# Korean Welfare System:
# Recent Reform and Achievements

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# Korean Public Assistance and Social Insurance Scheme

## 1. Background

The economic crisis in 1997 exposed the inability of Korea to deal with external shock and also exposed the weak domestic social infrastructure's inability to cushion against the impact of shock. As a result, based on the understanding that the already existing social policy system had a fundamental limit in dealing with economic crisis, Productive Welfare was established.

Productive Welfare is an ideology that seeks to secure minimum living standards for all low income households, provide human resource development programs to support self-reliance of the poor and guarantee a basic living standard by expanding the coverage of social insurance to all people for the purpose of maintaining human dignity. As such, Productive Welfare endeavors to improve the quality of life for all citizens by promoting social development and a fair distribution of wealth.

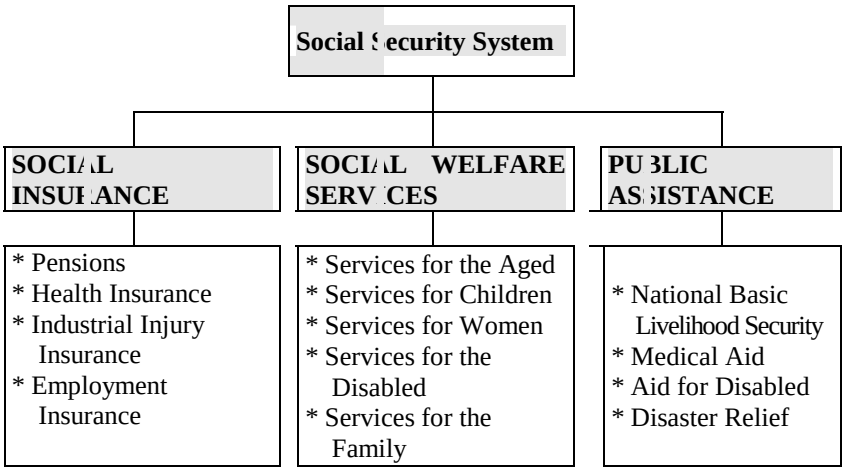
According to the concept defined above, introduction of the National Basic Livelihood Security Act (hereinafter NBLSA) and expanding the coverage of social insurance are characterized as the projected policies under Productive Welfare. In addition to these are enhancing the accessibility of the vulnerable class to the labor market through human resource development-which lays stress on labor

welfare, taking measures to protect irregular employees and extending the application of the minimum wage system to all industries.

## 2. Outline of Social Welfare System

The current social welfare system in Republic of Korea consists of three components: (i) social insurance (ii) public assistance (iii) social welfare services.

*Table 1. The Social Security System*




## 3. Public Assistance

The NBLSA, which started in October 2000 as a replacement of the Livelihood Protection Act, guarantees minimum living standards to all low income families whose income are below the official poverty line without considering their ability to work. So all low-income earners with the ability to work also become eligible for

benefits unlike the previous system. The NBLSA puts emphasis on the nation's responsibility for the low-income class. Its introduction has tripled the number of livelihood payment beneficiaries from 540,000 in 1999 to 1.51 million in 2001. The NBLSA, which is one of the public assistance programs, has improved the nation's welfare system greatly.

The official poverty line for the NBLSA beneficiaries or recipients is described in Table 1. Those who meet the criteria and do not have any family support will be chosen in the selection. The criteria for those who support the eligible are quite complex. It is limited to immediate family members, spouses, and any siblings who are financially supporting them. The supporters are furthermore divided into three groups based on their asset and income: those able to support those who have difficulty in supporting and those unable to support. Only in the latter two cases are their poor families eligible for the benefit. If the combined income or asset of an applicant's household and his financial supporter's household is over 120% of income criteria or property criteria of the official poverty line, the supporter under question is regarded as an official supporter. If the applicant is unable to work and have no income, but owns a house, then the combined income level is raised to over 150% of the official poverty line.

*Table 1. Official Poverty Line (2001)*

| No. of household member / Criteria | One | Two | Three | Four | Five | Six | Seven & More |
|---|---|---|---|---|---|---|---|
| Income (thousand Won) | 330 | 550 | 760 | 960 | 1,090 | 1,230 | Add 120 per person |
| Property (thousand Won) | 31,000 | | 34,000 | | 38,000 | | |

Source: Ministry of Health and Welfare, White Paper, 2001

Livelihood payment of the NBLSA is designed to provide supplementary payment to households whose income does not meet the official poverty line and the amount of support is equal to the difference of household income and the official poverty line. Also, civil rights were enhanced through acknowledging the NBLSA as a social duty. The NBLSA fostered a condition in which the number of *Self-Reliance Aid Centers* increased from 6 in 1997 to 161 in 2001 and the number of social workers increased from 3,000 persons in 1997 to 5,500 in 2001. Specifically, the increase in the number of *Self-Reliance Aid Center* participation in self-supporting assistance programs within the community and the inducement of social concerns to the program can be regarded as an achievement.

The Self-Reliance Aid Center was established in 1996 to support recipients of the Livelihood Protection System (LPS) as well as the low-income earners who are not covered by the LPS. The main activities of the center is to provide information on available jobs, to offer job counselling and job placement services to support the community-based business and self-employment, to mediate the self-reliance fund, and to teach skills and management techniques. Self-reliance Aid Centers are operated by the civil groups and designated by the Government, but both the central and local governments can partly or wholly provide the operating funds. (http://www.mohw.go.kr/english/intro8.html)

As one of the NBLS payments, medical aid program has played an important role of protecting health of the poor. Recipients of the medical aid are divided into two groups as follows; Group Ⅰ includes basically those unable to work among the NBLS recipients, and additionally, human cultural assets, escapees from N. Korea,

persons of national merit, etc., Group Ⅱ includes those able to work among the NBLS recipients. The treatment fee is free for those who are in Group 1, however, those in Group II should pay 1500 Won per visit of hospital and 20% of medical service fee for in-patient.

## 4. Social Insurance

The Social insurance system has undergone rapid changes since 1998. The rationality of this change is to: drastically reduce uncovered groups through applying the National Pension scheme to all people; integrate the management systems of *the Health Insurance Funds for Wage Earners* (hereinafter HIFW) with the *Health Insurance Funds for Non Wage Earners* (hereinafter HIFNW); and expand coverage of Employment Insurance and Industrial Injury Insurance to all workplaces. As a result, anyone who has an income is now covered by the National Pension scheme, regardless of employment category, opening an era of universal National Pension. Now, even if a pension premium is paid only once, pension payment for the disabled and survivors is permitted.

Major changes brought by the amendment of the National Pension Act in January 1999 are as follows. First, the self-employed in urban areas were included into the scheme beginning in April 1, 1999. The beneficiaries of the scheme are divided into two groups: wage earners employed by workplaces and local scheme members. Persons insured through the workplaces refer to employees aged between 18 and 60, who are either employees or employers at a workplace with five or more full time workers. Those 18 or younger are able to join the workplace pension plan with employer consent.

Those 60 or older can have the extended contribution period to age 65 if their insured period is less than 20 years. However, excluded from the coverage of the National Pension Scheme for the workplace are those who have temporary work with contracts of 3 months or less, those who have seasonal work with periods of three months or less, and those who often move from workplace to workplace. Temporary and part-time workers are also excluded from coverage of the National Pension Scheme for the work place. But those who are excluded from coverage of the National Pension Scheme for the workplace are nevertheless insured through the Local scheme of National Pension.

The new National Pension scheme strengthened pensioners' rights and sought for livelihood stability. The minimum contribution period was shortened from 15 years to 10 years. Pension installment is provided for those who turn 60 after divorce or those who divorce after 60 in case marriage has lasted for five years or more (But benefit provision is terminated when they are remarried). Deferred payment for pension contribution arrears is permitted for those obligated with child rearing and military service, as well as for students and those serving prison terms. A legislation is being formulated to provide loans to unemployed for livelihood stability.

In addition, through integration of management systems of Health Insurance, it could obtain a ground to raise the social solidarity and actualize fair charge. Also through abolishing limits on periods for Health Insurance services, one can get medical service throughout the year.

Since the introduction of Health Insurance in 1977, it has gone through several phases before maturing into a universal Health Insurance scheme. However, the Health Insurance system had inherent

problems. Specifically, Health Insurance Funds did not have the same premium calculation systems. As a result, the insured could have ended up paying different premiums if they belonged to different Health Insurance Funds, although their income and asset levels were the same. This caused equity problems and at the same time, widened the financial gap among Health Insurance Funds. The independent management of small-size Funds also brought up operational inefficiency. Because previously, the Health Insurance system was divided into Health Insurance Corporations for Employees of Government, Private School, Military, HIFW, and HIFNW. To resolve the problems, the government consolidated the HIFNW and Health Insurance Corporations for Employees of Government and Private Schools. It was the first step towards the grand consolidation of Health Insurance taken on October 1998. As the second step, the plan integrated HIF-WE into the already consolidated comprehensive Health Insurance Funds, to be the National Health Insurance Corporation. The new universal Health Insurance Corporation has the integrated management system for the insured but classifies them into two groups: HIFW and HIFNW. Those, who are covered by HIFW, consist of employees and employers at the workplace with 5 or more people, employees of government and private schools, who earn monthly wages. Those, who are covered by HIFNW, consist of the self-employed and employees at the workplace with four or less people. The new system applies the same premium rates in line with income level, regardless of which Health Insurance Funds in charge of the coverage. The new Health Insurance system has shifted its focus from treatment-orientation to prevention, rehabilitation and health promotion.

*Table 2. Process of Korea's Social Insurance Coverage Expansion: by Year and Group*

| National Pension | Health Insurance |
|---|---|
| 1960: government employees<br>1963: military personnel's<br>1975: private school teachers<br>1977: private school personnel's<br>1988: wage earners at workplace with 10 or more people<br>1992: wage earners at workplace with 5 or more people<br>1995: fishermen and farmers<br>1999: urban residents (national coverage) | 1977: wage earners at workplace with 500 or more people<br>1979: employees in government, private school and wage earners at workplace with 300 or more people<br>1980: wage earners at workplace with 300 or more people<br>1982: wage earners at workplace with 16 or more people<br>1988: wage earners at workplace with 5 or more people and fishermen and farmers<br>1989: urban residents (national coverage) |
| Employment Insurance | Industrial Injury Insurance |

The Health Insurance system abolished the regulation of limiting the period covered by Health Insurance to a certain level. Instead it promises unlimited Health Insurance coverage year-round beginning July 1, 2000. Previous Health Insurance laws covered only disease, injury, and death excluding pre-natal care from coverage. The new Health Insurance expanded the scope of coverage to include preventive care, diagnosis, rehabilitation, and health promotion, not to mention treatment and death.

Since the 1997 economic crisis, economic recession and dramatic restructuring accelerated the unemployment rate. Accordingly, the expansion of Employment Insurance coverage was applied earlier than previously planned, beginning March 1998, in order to provide unemployment benefits even to workers at the workplace with 5 or more persons. Considering the severe unemployment situation, the

coverage scope was again expanded again in October 1998, to include workers at the workplace with four or less persons as well as temporary or part-time workers.[1] As for Industrial Injury Insurance,[2] membership has become mandatory even for the workplace hiring less than 5 persons in beginning July 2000. Expanded implementation of social insurance by reducing the mandatory employment period was geared towards expanding coverage to include temporary and daily workers.

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[1] Since its introduction and implementation in 1995, Employment Insurance has become the primary social safety net for the unemployed during the economic crisis when the jobless rate surged. The number of recipients of Employment Insurance was estimated at 50,000 throughout 1997, but in 1998, the number surged to 438,000. Unemployment benefit provision also skyrocketed to 799.1 billion Won, 10 times that of 1997 of 78.7 billion Won. Likewise, the sharp increase in the number of beneficiaries for 1998 is attributable to the expanded scope of coverage, a string of bankruptcies and closures of firms, lay-offs, early retirement, the reduction of minimum coverage period, and the implementation of special expanded payments. In the end, the contribution income of 1998 worth 576 billion won was exceeded by unemployment benefits expenditure worth 799.2 billion won. In other words, the ratio of contribution income to benefit payment recorded 139%.Unemployment benefit serves the primary social safety net with extended coverage scope, eased eligibility criteria, extended coverage period and extended average coverage period. But despite the eased beneficiary standards, the ratio of unemployment benefit recipients to the total jobless is 10.5%, which is significantly lower in comparison to those of advanced nations such as Japan (27.8%, 1992), Germany (43.5%, 1990), the US (36.0%, 1990), and Britain (30.0%, 1998).

[2] Industrial Injury Insurance was the first social insurance to be adopted in Korea. In the initial stage of introduction, its implementation scope was limited to mines or manufacturing factories with 500 or more people. In industrial injury insurance, employers are fully liable for the contributions, which is different from other social insurances. The premium per person is determined by multiplying the premium rate and the total amount of salaries. In 1999, a major legal amendment was made to the industrial injury insurance system. The amendment was made to enhance the fairness by setting maximum and minimum coverage limits with the aim to narrow the benefit gap. Thanks to the amendment, new insurance payments were introduced, and more small and medium size firms were included into the system, thereby strengthening its role as a social safety net.

# National Pension

## 1. Introduction

The National Pension Scheme (NPS) is an income maintenance program providing its members with life-time pensions as a protection against the economic and social distress caused by retirement or substantial reduction of earning from old age, disability or death. The history of the public pension scheme in Korea goes back nearly 40 years ago when it started with a coverage of government employees under a special scheme in 1960, followed by the schemes specially designed for military personnel in 1963 and private school teachers in 1975.

The NPS for all the people of the country was provided by the National Pension Act in 1986, and implemented on January 1, 1988. The chronology of events has been as follows:

| | | |
|---|---|---|
| Dec. 31, 1986 | Legislation of National Pension Act |
| Sep. 18, 1987 | Establishment of the National Pension Corporation |
| Jan. 1, 1988 | Implementation of the NPS in workplaces with 10 or more employees |
| Jan. 1, 1992 | Expansion of compulsory coverage to the employed in workplaces with 5 or more employees |
| June 1, 1993 | Increase of contribution rates to 6% and beginning of payment of Special Old-age Pension |

| | | |
|---|---|---|
| July | 1, 1995 | Expansion of compulsory coverage to the employed in workplaces with less than 5 employees in rural areas, farmers and fishermen |
| Aug. | 4, 1995 | Expansion of compulsory coverage to the foreigners in workplaces |
| Jan. | 1, 1998 | Increase of contribution rates to 9% for the employed |
| April | 1, 1999 | Expansion of compulsory coverage to the self-employed and the employed in workplaces with less than 5 employees in urban areas |

In Korea, NPS's universal coverage for the entire population was realized in 1999, only 11 years after its first implementation in 1988.

## 2. Outline of the Program

### 2.1. Coverage

Those covered by the NPS are the persons whose age is from 18 years old to less than 60 years old and whose residence is in Korea. This scheme excludes government employees, military personnel and private school teachers because they are respectively covered under their own special schemes.

Coverage is divided into two types. One is the compulsorily insured persons, such as the employees and the self-employed, including foreigners. The other is the voluntarily insured persons, such as housewives and students.

Since January 1, 1988 when the NPS was implemented, the number of insured persons has increased continuously with the expansion of coverage. The total number of the insured persons is

16,276,000 (12,022, 013)at 0f October 2002.

*Table 1. Number of insured Persons*

(unit: thousand person)

| Year | The Compulsory Insured | | | The Voluntary Insured |
|---|---|---|---|---|
| | Total | The employed at workplaces with more than 5 workers | Self-employed and the employed 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 |
| 2002 | 16,276 (12,023) | 6,206 | 10,180 (5,630) | - |

## 2.2. Finance and contribution

The NPS is mainly financed from contributions paid by the insured. The financial support of the Government is a part of the administrative costs of the National Pension Corporation (NPC) and a part of the contributions of farmers and fishermen.

In order to lighten the financial burden on the insured and employers at the beginning stage, the contribution rate started at a low level for the first 10 years of the scheme and was increased gradually.

The contribution rate of the employed (including the voluntary

coverage) was raised from 3% in 1988 to 9% in 1998 and after. In the contribution of the employed, from 1988 to 1992, each of the employed and the employer paid a half of the contributions. From 1993 to March 1999, each of the employed, the employer and the retirement payment reserve paid a third of the contributions. From April 1999, each of the employed and the employer has been paying a half of the contributions. The contribution rates of the employed are as follows:

*Table 2. Contribution Rates of the Employed*

(unit: %)

| Year | | 1988 1992 | 1993 1997 | 1998 | 1999 and thereafter |
|---|---|---|---|---|---|
| Insured persons working at workplaces with more than 5 | Total | 3.0 | 6.0 | 9.0 | 9.0 |
| | Employees | 1.5 | 2.0 | 3.0 | 4.5 |
| | Employers | 1.5 | 2.0 | 3.0 | 4.5 |
| | Retirement Payment Reserve | - | 2.0 | 3.0 | - |
| Voluntarily insured persons in workplaces | | 3.0 | 6.0 | 9.0 | 9.0 |

| Year | 1995.7 2000.6 | 2000.7 2005.6 | 2005.7 and thereafter |
|---|---|---|---|
| Insured persons working at workplaces with less than 5 and self-employed voluntarily insured persons in urban and rural areas | 3.0 | 4.0 9.0 | 9.0 |

The contribution rates of the self-employed, including farmers and fishermen, and voluntarily insured persons in urban and rural areas was 3% to June 2000 and shall be raised by 1% every year from July 2000 until reaching 9% in 2005 and thereafter. The self-employed pay their contributions on their behalf. The Government subsidizes farmers and fishermen with an amount equivalent to a third of contributions of the lowest grade of 45 grades of the Standard Monthly Income, from July 1995 to December 2004.

## 2.3. Benefits

Under the NPS, the amount of benefits is calculated by the principle of income redistribution among the social strata. The formula of Basic Pension Amount has a "double layer" approach which combines both the average amount of the Standard Monthly Income of all insured persons(equalized part) and the average amount of Standard Monthly Income of an insured individual (earnings-related part). An increment of 5% is added to both parts per year in the case of excess of 20 years.

The standard level of pension benefits is estimated at 60% of the income paid to the insured person who retires after 40 years of the insured term and whose monthly income level is the median of the Standard Monthly Income of all insured persons.

The amount of benefits ranges from 60% up to 100% of his or her income if the amount of the monthly income is lower than the median mentioned above. Meanwhile, less than 60% of the income will be paid in case of the opposite. The real value of all benefits is also secured through a sliding-scale system by price index.

Pension benefits are divided into Old-age Pension, Disability Pension and Survivors' Pension. Lump-sum benefits are classified into Lump-sum Refund, Lump-sum Death Payment.

### 2.3.1. Old-Age Pension

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

The Basic Pension Amount of the Old-age Pension was designed to ensure that a person with 40 years of contribution, whose income level is the same as the median value of all the insured, would receive 60% of his average lifetime wage. The level of pension benefits is determined for each income group on the basis of the insured person's monthly income (Standard Monthly Income).

The Additional Pension amount is added to this pension if the beneficiary is supporting a spouse or children less than 18 years old or parents (including the spouse' parents) aged 60 or over who are supported by the beneficiary.

*Table 3. Pension Level for Those Who Completed 40 Years of Contribution Based on the Standard Monthly Income*

| Standard Monthly Income (B) | Monthly pension(P) | P/B*100% |
|---|---|---|
| 310,000 | 310,000 | 100 |
| 730,000 | 613,910 | 84.1 |
| 990,000 | 691,910 | 69.9 |
| 1,660,000 | 892,910 | 53.8 |
| 2,420,000 | 1,120,910 | 46.3 |
| 3,600,000 | 1,474,910 | 41.0 |

Note: The average monthly income of the total insured was 1,271,595 Won in 1999.

In the early years of implementation, it was necessary to modify the principle of 15 or 10 years contribution for the Old-age Pension, for those who are approaching the age of 60. Two devices are adopted for this purpose. Those who began to contribute at the age over 45 to under 60 when the scheme commenced in 1988, or in 1995, and over 50 to under 60 in 1999 shall be paid old-age pension (The Special Old-age Pension) when they have paid at least 5 years of contribution. This has been paid from 1993 and its beneficiaries were 149,430 persons at the end of 1999. The other device is that when the insured approached pension-given age with less than the qualifying period, they may continue their contribution up to the age of 65 on a voluntary basis.

### 2.3.2. Disability Pension

The Disability Pension is paid to a person who becomes sick or injured during the insured term and who is physically or mentally disabled so that the person's working ability is considerably reduced. The level of this pension is from 60% to 100% of the Basic Pension Amount according to the degree of disability. The number of disability beneficiaries including Lump-sum Compensation was 33,252 at the end of 1999.

### 2.3.3. Survivors' Pension

The Survivors' Pension is paid to survivors of a an insured person, or survivors of a previously insured person whose insured term is 10 years or more, or survivors of a person entitled to the Old-age Pension

or the Disability Pension of the second degree or higher.

The level of this pension is from 40% to 60% of the Basic Pension Amount according to the insured term of the deceased and the Additional Pension Amount.

In this pension scheme, the survivors are defined as spouse, whose age is 60 years old or more, children and grandchildren whose age is less than 18 years old or the disabled who are classified as the second degree or higher, and parents and grandparents whose age is 60 years old or more. The number of survivors' beneficiaries was 94,609 at the end of 1999.

### 2.3.4. Lump-sum Refund

The Lump-sum Refund is paid to survivors of a contributor whose insured term is less than 10 years. It is also paid to a contributor, whose insured term is less than 10 years and who has reached the age of 60, who has lost his or her Korean nationality, or who has emigrated from Korea, who has become a government official, military personnel, private school teacher or employee of a specially designated post office. The level of this benefit depends on the contributions and a legally fixed interest rate.

## 3. 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 documentation, 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 policy concerning the administration of the 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 important policy relating to the operation of the fund. The Committee is composed of 21 members including a chairman and a vice-chairman. The chairman is the Minister of Health and Welfare.

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

## 4. Reform of the National Pension Scheme

At the moment of National Pension coverage extension to all the citizens in April 1999, the amended National Pension Act of the late 1998 included comprehensive reformative actions proposed since the first implementation of the NPS in 1988. Some of the reforms are as

follows.

First, the long-term financial stabilization of the NPS was planned. The benefit level of the average earner who earned 40 years of coverage (income replacement ratio) was lowered from 70% to 60%, and the normal retirement age raised to 65 in the year 2033, gradually increasing one year every five years from 2013. In addition, financial projection every five years beginning from the year 2003 should guarantee the long-term financial balance through proper contributions and benefit levels.

Second, transparency, stability and profitability of the NPS fund management were reinforced. Above all, the representatives of the contributors actively participate in the National Pension Fund Management Committee and the National Pension Fund Operation Technical Evaluation Committee to increase transparency of fund management. The National Pension Fund Management Center was established in the NPC and the president of the Center is openly recruited to help enhance the expertise of the NPS fund management. Furthermore, the required deposit into the Public Fund Management Reserve is completely abolished from the year 2001, and the Government bond is used as an instrument for the public sector investments to increase the stability and the profitability of the fund.

Third, the pension eligibility requirements have been generalized for more insured to be eligible. Above all, the minimum period of coverage for the Old-Age Pension was reduced from the former 15 years to 10 years. The minimum periods of coverage for the Early Old-Age Pension and the Active Old-Age Pension were reduced from 20 years to 10 years. Additionally, the one-year period of coverage requirement for the Disability Benefits and the Survivors Pension is

abolished. Furthermore, to protect spouses with no earnings, mainly housewives, pension split was introduced to divide the Old Age Pension of the spouse at divorce.

# National Health Security

## 1. Health Insurance

### 1.1. History of Health Insurance

With the successful achievement of three consecutive 5-Year Economic Development Plans between 1962 and 1977, the Republic of Korea became one of the most economically successful countries among developing countries. The economic success had been accompanied by improvements in social welfare. In the 4th 5-Year Economic Development Plan, which began in 1977, the Government had the real capacity to consider the health insurance issue seriously. The purpose of the consideration was to relieve the excessive burden of household health care expenditures and to promote the health status of Korean people.

The Government entirely revised the Health Insurance Act in December 1976. The health insurance system was established on a compulsory basis. In July 1977, based on the new National Health Insurance Act, all companies with more than 500 employees were required to provide health insurance. During the next several years, the compulsory coverage requirement was gradually expanded to include companies with more than 300 employees, 16 employees, and finally all companies with at least 5 employees in 1988. It was

believed that big companies were more capable of absorbing the increased costs of health insurance coverage than small companies. In 1979, insurance programs covered government and private school employees. In addition, a pilot insurance program was carried out as a preparatory step to expand the health insurance to the self-employed in rural and urban areas in 1981.

Based on the result of the pilot study, self-employed individuals in rural and urban areas were covered by the insurance program in 1988 and in 1989 respectively. It took 12 years to accomplish universal health insurance coverage for all of citizens after the Government first implemented the health insurance program in 1977.

In 1997, enactment and promulgation of the National Health Insurance Act, integrating the 227 self-employed health insurance societies and the government and private school employees health insurance corporation, resulted in the creation of the National Health Insurance Corporation (NHIC). Also, the National Health Insurance Act, which aims to adopt all health insurance societies (140 employee health insurance societies) to the NHIC was passed by the National Assembly.

In July 2000, the integration of health insurance management system, including all insured persons, no matter if he/she is employed or self-employed, was finally accomplished. The integration would become the cornerstone of the health insurance development in the new millenium era. In addition, this integration of management system will contribute to increase the social solidarity and social partnership among social classes with the adoption of a new contribution levy system: flat rate contribution for all employees and the single contribution levy formula for the self-employed.

In addition the Health Insurance Review Agency (HIRA) was established in July 1, 2000, succeeding to the medical fees reviewing part of National Federation of Health Insurance (NFHI) which dissolved, on 30 June 2000. The HIRA was established to combine medical cost review and health care evaluation into an independent single agency separated from insurers, providers and other interested parties. The HIRA is responsible for reviewing medical fees, evaluating health care performance and the economy of health care service provided to health insurance beneficiaries. The HIRA served as a fair and objective organization to review and assure appropriate health care in partnership with the NHIC throughout the country.

## 1.2. Population coverage

### 1.2.1. The insured

All citizens residing in the territory of the Republic of Korea are covered by the NHIS as an employee insured or self-employed insured. Though, the present health insurance scheme is administered by a single insurer, the NHIC has two categories of insureds; the employee insured and the self-employed insured.

The employees covered by the NHIP are ordinary employees and the government and private school employees. It covers workers at companies with five or more employees and their dependents. Only daily wage-earners with less than two months of continuous employment are excluded. Government employees, including military personnel, and private school employees, and their family members, are covered as an employee insured.

The employees excluded from the category of employee insured are covered as a category of self-employed insured. Also, Koreans residing abroad and foreigners who are residing in Korea can be covered as self-employed insured if they make application.

The total number of insured at present is around 30.7 million; 7.2 million of the employee insured (5.8 million ordinary employees, 1.4 million government and private school employees), 23.5 million of self-employed insured, respectively.

### 1.2.2. The dependents

All self-employed persons and their family members are considered as the insured. But in the category of the employee insured, only the employees are considered to be the insured and their family members are considered as the dependents of the employee insured.

Currently, dependents in the category of the employees health insurance include the insured person's spouse, direct lineal ascendants (including those of the spouse), direct lineal descendants and their spouses, and brothers or sisters of the insured, providing that they can prove they meet the qualification standards set by the MOHW. Those qualification standards are low income and actual dependence on the insured. To minimize the number of aged insured in the self-employed insurance program, the employee insurance program covers fathers aged over 60 of age and mothers aged over 55 as the dependents of the employed insured even if they are financially independent.

At present, the total number of dependents are around 15.4 million; 11.9 million of the ordinary employees and 3.5 million of the government and private school employees. The average number of

dependents per insured is 2.14.

## 1.3. Health Insurance Fund

The fund resources of the NHIS are contributions paid by the insured and their employers and government subsidies. As the system has social insurance characteristics, contributions are the major source of income. In health insurance for employees including the government and private school employees, contributions are based on the incomes of the insured, the scope of income and the contribution rates are the same.

As of 2000, though the NHIS is operated under the single insurer (NHIC), the methods of contribution calculation are different between the two categories of the insured; the employee insured and the self-employed. Thus, the pooling of funds between the insured of ordinary employees and the government and private school employees is expected to begin on Jan. 2001. The final pooling of funds between the employee insured and self-employed insured is scheduled to start on January 2002. This step-by-step approach, however, is inevitable in order to achieve successful integration, to satisfy all the insured and beneficiaries during the policy-making process.

### 1.3.1. Contribution rate

The contribution rate is set by the Health Insurance Fund Management Committee, in accordance with the National Health Societies Act. According to the National Health Insurance Act, the committee is authorized to set the contribution rate for the employee

insured under 8% of monthly wages and salaries. The contribution rate of the employee insured are different from each other: 2.8% for the ordinary employees, 3.4% for the government and private school employees.

The minimum standard monthly wage as the basis of calculating contribution is 280,000 won. However, there is no ceiling.

### 1.3.2. Share of contribution

The contribution of the employee insured is borne by both employee and employer. For the ordinary employee, the employer pays 50% of the contribution and the employee pays the other 50%. For the government employee, the Government, as their legal employer, pays 50% of the contribution, whereas the employee pays the other 50%. For the private school employee, the owner of the private school, as their legal employer, pays only 30% of the contribution, with the government subsidizing 20%. The employee pays the other 50%.

For the self-employed insured, contribution is calculated by using a formula consisting of the insured person's properties, income, motor vehicles, age and gender. Contribution is calculated on the basis of income: less than or more than 5 million Won per year or with no income and property. The calculated contribution is paid by the insured and the government subsidizes about 26% of total amounts of the contribution by the self-employed insured.

### 1.3.3. Reduction of contribution

50% of the monthly contribution is reduced for insured persons who live in an island or in remote areas and work in foreign countries with their dependents in Korea.

### 1.3.4. Exemption of contribution

The insured working in foreign countries with no dependents in Korea, sergeants and privates serving in compulsory short-term military duty, military cadets and the insured person detained in a correctional institution or other facilities are exempt from their monthly contribution.

*Table 1. Status of Health Insurance Fund*

(Dec. 1999)

| Classifi-Cation | Total Revenue (A) | Total Expenditure (B) | Expenditure Rate(B/A) | Contribution (C) | Benefits(D) | Benefit Rate to Contribution (D/C) | Balance(A-B) |
|---|---|---|---|---|---|---|---|
| Unit | Million Won | Million Won | % | Million Won | Million Won | % | Million Won |
| Total | 8,892,385 | 9,610,122 | 108.1 | 7,291,119 | 7,867,563 | 107.9 | △717,737 |
| EHI | 3,122,910 | 3,699,316 | 118.5 | 2,501,418 | 2,921,621 | 116.8 | △576,405 |
| SHI | 4,551,976 | 4,728,917 | 103.9 | 3,712,242 | 3,954,208 | 106.5 | △176,941 |
| GHI | 1,217,498 | 1,181,889 | 97.1 | 1,077,459 | 991,735 | 92.0 | 35,609 |

EHI: Former Employee Health Insurance

SHI: Former Self-employed Health Insurance

GHI: Former Government and Private Employee Health Insurance

## 1.4. Benefits package

NHIS is a program for the enhancement of national health and social security. Towards these goals, benefits are payable to the insured and their dependents in cases of prevention and treatment of sickness and injury, childbirth, health promotion, and rehabilitation. Benefits are granted both in cash and in kind.

From October 1989, medication at pharmacies began to be included in the NHIS. The insured shares less of the cost of medication if he has a doctor's prescription.

However, with the implementation of the new National Health Insurance Act, effective on July 1, 2000, benefits that have not been entitled before: preventive care, rehabilitation, health education, and health promotion, etc. are included into the national health insurance benefit package of the NHIS.

### 1.4.1. Non-cash benefits

Non-cash benefits include health care benefits and health care services for childbirth. Health care benefits are payable for diagnosis, pharmaceutical or health care materials, surgery, other treatments, hospitalization, nursing, and transportation. Health care services for childbirth are payable when an insured woman or a dependent woman gives birth at a health care institution. Benefits in kind include health care benefits, maternity benefits, and health examinations.

(1) Health care benefits

In the event of sickness or injury, the insured and their dependents are entitled to receive health care services from health care

institutions. Health care benefits include in-patient and outpatient care, dental services, traditional oriental medicines, prescription drugs, essential preventive services, etc.

(2) Maternity benefits

When an insured woman or a dependent of the insured gives birth at a health care institution, she is entitled to maternity care benefits.

(3) Health Examinations

In order to prevent diseases by early detection, the insured and their dependents, who are 40 or more years and above are entitled to free health examinations every two years.

### 1.4.2. Cash benefits

Cash benefits are reimbursements for health care expenses and delivery expenses paid by the insured or their dependents and some fixed amounts for funeral expenses. Cash benefits, also, include compensatory grants when the total expenses borne by the insured or their dependents exceed 1,000,000 Won for every 30 days.

Health care expenses and delivery expenses can be offered when the insured or their dependents have, in an emergency or for other unavoidable reasons, been treated or gave childbirth in an institution not authorized by the NHIC as a health care services provider for the insured and their dependents.

Cash benefits in cash include health care allowances, maternity allowances, funeral allowances, compensatory reimbursement, and allowance on caring aids and appliances.

### 1.4.3. Co-payment

(1) In-patient services

In order to curtail the overuse of the health care services, and the concentration of the services in large urban hospitals, the level of co-payment for in-patients services was set differently in accordance with health care institutions. When a patient is admitted to a clinic, a hospital, or a general hospital, 20% of the total health care charges has to be paid by the patient.

(2) Outpatient medical services

For outpatient services provided at a clinic, the patient must pay 2,200 Won when the total charges do not exceed 12,000 Won (at a dental clinic; 2,700 Won). However, an aged patient pays 1,200 Won. When total charges exceed 12,000 Won, 30% of the total charges including the diagnosis and consultation fee are paid by the patient. For outpatient services provided at a hospital or a general hospital, 40% or 55%, respectively, of the total charges excluding the diagnosis and consultation fee is paid by the patient. When the patient visits a general hospital or a hospital for outpatient services, the patient if the total charges do not exceed 12,000 Won pays 3,800 Won or 3,300 Won.

(3) Pharmacy

In case of using a pharmacy, a patient must pay 30% of the dispensing and drug cost (a patient without a prescription slip must pay 40%). When the total drug and dispensing cost is less than 8,000Won(for a patient without prescription slip, it is 4,000Won) the patient pays only 1,000Won.

### 1.4.4. Exclusion from the benefits

The excluded items from coverage under the NHIS are treatments for simple fatigue, dermatology problems (e.g. freckles, macula, acne, etc), which cause no problems in everyday life, congenital, genetical malformation or urogenital and gynecological diseases which cause no problems in everyday life or at work, vaccination, except a serum injection of tetanus (when judged as necessary) physical examination without any symptoms, treatment of addiction to narcotics, cosmetic surgery, dental prosthesis, orthodontics and scaling only for prevention of dental disease.

### 1.4.5. Restriction and suspension of Benefits

For the purpose of maintaining financial stability and appropriate standardization of benefits, the current NHIS has some limiting conditions.

(1) Restrictions of Benefits

Special or non-standard treatments not recognized by the medical professional are excluded by application of health care standards. The impermissible cases are slight fatigue or ennui, health checkups, innoculation, cosmetic surgery, skin ailments not affecting daily life, special consultations, room charges beyond the allowed amount, etc.

The other limitations are physical harm suffered while committing criminal acts or from intentional accidents and expenses compensated by benefits or cash grants from other sources, etc.

(2) Suspension of Benefits

While in military service, during travel abroad, or in the care of

correctional institutions, benefits are suspended.

## 1.5. Healthcare supply

### 1.5.1. Healthcare institution

More than 90% of the health care services are provided by the private sector. All pharmacies are owned and operated by individual pharmacists. To provide health care services for patients who are insured or their dependents under the NHIS, every legal health care institutions is authorized to provide health services.

At present 61,007 health care institutions are supplying services for the NHIS. They include 288 general hospitals, 672 hospitals, 19,405 clinics, 137 oriental medical hospitals, oriental 7,140 herb medical clinics, 60 dental hospitals, 10,553 dental clinics, 19,189 pharmacies, 127 midwifery clinics and 3,436 public health centers.

### 1.5.2. Healthcare delivery system

To utilize medical resources more efficiently the Government introduced the health care delivery system in 1989.

The patient can select any practitioner or any health care institution. When a patient wishes to receive care from a secondary hospital (General or Special hospital), the patient must present a referral slip issued by the doctor who examines the patient first. There is an exception in the health care delivery system in case of a childbirth or emergency health care, dental care services, rehabilitation services, family medicine services, and health care

services for a hemophiliac. In these cases, any health care institution can be utilized without any limitation.

## 1.6. Payment for the healthcare services

### 1.6.1. Fee-schedule and the cost of drug and health care materials

MOHW announces the point of unit value of healthcare services based on RBRVS (Resources-based Relative-value Scale) following the decision made by the National Insurance Deliberation and Coordination Committee. This is composed of the representatives from the insurer, the insured, the employer, medical association, and the public. However, the Director-General of the NHIC and the chairman of the Medical Care Fee Contract Committee composed of the representative medical circles, make contract on the monetary value of each unit of health care services annually.

MOHW also announces the upper limit of the reimbursement of drug cost and the medical treatment materials. By controlling the level of fees, the Government tries to contain medical cost inflation.

### 1.6.2. Payment of healthcare fees

Health care services are paid for on the basis of an itemized cost for each health care services. The fee payment system is based on fee-for-service principle.

The payment of health care claims is made by the NHIC. The HIRA reviews and evaluates the claims submitted by the health care

institutions and conveys the result to the NHIC.

The cost of drug and healthcare materials are paid directly to the person or the entity which supplies the drug or healthcare materials to the medical care institution. Then, the amount of drug and health care materials and the name of the health care institution are reported to the NHIC.

### 1.7. Review and evaluation of health care services

Submitted claims are reviewed by the Healthcare Fees Review and Evaluation Committee at HIRA. The committee consists of ten full-time and 630 part-time members who are medical specialists. It is divided into a central committee and several local committees. The committee reviews the appropriateness of health care claims based on the fee schedule and announced drug prices.

The current system of the review for health care fees is an indirect system. Direct contact with the patients is made by health care institution which submits health claims to HIRA. HIRA then reviews claims according to the health benefits standards and fee schedule determined by the MOHW. The Act gives HIRA the authority to review services furnished by hospitals, health care practitioners, or other providers of health care services.

All relevant information on health care services, manpower, equipment, and facilities etc., which is reported by health care institutions, stored in a data base system, and readily used in the process of claims review. Every effort is exerted to make the review as accurate as possible.

## 1.8. Management and operation

MOHW manages and supervises the overall systems formulating policy with regard to the health insurance, enacts laws and regulations on health insurance, and approves the annual plans and budgets of the NHIC and the HIRA.

The NHIC is the only insurer controlling the administration of insurance. The NHIC is responsible for the management of the NHIS including, record-keeping of the insured and their dependents, collection of contributions, payment for the health care services and operation of other related projects.

The HIRA is responsible for reviewing health care fees, evaluating health care performance and economy of health care service provided to beneficiaries. HIRA served as a fair and objective organization to review and assure the appropriate health care in partnership with the NHIC throughout the country.

## 1.9. Performance and prospect of the National Health Insurance

The NHIS has contributed greatly to the promotion of people's health by reducing people's burden of health care expenses and improving the access to health care services. Even though the NHIS has achieved universal coverage after twelve years, there remain areas to be improved. Along with rapid economic development, the living standard in Korea has improved a lot, and the people have demanded high quality health care services.

To achieve more efficiency in operation of the NHIS, to extend

the benefits package to meet the demand of the insured person and to maintain equity and social solidarity among the insured, the Government has enforced the new National Health Insurance Act from July 1, 2000. As a result, the previous management systems changed into a single management system and changed the contribution levy and collection system ; a flat rate for all the employee insured and the same deadline for payment of contribution and the benefits package expanded to health care for the prevention of diseases and strengthened health promotion activities.

In the 21st century, further developments in the NHIS will be made to meet the needs of the insured person and play key roles to secure the people's health.

Though the Government achieved the universal coverage of health insurance, MOHW has just started the reform process with the expansion of benefits package and the integration of management. The goals are to achieve appropriate benefits and contribution, financial stability, and efficiency in the management of NHIS.

The 'low-contribution' policy and limited benefits coverage were inevitable in the last two decade to make the health insurance take root in its early stages. These policies resulted in many complaints about previous health insurance policies. To meditate these complaints the new NHIS should be developed on the basis of appropriate benefits and contribution structure by the adoption of various alternatives.

Due to rapid increase of aging population and advancements of new technology in the health care sector, financial instability becomes one of the major issues in the NHIS.

Actually, the deficit of the financial resources is unavoidable due to the expansion of the benefits package. The annual increase rate

during the last five years(from 1994 to 1998) was 20.5% whereas the increase rate of the contribution during that time has risen only 12.2% . In order to cope with the upcoming financial problems, a new medical fee payment system such as a global budget system or case payment system should be developed. Also, the increase of contribution rate and cost containment methods is required to achieve the financial stabilization.

One of the most important tasks is how to ensure the efficiency in the administration of the new NHIS. To overcome the potential bureaucratic failure of the single management system will be a critical determinant of the efficiency. The NHIS needs institutional mechanism to maximize the insured person's satisfaction in the program with the introduction of competition within all organization.

## 2. Medical Aid

### 2.1. Recipients

The Medical Aid Program is designed to assist people with low incomes, those receiving livelihood assistance, and those who are unable to pay for health care. It provides the poor with health care services with the national budget. Medical Aid, as a public assistance program, is categorized into Class I and Class II .

### 2.2. Selection of the Recipients

The mayor of a city or chief administrator of a county selects recipients through annual surveys of the income and household assets.

The criteria for selection is determined by the Minister of MOHW and may be subject to change yearly.

*Table 2. Recipients of Medical Aid*

(Oct. 2000)

| Classification | Recipients | Number (1,000 persons) |
|---|---|---|
| Total | 3.8% of the whole population | 1,546 |
| Class Ⅰ | Those unable to work as defined by the "National Basic Livelihood Security Act", Kwang-Ju Democratic Rising Vicitims, Human cultural assets, Escapees from N. Korea, Persons of national merit, Victims of calamity, STD patients | 797 |
| Class Ⅱ | Persons, other than Class Ⅰ, as defined by the "National Basic Livelihood Security Act" | 749 |

*Table 3. Criteria to Select Recipients*

(Oct. 2000)

| Classification | Recipients | Criteria | |
|---|---|---|---|
| | | Income (person/month) | Assets (per household) |
| Class Ⅰ | Those unable to work as defined by the "National Basic Livelihood Security Act" | Under 320,000won | Under 29mil.won(1,2) 32mil.won(3,4) 36mil.won(5,6) |
| | Persons in nursing and welfare facilities Victims of natural disasters | All recipients | |
| | National Heroes, Kwang-Ju Democratic Rising Victims, Persons of national merit, Human cultural assets, Escapees from N. Korea | | |
| | STD patients | | |
| Class Ⅱ | Persons, other than Class Ⅰ, as defined by the "National Basic Livelihood Security Act" | Under 320,000 Won | Under 29mil.won(1,2) 32mil.won(3,4) 36mil.won(5,6) |

# Social Welfare Services

## 1. Welfare for the Disabled

### 1.1. Introduction

According to the sample survey conducted by the Korea Institute for Health and Social Affairs (KIHASA) in 2000, the total number of persons with disabilities in Korea was estimated at 1,449,000 with an appearance rate of 30.9 per 1,000 persons. This survey has been conducting by KIHASA every five years. The number of persons with disabilities by each disability/handicap type is as follows;

*Table 1. The Number of Disabled Persons by Type*

(unit: thousand persons, in 2000)

| | | |
|---|---|---|
| Total | | 1,449 |
| Disability/ Handicap Types | Physical Disability | 605 |
| | Brain Disorder | 223 |
| | Visual Impair-ment | 182 |
| | Auditory Impair-ment | 149 |
| | Lingual Impair-ment | 27 |
| | Mental Retard | 109 |
| | Autism | 13 |
| | Mental Illness | 72 |
| | Kidney Failure | 25 |
| | Heart Failure | 44 |
| Appearance rate per 1,000 | | 30.9 |

To foster more effective welfare measures for persons with disabilities, the Government started a registration system for the

disabled in November 1988, and the registration rate is 68.6% in 2000.

Table 2. The Number of Registered Disabled Persons

(unit: person, in 2000)

| | | |
|---|---|---|
| Number Registered | | 972,087(%) |
| Disability/ Handicap Types | Physical Disability | 584,984(60.2) |
| | Mental Retard | 84,425(8.7) |
| | Visual Impairment | 83,391(8.6) |
| | Auditory Lingual Impairment | 82,906(8.5) |
| | * Five Expanded Types | 71,865(7.4) |
| Veterans | | 64,516(6.6) |

※ Five Expanded Types : Brain Disorder 24,394, Autism 1,190, Mental Illness 19,795, Kidney Failure 22,184, Heart Failure 4,302

## 1.2. Revision of disability-related acts

The Government has laid a foundation for comprehensive welfare programs for the disabled by amending related laws.

- Dec. 31, 1977 : Special Education Promotion Act was enacted.
- Jun. 5, 1981 : Welfare for Disabled Persons Act was enacted.
- Sep. 5, 1988 : President's Welfare Committee for Persons with Disabilities organized.
- Dec. 30, 1989 : Welfare for Disabled Persons Act was revised extensively.
- Jan. 13, 1990 : Promotion, etc., of Employment of Disabled Persons Act was enacted.
- Sep. 17, 1991 : Central Welfare Committee for Persons with Disabilities was organized.
- Dec. 30, 1994 : Barrier-free legislation for Persons with Disabilities was enacted.

- Apr. 10, 1997 : The Act on Installation of Convenience Facilities for the Disabled was enacted.
- Jan. 1. 2000 : Welfare for Disabled Persons Act was revised extensively
- Jan. 12. 2000 : Promotion, etc. of Employment of Disabled Persons Act was reenacted to Promotion of Employment and Vocational Rehabilitation of Disabled Persons Act

By amending laws that have excessively high qualification standards for some certificates, the Government has expanded opportunities for persons with disabilities to participate in society.

### 1.3. Strengthening welfare policies for the disabled

The Government endeavors to expand welfare institutions and improve the quality of their services to provide comprehensive protection for persons with severe and/or multiple disabilities. The Government is also expanding the income maintenance programs for persons with disabilities by providing welfare allowance and reducing taxes and fees.

The Government has been conducting information campaign to counter social prejudice against persons with disabilities and helping the disabled develop their self-reliance so that they can become active members of society.

The Government has been providing itinerant rehabilitation services to promote self-support so that disabled persons at home can perform social activities equal to non-disabled persons.

### 1.3.1. Prevention of disabilities

The incidence of disability can be reduced by strengthening the maternal and child health care systems and by early detection and treatment of disability producing sickness and injuries. A management system for maternal and child health care has been implemented. Infants and adolescents are vaccinated on a periodic basis.

The Government sets the medical examination for inborn metabolic disorders for all babies within three days following birth (eight cases of Hypothyroidism and three cases of R.K.U have been identified through this examination)

### 1.3.2. Expansion of welfare institutions for the disabled

The Government is expanding the scope of operation of welfare institutions in order to provide better vocational, medical, and social rehabilitation for the severely disabled.

*Table 3. Status of Welfare Institutions*

(1999)

| | Type of Institution | Number of Institution | Number of Persons in Institutions |
|---|---|---|---|
| Residential Institutions | Physically Disabled | 39 | 3,296 |
| | Mentally Retarded | 61 | 5,841 |
| | Visually Impaired | 11 | 676 |
| | Auditory-lingually Impaired | 14 | 913 |
| | Medical Care | 70 | 6,448 |
| | Sub Total | 195 | 17,174 |
| Non-residential Institutions | Welfare Center | 62 | - |
| | Special Hospital for Rehabilitation | 15 | - |
| | Day Care Center | 35 | - |
| | Short-term Care Center | 4 | - |
| | Group-Home | 16 | - |
| | Sport Center | 11 | - |
| | Service Center by Car | 16 | - |
| | Sign Language Interpreting Center | 16 | - |
| | Vocational Rehabilitation Institution | 172 | - |
| | Sub Total | 347 | - |
| | Total | 542 | 17,174 |

### 1.3.3. Measures to reduce the financial burden

To reduce the economic hardship of the disabled and their families, the Government has developed various measures, which enable persons with disabilities to support themselves. The Government provides 76,899 low- income disabled persons with disability allowance and 93,251 low-income disabled persons with medical aid, bearing all medical expenses. The Government also

provides loans for self-support, education aid, appliance aid and non-budgetary measures for reducing the economic burden, such as deduction of tax, discount of fee for public facilities, etc.

### 1.3.4. Non-residential institutions for the rehabilitation of persons with disabilities

The Government establishes many kinds of public rehabilitation institution to foster the development of persons with disabilities toward self-supporting status. As public rehabilitation institutions, there are Welfare Center, Special Hospital for Rehabilitation, Day Care Center, Short-term Care Center, Group Home, Sport Center, Service Center by Car and Sign Language Interpreting Center. The functions of public rehabilitation institutions include rehabilitation counseling, therapy, training, social surveys, general rehabilitation services and social action, etc.

### 1.3.5. Increase in the number of barrier-free facilities

The Government has been continuously eliminating social and physical barriers and has made access easier for persons with disabilities to participate in social activities. The Government also introduced the Act on the Installation of Convenience Facilities for the Disabled in April 1997 for the benefit of people with disabilities to improve their accessibility and to bring about their unrestricted social mobility and free access to information.

Under the Act, the installation of barrier-free facilities for roads, parks, public buildings and facilities, means of transportation and

communication equipment is compulsory. Also the government is subsidizing the private sector installation of barrier-free facilities by providing financial and technological benefits and tax breaks.

### 1.3.6. Increase in the educational opportunities and employment opportunities

Most disabled children are enrolled in regular schools. But for the disabled children who cannot adapt themselves effectively to the environment, the Government operates 129 special schools and 6,429 (3,825 in general schools) special classes, where 50,852 disabled students are being educated.

The Promotion, etc. of Employment of Disabled Persons Act was enacted in 1990. This Act was reenacted as Promotion of Employment and Vocational Rehabilitation of Disabled Persons Act in January, 2000. According to the law, the company with 300 employees or more must fill at least 2% of its positions with disabled workers. The Government has established the public vocational training centers for the disabled.

### 1.3.7. Establishment of the National Rehabilitation Center

The National Rehabilitation Center was established in October, 1986. The functions of the Center include counseling, medical rehabilitation, job-training, research and study. The Center has also constructed the National Rehabilitation Medical Center. The Medical Center will meet the growing need for specialized medical rehabilitation treatment of the handicapped and technically qualified

personnel. It was opened in April, 1994.

### 1.3.8. Sports activities

Since 1981, National Sports Games for the disabled have been held every year. The Government has participated in the Paralympic Games since 1968. Athletic activities serve as a form of social rehabilitation and as a way to maintain one's health. It is very important to provide persons with disabilities with equal opportunities for taking part in athletic activities and to develop such sports events in Korea.

## 2. Welfare for the Aged

### 2.1. Introduction

The population of the aged is increasing rapidly as a result of better living conditions and the advancement of medical technology. Between 1980 and 2000 the number of the aged population increased from 1,456,000 to 3,371,000, rates of 3.8% and 6.6% respectively.

Compared with other developed countries, the number of the aged is not yet a serious problem in Korea. However, Korea became an aging society in 2000, and the speed of aging rate is unprecedentedly high. The projected the aged population will be 7,527,084 with the proportion of 14.3% by 2022. Therefore Korea is expected to enter the aged society in the near future.

Korea has the strong tradition of family support for the aged, but now this has weakened due to social changes such as urbanization and

women's participation in economic activities. Therefore, Korea faces the need of care and support for senility and chronic illness, income maintenance programs for the aged, and some policies to foster productive aging.

Table 4. Population Aged 65 or Over

(unit: thousand persons)

| Classification | 1960 | 1970 | 1980 | 1990 | 2000 | 2010 | 2020 |
|---|---|---|---|---|---|---|---|
| Total Population<br>Elderly Population | 25,012<br>726 | 32,241<br>991 | 38,124<br>1,456 | 42,689<br>2,195 | 47,275<br>3,371 | 50,618<br>5,032 | 52,358<br>6,899 |
| Rate(%) | 2.9 | 3.1 | 3.8 | 5.1 | 7.1 | 10.0 | 13.2 |

### 2.2. Enhancement of spirit of respect for the aged

In order to enhance the spirit of respect for the aged, the Government officially honors filial sons and daughters-in-law and typical traditional families annually. Many events have been held to encourage the spirit of respect for the aged and to console the unhappy aged people, arranged by the local Governments and social organizations in every October, "the Month of Respect for the Aged". Since 1980, the Government has implemented a transportation allowance program for subway and bus tickets and provided free admission to the palaces, public museum and parks, and 50% discount for train tickets.

### 2.3. Expansion and diversification of the welfare services for the aged

The persons at risk of being admitted to some forms of institutional care have increased because of the trends of the nuclear family and the aging society of Korea. At present, the main welfare facilities for the aged are residential homes, nursing homes for the severely disabled aged and geriatric hospitals. These facilities are divided into three categories - free facilities, low-price facilities and paying facilities - depending on the person's ability to pay of the aged. The eligibility for free or low-price facilities is confined to the low-income aged group.

#### 2.3.1. Grants toward expansion and improvement of institutions

MOHW grants subsidy to free or low-price facilities for operational expenses. Total amount of subsidy was about 19.8 billion Won for 174 free facilities and 16 low-price facilities in 1999. At the same time, MOHW gives financial aid to build new facilities in order to provide services to a broad range of the aged. Building of additional institutions for dementia patients is very important as dementia patients are increasing.

#### 2.3.2. Government support to construct 'paying facilities'

At present, it is so important to enhance the quality of service of welfare institutions, that facilities which make charges were introduced to take care of the aged having ability to pay. The Government has provided mortgages to welfare foundations and

charitable individuals to facilitate new construction of residential homes, nursing homes, and other facilities.

*Table 5. Number of Welfare Institutions for the aged*

(1999)

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

As society has been transformed where traditional family support has weakened and the number of the aged living alone or has been increased, the need for non-residential services for the aged who continue living in their own home has grown.

Home help-services, day care centers and short-term care centers for the aged are available to aged recipients of public assistance at free. The poor aged can use the services at reduced-cost, while others have to pay the whole costs. The number of such centers is expected to increase so that each city or county has one and more.

The Government gives grants for home help services for the low-income aged such as homemaker services, meal service, bathing service, consultation, companion service, and visiting nursing care service. The personnel services are provided mostly by volunteers, except for the recipients who need some professional care services.

Day care center service is provided for the aged who need help during day-time because of the absence of family members who can

take care of them. At present only 42 daycare centers funded by the Government are operational, but the Government has a plan to expand the distribution of this service.

The aged who needs temporary hospitalization because of inadequate care by the family may enter short-term care facilities, which provide lodging, meal, physiotherapy and medical treatment. At present, Korea is short of these facilities and government plans to construct more in the future.

### 2.4. Management of senile dementia and physical examination

The increase in longevity and the advance of the aging society creates the demand for schemes for chronic degenerative and neurological disease of the aged.

The rate of senile dementia patients is estimated to be 8.3% in the age range of 65 years and above and the actual number is estimated to be about 280,000 persons. The Government has therefore started a 『10 Year Plan for Senile Dementia』 which includes building of nursing facilities and hospitals, research institutions for dementia, and operation of pilot projects of remote-clinics. Since 1993, the Government has established comprehensive dementia centers in the public health centers.

To improve the health of the aged through diagnosing geriatric diseases at an early stage and providing health education, the Government has given subsidies to local governments for physical examination of low-income aged since 1983. The patients who are suspected of some diseases through the first screening test should be given further examinations.

## 2.5. Establishing income maintenance policies for the aged

### 2.5.1. Introduction of Non-contributory Old-age Pension

For the aged in low-income brackets who are excluded from the national pension scheme, the Government has introduced so-called "Non-contributory Old-age Pension benefit". It was paid as "respect (for the aged) pension" from July 1998. This is an important complementary measure to the developing current pension scheme.

### 2.5.2. Policies to expand the employment of the aged

The labor force participation rate of those aged 60 years and over was 28.3% in 1980, 35.6% in 1990 and 38.1% in 1998, showing a steadily increasing trend.

*Table 6. Labor Force Participation Rate of the Aged by Sex (60+)*

(unit: %)

| Year | Total Pop. | aged(60+) | | |
|---|---|---|---|---|
| | | Total | Male | Female |
| 1980 | 59.0 | 28.3 | 45.1 | 17.0 |
| 1985 | 56.6 | 29.3 | 44.3 | 19.3 |
| 1990 | 60.0 | 35.6 | 49.8 | 26.4 |
| 1995 | 61.9 | 39.0 | 54.2 | 28.9 |
| 1996 | 62.0 | 39.6 | 54.6 | 29.3 |
| 1997 | 62.2 | 40.4 | 54.9 | 30.3 |
| 1998 | 60.7 | 38.1 | 52.1 | 28.1 |

Source: National Statistical Office, Annual Report on the Economically Active Population Survey, 1980 1999.

There are three job placement programs that provide the aged with an opportunity to earn money; the Aged Employment Services Center, the Aged Workplace and the Aged Employment Promotion.

The program of the Aged Employment Services Centers was started in 1981, and 70 centers were operated by local branch offices of the National Association of Senior Citizens in 2000. The Aged Workplace program was started in 1986 and 510 communal workplaces are being operated by voluntary organizations with government assistance.

To promote aged employment, the Government enacted the Aged Employment Promotion Act in 1991. It encourages business firms to employ 3% or more of its employees from population aged 55 and over. In addition, this Act stipulates that 77 types of jobs (selling bus tokens and cigarettes, attending parking lots and public parks, etc.) should be preferentially allocated to the aged.

## 3. Welfare for Children

### 3.1. Introduction

Child welfare services are provided for children aged below 18 according to the Child Welfare Act amended in 1981. The number of children has been decreasing since 1976, and the underprivileged children have been also decreasing due to effective policies of the Government. The number of underprivileged children is 318,891, which was 2.4% of the total child population in 1997. The Government is endeavoring to prevent occurrence of children in need, by providing those in need with proper accommodation at child

welfare facilities and to train social workers specialized in children's problems.

*Table 7. Number of Children in Welfare Facilities*

(1999)

| Item | Total | Facilities for Infants | Facilities for Children | Vocational Training Institutes | Others |
|---|---|---|---|---|---|
| No. of Facilities | 271 | 26 | 211 | 5 | 29 |
| No. of Persons | 17,840 | 2,017 | 14,408 | 180 | 1,235 |

## 3.2. Support for the underprivileged children at the welfare facilities

The Government supports living costs for the children accommodated at the welfare facilities and personnel expenses of the specialists at those institutions. In 1999, 13,318 of these children formed relationships with sponsors, who provided support of 8.8 billion Won for the children. In accordance with the revised government policy placing more emphasis on domestic adoption than foreign, 1,726 orphans were adopted by foster parents in Korea in 1999.

## 3.3. Technical and vocational training for the grown-up orphans

The Government has been operating a job-providing program for the grown-up orphans since 1976: technical and vocational training, consultation and guidance on the employment conditions, social

adjustment, etc.

*Table 8. Annual Number of Employed Grown-up Orphans*

(unit: persons)

| 1995 | 1996 | 1997 | 1998 | 1999 |
|---|---|---|---|---|
| 335 | 598 | 609 | 382 | 475 |

## 3.4. Support for the child-headed households

As of 1999, there were 7,924 child-headed households of which the numbers totaled 12,427. Most of them face difficulties because they have to take care of their own lives including education due to their parent's death or illness.

*Table 9. Annual Number of Child-headed Households*

| Year | Number of Households | Number of Persons in Households |
|---|---|---|
| 1990 | 6,696 | 13,778 |
| 1995 | 8,107 | 15,118 |
| 1996 | 8,849 | 16,001 |
| 1997 | 9,544 | 16,547 |
| 1998 | 8,407 | 13,627 |
| 1999 | 7,924 | 12,427 |

To protect these households and to provide better living for them to be sound society members, the Government includes them as beneficiaries in the livelihood protection and health aid schemes. The appropriate amount of financial support was given to them for their education and clothes as well.

### 3.5. Prevention of child abuse and neglect

The Government has established the legislative framework in order to take measures against increasing child abuse by reenacting the Child Welfare Act in January 2000. 24-Hour Hot Lines have been installed and operated for immediate reporting of child abuse. In addition, a center for the prevention of child abuse and neglect will be installed at every local government, in order to identify, treat, protect, and prevent child abuse.

### 3.6. Child Education-Care (Educare) Project

The purpose of this project is to bring up preschool children as sound members of society through physical and mental protection and suitable education. In addition, this project helps to improve the living standard of families through the enhancement of the breadwinner's socioeconomic activities.

*Table 10. Number of Child Educare Centers*

(Dec. 1999)

| Item | No. of Educare Centers | No. of Accommodated Children |
|---|---|---|
| Total | 18,768 | 640,915 |
| Public educare center | 1,300 | 99,866 |
| Private educare center | 10,558 | 466,477 |
| Educare center in working place | 207 | 7,278 |
| Home educare center | 6,703 | 67,294 |

MOHW has been in charge of the Child Educare Project since it promulgated the Infant Nursery Act in 1991. Under this project, the

Government provides subsidies to educare centers for the establishing and operating the centers and to support poor families, and so on. The Government spent 294 billion Won for the project in 1999.

## 4. Welfare for Women

### 4.1. Measures to guide and protect women in prostitution

Efforts have been made to prevent prostitution, provide counseling and guidance to women who are already engaged in prostitution, and to facilitate their return to society through a variety of rehabilitation measures including vocational training. In parallel with these efforts, the Government reformed the Prostitution Prevention Act in January 1996, primarily to allow women in prostitution to stay at protective guidance facilities. The Act also stipulates heavier punishment for all parties connected with prostitution, including not only prostitutes themselves but also their counterparts and those who arrange or solicit prostitution.

In addition, the Government has established 110 women's welfare counseling centers to provide counseling and guidance to women who are engaged in prostitution or ran away from home due to domestic hardship and who are highly likely to resort to prostitution. These facilities have 420 counselors. In addition, a total of 12 'temporary shelters', 'protective guidance facilities', and 'self-sustainment and rehabilitation facilities' are in operation throughout the country.

### 4.2. Prevention of violence against women and protection of victims

In January 1994, the Punishment of Sexual Violence and Protection of Victim Act was enacted to prevent sexual violence against women, protect victims of such violence, and to punish those who commit such crimes. For effective enforcement of this Act, 35 sexual violence counseling centers and 3 shelters for victims had been established throughout the country as of June 1997.

In order to protect women from domestic violence, a total of 7 temporary shelters have been established and placed in operation. To meet the need for more active protective measures for the victims of violent crime, the Government enacted the Domestic Violence Prevention and Protection of the Victim Act in December 1997. In accordance with the Act, both the central and local governments have devised legal and institutional arrangements to prevent domestic violence, protect victims, and provide health care and counseling to victims.

### 4.3. Livelihood stabilization support for the Comfort Women

In order to stabilize the lives of women, who were forcibly inducted into sexual slavery by the Japanese Armed Forces during World War II, the Government has enacted the Former Comfort Women's Livelihood Stabilization Act in June 1993. This humanitarian-principled law allows for the provision of livelihood support and health care to the women who were brutally mistreated by the Japanese.

The Government has also afforded the comfort women priority

on long-term housing rentals and social welfare services such as dispatch of volunteers and home care providers. Financial support for general medical needs and dental prosthesis is also available.

### 4.4. Self-sustainment support for low-income female-headed households

In accordance with the Mother and Child Welfare Act, educational grants have been provided to children of low-income female-headed households with less than a certain amount of assets, up to middle school. In 1993, the eligibility of such grants was expanded to include children at high schools. Financial support for child raising was also expanded from those aged 3 or under to age 6 or under.

In order to support low-income female headed-households in their self-sustainment efforts, low-interest livelihood support loans, long-term low-rental housing arrangement services, and job placement services are available. In addition, a total of 39 shelter residences are in operation to accommodate homeless female-headed families for a certain period of time in order to facilitate their efforts to achieve self-sufficiency.

### 4.5. Promotion of policies pertaining to women's health and welfare

In order to introduce policies which are not only future-oriented but also with realistic feasibility, MOHW perform researches on women's issues and problems, especially concentrating on women's health and welfare

Based on the Framework Act on Women's Development (Basic

Act on Women's Development), policies for the advancement of women are being revamped through five-year plans. To this end, MOHW different seminars and group meetings with specialists and pertinent staff within and outside the Ministry along with representatives of major women organizations and civil groups in order to collect their ideas and views.

### 4.6. Strengthen women's lifetime learning programs

In order to cultivate women's latent faculties, various means for strengthening women's lifetime learning programs are being pursued and carried out. Part of this effort includes firstly, the construction of a database, which incorporate information on lifetime learning programs for women. In addition, a Council on Women's Lifetime Leaning Program will be set up and managed at the central and district levels. Also, diverse programs are being developed and disseminated in addition to the specialized programs for trainers thereof.

### 4.7. Supporting women's organizations

In order to energize activities of non-governmental women's organizations, financial support totaling 228 million Won for the year 2000 is being provided at present to 10 different women's organizations which are registered with the Ministry's Division. The Division also publishes a handbook on women's organizations, and it is being renewed every two years. In addition, the Division collects views and opinions, especially concerning women's issues, by holding regular conferences with the representatives and executives of

women's organizations with a view to reflecting such opinions in the pertinent policies.

## 4.8. International cooperation

To vitalize international cooperation, the Division maintains close relations with the UN Commission on the Status of Women, the UN Commission on the Elimination of Discrimination against Women, and the World Conference on Women. Moreover, the Division scrutinizes projects and activities of agencies under the UN umbrella, and disseminates information thereon to the different domestic organizations that work with the aim of advancing the status of women in Korea.