Health Policy and UHC for COVID-19: Lessons for LMICs

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1. UHC (Universal Health Coverage)

Low financial barrier to access, organization of health care delivery through purchasing

Cost of treatment

- NHI with universal coverage of population
- Copayment is free (paid by government budget in case of communicable diseases)

Cost of testing

- Ex-ante free for those who traveled abroad, exposed to contacts, or with doctor's prescription
- Ex-post free if tested positive

UHC and Purchasing (from Providers)

Unique ID

Mobilizing private providers is important for

- Testing in a large scale
- Treatment of patients: surge of patients

NHI law mandates all providers (public and private) to join NHI in Korea

- At the beginning of NHI, government worried that private providers would not join due to low fee
- Mandate on private providers has been controversial

Health Service Delivery

Allocation of patients based on severity to avoid the over-burdening of health system

- Severe patients: Inpatient care
- Milder patients: Support/accommodation centers monitored by a smaller number of health personnel

Number of beds per capita: second highest after Japan among OECD countries

- Paradox of (too) many beds but flexibility to respond to the surge of patients?

2. UHC and Financing in LMIC

Public Financial Management (PFM)

- Need emergency budgets to provide medicines and equipment to public providers
- Need emergency budget support to health insurance

Q: How to mobilize private providers

- Contractual measure is not feasible or not enough in an emergency situation
- May need a legal framework for government to mobilize private providers in a pandemic situation

3. Governance

Transparency in communication

- Trust in the government

Social capital and trust: personal hygiene, no rush to shopping for stock piling, compliance with social distancing

Landslide victory of the ruling (progressive) party in the recent general election (April 15):

smallest number of seats for conservative party in National Assembly since 1992

-> Political economy of disease control:

inter-relation between health and politics

4. Challenges and Lessons for LMICs

Vulnerable population

- Mass infection in geriatric hospitals, long-term care facilities
- Poor, daily workers: cannot work from home, job loss
- No school or internet-based classes have differential impacts on students with different socioeconomic status

4. Challenges (continued)

Mass testing: cost-effective? Over-burden on hospitals?

- Capacity of LMICs

Privacy issues in the tracing of contacts

- Widely support by the public in Korea (especially after the experience of MERSE)
- Should be based on social acceptability and consensus
- Should avoid the potential abuse (in case of authoritarian regime)

Role of public hospitals: little incentive for private providers to invest in the special ward with low profit

4. Challenges (continued)

Decision making process

- Overly medical-driven
- Need to pay more attention to socioeconomic benefits and costs of various intervention measures

New paradigm

- Evidence: nature of the epidemic, benefit/cost/risk of various intervention measures
- Value judgment to determine the RISK that a society can or is willing to accept