National Health Insurance in South Korea

NHA, India
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I. NHI and UHC in Korea: Achievements

1. Extension of Population Coverage

Incremental Approach

In 1977, firms with > 500 employees, the poor

In 1979, public employees and teachers and firms with > 300 employees

Pilot programs for the self employed

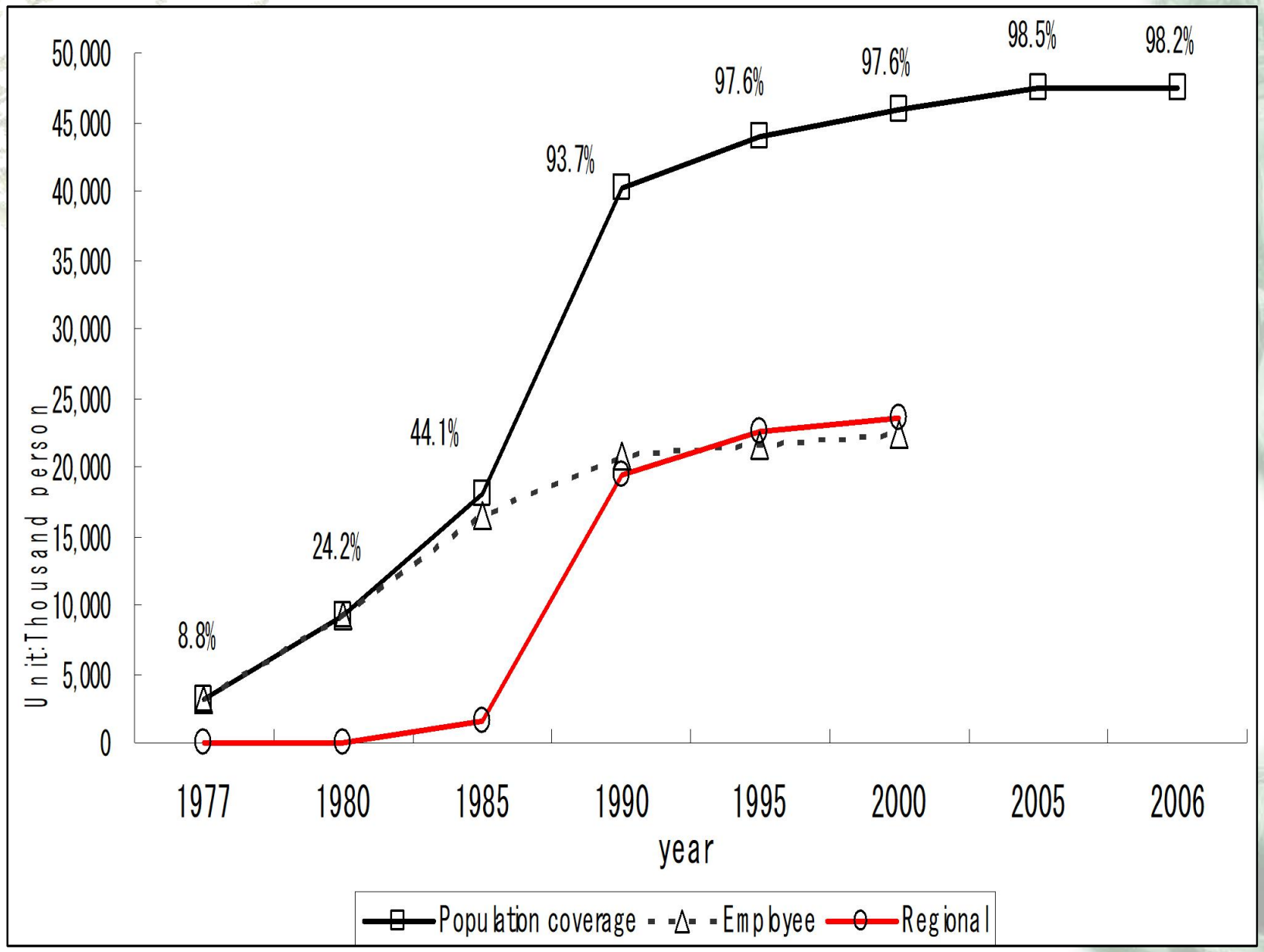
Presidential election in 1987

In 1988, all rural self-employed

In 1989, all urban self-employed (UC of population)

Employees: based on firms/employment

Self employed: based on residential areas


50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Unit:Thousand person
8.8%
24.2%
44.1%
93.7%
97.6%
97.6%
98.5%
98.2%
1977
1980
1985
1990
1995
2000
2005
2006
year
Population coverage
Empbyee
Regional

Facilitating Factors

Politics of legitimization: Mandatory enrollment enforced by authoritarian political regime

Economic growth: rapidly increased the employment in the formal sector

Full subsidy for the poor

Partial subsidy for the informal sector (self employed)

Family-based membership as an effective way to increase population coverage rapidly

2. Single Pool

a. Before the merger of plans in 2000, three types of schemes (about 350 insurance societies) existed for

Public employees and teachers; Private-sector (industrial) workers; Self-employed

Risk adjustment across schemes based on catastrophic expenses and the proportion of the elderly, but many (especially rural) insurance societies experienced fiscal instability and chronic deficits

b. Even before the merger in 2000, Korean SHI functioned as a single scheme

- Uniform statutory benefit coverage across schemes
- Uniform payment system to health providers
- Claim review by a central agency

3. Insurer Organization

a. National Health Insurance Service (NHIS) is an independent quasi-public organization

- From 2011, contribution of all social security programs (pension, unemployment insurance, work-place injury) is collected by NHIS

b. Health insurer in Korea is divided into two agencies based on their functions

- NHIS: premium collection, fund management, reimbursement to providers
- HIRA (Health Insurance Review and Assessment):
  claim review, assessment of appropriateness of health care -> Purchasing decision (including payment system design)

4. NHI Policy Making and Governance

Health Insurance Policy Committee

Major decisions on premium contribution, pricing (medical care, pharmaceuticals), benefit packages, etc.

25 members, Vice Minister of HW as the chair

- 8 from payers (labor unions, employer associations, civic groups, etc)
- 8 from providers (physician, hospital, dentist, pharmacist, etc)
- 8 from the public interests (MoHW, MoPF, NHIS, HIRA, 4 experts)

II. Service Delivery and Purchasing

1. Dominance of Big Tertiary Care Hospitals

Health insurance increased demand, which was met by the increase the supply of private hospitals

- More than 90% of hospitals are private
- Private hospitals have been stumbling blocks to health care reforms

Different cost sharing for outpatient care in Korea:

30%, 40%, 50%, and 60% depending on the level of providers

-> But market share of big hospitals keeps increasing

-> Result: Over-specialization, Cost escalation

2. Provider Payment Systems: Inefficiency

Mainly fee-for-service (FFS)
(DRG-based payment for only 6 diseases)

Regulated fee-for-service system
- Providers are not allowed to charge more than fee schedule: No balance billing
- Regulated FFS is still inefficient because of its volume effect

Domination of private providers paid by FFS
- Demand inducement
- Negative impacts on financial protection
- Strong opposition to payment system reform

3. Purchasing for Quality of Care

Crucial role of the health insurer as a purchaser

a. **Purchasing power** of health insurance: role of state budget is very low for public hospitals

b. **Quality Evaluation** by HIRA (Health Insurance Review and Assessment)

- Review and assessment of medical claims
- Public disclosure of provider performance: e.g., prescription rate of antibiotics and injectables, number of medicines per prescription, and expense of medicines prescribed
- Pay-for-performance
- DUR (Drug Utilization Review)

III. Evolution

1. Financial Protection

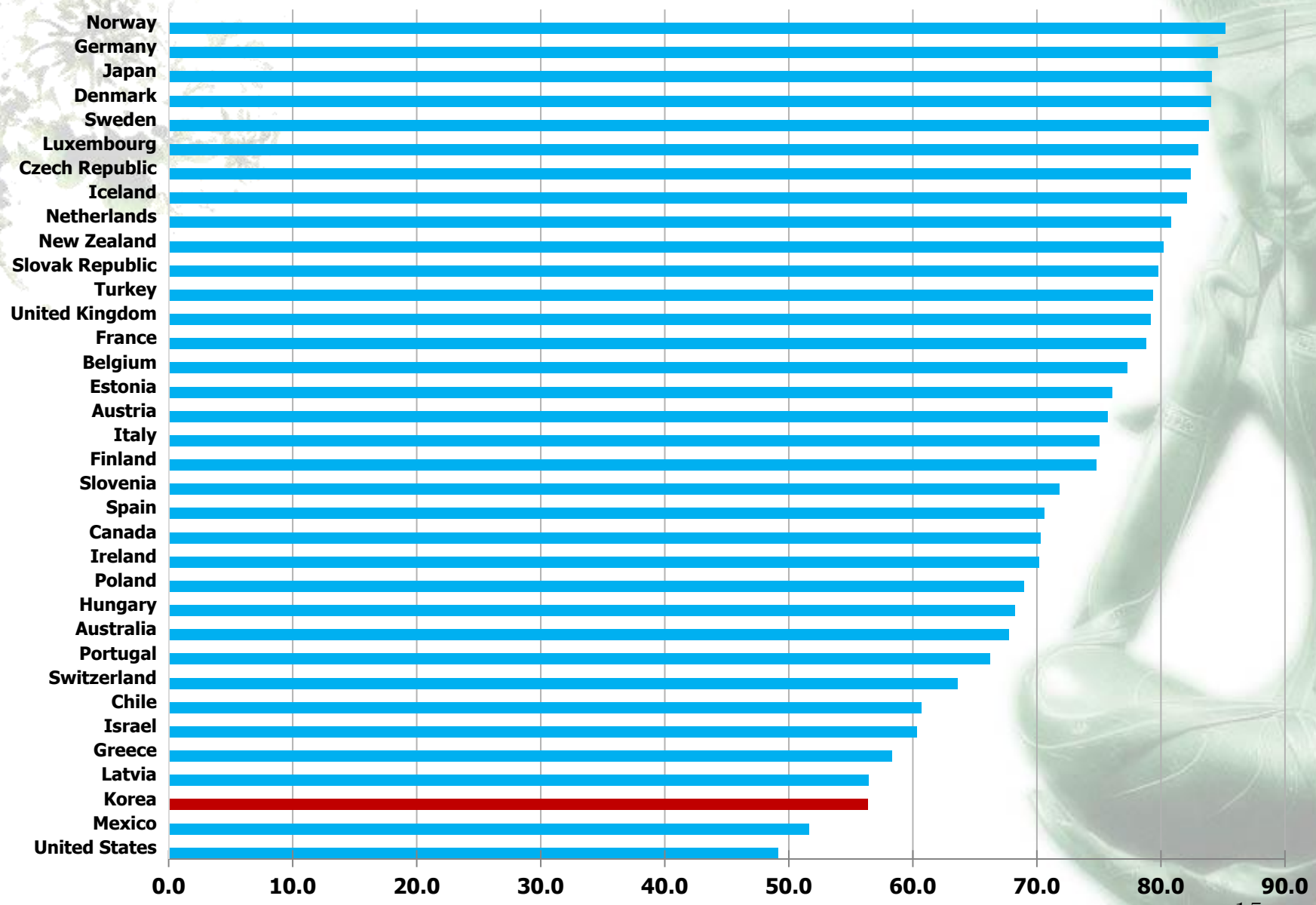
Demand inducement by private providers paid by FFS: incr
eased utilization of un-covered health services

- **Protection Mechanisms in Korea**

- Discounted copayment: elderly, children under 6
  -> Demogrant approach
- 5% OOP pay for catastrophic conditions: e.g., cancer
  -> Disease-based approach
- Ceiling on out-of-pocket payment for covered services:
  7 different ceilings for 7 income groups
  -> cost-based approach

Efficiency and equity of patch-work or cocktail approach?

% Public in Total Health Expenditure, 2016



Source: OECD Health Data 2017

2. Benefits Package Decisions

The decisions on which services to cover at which level o f patient cost sharing should be based on objective criter ia through a transparent process

- Inherently priority setting process associated with valu e judgment: cost-effectiveness alone is not enough

Citizen participation (discussion and deliberation)

for value judgment in benefits decisions

- Fairness in process or procedural justice
- Need *evidence* generation by experts, but also need t o add *value* of lay person/payer/citizen

3. Income-Based Contribution Setting

Contribution of the self employed

- Challenges of combining flow (income) and stock (asset)
- Inequity between the self employed and employees
- Most of the self employed are vulnerable population

Eventually should be income-based contribution

- Simple and transparent
- Include all types of income

  e.g., rental, financial incomes

IV. Challenges

1. Financial Sustainability

1) Health care financing system based on wage in the for mal labor market is not financially sustainable

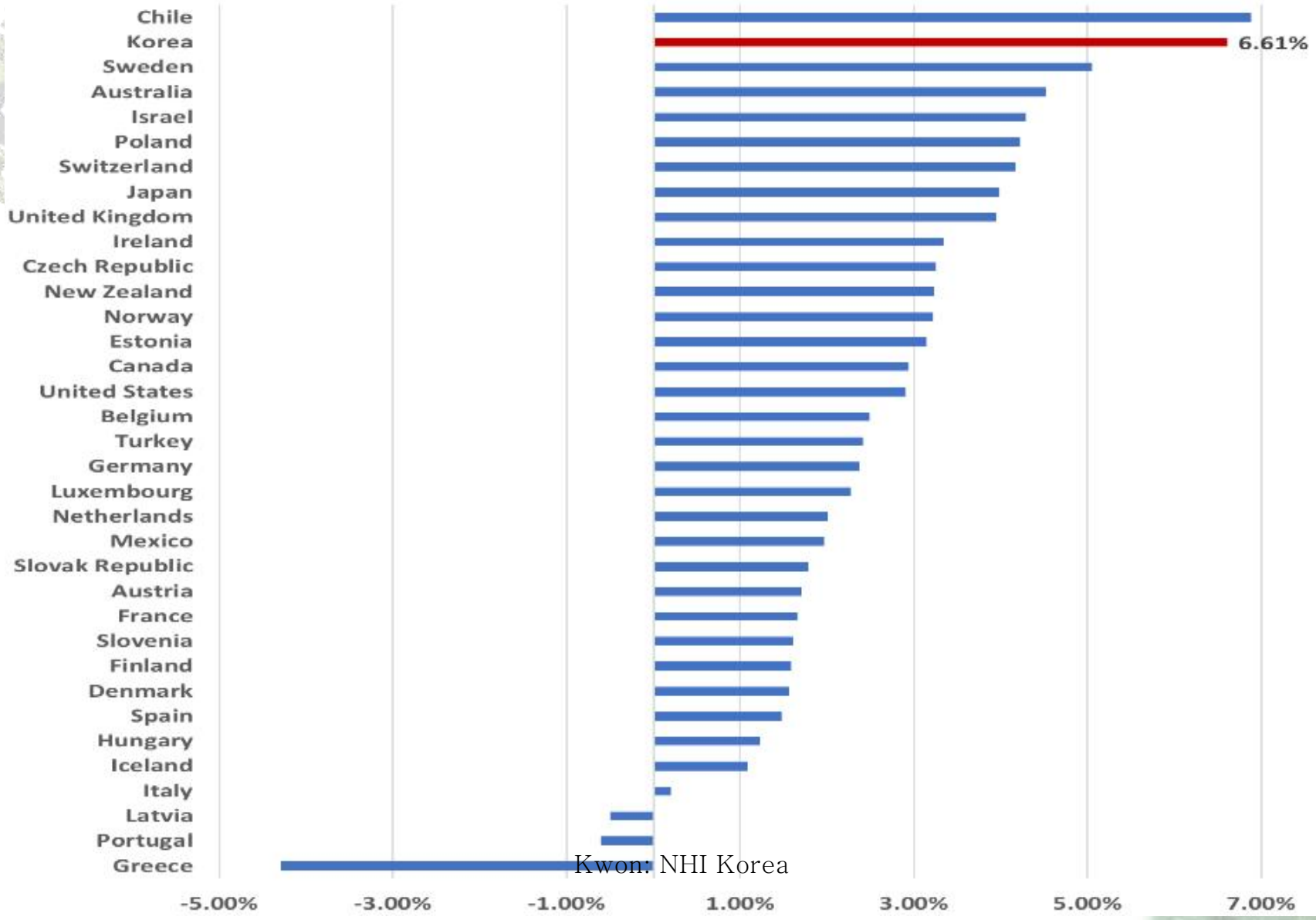
- Need to include all types of income (e.g., financial inco me) for contribution payment
- May need to consider increasing consumption tax: Cons umption tax may not be as regressive as worried

-> Decreasing difference between NHI and NHS in terms of revenue generation

2) Payment system reform for health care providers

- Case-based payment with a macro-level spending cap
- Reform politics: strong oppositions by private providers

Annual Rate of Increase in H Exp (2007-2016)



2. Rapid Aging of Population

Rapid increase in life expectancy and decrease in fertility

Introduced long-term care (LTC) insurance for the elderly in July 2009, which covers about 6-7% of the elderly (+65)

- Balance between institutional care and community-based (CB) care
- Coordination between health insurance and long-term care insurance (e.g., LTC hospitals covered by health insurance, LTC facilities (nursing home) covered by LTC insurance)

THANK YOU !!!

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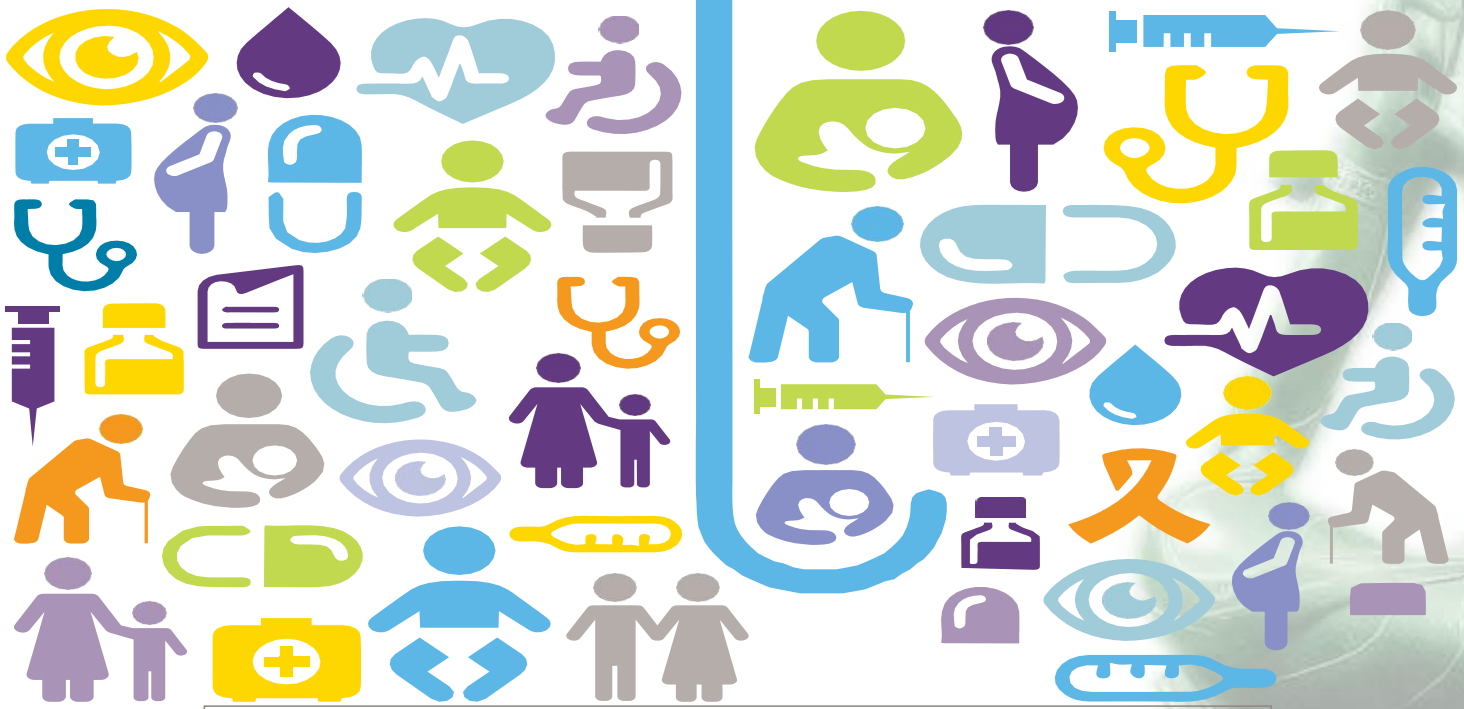
UNIVERSAL HEALTH COVERAGE STUDY SERIES NO. 33

Advancing Universal Health Coverage: What Developing Countries Can Learn from the Korean Experience?



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Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage

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South Korea introduced mandatory social health insurance for industrial workers in large corporations in 1977, and extended it incrementally to the self-employed until it covered the entire population in 1989. Thirty years of national health insurance in Korea can provide valuable lessons on key issues in health care financing policy which now face many low- and middle-income countries aiming to achieve universal health care coverage, such as: tax versus social health insurance; population and benefit coverage; single scheme versus multiple schemes; purchasing and provider payment method; and the role of politics and political commitment. National health insurance in Korea has been successful in mobilizing resources for health care, rapidly extending population coverage, effectively pooling public and private resources to purchase health care for the entire population, and containing health care expenditure. However, there are also challenges posed by the dominance of private providers paid by fee-for-service, the rapid aging of the population, and the public-private mix related to private health insurance.

Keywords Health care financing, health insurance, universal coverage, Korea

IMPROVING HEALTH SYSTEM EFFICIENCY

REPUBLIC OF KOREA

Merger of statutory health insurance funds

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Health Systems
Governance & Financing

World Health Organization

The Changing Process and Politics of Health Policy in Korea

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Abstract Korea recently introduced three major health care reforms: in financing (1999), pharmaceuticals (2000), and provider payment (2001). In these three reforms, new government policies merged more than 350 health insurance societies into a single payer, separated drug prescribing by physicians from dispensing by pharmacists, and attempted to introduce a new prospective payment system. This essay compares the three reforms in Korea and draws important lessons about the country's changing process and politics of health care policy. The change of government, the president's keen interest in health policy, and democratization in the public policy process toward a more pluralist context opened a policy window for reform. Civic groups played an active role in the policy process by shaping the proposals for reform—a major change from the previous policy process that was dominated by government bureaucrats. The three reforms also showed important differences in the role of interest groups. Strong support by the rural population and labor unions contributed to the financing reform. In the pharmaceutical reform, which was a big threat to physician income, the president and civic groups succeeded in quickly setting the reform agenda; the medical profession was unable to block the adoption of the reform but their strikes influenced the content of the reform during implementation. Physician strikes also helped block the implementation of the payment reform. Future reform efforts in Korea will need to consider the political management of vested interest groups and the design of strategies for both scope and sequencing of policy reforms.

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Research Article

Participation of the Lay Public in Decision-Making for Benefit Coverage of National Health Insurance in South Korea

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CONTENTS

Abstract—Although South Korea successfully established national health insurance (NHI) in 1977, and has maintained universal coverage since 1989, it has long been criticized for insufficient benefit coverage. Korea has been under public pressure to increase its NHI benefit coverage, while also facing controversies over the appropriateness of items that were newly added to the benefit package. Pressured by the controversies and difficulties regarding national policy decisions on the benefits package, the Korea National Health Insurance Services eventually decided to establish a lay citizen's council, named the Citizen Committee for Participation, to help incorporate social value judgments in benefit

Kwon: NHI Korea

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Impact of the policy of expanding benefit coverage for cancer patients on catastrophic health expenditure across different income groups in South Korea

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ABSTRACT

To increase financial protection for catastrophic illness, South Korean government expanded the National Health Insurance (NHI) benefit coverage for cancer patients in September 2005. This paper investigated whether the policy has reduced inequality in catastrophic payments, defined as annual out-of-pocket (OOP) health payments exceeding 10% annual income, across different income groups. This study used the NHI claims data from 2002 to 2004 and 2006 to 2010. Triple difference estimator was employed to compare cancer patients as a treatment group with those with liver and cardio-cerebrovascular diseases as control groups and the low-income with the high-income groups. While catastrophic payments decreased in cancer patients compared with those of two diseases, they appeared to decrease more in the high-income than the low-income group. Considering that increased health care utilization and poor economic capacity may lead to a smaller reduction in catastrophic payments for the low-income than the high-income patients, the government needs to consider additional policy measures to increase financial protection for the poor.

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Research Article

Health and Long-Term Care Systems for Older People in the Republic of Korea: Policy Challenges and Lessons

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CONTENTS

Abstract—The Republic of Korea is experiencing a rapidly aging population with increased life expectancy and lowered fertility. National health insurance has provided universal access to health care for all since 1989, and mandatory long-term care insurance (LTCI) was introduced in 2008, in which everybody who contributes to health insurance simultaneously contributes to LTCI. Although health services and long-term care are universally accessible, health differentials remain across socioeconomic groups. LTCI covers about 7% of older people through eligibility assessment and provides benefits for institutional and home-based care and cash benefits in exceptional cases. Long-term care (LTC) benefit eligibility has been criticized for being excessively reliant on physical functionality, and recently eligibility has been extended to people with dementia. Despite the oversupply of LTC providers, quality of care has been a concern and calls for more investment in the quality evaluation system and training of care workers. There continues to be overreliance on inpatient care and unmet health care needs among LTC users as a result of weak gatekeeping by primary care and a lack of effective coordination between health care and LTC.

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Research Article

Health Financing Reforms for Moving towards Universal Health Coverage in the Western Pacific Region

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CONTENTS

Abstract—This article provides an overview of health financing reforms across countries in the Western Pacific Region as progress is made toward universal health coverage (UHC). Moving toward UHC requires a strong health system with sustainable financing, which countries strive to achieve through various approaches appropriate to their country contexts. Great efforts have been made by financing reforms through resource mobilization, risk pooling,

Kwon: NHI Korea

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How and why do countries make Universal Health Care policies? Interplay of country and global factors

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Background An examination of country policy making tends to reveal more complex processes that reflect domestic as well as external pressures and influences. The paper examines the interplay of external and internal, as well as other, factors in universal health care (UHC) decision-making for a select number of countries spanning the income range from low to high income.

Methods After developing a conceptual framework to help identify variables to explore in answering our study questions, we reviewed literature on health policies and policy making, especially around the time of the adoption of relevant policies for a number of UHC reform countries, followed by a narrative review of countries for more in-depth study. For more quantitative data, we consulted databases maintained by international institutions.

Results We found that, for low-income countries (LICs)/lower-middle-income countries (LMICs), the external environment helps set the policy agenda that drives national priorities and resource allocation decisions, while national actors take the actual decisions consistent

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Pathways to DRG-based hospital payment systems in Japan, Korea, and Thailand

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ABSTRACT

Countries in Asia are working towards achieving universal health coverage while ensuring improved quality of care. One element is controlling hospital costs through payment reforms. In this paper we review experiences in using Diagnosis Related Groups (DRG) based hospital payments in three Asian countries and ask if there is an Äsian way to DRGs. We focus first on technical issues and follow with a discussion of implementation challenges and policy questions. We reviewed the literature and worked as an expert team to investigate existing documentation from Japan, Republic of Korea, and Thailand. We reviewed the design of case-based payment systems, their experience with implementation, evidence about impact on service delivery, and lessons drawn for the Asian region. We found that countries must first establish adequate infrastructure, human resource capacity and information management systems. Capping of volumes and prices is sometimes essential along with a high degree of hospital autonomy. Rather than introduce a complete classification system in one stroke, these countries have phased in DRGs, in some cases with hospitals volunteering to participate as a first step (Korea), and in others using a blend of different units for hospital payment, including length of stay, and fee-for-service (Japan). Case-based payment systems are not a panacea. Their value is dependent on their design and implementation and the capacity of the health system.