From Insurance to Integration

Person-Centred Long-Term Care in South Korea

Korea built coverage in eighteen years. The harder half has been moving delivery.

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Eighteen years of universal long-term care

2008

Public Long-Term Care Insurance introduced, early in the demographic transition

11.2%

of people aged 65 and over are certified recipients (2025) - roughly one in nine

March 2026

Community Integrated Care launched nationwide as a second pillar

Two distinct achievements, eighteen years apart. The first was a financing and entitlement system. The second is an attempt to change how care actually reaches a person - and it is only seven months old.

Coverage was the achievable half. This talk is about the other half.

National Health Insurance Service, 2025 Long-Term Care Insurance Statistical Yearbook (published June 2026). Denominator: population aged 65+ under medical security coverage (11.0 million).

Supply was not the major constraint

1.24m

certified recipients in 2025, up 6.0% in one year

29,734

contracted provider organisations nationwide

726,809

workers in long-term care; 90% are care workers

KRW 17.7tn

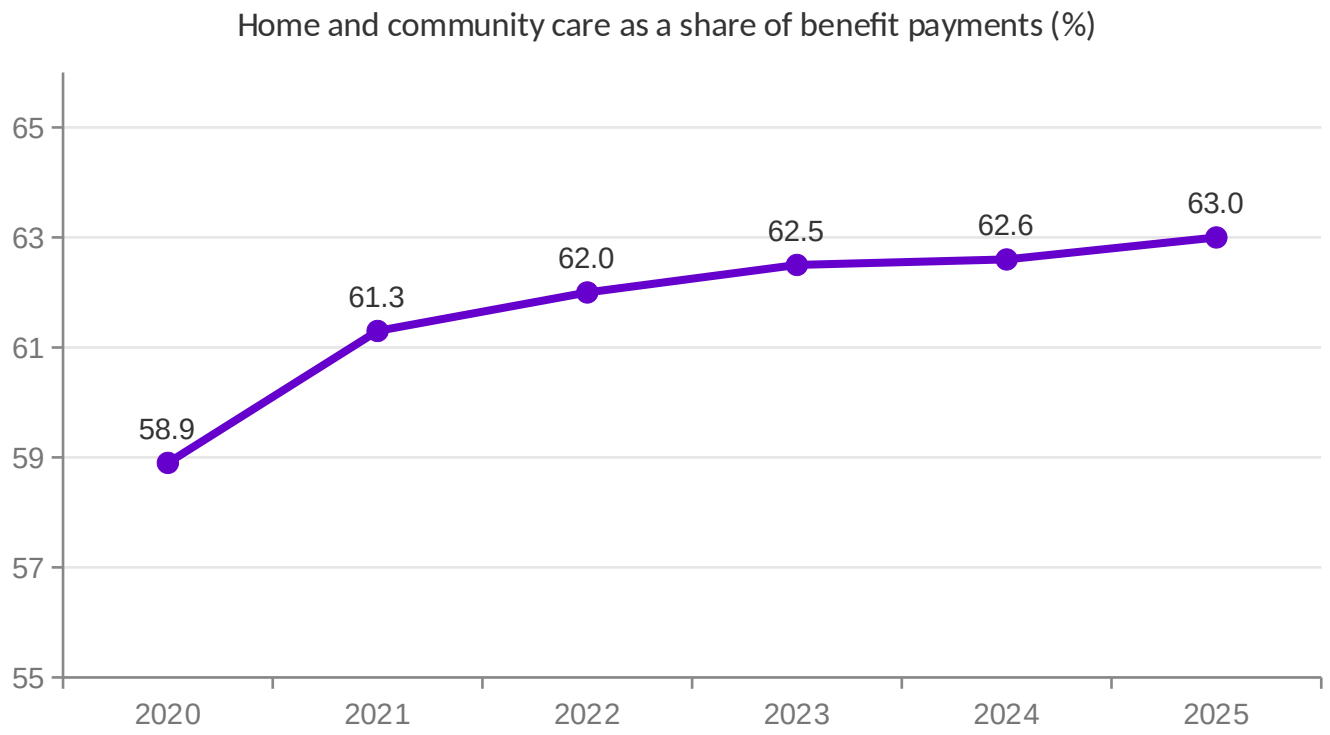
in benefit expenditure in 2025, up 9.3% in one year

Korea did not fail to build supply. It built a great deal of it, quickly, through a single public insurer contracting with a largely private provider market.

The question is what that capacity was organised to deliver.

National Health Insurance Service, 2025 Long-Term Care Insurance Statistical Yearbook (published June 2026).

Aging in place has been the stated direction since 2008



Recipients grew by 44% over these six years. The home share grew by four points.

Recipients rose from 857,984 in 2020 to 1,235,045 in 2025. The share of spending going to home and community care rose 4.1 points.

The system grew quickly. Where care happens moved slowly. Institutional entry remains the default path once care needs rise.

And this chart understates the problem: long-term care hospitals, financed separately under health insurance, sit outside it entirely. A large share of institutional care for older people is invisible in long-term care statistics.

National Health Insurance Service, Long-Term Care Insurance Statistical Yearbooks 2020-2025. Share of insurer benefit payments.

Where people are cared for does not match what they need

About 11% of older Koreans have complex long-term medical and care needs. Linking the two national assessment systems - health insurance and long-term care insurance - makes those needs, and the settings people end up in, visible together.

	Lower care need	Higher care need
Higher medical need	**36.3%** admitted to a long-term care hospital for six months or more	**32.2%** admitted to a long-term care facility, where medical services are limited
Lower medical need	**30.2%** admitted to a long-term care hospital or facility	**16.0%** admitted to a long-term care hospital

In every group, between one in six and one in three were in a setting that did not fit.

The two shaded groups have high medical needs and are the clearest failures: long hospital stays that are not medically required, or residence where medical care is limited.

This is not a shortage of services. It is a failure to match a person to a setting - and it is measurable from data the system already collects.

Across all four groups, 31.0% were in a setting that did not match their needs.

Kim H, Yoon NH, Seo D, Kim Y. Development of a practical framework and indicators for monitoring integrated long-term health and care needs and service use. Health Policy 2024;149:105167, Table 2.

Care was contracted service by service, not person by person

1	**Contracting**	One provider, one service. In June 2025, 79.5% of home-care recipients used only a single type of benefit, and 59.0% of those used visiting personal care alone.
2	**Workforce**	Nine in ten long-term care workers belong to a single occupation, trained principally for physical assistance.
3	**Medical care at home**	Long-term care insurance does not pay for physician services. Health insurance does not follow the person home.

Person-centredness is not only an attitude in the care encounter. In a national system it is decided by what gets contracted, who is hired, and what is paid for.

What Korea is now changing is what gets contracted.

National Health Insurance Service, Integrated Home Care Operating Manual, January 2026; 2025 Long-Term Care Insurance Statistical Yearbook; Act on Long-Term Care Insurance for the Aged.

Delivery infrastructure: one instrument, one insurer, since 2008

- Korea runs a single national needs-assessment system. Every applicant is assessed at home by trained staff of the one public insurer, using a 90-item instrument of which 52 items generate the care-need score.
- Once assessed, the grade holds everywhere. A person keeps it across all 29,734 providers - changing provider does not mean being assessed again - and it sets the monthly benefit ceiling.
- Because the instrument has not changed, eighteen years of records can be read against each other: across regions, across providers, and over time.

What it does not capture.

The instrument measures dependency well. It does not record what the person wants to keep doing, their participation in community life, or the capacity of the family around them - the things person-centred care is supposed to protect.

National Health Insurance Service, long-term care eligibility assessment; MOHW Notice No. 2018-146.

In facilities: bringing medicine and staffing inside

- Contracted physicians and partner medical institutions. Facilities designate a physician recommended by the local medical association; the physician examines each resident at least twice a month, issues nursing and medication orders, and advises on transfer.
- Staffing standard tightened to one care worker per 2.1 residents from January 2025, with the fee schedule adjusted to fund the additional staff.
- Periodic quality evaluation of every facility since 2020, using around fifty indicators covering operations, infection prevention and safety, residents' rights, and care processes and outcomes.

One tested model: SPEC - an ICT-supported comprehensive geriatric assessment, individualised care planning and interdisciplinary case conference model, evaluated in Korean nursing homes in a stepped-wedge cluster randomised trial.

MOHW press releases (2024, 2025); NHIS long-term care institution evaluation; Kim H et al. BMC Geriatrics 2017;17:88 (SPEC study protocol).

At home: re-bundling care around the person

Integrated Home Care

Legal basis added to the Act in January 2024; national rollout from 2026

One organisation delivers visiting nursing, personal care, bathing, day care and short-term respite as a single package. A nurse instructs care workers on health-related care and a multidisciplinary team plans together, with case management and referral to community and medical services.

Open rolling designation nationwide from 2026

Home-Based Medical Care Centres

Pilot since December 2022; nationwide coverage reached February 2026

A physician, nurse and social worker visit as one team: physician visits at least monthly, nursing visits at least twice monthly, a comprehensive care plan, case conferences and referral to community services.

422 institutions - now in all 229 municipalities

A pre-post analysis by the NHIS research institute reported inpatient days falling from 6.6 to 3.6 among users, against 6.3 to 8.5 among non-users. This is an observational comparison, not a trial.

Both change what is contracted, not only what is offered.

NHIS Integrated Home Care Operating Manual (January 2026); MOHW press releases, 13 February 2026 and 28 October 2025; NHIS Research Institute, effect analysis of the home-based medical care centre pilot.

A second pillar, delivered locally

2019-2022

Community integrated care leading pilots
16 localities, competing models

2023-2025

Medical-care integration pilots
From 12 localities to all 229 by September 2025

27 March 2026

Statutory nationwide operation
All 229 municipalities, a legal duty rather than a choice

- Local government now carries a statutory duty for case finding, comprehensive needs assessment, an individual support plan, service coordination, and hospital-to-community linkage.
- Five domains are brought under one plan: health care, health management, long-term care, daily living support, and housing.
- In the first hundred days, over 40,000 people applied and 37,000 were linked to services. Applications per 10,000 older residents ranged from 93.3 in the highest province to 21.0 in the lowest. These are administrative counts of uptake, not evidence of effect.

For the first time, one body is responsible for the whole plan rather than for one benefit.

Act on Integrated Support for Community-Based Medical and Long-Term Care (2024); MOHW press releases, 14 April, 2 July and 10 July 2026.

Technology entering delivery: announced as policy, not yet as evidence

In April 2026 the Ministry of Health and Welfare and the Ministry of Science and ICT jointly announced a whole-lifecycle support strategy for AI care technology, at the seventh Science and Technology Ministers' Meeting.

Service

Smart home environments for individually tailored, prevention-oriented care at home, and assistive technology in facilities to reduce staff workload

Technology

Demand-driven development, demonstration and diffusion, staged from AI and IoT to physical AI and robotics through 2032

Foundations

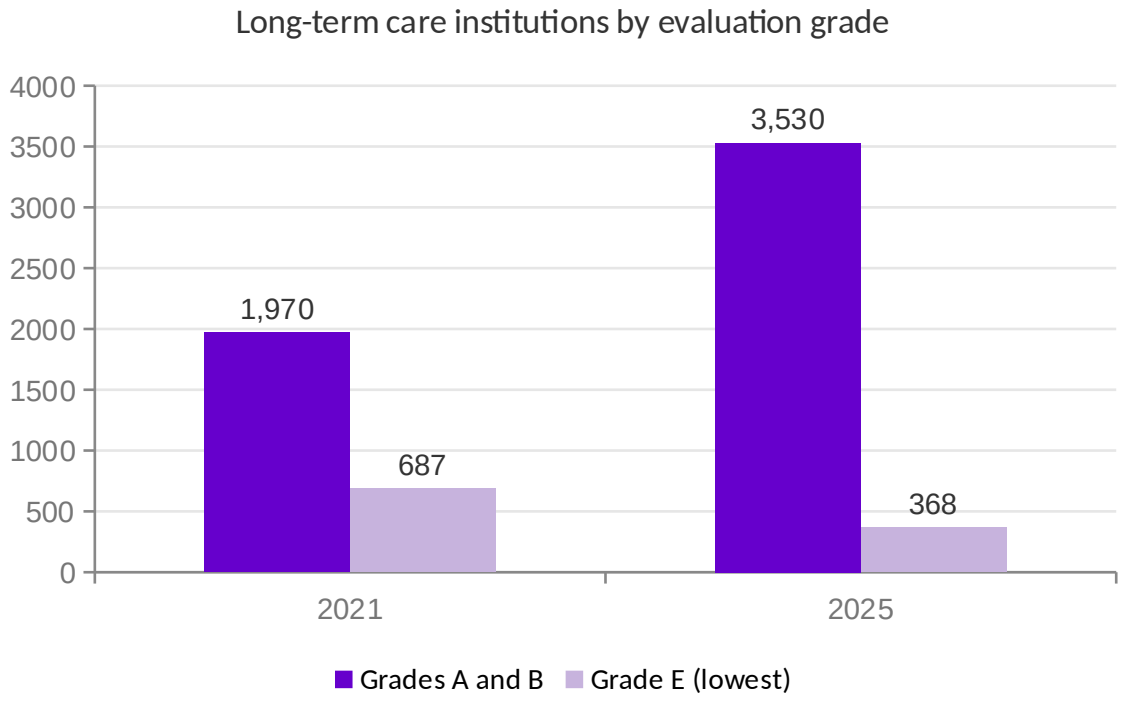
Legal basis and AI ethics guidance for care settings, plus digital capability among the care workforce

- The strategy is explicitly paired with reform of long-term care insurance and social service vouchers - technology is being positioned inside the delivery and payment system, not beside it.
- The detailed roadmap is still being written: expert consultations on it were being held in September 2026.

A direction has been set. The effectiveness evidence has not been produced.

MOHW and MSIT, Whole-Lifecycle Support Strategy for AI Care Technology, 16 April 2026; MOHW expert consultation on the welfare and care AI transition roadmap, 21 September 2026.

We can measure providers. We cannot yet measure the transition.



In place.

5,406 institutions evaluated between February and November 2025; mean score 83.5, up 4.5 points on the previous round. Twenty years of comparable delivery-quality data.

Not yet.

For Community Integrated Care, the indicators now in force are structural and process measures: dedicated staffing ratios, establishment of integrated support committees, case finding, discharge support.

Outcome indicators - length of continued community living, change in long-term care hospital admission, user experience - were still under review in July 2026. The first evaluation cycle closes in November 2026.

National operation began before the outcome measures were settled.

NHIS long-term care institution evaluation results (2026); Act on Integrated Support, Art. 9 and Enforcement Rule Art. 6; MOHW, 16 March and 2 July 2026.

Three questions we share

1	**Standardised needs assessment**	Korea has eighteen years of answers. It also knows the instrument measures dependency and little else.
2	**Care coordination**	With financing split across separate schemes, who is accountable for the whole person?
3	**Delivery evaluation**	How do we know a shift to community living has happened, rather than been declared?

Korea has most to say on the first, and least on the third.

Backup: Korea's long-term care insurance at a glance

- Eligibility: people aged 65 and over, and people under 65 with geriatric conditions, who need help with daily living for six months or more. Assessed by the insurer; six grades (1-5 and a cognitive support grade).
- Financing: a long-term care contribution levied alongside the health insurance contribution (13.14% of the health insurance contribution in 2026), a state subsidy of about 20% of expected contribution revenue, and user co-payments.
- Co-payment: 15% for home and community benefits, 20% for institutional benefits; reduced by 40-60% for lower-income users and waived for basic livelihood recipients.
- Benefits: home and community benefits (visiting care, bathing, nursing, day and night care, short-term respite, assistive devices), institutional benefits, and limited cash benefits for remote areas.
- Not covered: long-term care hospitals, which are financed under national health insurance.

Act on Long-Term Care Insurance for the Aged; National Health Insurance Service (2026).

Backup: the region's long-term care systems are at different stages

	China	Japan	Republic of Korea
Public LTC scheme	Pilots from 2016; national scheme announced March 2026	LTCI since 2000	LTCI since 2008
Recipients	3.3m+ beneficiaries under pilots	7.08m certified (March 2024)	1.24m certified (2025)
Share of people 65+	not comparable	19.4%	11.2%
LTC workers per 100 people 65+	-	6.8	5.3
Total LTC spending, % of GDP	-	2.4%	1.1%

Coverage rates are not directly comparable. Japan's scheme includes lighter support levels, which make up about two thirds of its certified population. OECD long-term care spending covers health and social care together, and several countries do not report the social component.

NHIS (2026); MHLW, Long-Term Care Insurance Status Report FY2023; OECD, Health at a Glance 2025, Figure 10.23 and country notes. Figures for China are as reported in official policy announcements of March 2026, not from a statistical series, and are not directly comparable.