table 4.2). In addition, there were five public Dementia-Specialized Long-Term Care Hospitals operating under local government in 2000. Elderly asylums facilities are also classified into the long-term care facility category because are many elderly individuals in need of long-term care services provided by these facilities in Korea[11].

Home and community care (HACC) service for frail older persons as a long-term care service has been introduced since the middle of 1990s under the revised *Older Persons Welfare Act* (1993). The Act classifies home care services into three types[12]: home-help services, adult day care services, and short-stay services.

Home-help services include domestic support services (such as preparing meals, shopping, cleaning etc.), personal care services (such as self-care), and humane support services (such as

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Also, it should be considered to reduce out-of-pocket burden for patients receiving outpatient services at hospitals.

11) According to Korea Association of Senior Citizen Welfare Institutions, 59% of older persons admitted in no-charge asylum for the aged needed intensive medical care services.

12) According to the Policy Planning Committee for Long-Term Care for Older Koreans, community nursing service provided under Community Health Care Act should also be taken as a type of long-term care service.

telephoning, conversing, writing letters etc.). Services being provided by adult day care centers include rehabilitative services for recovering ADLs, wheels-on-meals, bathing, recreative services. An elderly person eligible for short-stay care facility is allowable to stay for 45 days at a time or a maximum of 90 days a year.

According to a report published by *Policy Planning Committee for Long-Term Care for Older Koreans*, Ministry of Health and Welfare, some 19% of older Koreans living in private dwellings in 2000 were in need of long-term care services, of whom 7.3% with a mild status, 10.1% with a severe status and 1.5% with a profound status (MOHW, Policy Planning Committee for Long-Term Care for Older Koreans, 2000).

*Table 4.2 Changes in the Number of Long-term Care Facilities (nursing home)*

| | No-charging home | | No-charging Skilled home | | Partly charging home | | Full charging home | |
|---|---|---|---|---|---|---|---|---|
| | No. of Facilities | No. of residents | No. of Facilities | No. of residents | No. of Facilities | No. of residents | No. of Facilities | No. of residents |
| 1983 | 2 | 108 | - | - | - | - | - | - |
| 1984 | 2 | 135 | - | - | - | - | - | - |
| 1985 | 4 | 290 | - | - | - | - | - | - |
| 1986 | 8 | 599 | - | - | - | - | - | - |
| 1987 | 10 | 687 | - | - | - | - | - | - |
| 1988 | 12 | 1,081 | - | - | - | - | - | - |
| 1989 | 18 | 1,324 | - | - | 4 | 37 | - | - |
| 1990 | 18 | 1,447 | - | - | 6 | 114 | - | - |
| 1991 | 19 | 1,497 | - | - | 10 | 226 | 1 | 17 |
| 1992 | 28 | 1,802 | - | - | 14 | 318 | 1 | 17 |
| 1993 | 34 | 2,008 | - | - | 14 | 377 | 1 | 27 |
| 1994 | 36 | 2,418 | - | - | 14 | 447 | 1 | 35 |
| 1995 | 41 | 2,781 | - | - | 12 | 472 | 1 | 23 |
| 1996 | 50 | 3,401 | - | - | 12 | 502 | 1 | 35 |
| 1997 | 53 | 3,243 | 4 | 659 | 12 | 562 | 3 | 50 |
| 1998 | 63 | 3,694 | 12 | 1,155 | 13 | 589 | 4 | 47 |
| 1999 | 69 | 4,346 | 20 | 1,812 | 13 | 689 | 4 | 101 |
| 2000 | 77 | 4,692 | 25 | 2,105 | 13 | 711 | 13 | 356 |

Source: Ministry of Health and Welfare, *2000 Health and Welfare (White Paper)*, 2001.

## 4.5 Implications

Korea's overall health care system has been widely criticized for its lopsided concentration on curative medical treatments rather than prevention of diseases. Despite the fact that public health centers have been making strenuous efforts to provide preventive treatments and rehabilitative services, beneficiaries of these endeavors have been restricted to the low income group, largely due to lack of government budgets.

In the case of health examination services, the number of users is very low. To make the matters worse, the scope of these services is almost exclusively confined to examining and detecting illness, largely overlooking the importance of risk factor information and the significance of follow-up treatments attuned to examination results.

Although community visiting nurse services target elderly individuals living in private dwellings through public health centers, home visits are not made as often as they should be, primarily because of the numerical shortage of home visiting nurses working at community health centers.

Currently, community visiting nurse services are not well coordinated with other welfare facilities and services, especially with acute hospitals. As a result, relatively healthy elderly persons tend to get admitted nursing home facilities or to utilize home-help services and adult day services.

The government is required to place priority on refining the eligibility criteria so as to maximize the efficiency of health and long-term care for the elderly.

# Chapter Ⅴ. Income Support Policy for the Elderly

## 5.1 Old-age Pension under Social Insurance System

Old age pension in Korea is composed of four pillars: the National Pension (introduced in 1988); Government Employees Pension (1960); Military Personnel Pension (1963); and Private School Staff Pension (1975). The target population for the National Pension Scheme (NPS) consists of the self-employed and employees aged between 18 and 60[13]. The number of participants in NPS was in the region of 16.7 million as of November 2000, of whom 5.7 million were employees and 10.9 million (52%) were the self-employed, and 0.1 million were voluntary participants (see Table 5.1).

The National Pension is currently payable from age 60 to men and women alike. The minimum pensionable age, however, will rise by one year every five years from the year 2013 until reaching 65 in 2033. Of the 1,249 thousand persons who have received National Pension benefits in 1999, 176 thousand (14.1%) were Special Old-age Pensioners[14].

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13) Voluntary participants include housewives and students while the rest fall under the 'mandatory participants'. The total number of participants was 16.7 million as of July 2000.

14) Special Old-age Pension benefits were paid before the inception of NPS to those who had been participating for 5~19 years.

*Table 5.1 Participants in the National Pension Scheme, 2000*

(unit: 1,000 person, %)

| Total | employee | the self-employed | | | Voluntary |
|---|---|---|---|---|---|
| | | Sub-total | Income-reporter | Exeception of contribution | |
| 16,683 (100.0) | 5,680 (34.0) | 10,889 (65.3) | 5,963 (35.7) | 4,926 (29.5) | 114 (0.7) |

Source: National Pension Corporation(2001).

Old-age pension in Korea is an income security system for elderly persons who are unable to self-provide throughout their post-retirement life. The primary objective of the pension scheme, then, is to alleviate, if not eliminate, poverty. The income replacement rate, indexed to the Consumer Price Index (CPI), is in the range of 60% of average lifetime wage for a pensioner with a 40 year contribution history. (see Table 5.2).

*Table 5.2 Income Replacement Rates under NPS, 1999*

(unit: Won)

| Rank | Standard monthly wage | Monthly contribution | Special old-age Pension | Contribution period (years) | | |
|---|---|---|---|---|---|---|
| | | | 5 years | 15 | 20 | 30 |
| 1 | 220,000 | 19,800 | 69,470 (31.6) | 175,750 (79.9) | 220,000 (100.0) | 220,000 (100.0) |
| 10 | 370,000 | 33,300 | 75,100 (20.3) | 192,060 (51.9) | 259,780 (70.2) | 370,000 (100.0) |
| 22 | 990,000 | 89,100 | 98,350 (9.9) | 259,490 (26.2) | 352,780 (35.6) | 522,400 (52.8) |
| 30 | 1,660,000 | 149,400 | 123,470 (7.4) | 332,350 (20.0) | 453,280 (27.3) | 673,150 (40.6) |
| 40 | 2,800,000 | 252,000 | 166,220 (5.9) | 456,330 (16.3) | 624,280 (22.3) | 929,650 (33.2) |
| 45 | 3,600,000 | 324,000 | 196,220 (5.5) | 543,330 (15.0) | 744,280 (20.7) | 1,109,650 (30.8) |

Note: The statistics in parenthesis is rate of return.

Source: Ministry of Health and Welfare, *2000 Health and Welfare (White Paper)*, 2001.

## 5.2 Livelihood Protection under Public Assistance System

Livelihood Protection System[15] is one of the centerpieces of Korea's anti-poverty landscape. Recipients of the Livelihood Protection System are low income earners who do not have supporters or cannot receive support from others[16]. The number of elderly persons under Livelihood Protection System as a share of the total population was 8.2% in 1999, while those who benefited from the system remained at 2.5%. (see Table 5.3).

The Livelihood Cost Aid, which is provided to older persons in private home and institutional facilities, stood at an average of 178,000 Won per month per person in 1999. The aid includes cash grant for the principal food, clothing and other necessities.

*Table 5.3 Percentage of Livelihood Protection Recipients, 1999*

| | All ages (person) | Older persons (person) |
|---|---|---|
| Total population (A) | 46,858,463 | 3,204,095 |
| Number of Livelihood Protection recipients (B) | 1,175,187 | 245,891 |
| Percentage (B/A, %) | 2.5% | 8.2% |

Source: Ministry of Health and Welfare(1999 Livelihood Protection Data, 2000).

15) This system was changed to National Basic Livelihood Security System from October of 2000.

16) Care service varies according to the level of income, assets and capability to work. Home resident care services are provided to those with income below 230,000 Won per month and assets under 28 million Won. Older persons in institutional facilities and self-supporting residents in private homes are required to have income below 230,000 Won per month and assets under 29 million Won.

## 5.3 Old-age Allowance under Government Budgets

Since introduced in 1991 the Old-age Allowance scheme had been restricted to Livelihood Protection Recipients aged 70 and over until 1998. After 1998, however, it was extended to cover low wage earners as well as Livelihood Protection Recipients aged 65 and over, providing the former with a monthly assistance of 30 thousand won per person and the latter with 50 thousand won per person. The total number of recipients of the Old-age Allowance scheme was 715 thousand (21.2% of the total elderly group) in 2000 (see Table 5.4).

The Old-age Allowance scheme provides its 'non-contributory old-age pension benefits' to the low income elderly who are excluded from the National Pension Scheme, functioning as a complementary mechanism to the public pension scheme.

*Table 5.4 Old-age Allowance Recipients*

| | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|
| Recipients (thousand) | 660 | 715 | 924 | 891 | 859 |
| Amounts (thousand won) | | | | | |
| The poor[1)] | 40~50 | 50 | 50 | 50 | 50 |
| The low income persons | 20 | 30 | 40 | 50 | 50 |

Note: 1) Those are Livelihood Protection Recipients.
Source: Ministry of Health and Welfare(1999 Livelihood Protection Data, 2000).

## 5.4 Employment Promotion for the Elderly

Introduced in 1991 as one of measures to promote employment of older persons, the *Older Persons Employment Promotion Act* induces employers of workplaces with 300 more employes to hire older persons aged 55 and over at least 3% of their employee pools. As a result, older employees made up 3.2%

of all employees at these workplaces in 1996 (see Table 5.5). But the number of older workers at workplaces with 5 or more workers in the same year reached 6.2% (see Table 5.6), opening the possibility of raising the percentage of older workers in larger workplaces above 6%.

*Table 5.5 Older Employees Working in Firm with 300 Persons or More*

| | Firms | Total employees (persons) | Older employees (persons) | Rate(%) |
|---|---|---|---|---|
| 1994 | 2,086 | 1,785,777 | 50,937 | 2.85 |
| 1995 | 2,113 | 1,719,201 | 52,176 | 3.03 |
| 1996 | 2,113 | 1,694,295 | 54,488 | 3.21 |

Source: Ministry of Labour, *Labour Policy (White Paper)*, 2000

*Table 5.6 Older Employees Working in Firm with 5 Persons or More*

(unit: 1,000 persons, %)

| | Total | Age group | | |
|---|---|---|---|---|
| | | 15~49 | 50~54 | 55+ |
| 1990 | 5,366 (100.0) | 4,975 (92.7) | 272 (5.1) | 119 (2.2) |
| 1992 | 5,883 (100.0) | 5,338 (90.7) | 326 (5.6) | 219 (3.7) |
| 1994 | 6,085 (100.0) | 5,350 (87.9) | 420 (6.9) | 316 (5.2) |
| 1995 | 6,168 (100.0) | 5,392 (87.4) | 423 (6.9) | 353 (5.7) |
| 1996 | 6,236 (100.0) | 5,429 (87.1) | 417 (6.7) | 390 (6.2) |

Source: Ministry of Labour, *Labour Policy (White Paper)*, 2000.

In addition, the same Act stipulates that 77 types of jobs, including selling cigarettes, attending parking lots and public parks, etc., in 1999 should be preferentially allocated to older persons.

Older Persons Job Placement Centers began to be implemented

since 1981. There were a total of 70 such centers being operated by the National Association of Senior Citizens in 2000. Also, Older Persons Workplace Program was introduced in 1986 under the *Older Persons Welfare Act*. There were 510 workplaces arranged in Community Senior Welfare Centers or Community Senior Halls in 2000.

*Living Profile & Welfare Service Needs of Older Persons*, a survey conducted by KIHASA in 1998, shows that only 29% of older persons aged 65 and over had job-generated incomes, mainly engaging in areas of agriculture, forestry & fishery (60.4% of total), and manual work (21.5%) (see Table 5.7). The high percentage of older persons in agriculture, forestry & fishery can be traceable to the increasing rate young people in rural and fishery areas emigrating to urban cities and also to the fact that there is no retirement age for engaging in farming and fishery activities.

*Table 5.7 Employment of Older Persons Aged 65 and over, by Sex and Age Group*

(unit: %)

| Type | Total | Sex | | Age group | | |
|---|---|---|---|---|---|---|
| | | Males | Females | 65~69 | 70~74 | 75+ |
| Job status | | | | | | |
| Job | 29.0 | 39.8 | 22.6 | 40.2 | 28.5 | 16.3 |
| No job | 71.0 | 60.2 | 77.4 | 59.8 | 71.5 | 83.7 |
| Type of occupation | | | | | | |
| Agriculture, Forestry, Fishery | 60.4 | 62.5 | 58.3 | 55.4 | 65.6 | 66.8 |
| Manual work | 21.5 | 14.9 | 28.3 | 23.2 | 17.9 | 22.2 |
| Services & Sales | 8.8 | 7.8 | 9.9 | 9.8 | 10.0 | 4.0 |
| Clerical work | 1.2 | 2.3 | 0.0 | 1.6 | 0.7 | 0.5 |
| Mechanical work | 2.7 | 3.4 | 2.1 | 3.4 | 2.3 | 1.6 |
| Professional work | 1.9 | 2.9 | 0.9 | 1.9 | 0.6 | 3.8 |
| Technician & Semiprofessionals | 1.1 | 1.9 | 0.2 | 0.8 | 2.2 | 0.0 |
| Manufacturing | 0.4 | 0.9 | 0.0 | 0.8 | 0.0 | 0.0 |
| Regislative & High-ranked officials | 2.0 | 3.5 | 0.4 | 2.9 | 0.7 | 1.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source: Chung et al. (1998)

*Living Profile & Welfare Service Needs of Older Persons*, a survey conducted by KIHASA in 1998, 66.3% of older persons aged 65 and over were receiving living support from their non-resident off-springs in 1998 (see table A2.2). Therefore, it can be considered that public security for living support is not equiped yet.

## 5.5 Implications

Old age income security in Korea is not sufficient to support livelihood of older people not only because its public component lacks maturity and its private component is devoid of universal coverage, keeping non-co-resident children largely responsible for providing their old parents with livelihood assistance. Although old-age allowance is being paid to the lower income group, many qualified older persons are excluded from the beneficiary group.

Thanks to the introduction of the new public assistance scheme, the livelihood condition of the poor has been substantially improved. Furthermore, NPS participants with a 20 year contribution period will receive full pension entitlement by the year 2008. There are, however, many elderly persons who are excluded from both schemes.

For the time being it is necessary to develop effective employment promotion system as a indirect support mechanism for the poor old. Also, the current eligibility criteria for old-age allowance should be made less stringent to increase the number of beneficiaries.

# Chapter Ⅵ. Social Welfare Service Policy for the Elderly

## 6.1 Risk Factors against Active Aging

According to the WHO definition, 'health' is not just the absence of disease, but a state of complete physical, mental and social wellbeing, and Korea's health policies for the elderly are on the way to achieve such an objective. In the industrialized countries WHO's efforts have been proven effective. A number of research reports show that most older persons retained high levels of independence, and indeed made substantial contributions to society in general (OECD, 2000). Many difficulties associated with maintaining health, which once were thought inevitable in old age, are now known to be preventable, or postponable, by means of controlling unhealthy lifestyles (Khaw, 1997).

The *1998 Survey of National Health & Nutrition*, jointly conducted by KIHASA and Ministry of Health and Welfare on the basis of interviews with 1,106 older persons across the country, found that what 'feeling unhealthy' meant for the respondents was a negative outlook on life. The majority (71.2%) of older Koreans responded that they ‘always or often worried about' their health (see Table 6.1). But, the proportion of those who are ‘not at all worried about’ (8.5%) among older persons aged 75 and over was higher than those among the 65~69 age group (6.0%), a result presumably stemming from the sampling bias in selecting relatively healthy respondents among those aged 75 and over.

Many older people in Korea ‘worry about’ their health, largely because medical care services in Korea are delivered predominantly through privately financed health care system,

which makes long-term care and other desirable services inaccessible to the frail elderly.

*Table 6.1 Level of Worries Concerning Health, by Sex and Age Group, 1998*

(unit: %)

| | Always worry | Often worry | Rarely worry | Not at all worry | Total(N) |
|---|---|---|---|---|---|
| Average | 39.1 | 32.1 | 22.3 | 6.5 | 100.0(1,106) |
| Sex | | | | | |
| Males | 31.8 | 34.2 | 26.0 | 8.0 | 100.0( 415) |
| Females | 43.5 | 30.9 | 20.0 | 5.7 | 100.0( 691) |
| Age group | | | | | |
| 65~69 | 34.0 | 35.6 | 24.4 | 6.0 | 100.0( 436) |
| 70~74 | 44.9 | 27.8 | 22.2 | 5.1 | 100.0( 315) |
| 75+ | 40.0 | 31.8 | 19.7 | 8.5 | 100.0( 355) |

Source: MOHW & KIHASA, *1998 National Health & Nutrition Survey*, 1999.

The majority responded that they were making efforts to enhance and maintain healthy lifestyles, primarily by promoting non-smoking and non-drinking habits as well as by engaging in social activities. The proportion of non-smokers among of older persons was 71.2% and proportion of non-drinker stood at 63.9% (see Tables 6.2 and 6.3). The vast majority (88.8%), however, were found to have no physical exercise at all even though many of them were physically capable (see Table 6.4).

The proportion of those who responded that they are 'not having physical exercise at all' was higher among women (92.0%) than among men (83.3%). This tendency may lead to a higher prevalence of chronic diseases for older women.

*Table 6.2 Level of Smoking, by Sex and Age Group, 1998*

(unit: %)

| | Daily smoke | Often smoke | Past smoked | Not at all | Total(N) |
|---|---|---|---|---|---|
| Average | 27.3 | 1.4 | 19.5 | 51.7 | 100.0(1,106) |
| Sex | | | | | |
| Males | 50.0 | 1.9 | 32.9 | 15.1 | 100.0( 415) |
| Females | 13.6 | 1.3 | 11.4 | 73.6 | 100.0( 691) |
| Age group | | | | | |
| 65~69 | 30.7 | 1.4 | 16.1 | 51.8 | 100.0( 436) |
| 70~74 | 28.8 | 2.5 | 18.7 | 50.0 | 100.0( 315) |
| 75+ | 21.4 | 0.8 | 24.8 | 53.0 | 100.0( 355) |

Source: MOHW & KIHASA, *1998 National Health & Nutrition Survey*, 1999.

*Table 6.3 Level of Alcohol Consumption, by Sex and Age Group, 1998*

(unit: %)

| | Frequently drink | Often drink | Rarely drink | Past drank | Not at all | Total(N) |
|---|---|---|---|---|---|---|
| Average | 13.5 | 12.5 | 10.1 | 14.4 | 49.5 | 100.0(1,106) |
| Sex | | | | | | |
| Males | 29.6 | 17.1 | 10.4 | 22.2 | 20.7 | 100.0( 415) |
| Females | 3.8 | 9.7 | 9.9 | 9.7 | 67.0 | 100.0( 691) |
| Age group | | | | | | |
| 65~69 | 15.6 | 14.9 | 13.1 | 10.1 | 46.2 | 100.0( 436) |
| 70~74 | 16.2 | 14.0 | 9.5 | 14.6 | 45.7 | 100.0( 315) |
| 75+ | 8.5 | 7.9 | 7.1 | 19.2 | 57.3 | 100.0( 355) |

Source: MOHW & KIHASA, *1998 National Health & Nutrition Survey*, 1999.

*Table 6.4 Level of Physical Exercise, by Sex and Age Group, 1998*

(unit: %)

| | Regular excercise | Irregular excercise | No exercise | Total(N) |
|---|---|---|---|---|
| Average | 5.6 | 5.6 | 88.8 | 100.0(1,106) |
| Sex | | | | |
| Males | 8.7 | 8.0 | 83.3 | 100.0( 415) |
| Females | 3.8 | 4.2 | 92.0 | 100.0( 691) |
| Age group | | | | |
| 65~69 | 9.6 | 9.6 | 80.8 | 100.0( 436) |
| 70~74 | 4.1 | 5.4 | 90.5 | 100.0( 315) |
| 75+ | 2.0 | 0.8 | 97.2 | 100.0( 355) |

Source: MOHW & KIHASA, *1998 National Health & Nutrition Survey*, 1999.

## 6.2 Social Participation for Active Aging

Active aging means a higher possibility for older persons to independently and actively participate in society. The *1998 Survey of Living Profile & Welfare Service Needs of Older Persons* shows that 67.9% of older persons were engaged in a variety of social—including religious and club-based—activities (see Table 6.5).

There are senior welfare facilities regulated under the *Older Persons Welfare Act* to promote social activity among older Koreans by providing them with leisure programs. These facilities combine 118 Community Senior Welfare Centers and 40,691 Community Senior Halls. Also, older persons workplaces were established in Community Senior Welfare Centers and Community Senior Halls to create jobs for older people. In addition, there were 583 elderly schools (lifelong learning facilities) and 6 elderly respite sites in 2000.

*Table 6.5 Level of Social Activity Participation, by Sex and Age Group, 1998*

(unit: %)

| | Participate | Not participate | Total(N) |
|---|---|---|---|
| Average | 67.9 | 32.1 | 100.0(2,224) |
| Sex | | | |
| Males | 66.5 | 33.5 | 100.0( 825) |
| Females | 68.8 | 31.2 | 100.0(1,399) |
| Age group | | | |
| 65~69 | 73.4 | 26.6 | 100.0( 436) |
| 70~74 | 69.0 | 31.0 | 100.0( 315) |
| 75+ | 59.6 | 40.4 | 100.0( 355) |

Source: Chung, et al. (1998)

The *1999 National Survey of Lifelong Learning Institutions for Older Persons*, conducted by KIHASA, revealed that there were 1,194 institutions[17]—including elderly schools registrated in the Ministry of Health Welfare, Catholic & Christian Churches, and Community Senior Welfare Centers or Community Welfare Centers—offering lifelong learning programs.

## 6.3 Informal Care

While the importance of home and community-based care is increasingly emphasized, the need for informal care by family members, friends and neighbours as an important source of support to older persons is also being accentuated among the industrialized countries. Since informal care plays a key role in maintaining functioning capacity of frail older persons, the need for such

17) 29% of total institutions is located in Seoul city and 54% in 6 metropolitan cities including Seoul city. It can be said that lifelong learning institutions are concentrated in metropolitan cities, compared with the proportion of residents in those cities (37%).

support will be a central concern to Korea for years to come.

According to the *1998 Survey of Living Profile & Welfare Service Needs of Older Persons*, 86.8% of older persons with a mild, severe or profound activity restriction—persons who need help in carrying out ADLs and Instrumental ADLs such as self-care and mobility etc.—received informal care from female helpers (see Table 6.6).

*Table 6.6 Older Persons in Households Receiving Assistance, by Level of Activity Restriction, 1998*

(unit: %)

| Carer type | Level of activity restriction | | | |
|---|---|---|---|---|
| | Mild | Severe | Profound | Total |
| Spouse aged 70 and over | 8.3 | 9.8 | 20.0 | 10.1 |
| Spouse aged 69 and under | 11.1 | 16.7 | 13.3 | 14.3 |
| Daughter & Son | 75.0 | 53.9 | 60.0 | 62.4 |
| None | 5.6 | 19.6 | 6.7 | 13.2 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

Note: 'Mild' means restriction in Instrumental ADLs only.
'Severe' means restriction in 1-5 ADLs.
'Profound' means restriction in all ADLs.

Source: MOHW, Policy Planning Committee for Long-Term Care for Older Koreans(2000)

The survey shows that 24.4% of older persons needing help in conducting ADLs or Instrumental ADLs were assisted by their spouses living in the same household and 62.4% by their daughters or sons irrespective of co-residency, and that the remaining 13.2% received assistance neither from informal helpers nor from formal helpers.

There was a clear gender difference in the helped/helper relationship in that most activities of caring for elderly family members were carried out by female spouses or/and daughters. Most of older men having difficulties in conducting ADLs tend to be assisted by their spouses (78.4%), while a majority (79.1%) of

older women with the same difficulties tend, in the absence of their husbands, to be assisted by their sons or/and daughters, generally because wives outlive their husbands (see Table 6.7). Shown in the Table 6.8 is a similar profile of Instrumental ADLs.

While the current rate of informal support from spouse or children is considerably high, it is hard at this point to expect the percentage will go up or even remain at the same level because spouses are increasingly aging and the number of children living with their elderly parents will continue to decrease.

*Table 6.7 Older Persons in Households Receiving Assistance in the Areas of ADLs, by Primary Informal Helper Type, 1998*

(unit: %)

| | Average | Age group | | | Sex | |
|---|---|---|---|---|---|---|
| | | 65~69 | 70~74 | 75+ | Males | Females |
| Spouse | 34.2 | 56.2 | 40.6 | 20.8 | 78.4 | 13.0 |
| Sons & daughters | 58.4 | 36.6 | 49.7 | 73.3 | 15.7 | 79.1 |
| Friends & neighbours | 5.1 | 4.8 | 4.5 | 5.5 | 5.9 | 4.6 |
| Others | 2.3 | 2.4 | 5.2 | 0.4 | 0.0 | 3.3 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source: Chung, et al. (1998)

*Table 6.8 Older Persons in Households Receiving Assistance in the Areas of Instrumental ADLs, by Primary Informal Helper Type, 1998*

(unit: %)

| | Average | Age group | | | Sex | |
|---|---|---|---|---|---|---|
| | | 65~69 | 70~74 | 75+ | Males | Females |
| Spouse | 24.5 | 42.9 | 30.9 | 14.2 | 68.4 | 11.8 |
| Sons & daughters | 63.5 | 47.4 | 53.9 | 74.8 | 17.9 | 82.5 |
| Friends & neighbours | 8.3 | 7.2 | 8.9 | 8.3 | 4.2 | 1.3 |
| Others | 3.7 | 2.5 | 6.3 | 2.7 | 9.5 | 4.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

Source: Chung, et al. (1998)

Most formal support providers who deliver their services through home-help service centers are private non-profit agencies, services in some areas—self-care, mobility, and transportation services—are almost exclusively delivered by them. There were 78 government-supported home-help service centers in 2000.

In 2000, there were an estimated 635,000 persons aged 65 and over and living in the households who reported a need for help with at least one ADLs or Instrumental ADLs (about 19%[18]) of the estimated 3.3 million older Koreans). Of those who received help, a half (50.2%) reported that their needs for help with ADLs were fully met and 17.3% reported that their needs were partly met (see Table 6.9).

*Table 6.9 Older Persons' Satisfaction Level Regarding Help with ADLs, 1998*

(unit: %)

| | Areas of ADLs | | | Areas of Instrumental ADLs | | |
|---|---|---|---|---|---|---|
| | Fully | Adequately | partly | Fully | Adequately | partly |
| Average | 50.2 | 32.5 | 17.3 | 49.8 | 34.8 | 15.4 |
| Sex | | | | | | |
| Males | 52.8 | 34.9 | 10.9 | 48.3 | 38.9 | 12.8 |
| Females | 49.0 | 31.3 | 22.2 | 49.8 | 33.6 | 16.6 |
| Age group | | | | | | |
| 65~69 | 50.6 | 38.5 | 16.9 | 46.9 | 39.5 | 13.6 |
| 70~74 | 42.8 | 35.0 | 12.3 | 42.4 | 39.3 | 18.3 |
| 75+ | 54.6 | 28.5 | 19.7 | 54.2 | 30.7 | 15.1 |

Source: Chung, et al. (1998)

## 6.4 Senior Home Care Services

In 1987, an array of home-help services were made available

18) This proportion is calculated after excluding older persons with "little" difficulties in conducting activities of daily living, who are included in Figure 3.1.

to the senior population by a private organization (Korean Association for Older Persons's Welfare) supported by UK HelpAge International. However, home-based care services in Korea had been rarely and poorly provided until 1993, when home senior care programs began to be implemented, aiming at extending the scope of the service to cover more number of frail, home-ridden, or disabled older persons with the revision of the *Older Persons Welfare Act*.

Since that year, both the quantity and variety of home-helps and related services increased substantially. In 1999, 807,350 persons have received home help services, 370,719 persons have benefited from adult day care services, and 53,429 persons were provided with short-stay services (see Table 6.10).

*Table 6.10 Senior Home Care Services for Older Persons, 1999*

(unit: person)

| | Total | Home-help service | Adult day care service | Short-stay service |
|---|---|---|---|---|
| No. of recipients | 1,232,218 | 807,350 | 370,719 | 53,429 |
| No. of facilities[1)] | 141 | 78 | 42 | 21 |

Note: 1) 2000

Source: Ministry of Health and Welfare, *2000 Health and Welfare (White Paper)*, 2001.

The home care programs are provided to younger persons with disabilities as well as older persons and their care-givers in the family. One of the findings of the survey was that most home care users were older women living alone under the Livelihood Protection. For example, the 1995 survey conducted by the Department of Family Welfare in Seoul city government showed that almost all home-help service clients (98.2%) were Livelihood Protection recipients and an estimated 75.0% were those aged 70 and over. Also, 83.9% of home-help service clients were either living alone or living in an elderly couple household.

In 1996, a research report showed that most of day-care service clients (85.7%) were women and that 42.9% were persons aged 80 and over. Also known was that as many as a half of clients were older persons with mild dementia. The report further revealed that domestic and emotional support services mainly were provided to home-help clients and that an average home helper provided 3.3 hours of service per week (Suh, et al., 1998).

## 6.5 Institutional Care Services

Korea's current framework of institutional care consists of two discrete pillars: the asylums for the aged (for lower-income or non-dependent residents who do not need personal care assistance) and the nursing homes (for highly dependent residents). Nursing homes are divided into General Nursing Homes and Skilled Nursing Homes targeting older persons with dementia or stroke. But as part of the reforms being implemented under the National Long-Term Care Strategy for Older Persons gradually asylums for the aged are being transferred into General Nursing Home or Skilled Nursing Home.

As of December 31, 2000, there were 119 asylums—no-charge, part charge, or full charge—for the aged. This is tantamount to 25,000 persons aged 65 and over per facility. The total number of residents in those facilities was 5,694, which is equivalent to 0.2% of total older persons aged 65 and over in the country. The low rate of institutionalization, compared to the industrialized OECD countries, may be stemming from a combination of shortage of long-term care facilities and the pervasive cultural mores against the idea of putting older parents into, or letting them be admitted to, such facilities.

There were 128 nursing homes—no-charge, part charge or full charge—in Korea. This is tantamount to 0.04 place per 1,000 persons aged 65 and over. The number of residents in those

facilities was 7,864 residents, 0.2% of older persons aged 65 and over (see Table 6.11). The number of nursing homes will increase in line with a deliberate plan (National Long-Term Care Strategy for Older Persons) to cover more older persons in private dwellings, who have profound disabilities.

According to the *Long-Term Institutional Care Facilities for Old Persons Survey* conducted by KIHASA in 1998, 71.7% of total residents of elderly asylums and were women, most of whom were those aged 70 and over, 43% were those aged 70 to 79, 35.2% aged 80 to 89, and 3.4% aged 90 and over (see Table 6.12).

*Table 6.11 Institutional Care Facilities for Older Persons, 1999*

(unit: person)

| | Total | No charge facility | | | Part charge facility | | Full charge facility | |
|---|---|---|---|---|---|---|---|---|
| | | asylum for the aged | Nursing home | Skilled nursing home | asylum for the aged | Nursing home | asylum for the aged | Nursing home |
| Number of facilities | 247 | 93 | 77 | 25 | 4 | 13 | 22 | 13 |
| Number of residents | 13,558 | 4,872 | 4,692 | 2,105 | 120 | 711 | 702 | 356 |

Source: Ministry of Health and Welfare, *2001 Health and Welfare (White Paper)*, 2001.

*Table 6.12 Characteristics of Long-term Institutional Care Facility Residents, 1998*

(unit: %)

| | Total | No charge asylum for the aged | No charge nursing Home | Part charge asylum for the aged | Part charge nursing home |
|---|---|---|---|---|---|
| Sex | | | | | |
| Males | 28.3 | 30.5 | 22.2 | 44.0 | 29.4 |
| Females | 71.7 | 69.5 | 77.8 | 56.0 | 70.6 |
| Age group | | | | | |
| ~64 | 5.9 | 4.5 | 9.8 | 8.0 | 2.9 |
| 65~69 | 12.6 | 12.2 | 13.0 | 4.0 | 14.7 |
| 70~74 | 17.8 | 18.8 | 14.6 | 24.0 | 19.9 |
| 75~79 | 25.2 | 24.0 | 28.3 | 20.0 | 24.3 |
| 80~84 | 23.7 | 25.1 | 21.0 | 28.0 | 22.8 |
| 85~89 | 11.5 | 12.7 | 9.9 | 16.0 | 11.0 |
| 90+ | 3.4 | 2.7 | 4.4 | 0.0 | 4.4 |

Source: Byeon, et al. (1999)

## 6.6 Implications

The policy of social welfare services for older Koreans has been concentrated mainly on lower income group, largely downplaying its original objective of covering the entire elderly population. To achieve the original goal would require the following efforts.

First, it is necessary to expand the scope of senior welfare facilities being regulated under the *Older Persons Welfare Act* so as to raise the level of social participation among healthy older persons, thereby enabling them manage and improve their health.

Second, the social welfare service policy for frail and unhealthy older persons should focus on the delivery of informal and formal care services the expansion of senior home care facilities and long-term nursing homes to help the elderly maintain and improve their physical functions. In addition, special

training programs should be designed to foster specialized home helpers and improve the quality of formal care services.

An estimated one-third of the elderly residents of long-term institutional care facilities are aged 80 years and over. However, experiences of the aged OECD countries suggests Korea to give higher priority to the older and oldest elderly in all cases of admissions.

# Chapter Ⅶ. Expenditure on Older Persons

## 7.1 Trends in Expenditure on Aged Care

Expenditure level is a primary indicator of changes taking place in service delivery system over time, which is to say that one can get a good grip on the direction of the policy for aged care by looking at trends in allocation of resources among institutional care and home care. The central government (Ministry of Health and Welfare) is expected to earmark, under the *Older Persons Welfare Act*, 75 billion won for aged care and related services in 2001. Institutional aged care facilities (including nursing homes and asylums for the aged) attract by far the largest component of aged care funding, at 62.5 billion (83.3%).

Expenditure on aged care has increased since the middle of 1990s. Between 1999 and 2001, recurrent expenditures on HACC increased by 13.9% (per annum) and on institutional care by 62.4% (see Table 7.1).

The proportion of aged care expenditure allocated to HACC dropped dramatically from 11.2% of total expenditure on aged care program to 6.1% in 1999~2001 period, while that for nursing home increased from 46.9% to 67.4%. About two-thirds (64.7%) of the total government expenditure on elderly people was spent on old-age allowance in 2001 (see Table 7.2).

*Table 7.1 Government Funding for Aged Care in Current Prices*

(unit: million Won, %)

| | HACC[1)] | asylums for the aged | Nursing homes | Hall-based meals | Health examination | Total |
|---|---|---|---|---|---|---|
| 1999 | 3,514(11.2) | 9,016(28.8) | 14,680(46.9) | 3,836(12.3) | 252(0.8) | 31,298(100.0) |
| 2000 | 3,869( 7.4) | 10,564(20.3) | 29,558(56.9) | 7,672(14.8) | 277(0.5) | 51,940(100.0) |
| 2001 | 4,562( 6.1) | 11,924(15.9) | 50,570(67.4) | 7,672(10.2) | 277(0.4) | 75,005(100.0) |

Note: Excluding operational costs for supporting community senior halls.
Source: Ministry of Health and Welfare, *2001 Guidelines on Government Funding Services for Older persons Health and Social Welfare*, 1999, 2000, 2001.

*Table 7.2 Expenditure on Elderly Health/Welfare(Central Government, 2001)*

(unit: million Won, %)

| Health and Welfare | Budget |
|---|---|
| Welfare Service | 230,976 (74.7) |
| Supporting operation costs of community senior halls | 11,118 ( 3.6) |
| Paying old-age allowance | 199,867 (64.7) |
| Supporting operation costs of asylums for the aged | 9,316 ( 3.0) |
| Supporting reinforcement costs of asylums for the aged | 2,608 ( 0.8) |
| Supporting reinforcement costs of the other facilities | 4,392 ( 1.4) |
| The others | 3,675 ( 1.2) |
| Health Service | 78,044 (25.3) |
| Home and community care | 4,562 ( 1.5) |
| Health examination services | 277 ( 0.1) |
| Wheels-on-meals services | 12,631 ( 4.1) |
| Supporting operation costs of dementia councelling center | 110 ( 0.0) |
| Supporting operation costs of nursing home | 29,182 ( 9.4) |
| Supporting reinforcement costs of nursing home | 21,388 ( 6.9) |
| Supporting reinforcement costs of geriatric hospital | 9,195 ( 3.0) |
| The others | 699 ( 0.2) |
| Total expenditures | 309,020 (100.0) |

Source: Ministry of Health and Welfare, *2001 Guidelines on Government Funding Services for Older persons Health and Social Welfare*, 2001.

## 7.2 Health Expenditures on Older Persons in Korea

As would be expected, health expenditure per person for older persons is greater than that for younger persons. In 1998, health expenditure per person aged 65 and over was about three times greater than for those aged under 65. Although older Koreans constitute only 7% of the total population, they used 2,089.6 billion Won (17.6%) of total expenditures on health services through public health insurance in 2000. During the period 1985~2000, the rate of increase in public health insurance expenditures on health services for older persons aged 65 and over was 3.7 times faster than that for all ages (see Table 7.3).

*Table 7.3 Health Expenditures by Public Health Insurance*

(unit: million Won)

| Year | All ages (A) | Older persons aged 65 and over (B) | Rate (B/A) (%) |
|---|---|---|---|
| 1985 | 583,278 ( 100) | 27,515 ( 100) | 4.7 |
| 1990 | 2,219,773 ( 501) | 239,173 ( 692) | 8.2 |
| 1995 | 5,977,453 (1,025) | 728,137 (2,643) | 12.2 |
| 2000 | 11,873,436 (2,036) | 2,089,640 (7,595) | 17.6 |

Note: Numbers in parenthesis are index in case of 1985=100.
Source: Ministry of Health and Welfare (2001).

Overall, health expenditure per person for those aged 65 and over was 2.7 times higher than that for those aged under 65 in 1998. The ratio of health expenditure per person aged 65 and over to those under 65 was higher for men (3.2) than for women (2.4). In absolute numbers, per person health expenditure for the 65 and over population was 530,895 Won, compared to 197,120 Won for those under 65 and 218,203 Won for all ages (see Table 7.4).

*Table 7.4 Health Expenditures per Person by Public Health Insurance, by Sex, 1998*

(unit: Won)

| Age group | Male | Female | Total | Ratio (Female/Male) |
|---|---|---|---|---|
| 0~14 | 198,395 | 169,855 | 184,940 | 1.17 |
| 15~24 | 102,158 | 143,412 | 119,464 | 0.71 |
| 25~34 | 120,085 | 192,593 | 156,039 | 0.62 |
| 35~44 | 168,020 | 185,446 | 176,538 | 0.91 |
| 45~54 | 267,649 | 297,165 | 282,301 | 0.90 |
| 55~64 | 451,343 | 445,822 | 448,439 | 1.01 |
| 65~74 | 607,558 | 539,377 | 567,152 | 1.13 |
| 75+ | 565,695 | 404,276 | 457,853 | 1.40 |
| 0~64 (A) | 188,240 | 206,283 | 197,120 | 0.91 |
| 65+ (B) | 595,436 | 490,942 | 530,895 | 1.21 |
| Total | 207,911 | 228,490 | 218,203 | 0.91 |
| (B)/(A) | 3.16 | 2.38 | 2.69 | |

Source: Ministry of Health and Welfare (2000).

Major contributing factors for the growth in expenditures used by older persons over the period include the increasing use of medical services owing to continuous expansion of coverage, abolishment of the maximum period of benefit payment (1995), the inclusion of computerized tomography in the list of reimbursable services (1996), and the reduction in patient charge. It is widely recognized that these factors underlying both public and private pension systems are among the first to contribute to the increases in both the number of older beneficiaries and the old age income level.

## 7.3 Implications

With the increasing portion of aged care expenditure directed toward the operational aspect of long-term institutional care facilities, the expenditure on home and community care,

regarded as of secondary importance, has been decreasing since 1999, leaving many frail older persons alone at home.

Although the old-age allowance expenditure as a percentage of the elderly health/welfare service budget has been tending to decrease, the current proportion is still too high, and this keeps other service areas from expanding at a desirable rate.

The level of expenditure on elderly health care—both the total expenditure as a percentage of GDP and the per capita expenditure—in Korea is still low in comparison with those in many other industrialized OECD countries. But it is important to notice at this point that the size of expenditure on elderly health is growing fast. In the absence of a well-developed and well-prepared home/community care services, frail older persons do not have other choice than being admitted to acute hospitals. In light of such general trends, it is not surprising to see expenditures on elderly health actually increasing much faster than expected.

# Chapter Ⅷ. Policy Issues of Health and Social Service for Older Persons

## 8.1 Fundamental Direction for Health and Social Service

Basic objectives of health/social services for older persons in Korea should be set as follows.

First, basic old-age protection regarding income, health, housing and personal care should be delivered to all older persons irrespective of sex, age and income level to help them maintain their basic livelihood. Income protection can be arranged by the combination of the National Pension Scheme and National Basic Livelihood Security Scheme. The National Health Insurance Scheme, along with Medical Care Scheme, should be able to protect elderly health. Basic housing and personal care services can be delivered by public rental housing arrangements for older persons and long-term care system, although such systems are currently at their nascent stages.

Second, health and social services conducive to recovering, maintaining and improving ADLs need to be provided on the basis of elderly individual's level of ability (see Figure 8.1). To repeat, health and social services must be preventive, as well as curative, in outlook. In other words, they should be designed to prevent elderly individuals from losing their ability of conducting activities of daily living even when they have an acute or chronic disease and, in turn, contribute to the maintenance of their human dignity and towards reducing the burden on the individual and society.

Also, institutional and home & community care services for

older persons who have limitations in ADLs or IADLs should be provided in a manner attuned to the severity of disease and the degree of dependency.

*Figure 8.1 Basic Direction of Health and Social Service for Older People*

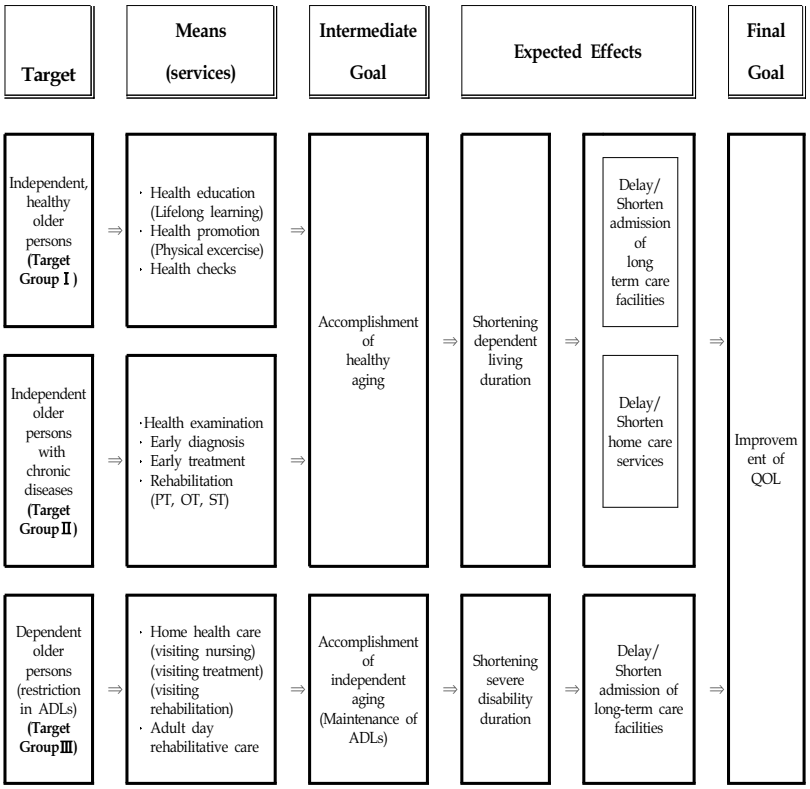
Service delivery system in the area of health and long-term care services for older persons should be equipped as follows (see Figure 8.2).

First, target group for health and long term care services can be divided into three subgroups in accordance with different levels of physical dependency: (1) independent, healthy older persons without chronic diseases (Target Ⅰ); (2) independent older persons with chronic diseases (Target Ⅱ); and (3) dependent older persons with restriction in ADLs (Target Ⅲ). When the services appropriate for each subgroup are delivered, the effects can be maximized.

Second, health services for older persons should be delivered with full recognition of differences in target groups. For instance, services for Target Group Ⅰ need to be provided to promote active health, emphasizing on health, lifelong learning and health promotion based on physical exercises and regular health check-ups. Services for Target Group Ⅱ need to be provided to help older individuals maintain basic level of health. These services should concentrate on health examination and early diagnosis, treatment and rehabilitation. Services for Target Group Ⅲ should be designed to promote health recovery and enhance physical functions, with much emphasis on home health care, and visiting nurse services, and day rehabilitation centers.

Third, the above mentioned services should be aimed to achieve the intermediate objective of promoting healthy aging for Target Group Ⅰ and Ⅱ and maintaining ADLs for Target Group Ⅲ. While the strategy on healthy aging for healthy older persons concentrate on promoting social activities and avoiding adverse factors including smoking, excessive alcohol consumption, and sedentary life style, the strategy on independent aging for frail older persons proceed through rehabilitative services focusing on ADL and Instrumental ADL training programs.

*Figure 8.2 Policy Direction for Health Care Services for Older Persons, by Target Group*




The strategy on independent aging in the process of maintaining ADLs is expected to shorten the duration of dependent life for Target Group Ⅰ and Ⅱ and the duration of disability for Target Group Ⅲ. These can increase the adequacy of admission to, and shorten the period of stay in, long-term care facilities or hospitals and facilities supporting home care. Both individual and costs of elderly care in this case will decrease, lightening financial burdens that family members and formal helpers may have.

## 8.2 Further Considerations for Developing Health and Social Services

The process of population aging Korea is facing, impelled by the decline of total fertility rate (TFR), is faster than any aging process any country has experienced in the past. This will inevitably increase the welfare needs and requires Korea to get prepared for protecting, in particular, frail older persons. The following policies need to be developed and implemented in a manner consistent with the basic policy directions mentioned earlier.

### Establishment of active (or healthy) aging and independent aging strategies

Health and social services in respect of maintenance and promotion of health should be developed and provided to healthy older persons who, irrespective of existence of chronic disease, have no limitations in conducting activities of daily living, and this is what active (or healthy) aging strategy is about. To this end, it would be necessary to expand and activate senior leisure welfare facilities, including community senior welfare centers, community senior halls, elderly schools, to rural areas. In addition to expanding these facilities, a variety of programs need to be developed and activated to encourage social participation involving community volunteering activities and job-seeking efforts.

On the other hand, health and social services with respect to recovery and maintenance of physical functions should be developed and provided on the basis of independent aging strategy to frail older persons who, irrespective of existence of chronic diseases, have limitations in conducting activities of daily living. To achieve this would require efforts to expand and activate facilities supporting home/community care and long-term care including home-help services, adult day care, short-stay

services and institutional care. In addition, specialized manpower must be fostered to ensure the effective delivery of these services.

### Foundation of long-term care service system

Long-term care service system should be grounded on a comprehensive set of plans concerning the following components: accurate estimation of the current and future needs of older persons in the area of long-term care; decisions over the right combination and scope of long-term health and social services; adequate facilities and manpower to deliver these services; and prudent steps to increase long-term care expenditure. As long-term care policies in developed countries are placing emphasis on de-institutionalization, it seems increasingly appropriate for Korea to consider a policy direction that underscores the importance of home/community care.

#### Integrating health and social services for efficient home/community care

There has been frequent criticism that health and social services are delivered in a highly uncoordinated way. This often results in inefficient duplication of services delivered by a diverse range of providers including public health centers, community senior welfare centers, and long-term care hospitals. Therefore, a model of integrated health/social service system should be developed with a view to strengthen consumer-oriented services.

Service needs of older persons are various in kind and complex in nature, but administrative inefficiencies in the current health and social service system leave elderly individuals no choice other than to visit a diverse range of facilities, including public health centers, hospitals, adult day care centers, short-stay care centers, home-help service centers or community senior welfare centers, each kind of which in many cases delivering

fragmented services that usually do not meet the needs effectively. Therefore, services should be delivered under a more unified and coordinated administrative system to eliminate unnecessary duplication of services with a view to saving cost and time.

**Unified elderly health management system**

To maximize cost-effectiveness of primary health care for the elderly would involve efforts to integrate the following components: chronic disease treatment with emphasis on stroke, cardiovascular diseases and osteoporosis; elderly nutrition management; rehabilitation services as part of acute treatment process; preventive/curative services for accidental falls; oral health services with emphasis on maintenance of healthy teeth; infectious disease management such as influenza. To repeat, these elements should be delivered within the continuum of prevention, treatment, nursing and rehabilitation.

**Developing service support system for middle and upper income class older persons**

Up until now health and social services for older Koreans have been provided exclusively to the low-income groups. This is why government budgets invested in elderly welfare sectors have been seriously limited. This in turn greatly discouraged private investments, which left service programmes for middle and upper income groups largely underdeveloped.

It would be too far-fetched to expect that government budgets alone would make it possible to deliver health and social services to all elderly individuals, including those in middle and upper income groups. Indirect support policies, therefore, should be implemented to allow private sectors enter elderly market and participate in a variety of projects including construction of cheaper social welfare facilities for older persons with a view to

reducing the financial burden on middle and upper income groups when they are hospitalized into medical care facilities.

**Substantiality of public income security and developing employment promotion policy**

It is likely that the number of older persons in Korea will be increasing at a rate faster than anticipated, but benefit levels of the national pension and olde-age allowance system are unlikely to rise to ensure old age security. What is needed, then, is an indirect support system that would help people stabilize their old age life. Creation of SOHOs and re-employment, especially for older persons who have experiences in professional or technician jobs is one of efforts that can be made within the framework of such a system. Also, it would be necessary to establish professional senior manpower banks to provide the elderly with job/business information and more jobs.

# Chapter Ⅸ. Conclusion

Among the difficulties facing Korea in the 21st century is the problem of population aging. The most outstanding feature of this process is its bewildering speed, and this is what makes the issue of developing an elderly support system more urgent for Korea than for any other developed countries: absence of a proper support system for the aged spells an unbearable burden on individuals and society.

Policy for the elderly in Korea should be capable of protecting both healthy older persons and frail older persons. The former part of such policy should be established within the framework of economic development strategy that involves labor policy, and the latter within a more balanced social development strategy that includes health/social care policies.

The first two years that followed the outbreak of the 1997 economic crisis had been a staggering shock to the middle-aged and the elderly alike. The mass unemployment brought serious degradation of household heads' ability of supporting their older parents. As a result, the economic and health conditions of the elderly have worsened under the current social protection scheme that only provides them with a minimum benefits and services.

Conclusively speaking, the direction to be gone forward in the case of Korea is to strengthen older persons's social welfare system fulfilling function of a social safety net, that is, the first net through social insurance scheme, the second net through public assistance scheme and the third net through emergent support scheme irrespective of income.

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# Annex Ⅰ. The National Pension Scheme[19)]

## 1. Coverage

The National Pension Scheme (NPS) targets persons aged 18-60 who are living in Korea, excluding government employees, military personnel and private school teachers who are covered under their own pension schemes. NPS participants are divided into two groups: mandatory participants including employees and the self-employed (and foreigners). The rest are voluntary participants including housewives and students.

Since the inception of the scheme in 1988, the number of participants has continuously increased. The total number of participants was 16 million as of 1999.

19) This part is based on *2000 Health and Welfare Services* published by Ministry of Health and Welfare in 2000.

*Table A1.1 Number of Participants*

(unit: 1,000 persons)

| Year | Mandatory participants | | | Voluntary participants |
|---|---|---|---|---|
| | Total | Employees at workplaces with more than 5 workers | Self-employed persons and employees at workplaces with less than 5 workers | |
| 1988 | 4,431 | 4,431 | - | 1 |
| 1992 | 4,977 | 4,977 | - | 32 |
| 1995 | 7,193 | 5,542 | 1,651 | 49 |
| 1996 | 7,360 | 5,678 | 1,682 | 51 |
| 1997 | 7,208 | 5,601 | 1,607 | 47 |
| 1998 | 6,433 | 4,850 | 1,583 | 29 |
| 1999 | 16,060 | 5,238 | 10,822 | 33 |

Source: National Pension Corporation(2000).

## 2. Finance and contribution

The National Pension fund is mainly financed from participants' contributions, and the government provides financial support to the administrative costs for the National Pension Corporation (NPC) and as well as to the contributions of rural participants (farmers and fishermen).

The contribution rate was raised from 3% in 1988 to 9% in 1998. While each of the employed and the employer paid a half of the contributions from 1988 to 1992, the total contribution liability was equally allocated among the employee, employer, and the severance allowance reserve during 1993 to March 1999. Since April 1999, the employed and the employer has been equally sharing the contribution liability. Changes in the National Pension contribution rate are shown in the following table.

*Table A1.2 Changes in the National Pension Contribution Rate*

(unit: %)

| Year | | 1988～1992 | 1993～1997 | 1998 | 1999 and after |
|---|---|---|---|---|---|
| Participants working at workplaces with more than 5 employees | Total | 3.0 | 6.0 | 9.0 | 9.0 |
| | Employee | 1.5 | 2.0 | 3.0 | 4.5 |
| | Employer | 1.5 | 2.0 | 3.0 | 4.5 |
| | Severance Payment Reserve | - | 2.0 | 3.0 | - |
| Voluntary participants at workplaces | | 3.0 | 6.0 | 9.0 | 9.0 |

| Year | 1995.7～2000.6 | 2000.7～2005.6 | 2005.7 and thereafter |
|---|---|---|---|
| Self-employed persons and employees at workplaces with less than 5 workers<br><br>Voluntary participants in urban and rural areas | 3.0 | 4.0～9.0 | 9.0 |

The contribution rates for the self-employed (including farmers and fishermen) and voluntary participants was 3% until June of 2000 and will be raised by 1% every year from July of 2000 until reaching 9% in 2005. The government subsidizes farmers and fishermen with an amount equivalent to a third of contributions of the lowest of 45 grades of Standard Monthly Income from July of 1995 to December of 2004.

## 3. Benefits

The amount of benefits is calculated by the principle of income redistribution among participants. The formula of Basic Pension Amount has a "double layer" approach which combines both the average amount of Standard Monthly Income of all

participants (flat component) and the average amount of Standard Monthly Income of an insured individual (earnings-related component). An yearly increment of 5% is added to both components in the case of a participant with more than a 20-year contribution period. In the case of a worker with a 40-year contribution period, the NPS benefit formula means a 60% replacement rate that reflects both the worker's lifetime average wage revalued in line with earnings growth and the economy-wide average at time retirement.

The income replacement rate ranges from 60% to 100% of the worker's income if his or her lifetime average is below the economy-wide average. The real value of all benefits are price-indexed.

The National Pension benefit includes Old-age Pension, Disability Pension and Survivors Pension benefits.

### 3.1 Old-Age Pension

The participant will be entitled to an Old-age Pension upon reaching the age of 60 (55 for miners and fishermen) if the he or she has contributed for at least 10 years.

The basic pension amount of the Old-age Pension is being provided to ensure that a worker with a 40-year contribution period receive 60% of his lifetime average. The level of pension benefits is determined for each income group on the basis of the participant's monthly income (Standard Monthly Income). The Additional Pension amount is added to this pension if the beneficiary is supporting a spouse or children under 18 or parents (including the spouse's parents) aged 60 or older.

In the early stage of its implementation, the Old-age Pension required those who were approaching 60 of 10 or 15 years contribution. Those who began to contribute at the age over 45 to under 60 when the scheme introduced in 1988, or in 1995, and over 50 to under 60 in 1999 will be paid old-age pension

(Special Old-age Pension) when they have paid contributions at least for 5 years. This rule has been applied from 1993. The number of total beneficiaries of Special Old-age Pension at the end of 1999 reached 149,430. On the other hand, in the case of participants reaching the pensionable age without fulfilling the minimum contribution period, they may continue to pay contributions until becoming 65 on a voluntary basis.

### 3.2. Disability Pension

Disability Pension benefits are paid to participants who become physically or mentally disabled. The benefit level ranges from 60-100% of the Basic Pension Amount according to the severity of the disability. The number of disabled beneficiaries was 33,252 at the end of 1999.

### 3.3 Survivors' Pension

Survivors' Pension benefits are paid to survivors of the participant, or survivors of a former participant with a 10 or more years of participation period, or survivors of a person entitled to Old-age Pension or Disability Pension.

The pension benefit, which includes additional pension amount, ranges 40～60% of the Basic Pension Amount depending on the participation period. Survivors include spouse aged 60 and over, children and grandchildren aged less than 18, the disabled with the second or severer disability, and parents and grandparents aged 60 and over. The number of beneficiaries was 94,609 as of 1999.

### 3.4. Lump-sum Refund

Lump-sum Refund is paid to survivors of a participant with a contribution period under 10 years. It is also paid to participants with under 10 years of contribution period upon reaching 60 years of age, or participants who have become

government official, military personnel, or private school teacher. The benefit level depends on the contributions and a legally fixed interest rate.

## 4. Administration

The NPS is administered by the NPC in accordance with the National Pension Act under the general supervision of the MOHW. The NPC is responsible for record-keeping, pension payment and collection of contributions.

The Pension and Health Insurance Bureau of MOHW is responsible for overall planning, coordination and research, and guidance and supervision of the NPC. At the Ministerial level, there are three committees; the National Pension Council, the National Pension Fund Operation Committee and the National Pension Review Committee.

The National Pension Council was established in order to advise the Minister of Health and Welfare on important policies concerning the administration of NPS. The Council is composed of four members representing employees, four members representing employers, six members representing the self-employed (including farmers and fishermen), and five members representing public interests.

The National Pension Fund Operation Committee was established to deliberate and decide policies pertaining to the operation of the fund. The Committee is composed of 21 members including a chairman (the Minister of health and Welfare) a vice-chairman.

The National Pension Review Committee is established in MOHW to examine the decisions concerning the NPC. The Committee is composed of seven members including the chairman, the Vice-minister of Health and Welfare.

# Annex Ⅱ. Health and Social Services (Tables)

*Table A2.1 Dependency Ratio & Index of Aging*

(unit: 1,000 persons, %)

| | Population Aged 14 Years Old & Under | Population Aged 15 to 64 Years Old | Population Aged 65 Years Old & Over | Total Dependency Ratio | Youth Dependency Ratio | Aged Dependency Ratio | Index of Aging |
|---|---|---|---|---|---|---|---|
| 1980 | 12,951 | 23,717 | 1,456 | 60.7 | 54.6 | 6.1 | 11.2 |
| 1985 | 12,305 | 26,759 | 1,742 | 52.5 | 46.0 | 6.5 | 14.2 |
| 1990 | 10,974 | 29,701 | 2,195 | 44.3 | 36.9 | 7.4 | 20.0 |
| 1991 | 10,859 | 30,171 | 2,266 | 43.5 | 36.0 | 7.5 | 20.9 |
| 1992 | 10,791 | 30,611 | 2,346 | 42.9 | 35.3 | 7.7 | 21.7 |
| 1993 | 10,735 | 31,023 | 2,437 | 42.5 | 34.6 | 7.9 | 22.7 |
| 1994 | 10,653 | 31,446 | 2,542 | 42.0 | 33.9 | 8.1 | 23.9 |
| 1995 | 10,537 | 31,900 | 2,657 | 41.4 | 33.0 | 8.3 | 25.2 |
| 1996 | 10,410 | 32,360 | 2,776 | 40.7 | 32.2 | 8.6 | 26.7 |
| 1997 | 10,292 | 32,791 | 2,908 | 40.3 | 31.4 | 8.9 | 28.3 |
| 1998 | 10,217 | 33,162 | 3,051 | 40.0 | 30.8 | 9.2 | 29.9 |
| 1999 | 10,203 | 33,452 | 3,204 | 40.1 | 30.5 | 9.6 | 31.4 |
| 2000 | 10,233 | 33,671 | 3,371 | 40.4 | 30.4 | 10.0 | 32.9 |
| 2005 | 10,421 | 34,450 | 4,253 | 42.6 | 30.2 | 12.3 | 40.8 |
| 2010 | 10,080 | 35,506 | 5,032 | 42.6 | 28.4 | 14.2 | 49.9 |
| 2015 | 9,515 | 36,316 | 5,846 | 42.3 | 26.2 | 16.1 | 61.4 |
| 2020 | 9,013 | 36,446 | 6,899 | 43.7 | 24.7 | 18.9 | 76.5 |
| 2025 | 8,633 | 35,465 | 8,613 | 48.6 | 24.3 | 24.3 | 99.8 |
| 2030 | 8,448 | 34,130 | 10,165 | 54.5 | 24.8 | 29.8 | 120.3 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.2 Ways to Prepare for Old-age Security, 1998*

(unit: %)

| | Earning from Job | Public Pension | Private Pension | Retirement Allowance | Savings, Insurance |
|---|---|---|---|---|---|
| Whole country | 33.7 | 2.8 | 0.2 | 0.9 | 5.7 |
| Dongs | 23.1 | 4.0 | 0.3 | 1.0 | 6.8 |
| Eups & Myeons | 52.0 | 0.9 | 0.2 | 0.7 | 3.7 |
| Male | 48.2 | 5.1 | 0.2 | 1.7 | 8.1 |
| Female | 25.2 | 1.5 | 0.3 | 0.4 | 4.3 |
| Primary School Graduates | 37.3 | 2.8 | 0.0 | 0.7 | 6.9 |
| Middle & high School Graduates | 36.0 | 6.6 | 0.9 | 3.7 | 12.0 |
| College, University Graduates & Over | 34.4 | 20.9 | 1.3 | 2.8 | 16.3 |

| | Real Estate | Support from non co-resident off-springs | Support from co-resident off-springs | Public assistance | Others |
|---|---|---|---|---|---|
| Whole country | 12.0 | 66.3 | 23.3 | 9.2 | 1.2 |
| Dongs | 13.2 | 64.0 | 24.8 | 9.4 | 1.8 |
| Eups & Myeons | 9.8 | 70.3 | 20.8 | 8.6 | 0.2 |
| Male | 13.6 | 62.4 | 16.3 | 7.4 | 0.7 |
| Female | 11.0 | 68.6 | 27.5 | 10.2 | 1.5 |
| Primary School Graduates | 15.9 | 68.4 | 19.6 | 7.1 | 0.6 |
| Middle & high School Graduates | 18.4 | 61.0 | 17.0 | 4.2 | 2.1 |
| College, University Graduates & Over | 17.4 | 59.1 | 11.8 | 6.4 | 1.3 |

Source: Chung, et al. (1998)

*Table A2.3 Financial Support for Parents*

(unit: %)

| | Children Support | | | | |
|---|---|---|---|---|---|
| | Total | Eldest Son | Other Sons | All Sons | Daughters |
| <1994> | 62.1 | 33.1 | 7.6 | 8.7 | 1.6 |
| Urban Area | 58.8 | 29.9 | 7.0 | 8.8 | 1.6 |
| Rural Area | 77.8 | 48.4 | 10.4 | 7.9 | 1.5 |
| Male | 63.2 | 33.9 | 8.2 | 9.4 | 0.9 |
| Female | 56.4 | 28.7 | 4.6 | 4.6 | 5.7 |
| Primary School Graduates &Under | 83.1 | 50.6 | 11.8 | 7.9 | 2.3 |
| Middle School Graduates | 72.7 | 40.2 | 9.7 | 8.6 | 1.7 |
| High School Graduates | 59.1 | 30.3 | 7.1 | 8.9 | 1.6 |
| College, University Graduates & Over | 50.5 | 25.1 | 5.2 | 8.7 | 1.2 |
| <1998> | 58.2 | 27.0 | 10.9 | 8.9 | 1.4 |
| Dongs | 55.8 | 24.5 | 10.3 | 9.1 | 1.4 |
| Eups & Myeons | 73.0 | 42.3 | 14.6 | 7.3 | 1.1 |
| Male | 59.0 | 27.8 | 11.4 | 9.7 | 0.5 |
| Female | 53.8 | 22.4 | 8.3 | 4.1 | 5.9 |
| Primary School Graduates &Under | 82.1 | 45.1 | 16.9 | 8.1 | 2.3 |
| Middle School Graduates | 72.2 | 35.2 | 14.7 | 9.5 | 1.8 |
| High School Graduates | 56.2 | 25.3 | 11.0 | 8.9 | 1.2 |
| College, University Graduates & Over | 48.1 | 20.7 | 7.4 | 8.7 | 1.2 |

*Table A2.3 (contd.)*

| | | | Self-support | Others |
|---|---|---|---|---|
| | All Daughters | All Children | | |
| <1994> | - | 11.1 | 37.6 | 0.3 |
| Urban Area | - | 11.4 | 40.9 | 0.3 |
| Rural Area | - | 9.6 | 22.1 | 0.1 |
| Male | - | 10.8 | 36.6 | 0.2 |
| Female | - | 12.9 | 42.9 | 0.7 |
| Primary School Graduates &Under | - | 10.4 | 16.4 | 0.5 |
| Middle School Graduates | - | 12.5 | 27.1 | 0.2 |
| High School Graduates | - | 11.3 | 40.7 | 0.2 |
| College, University Graduates & Over | - | 10.3 | 49.3 | 0.2 |
| <1998> | 0.4 | 9.6 | 41.6 | 0.2 |
| Dongs | 0.4 | 9.9 | 44.0 | 0.2 |
| Eups & Myeons | 0.2 | 7.5 | 26.8 | 0.2 |
| Male | 0.2 | 9.2 | 40.8 | 0.2 |
| Female | 1.8 | 11.3 | 45.7 | 0.5 |
| Primary School Graduates &Under | 0.7 | 9.1 | 16.9 | 1.0 |
| Middle School Graduates | 0.6 | 10.3 | 27.6 | 0.3 |
| High School Graduates | 0.4 | 9.4 | 43.6 | 0.1 |
| College, University Graduates & Over | 0.3 | 9.7 | 51.8 | 0.2 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.4 Percentage of Employed Persons Aged 55 & over*

(unit: 1,000 persons, %)

| | Total Employed Persons Aged 55+ | Percentage of Employed Persons Aged 55+ | | | | |
|---|---|---|---|---|---|---|
| | | Total | Male | Female | Farm | Non-farm |
| 1978 | 1,389 | 10.4 | 10.6 | 10.0 | - | - |
| 1979 | 1,482 | 10.9 | 11.0 | 10.7 | - | - |
| 1980 | 1,477 | 10.8 | 10.9 | 10.7 | 19.3 | 5.7 |
| 1981 | 1,562 | 11.1 | 11.0 | 11.3 | 20.3 | 5.8 |
| 1982 | 1,645 | 11.4 | 11.3 | 11.7 | 21.0 | 6.6 |
| 1983 | 1,617 | 11.1 | 10.9 | 11.5 | 21.4 | 6.6 |
| 1984 | 1,598 | 11.1 | 10.7 | 11.7 | 23.5 | 6.4 |
| 1985 | 1,688 | 11.3 | 10.8 | 12.0 | 24.3 | 6.8 |
| 1986 | 1,767 | 11.4 | 10.7 | 12.5 | 25.9 | 6.8 |
| 1987 | 1,926 | 11.8 | 11.0 | 12.9 | 28.3 | 6.9 |
| 1988 | 2,049 | 12.1 | 11.6 | 13.0 | 30.1 | 7.2 |
| 1989 | 2,271 | 12.9 | 12.4 | 13.4 | 33.0 | 7.7 |
| 1990 | 2,455 | 13.6 | 13.1 | 14.3 | 35.9 | 8.3 |
| 1991 | 2,611 | 14.0 | 13.6 | 14.6 | 38.3 | 8.7 |
| 1992 | 2,808 | 14.8 | 14.3 | 15.5 | 41.4 | 9.2 |
| 1993 | 2,785 | 14.4 | 14.0 | 15.1 | 42.5 | 9.2 |
| 1994 | 2,980 | 15.0 | 14.4 | 15.7 | 44.7 | 9.8 |
| 1995 | 3,069 | 15.0 | 14.4 | 16.0 | 46.5 | 10.1 |
| 1996 | 3,229 | 15.5 | 15.0 | 16.2 | 48.2 | 10.7 |
| 1997 | 3,465 | 16.4 | 15.9 | 17.1 | 50.2 | 11.6 |
| 1998 | 3,273 | 16.4 | 15.9 | 17.0 | 52.0 | 10.9 |
| 1999 | 3,351 | 16.5 | 15.8 | 17.5 | 53.0 | 11.4 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.5 Percentage of Employed Persons Aged 55 & over, by Industry*

(unit: %)

| | Whole Industry | Agri., Forestry & Fisheries | Mining & Manufacturing | Manufacturing | SOC & Others |
|---|---|---|---|---|---|
| 1978 | 10.4 | 18.4 | 2.6 | - | 6.9 |
| 1979 | 10.9 | 21.0 | 2.8 | - | 6.7 |
| 1980 | 10.8 | 21.2 | 3.2 | 3.3 | 6.6 |
| 1981 | 11.1 | 22.0 | 3.0 | 3.1 | 6.7 |
| 1982 | 11.4 | 22.7 | 3.3 | 3.4 | 7.5 |
| 1983 | 11.1 | 23.1 | 3.6 | 3.7 | 7.3 |
| 1984 | 11.1 | 24.7 | 3.4 | 3.5 | 7.3 |
| 1985 | 11.3 | 26.1 | 3.6 | 3.6 | 7.7 |
| 1986 | 11.4 | 27.7 | 3.7 | 3.8 | 7.7 |
| 1987 | 11.8 | 30.6 | 3.7 | 3.8 | 8.1 |
| 1988 | 12.1 | 32.8 | 4.1 | 4.1 | 8.3 |
| 1989 | 12.9 | 36.0 | 4.7 | 4.6 | 8.8 |
| 1990 | 13.6 | 39.2 | 5.3 | 5.2 | 9.3 |
| 1991 | 14.0 | 42.1 | 6.0 | 5.9 | 9.7 |
| 1992 | 14.8 | 45.4 | 6.7 | 6.5 | 10.1 |
| 1993 | 14.4 | 47.1 | 5.9 | 5.8 | 9.9 |
| 1994 | 15.0 | 49.9 | 6.8 | 6.7 | 10.4 |
| 1995 | 15.0 | 52.1 | 7.5 | 7.4 | 10.6 |
| 1996 | 15.5 | 54.6 | 8.0 | 8.0 | 11.2 |
| 1997 | 16.4 | 57.0 | 8.5 | 8.4 | 12.1 |
| 1998 | 16.4 | 56.8 | 7.3 | 7.3 | 11.6 |
| 1999 | 16.5 | 58.5 | 7.8 | 7.7 | 12.0 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.6 Morbidity Rates on Adult Diseases*

(unit: Per 1,000 adults)

| | Total | 20~29 Years Old | 30~39 Years Old | 40~49 Years Old | 50~59 Years Old | 60~69 Years Old | 70 Years Old |
|---|---|---|---|---|---|---|---|
| Total | | | | | | | |
| Melignant Neoplasm of Stomach | 0.85 | - | - | 0.96 | 2.58 | 4.89 | 2.67 |
| Diabetes Mellitus | 22.38 | 1.06 | 6.15 | 27.15 | 69.01 | 101.11 | 76.47 |
| Hypertensive Disease | 44.73 | 2.42 | 16.44 | 50.95 | 119.72 | 197.00 | 196.79 |
| Cerebrovascular Disease | 6.48 | 0.15 | 1.13 | 2.24 | 14.08 | 29.68 | 56.68 |
| Heart Disease | 18.29 | 4.24 | 6.65 | 20.44 | 44.13 | 79.91 | 67.38 |
| Liver Disease | 17.04 | 11.65 | 20.71 | 33.38 | 34.51 | 24.46 | 13.37 |
| Male | | | | | | | |
| Melignant Neoplasm of Stomach | 1.29 | - | - | 0.94 | 4.80 | 7.25 | 6.38 |
| Diabetes Mellitus | 22.71 | 1.32 | 6.59 | 37.36 | 76.81 | 97.17 | 66.99 |
| Hypertensive Disease | 37.15 | 2.64 | 23.84 | 55.57 | 95.54 | 155.18 | 157.89 |
| Cerebrovascular Disease | 6.13 | 0.33 | 1.52 | 2.83 | 14.40 | 31.91 | 62.20 |
| Heart Disease | 11.14 | 1.98 | 5.07 | 10.05 | 29.76 | 47.14 | 52.63 |
| Liver Disease | 24.26 | 17.50 | 29.17 | 48.98 | 50.89 | 35.53 | 23.92 |
| Female | | | | | | | |
| Melignant Neoplasm of Stomach | 0.44 | - | - | 0.98 | 0.46 | 2.96 | 0.81 |
| Diabetes Mellitus | 22.07 | 0.84 | 5.72 | 16.58 | 61.55 | 104.27 | 81.32 |
| Hypertensive Disease | 51.98 | 2.24 | 9.19 | 46.16 | 142.86 | 231.04 | 216.59 |
| Cerebrovascular Disease | 6.81 | - | 0.75 | 1.63 | 13.78 | 27.84 | 53.95 |
| Heart Disease | 25.18 | 6.15 | 8.20 | 31.21 | 57.88 | 106.64 | 74.88 |
| Liver Disease | 10.14 | 6.71 | 12.43 | 17.23 | 18.83 | 15.40 | 8.05 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.7 No. of Visitors to Medical Doctors & Days of Medical Treatment (during the previous 2 weeks)*

(unit: persons, days)

| | No. of Visitors to M.D. (Per 1,000 Persons) | | | | No. of Days of Medical Treatment per Patient | | | |
|---|---|---|---|---|---|---|---|---|
| | 1989 | 1992 | 1995 | 1999 | 1989 | 1992 | 1995 | 1999 |
| Whole Country | 80.9 | 97.1 | 98.5 | 135.0 | 4.5 | 4.7 | 4.7 | 4.8 |
| Urban Area | 84.9 | 101.2 | 98.1 | 127.5 | 4.6 | 4.8 | 4.7 | 4.8 |
| Rural Area | 70.6 | 84.5 | 99.8 | 165.7 | 4.2 | 4.6 | 4.6 | 5.0 |
| Male | 76.9 | 89.4 | 88.4 | 118.4 | 4.6 | 4.8 | 4.8 | 5.0 |
| Female | 84.6 | 104.7 | 108.4 | 151.3 | 4.5 | 4.6 | 4.6 | 4.7 |
| 0~4 | 273.1 | 317.7 | 279.6 | 360.2 | 3.8 | 4.2 | 3.9 | 4.1 |
| 5~9 | 88.7 | 121.3 | 125.0 | 182.7 | 3.3 | 3.6 | 3.5 | 3.8 |
| 10~14 | 43.1 | 50.1 | 51.4 | 84.1 | 3.3 | 4.0 | 3.5 | 3.9 |
| 15~19 | 29.5 | 35.3 | 37.1 | 47.7 | 4.5 | 4.3 | 4.2 | 4.2 |
| 20~24 | 42.7 | 39.4 | 42.9 | 62.8 | 4.7 | 4.9 | 4.7 | 4.2 |
| 25~29 | 51.6 | 54.1 | 53.4 | 63.6 | 4.4 | 4.5 | 3.8 | 4.4 |
| 30~34 | 67.5 | 68.7 | 66.7 | 72.7 | 5.0 | 4.5 | 4.2 | 4.4 |
| 35~39 | 67.0 | 76.6 | 76.6 | 79.1 | 5.2 | 5.0 | 4.8 | 4.6 |
| 40~44 | 72.4 | 90.1 | 79.3 | 94.3 | 5.3 | 5.3 | 4.9 | 5.0 |
| 45~49 | 72.9 | 102.3 | 89.8 | 116.1 | 5.5 | 5.1 | 5.5 | 5.4 |
| 50~54 | 93.0 | 109.7 | 108.9 | 142.1 | 5.3 | 5.5 | 5.8 | 5.6 |
| 55~59 | 103.5 | 125.6 | 127.4 | 176.8 | 5.6 | 5.3 | 5.7 | 5.3 |
| 60~64 | 107.1 | 144.2 | 155.5 | 223.3 | 5.3 | 5.6 | 5.8 | 5.7 |
| 65+ | 107.5 | 140.8 | 171.6 | 281.6 | 5.0 | 5.8 | 6.2 | 6.2 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.8 Types of Housing, 1997*

(unit: %)

| | Detached Dwelling | Town House | Apartment | Apartment Unit in a Private House | Others |
|---|---|---|---|---|---|
| Whole Country | 61.4 | 2.1 | 35.2 | 0.8 | 0.6 |
| Urban Area | 55.2 | 2.5 | 40.8 | 0.9 | 0.6 |
| Rural Area | 84.9 | 0.6 | 13.6 | 0.3 | 0.5 |
| Male | 61.9 | 2.1 | 34.7 | 0.7 | 0.6 |
| Female | 59.3 | 2.1 | 37.1 | 0.8 | 0.6 |
| 15～29 | 39.7 | 2.4 | 56.1 | 1.1 | 0.7 |
| 30～39 | 49.2 | 2.4 | 47.2 | 0.8 | 0.4 |
| 40～49 | 62.0 | 2.0 | 34.4 | 1.0 | 0.7 |
| 50～59 | 75.5 | 1.8 | 21.3 | 0.6 | 0.8 |
| 65+ | 84.9 | 1.7 | 12.7 | 0.3 | 0.4 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.9 Ability of Using PC*

(unit: %)

| | Total | Never Experience | Beginner Level | Middle Level | Expert Level |
|---|---|---|---|---|---|
| Whole Country | 100.0 | 60.1 | 30.9 | 7.2 | 1.8 |
| Urban Area | 100.0 | 56.3 | 33.4 | 8.1 | 2.1 |
| Rural Area | 100.0 | 75.2 | 20.7 | 3.5 | 0.6 |
| Male | 100.0 | 53.8 | 33.6 | 9.8 | 2.9 |
| Female | 100.0 | 66.1 | 28.4 | 4.7 | 0.8 |
| 6～ 9 | 100.0 | 71.4 | 27.5 | 1.0 | 0.0 |
| 10～14 | 100.0 | 35.4 | 57.4 | 6.6 | 0.6 |
| 15～19 | 100.0 | 20.6 | 64.0 | 13.7 | 1.6 |
| 20～29 | 100.0 | 31.1 | 47.6 | 16.4 | 4.9 |
| 30～39 | 100.0 | 60.6 | 28.8 | 7.8 | 2.8 |
| 40～49 | 100.0 | 78.7 | 17.0 | 3.5 | 0.9 |
| 50～59 | 100.0 | 90.5 | 8.1 | 1.2 | 0.2 |
| 65+ | 100.0 | 98.4 | 1.5 | 0.2 | 0.0 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.10 Percentage of Public Pension Participants*

(unit: 1,000 persons, %)

| | Employed Persons Aged 18 & Over | Public Pension Insurants | National Pension | Government Employees Pension | Private School Teachers Pension | B/A (%) |
|---|---|---|---|---|---|---|
| 1982 | 13,961 | 775 | - | 668 | 108 | 5.6 |
| 1983 | 14,229 | 780 | - | 670 | 110 | 5.5 |
| 1984 | 14,168 | 799 | - | 682 | 117 | 5.6 |
| 1985 | 14,667 | 821 | - | 697 | 124 | 5.6 |
| 1986 | 15,250 | 844 | - | 717 | 127 | 5.5 |
| 1987 | 16,072 | 870 | - | 738 | 133 | 5.4 |
| 1988 | 16,728 | 5,341 | 4,433 | 767 | 141 | 31.9 |
| 1989 | 17,428 | 5,481 | 4,521 | 810 | 150 | 31.4 |
| 1990 | 17,983 | 5,649 | 4,652 | 843 | 154 | 31.4 |
| 1991 | 18,527 | 5,812 | 4,769 | 885 | 159 | 31.4 |
| 1992 | 18,890 | 6,108 | 5,021 | 922 | 165 | 32.3 |
| 1993 | 19,203 | 6,271 | 5,160 | 940 | 171 | 32.7 |
| 1994 | 19,789 | 6,567 | 5,445 | 948 | 175 | 33.2 |
| 1995 | 20,330 | 8,396 | 7,257 | 958 | 181 | 41.3 |
| 1996 | 20,721 | 8,589 | 7,426 | 971 | 192 | 41.5 |
| 1997 | 20,998 | 8,542 | 7,357 | 982 | 203 | 40.7 |
| 1998 | 19,952 | 7,738 | 6,580 | 952 | 206 | 38.8 |
| 1999 | 20,236 | 11,871 | 10,749 | 914 | 208 | 58.7 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.11 Percentage of Public Pension Beneficiaries*

(unit: 1,000 persons, %)

| | National Persons Beneficiaries | As % of Insurants | Government Employees Pension Beneficiaries | As % of Insurants | Private School Teachers Pension Beneficiaries | As % of Insurants |
|---|---|---|---|---|---|---|
| 1982 | - | - | 3,742 | 0.6 | 13 | 0.0 |
| 1983 | - | - | 5,618 | 0.8 | 60 | 0.1 |
| 1984 | - | - | 7,235 | 1.1 | 112 | 0.1 |
| 1985 | - | - | 9,078 | 1.3 | 233 | 0.2 |
| 1986 | - | - | 10,926 | 1.5 | 383 | 0.3 |
| 1987 | - | - | 14,832 | 2.0 | 533 | 0.4 |
| 1988 | 3,136 | 0.1 | 18,084 | 2.4 | 783 | 0.6 |
| 1989 | 59,438 | 0.3 | 21,204 | 2.6 | 1,069 | 0.7 |
| 1990 | 257,318 | 5.5 | 25,396 | 3.0 | 1,345 | 0.9 |
| 1991 | 383,251 | 8.0 | 29,719 | 3.4 | 1,705 | 1.1 |
| 1992 | 493,217 | 9.8 | 34,333 | 3.7 | 2,103 | 1.3 |
| 1993 | 584,206 | 11.3 | 40,849 | 4.4 | 2,674 | 1.6 |
| 1994 | 847,199 | 15.6 | 48,016 | 5.1 | 3,370 | 1.9 |
| 1995 | 878,102 | 12.1 | 56,343 | 5.9 | 3,950 | 2.2 |
| 1996 | 945,848 | 12.7 | 63,693 | 6.6 | 4,618 | 2.4 |
| 1997 | 987,888 | 13.4 | 72,889 | 7.4 | 5,457 | 2.7 |
| 1998 | 1,268,984 | 19.3 | 89,322 | 9.4 | 6,412 | 3.1 |
| 1999 | 1,254,621 | 11.7 | 128,940 | 14.1 | 10,687 | 5.1 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.12 Percentage of Elderly Livelihood Protection & Elderly Inmates in Welfare Institutes*

(unit: persons)

| | Elderly Population (A) | Elderly Livelihood Protection (B) | (B)/(A) (%) | Elderly Inmates in Welfare Institute (C) | (C)/(A) (%) |
|---|---|---|---|---|---|
| 1982 | 1,559,415 | - | - | 3,753 | 0.2 |
| 1983 | 1,614,534 | - | - | 4,288 | 0.3 |
| 1984 | 1,673,615 | - | - | 4,785 | 0.3 |
| 1985 | 1,741,849 | - | - | 5,059 | 0.3 |
| 1986 | 1,800,736 | - | - | 5,387 | 0.3 |
| 1987 | 1,876,428 | - | - | 5,648 | 0.3 |
| 1988 | 1,961,860 | - | - | 6,124 | 0.3 |
| 1989 | 2,052,985 | 263,344 | 12.8 | 6,286 | 0.3 |
| 1990 | 2,195,084 | 300,380 | 13.7 | 6,409 | 0.3 |
| 1991 | 2,266,441 | 321,187 | 14.2 | 6,822 | 0.3 |
| 1992 | 2,345,856 | 316,949 | 13.5 | 7,239 | 0.3 |
| 1993 | 2,436,993 | 309,599 | 12.7 | 7,525 | 0.3 |
| 1994 | 2,542,492 | 271,051 | 10.7 | 8,089 | 0.3 |
| 1995 | 2,656,652 | 257,556 | 9.7 | 8,396 | 0.3 |
| 1996 | 2,775,566 | 247,163 | 8.9 | 8,996 | 0.3 |
| 1997 | 2,908,283 | 242,664 | 8.3 | 9,539 | 0.3 |
| 1998 | 3,050,637 | 241,421 | 7.9 | 10,646 | 0.3 |
| 1999 | 3,204,095 | 241,303 | 7.5 | 12.751 | 0.4 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.13 Perception of the Problems of the Aged*

(unit: %)

| | Economic Problem | Employment Problem | Don't have anything to do | Health | Loneliness |
|---|---|---|---|---|---|
| Whole Country | 29.3 | 4.5 | 10.7 | 23.5 | 20.8 |
| Dongs | 30.4 | 4.7 | 11.0 | 21.3 | 21.5 |
| Eups & Myeon | 24.5 | 3.6 | 9.0 | 32.9 | 17.5 |
| Male | 29.2 | 5.0 | 11.0 | 22.5 | 20.5 |
| Female | 29.4 | 4.0 | 10.3 | 24.3 | 21.0 |
| Primary School Graduates & Under | 29.7 | 4.2 | 8.9 | 30.4 | 15.0 |
| Middle School Graduates | 29.2 | 4.7 | 10.6 | 22.8 | 19.8 |
| High School Graduates | 29.6 | 4.6 | 11.1 | 21.7 | 22.1 |
| College, University Graduates & Over | 28.5 | 4.5 | 11.8 | 19.8 | 25.8 |
| 15～19 | 22.3 | 4.5 | 9.9 | 21.7 | 26.7 |
| 20～29 | 25.0 | 4.7 | 10.9 | 20.6 | 27.9 |
| 30～39 | 32.3 | 4.7 | 10.8 | 21.3 | 21.5 |
| 40～49 | 30.1 | 4.1 | 12.4 | 24.0 | 18.0 |
| 50～59 | 32.1 | 4.6 | 10.4 | 23.8 | 16.9 |
| 65+ | 32.4 | 4.4 | 8.8 | 31.5 | 12.1 |

| | Unkind Treatment by Family | Weaken of Respecting for the Aged | Lack of Facilities for the Aged | Others |
|---|---|---|---|---|
| Whole Country | 4.8 | 1.9 | 3.3 | 1.2 |
| Dongs | 5.0 | 1.8 | 3.1 | 1.0 |
| Eups & Myeon | 4.0 | 2.0 | 4.4 | 2.1 |
| Male | 4.7 | 2.1 | 3.6 | 1.2 |
| Female | 4.8 | 1.7 | 3.1 | 1.4 |
| Primary School Graduates & Under | 4.4 | 1.7 | 3.4 | 2.3 |
| Middle School Graduates | 5.7 | 1.9 | 3.5 | 1.7 |
| High School Graduates | 4.9 | 1.8 | 3.3 | 0.9 |
| College, University Graduates & Over | 3.9 | 2.1 | 3.1 | 0.4 |
| 15～19 | 6.4 | 2.6 | 3.1 | 2.8 |
| 20～29 | 5.0 | 2.0 | 3.0 | 0.9 |
| 30～39 | 4.5 | 1.7 | 2.8 | 0.5 |
| 40～49 | 5.1 | 1.7 | 3.6 | 0.8 |
| 50～59 | 4.9 | 1.8 | 4.2 | 1.0 |
| 65+ | 3.3 | 1.7 | 3.6 | 2.3 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.14 Participation Rate in Social Group*

(unit: %)

| Age Group | Participation Rate | Social Community | Religion | Leisure | Social service |
|---|---|---|---|---|---|
| 15～19 | 11.5 | 26.5 | 26.4 | 23.5 | 21.6 |
| 20～29 | 22.6 | 57.0 | 15.0 | 20.0 | 5.2 |
| 30～39 | 26.3 | 52.7 | 17.4 | 18.7 | 6.7 |
| 40～49 | 31.0 | 55.4 | 20.0 | 13.4 | 7.6 |
| 50～59 | 27.5 | 58.5 | 19.4 | 10.4 | 7.7 |
| 65+ | 13.5 | 56.7 | 24.3 | 8.9 | 6.2 |

| Age Group | Academic group | Association | Political body | Others | None |
|---|---|---|---|---|---|
| 15～19 | 0.6 | 0.0 | - | 1.4 | 88.5 |
| 20～29 | 1.3 | 1.3 | 0.1 | 0.2 | 77.4 |
| 30～39 | 0.8 | 2.6 | 0.6 | 0.5 | 73.7 |
| 40～49 | 0.8 | 1.5 | 0.8 | 0.5 | 69.0 |
| 50～59 | 0.9 | 1.3 | 1.1 | 0.8 | 72.5 |
| 65+ | 1.2 | 0.7 | 1.2 | 0.8 | 86.5 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.15 Participation Rate in Voluntary Service*

(unit: %)

| Age Group | Participation Rate | Regional Environment | Volunteering National & Regional Fair | Children Education | Welfare Facilities | Disaster Relief | Others |
|---|---|---|---|---|---|---|---|
| 15～19 | 33.8 | 42.4 | 7.6 | - | 45.3 | 4.9 | 14.6 |
| 20～29 | 7.8 | 19.8 | 8.3 | 2.5 | 45.2 | 13.6 | 23.6 |
| 30～39 | 13.2 | 32.1 | 6.3 | 38.3 | 20.9 | 9.0 | 8.7 |
| 40～49 | 13.0 | 42.3 | 10.7 | 14.4 | 33.4 | 10.5 | 9.5 |
| 50～59 | 10.8 | 48.8 | 9.9 | 2.1 | 33.1 | 11.8 | 6.8 |
| 65+ | 6.7 | 68.8 | 6.2 | 2.6 | 22.2 | 4.9 | 5.3 |

Source: National Statistical Office, *Social Indicators in Korea*, 2000.

*Table A2.16 Dependency Ratio, 1960~2030*

(unit: %)

| | 1960 | 1990 | 2000 | 2010 | 2020 | 2030 |
|---|---|---|---|---|---|---|
| Australia | 62.8 | 49.4 | 48.9 | 48.4 | 54.7 | 61.8 |
| Austria | 51.9 | 47.9 | 46.0 | 44.5 | 49.0 | 62.1 |
| Belgium | 55.0 | 49.7 | 51.0 | 49.5 | 56.8 | 68.0 |
| Canada | 69.6 | 47.0 | 46.8 | 45.1 | 54.8 | 67.6 |
| Czech Republic | 53.3 | 51.4 | 43.3 | 41 | 48.6 | 50.9 |
| Denmark | 55.8 | 48.4 | 50.0 | 52.5 | 57.3 | 65.0 |
| Finland | 60.3 | 48.6 | 49.1 | 50.1 | 62.8 | 69.9 |
| France | 61.3 | 52.1 | 52.9 | 50.5 | 59.0 | 67.5 |
| Germany | 48.8 | 45.0 | 45.4 | 47.3 | 49.8 | 62.1 |
| Greece | 53.2 | 49.1 | 49.5 | 52.4 | 56.0 | 62.7 |
| Hungary | 52.4 | 50.5 | 46.0 | 44.2 | 49.9 | 51.3 |
| Iceland | 74.3 | 54.9 | 53.8 | 51.7 | 55.0 | 62.1 |
| Ireland | 73.2 | 63.1 | 48.2 | 47.5 | 55.5 | 56.8 |
| Italy | 51.7 | 45.3 | 46.8 | 49.7 | 54.4 | 66.9 |
| Japan | 56.1 | 43.7 | 46.4 | 56.0 | 65.6 | 67.4 |
| Korea | 82.7 | 44.6 | 38.9 | 40.3 | 41.6 | 52.5 |
| Luxembourg | 47.4 | 44.9 | 47.8 | 49.3 | 55.0 | 64.3 |
| Mexico | 98.4 | 74.0 | 61.0 | 52.4 | 48.1 | 49.1 |
| Netherlands | 63.9 | 45.1 | 46.6 | 45.8 | 54.1 | 68.5 |
| New Zealand | 71.0 | 52.7 | 52.4 | 50.3 | 53.8 | 58.9 |
| Norway | 58.7 | 54.5 | 53.5 | 51.4 | 57.7 | 64.7 |
| Poland | 64.6 | 54.3 | 46.3 | 42.8 | 51.1 | 54.5 |
| Portugal | 59.1 | 50.6 | 48.1 | 49.3 | 52.1 | 58.8 |
| Spain | 55.4 | 49.5 | 46.2 | 46.9 | 50.0 | 60.2 |
| Sweden | 51.4 | 55.6 | 55.6 | 55.0 | 63.3 | 69.0 |
| Switzerland | 50.8 | 45.4 | 46.8 | 47.2 | 54.5 | 70.3 |
| Turkey | 81.1 | 64.7 | 52.2 | 48.4 | 45.4 | 48.5 |
| UK | 53.7 | 53.5 | 52.9 | 51.1 | 57.5 | 66.1 |
| United States | 66.7 | 52.2 | 51.1 | 48.0 | 56.2 | 64.5 |
| OECD | 61.6 | 51.6 | 49.6 | 48.9 | 53.8 | 60.7 |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.

*Table A2.17 Recent Trends in the Number of Lone-parent Families*

| Country/Year | Number | Index | Incidence |
|---|---|---|---|
| Australia | | | |
| 1983 | 296,025 | 100 | 13.6 |
| 1993 | 417,420 | 141 | 17.2 |
| Austria | | | |
| 1981 | 257,276 | 100 | 19.3 |
| 1991 | 282,102 | 110 | 19.7 |
| Belgium | | | |
| 1981 | 252,096 | 100 | 14.6 |
| 1991 | 362,000 | 144 | 20.0 |
| Canada | | | |
| 1981 | - | - | - |
| 1991 | 954,710 | - | 20.0 |
| Denmark | | | |
| 1981 | 144,704 | 100 | 18.0 |
| 1991 | 131,000 | 91 | 18.0 |
| Finland | | | |
| 1983 | 100,000 | 100 | 13.0 |
| 1993 | 103,584 | 104 | 11.9 |
| France | | | |
| 1981 | 842,680 | 100 | 9.9 |
| 1991 | 1,544,000 | 183 | 15.6 |
| Germany | | | |
| 1981 | 1,559,400 | 100 | 14.6 |
| 1991 | 2,232,000 | 143 | 16.4 |
| Greece | | | |
| 1981 | - | - | - |
| 1991 | 193,000 | - | 10.9 |
| Hungary | | | |
| 1980 | 300,000 | 100 | 15.6 |
| 1990 | 450,000 | 150 | 23.6 |
| Iceland | | | |
| 1984 | 6,000 | 100 | 23.1 |
| 1993 | 8,000 | 133 | 21.1 |
| Ireland | | | |
| 1981 | 86,754 | 100 | 15.8 |
| 1991 | 110,000 | 127 | 17.9 |

*Table A2.17 (contd.)*

| Country/Year | Number | Index | Incidence |
|---|---|---|---|
| Italy | | | |
| 1981 | 1,522,455 | 100 | 13.6 |
| 1991 | 1,700,000 | 112 | 14.9 |
| Japan | | | |
| 1980 | 1,480,000 | 100 | 8.9 |
| 1995 | 2,120,040 | 143 | 12.8 |
| Korea | | | |
| 1985 | 593,840 | 100 | 8.8 |
| 1995 | 743,900 | 125 | 8.5 |
| Luxembourg | | | |
| 1981 | 8,946 | 100 | 14.1 |
| 1991 | 11,000 | 123 | 15.7 |
| Netherlands | | | |
| 1981 | 294,543 | 100 | 11.9 |
| 1991 | 388,000 | 132 | 15.9 |
| New Zealand | | | |
| 1981 | - | - | - |
| 1996 | 148,000 | - | 25.5 |
| Norway | | | |
| 1983 | 111,000 | 100 | 17.8 |
| 1993 | 117,600 | 106 | 19.7 |
| Portugal | | | |
| 1981 | 227,000 | 100 | 14.5 |
| 1991 | 254,000 | 112 | 13.1 |
| Spain | | | |
| 1981 | - | - | - |
| 1991 | 133,000 | - | 12.8 |
| Sweden | | | |
| 1983 | 204,000 | 100 | 19.0 |
| 1993 | 182,880 | 90 | 18.0 |
| Switzerland | | | |
| 1981 | 125,000 | 100 | 12.1 |
| 1991 | 146,000 | 117 | 13.7 |
| UK | | | |
| 1981 | 1,679,440 | 100 | 17.8 |
| 1991 | 2,007,000 | 120 | 20.7 |
| USA | | | |
| 1986 | 7,040,000 | 100 | 22.7 |
| 1996 | 9,285,087 | 132 | 27.1 |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.

*Table A2.18 Trends in Life Expectancy without Disability at Age 65*

| Country | Males | | Females | |
|---|---|---|---|---|
| | Life expectancy | Disability-free life expectancy | Life expectancy | Disability-free life expectancy |
| | Moderate Disability Free Life Expectancy(1) | | | |
| Austrailia | | | | |
| 1981 | 13.9 | 7.9 | 18.1 | 10.1 |
| 1993 | 15.7 | 6.5 | 19.5 | 9.1 |
| Canada | | | | |
| 1986 | 14.9 | 8.5 | 19.2 | 9.4 |
| 1991 | 15.6 | 8.3 | 19.7 | 9.2 |
| France | | | | |
| 1981 | 14.1 | 8.8 | 18.3 | 9.8 |
| 1991 | 15.7 | 10.1 | 20.1 | 12.1 |
| Netherlands | | | | |
| 1983 | 14.0 | 8.0 | 18.6 | 7.4 |
| 1990 | 14.4 | 9.0 | 19.0 | 8.0 |
| United-States | | | | |
| 1980 | 14.2 | 6.8 | 18.4 | 9.3 |
| 1990 | 15.1 | 7.4 | 18.9 | 9.8 |
| New Zealand | | | | |
| 1981 | 13.3 | 9.9 | 17.1 | 10.5 |
| 1993 | 14.8 | 10.0 | 18.4 | 10.2 |
| Germany | | | | |
| 1986 | 13.8 | 10.6 | 17.6 | 13.0 |
| 1995 | 14.9 | 12.2 | 18.7 | 14.9 |
| Korea | | | | |
| 1997 | 13.6 | - | 17.3 | - |
| 1998 | - | 8.5 | - | 8.4 |

*Table A2.18 (contd.)*

| | Males | | Females | |
|---|---|---|---|---|
| | Severe Disability Free Life Expectancy(1) | | | |
| Austrailia | | | | |
| 1981 | 13.9 | 11.9 | 18.1 | 13.8 |
| 1993 | 15.7 | 13.4 | 18.7 | 14.8 |
| Canada | | | | |
| 1986 | 14.9 | 12.8 | 19.2 | 14.9 |
| 1991 | 15.6 | 13.3 | 19.7 | 15.4 |
| France | | | | |
| 1981 | 14.1 | 13.1 | 18.3 | 16.5 |
| 1991 | 15.7 | 14.8 | 20.1 | 18.1 |
| Japan | | | | |
| 1980 | 14.6 | 13.2 | 17.7 | 15.8 |
| 1990 | 16.2 | 14.9 | 20 | 17.3 |
| UK | | | | |
| 1980 | 12.9 | 11.8 | 16.9 | 15.0 |
| 1991 | 14.5 | 13.6 | 18.1 | 16.9 |
| Norway | | | | |
| 1975 | 14.0 | 13.3 | 17.2 | 16.1 |
| 1985 | 14.4 | 13.3 | 18.2 | 16.9 |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.

*Table A2.19 Prevalance of Severe Disability*

| Country | Share of population Aged over 80 in total population (1995) | Share of frail elderly in population aged over 65 (% of total) | Share of very severe disability in population aged over 65 (% of total) |
|---|---|---|---|
| Australia | 2.5 | 16.7 | n/a |
| Austria | 3.5 | 25.0 | 2.9 |
| Belgium | 3.6 | 5.9 to 16.4 | 3.3 |
| Canada | 2.6 | 16 to 32 | n/a |
| Finland | 3.2 | 18 to 20 | n/a |
| France | 4.1 | 13 to 17 | 3.7 |
| Germany | 4.1 | 12.1 | 3.5 |
| Italy | 3.6 | 22.1 | 2.0 |
| Japan | 2.8 | 11.2 | 4.2 |
| Korea | 0.9 | 13.5 | n/a |
| Netherlands | 3.0 | 18.9 | n/a |
| Norway | 3.9 | 18.0 | n/a |
| Sweden | 4.5 | 15.1 | 3.4 |
| UK | 3.8 | 14.1 to 28 | n/a |
| USA | 3.0 | 12 to 26 | n/a |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.

*Table A2.20 Men, Aged 55-64, Receiving an Old-age Cash Benefit, as a Percentage of the Population 1975~1995*

| Country | Programme | 1975 | 1980 | 1985 | 1990 | 1995 |
|---|---|---|---|---|---|---|
| Austria | Anticipated old aged pension in case of long insurance time | - | 11.4 | 16 | 16.3 | 13.0 |
| Belgium | Private employeea and public temporary personnel | - | - | - | 8.2 | 9.8 |
| Denmark | Early retirement in the form of Basic Pension | - | - | 5.5 | 4.6 | 5.8 |
| Finland(3) | Standard Retirement Pension | - | 7.9 | 7.8 | 9.6 | 9.7 |
| France | General scheme for employees in industry and trade(CNAVTS) | - | - | - | - | 37.9 |
| W.Germany | General pension insurance scheme: employees and self-employed | 4.6 | 6.4 | 9.6 | 9.6 | 11.2 |
| Greece | General scheme for employees (IKA) | 4.4 | 3.9 | 6.6 | 9.5 | 10.5 |
| Italy(4) | Old age benefit | - | - | - | - | 24.8 |
| Japan(5) | Employees' pension insurance (KOUSEI-NENNKINN) | - | - | - | 0.6 | 0.4 |
| Korea | National Pension Insurance | - | - | - | - | - |
| Luxembourg | Vieillesse - contributif | - | - | 8.4 | 21.4 | 29.7 |
| Netherlands | Civil servants and teachers(ABP) | 2.6 | 4.3 | 4.9 | 4.2 | 3.6 |
| Portugal | General(non-ag.) scheme: employed &self-employed(IGFSS) | 0.9 | 2.1 | 2.6 | 2.5 | 3.8 |
| Spain | Employees & self-employed, social security pension | - | 4.4 | 6.8 | 10.8 | 14.3 |
| Sweden | Old-Age Basic Pension | 0.6 | 1.3 | 2.2 | 1.7 | 2.9 |
| Turkey | Old-Age Pension | - | - | - | - | 48.5 |
| USA | OA Retired Workers | 8.7 | 9.5 | 12 | 12.9 | 12.7 |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.

*Table A2.21 Comparisons of Care Systems*

| Country | Estimated total spending on LTC (1992-1995) | Estimated public spending on LTC (1992-1995) | Share of population aged 65 and over in institutions |
|---|---|---|---|
| | % GDP | % GDP | % of total |
| Australia | 0.90 | 0.73 | 6.8 |
| Austria | 1.40 | n/a | 4.9 |
| Belgium | 1.21 | 0.66 | 6.4 |
| Canada | 1.08 | 0.76 | 6.2 to 7.5 |
| Denmark | n/a | 2.24 | 7 |
| Finland | 1.12 | 0.89 | 5.3 to 7.6 |
| France | n/a | 0.50 | 6.5 |
| Germany | n/a | 0.82 | 6.8 |
| Greece | 0.17 | n/a | n/a |
| Ireland | 0.86 | n/a | 5 |
| Italy | 0.58 | n/a | 3.9 |
| Japan | n/a | 0.15/0.62 | 6.0 (3.0 NH)(6) |
| Korea | n/a | n/a | 0.4(2000) |
| Netherlands | 2.70 | 1.80 | 8.8 (2.7 NH)(6) |
| Norway | 2.80 | 2.80 | 6.6 |
| Portugal | 0.39 | n/a | n/a |
| Spain | 0.56 | n/a | 2.8 |
| Sweden | 2.70 | 2.7 | 8.7 |
| Switzerland | 0.75 | n/a | n/a |
| UK | 1.30 | 1.00 | 5.1 |
| USA | 1.32 | 0.70 | 5.7 |

*Table A2.21 (contd.)*

| Country | Share of population aged 65 and over receiving formal help at home | Share of private beds among institutions | Share of spending towards institutions in total public spending on long-term care |
|---|---|---|---|
| | % of total | % of total | % of total |
| Australia | 11.7 | 26 | 73 |
| Austria | 24 | n/a | n/a |
| Belgium | 4.5 | 49 | 53 |
| Canada | 17 | 38 | 67 |
| Denmark | 20.3 | n/a | 80 |
| Finland | 14 | 12 | 86 |
| France | 6.1 | 32 | 59 |
| Germany | 9.6 | 33 | 48 |
| Greece | n/a | n/a | n/a |
| Ireland | 3.5 | 47 | n/a |
| Italy | 3.0 | 33 | n/a |
| Japan | 5 | n/a | n/a |
| Korea | n/a | n/a | n/a |
| Netherlands | 12 | n/a | 76 |
| Norway | 17 | 10 | 63 |
| Portugal | n/a | n/a | n/a |
| Spain | 2 | n/a | n/a |
| Sweden | 11.2 | n/a | n/a |
| Switzerland | n/a | n/a | n/a |
| UK | 5.5 | 44 | 70 |
| USA | 16 | 100 | 67 |

Source: OECD, *The Caring World: An Analysis of Tables and Charts*, 1998.