NHI and ICT in Korea

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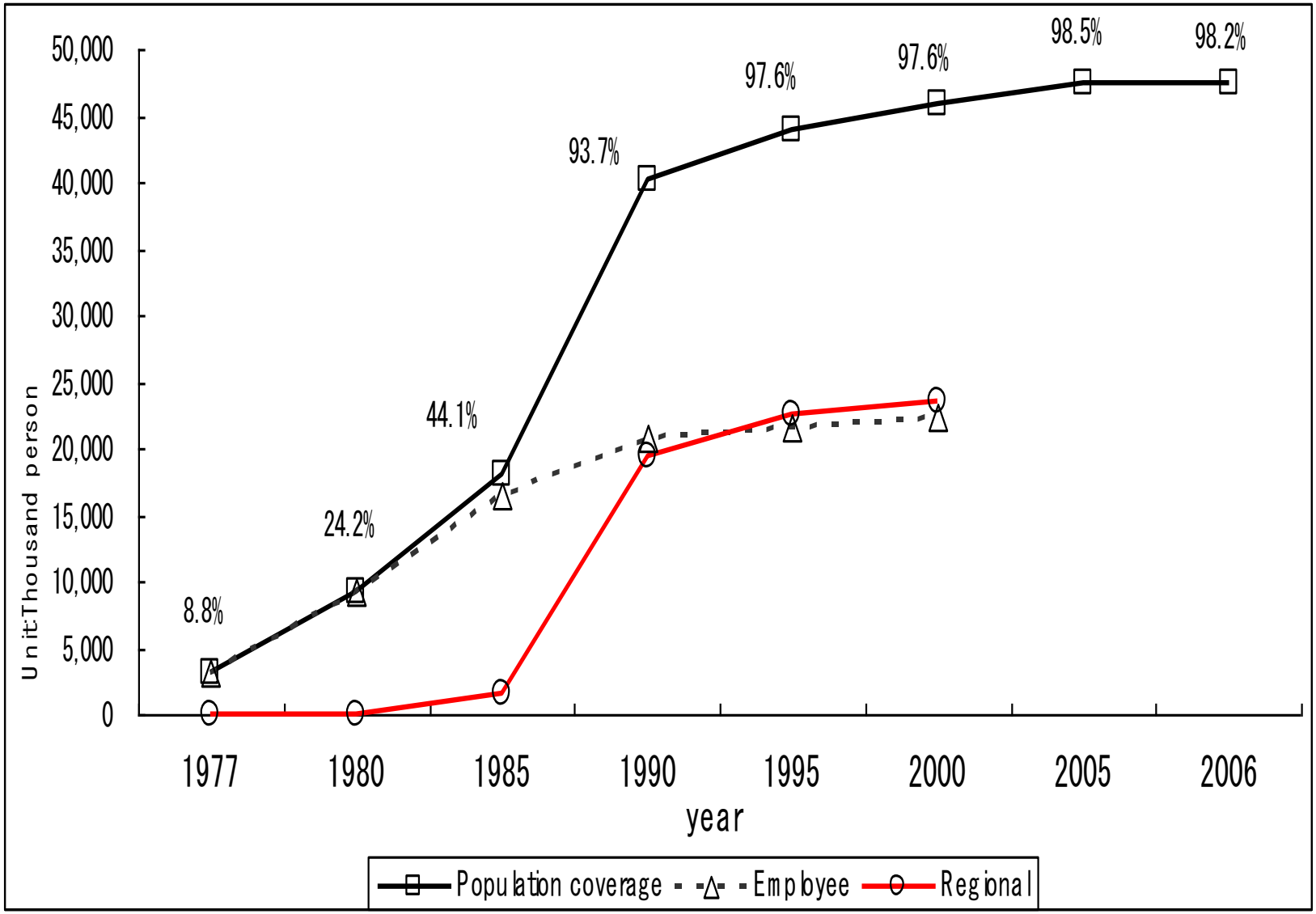
1. Extension of Population Coverage

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

In 1988, all rural self-employed
In 1989, all urban self-employed (Universal Coverage of population)


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
Employee
Regional

Political and Economic Environments

Mandatory enrollment enforced by authoritarian political regime

Political will and need for political legitimization

Economic growth: export-driven economic development rapidly increased the employment in the formal sector and reduces the size of the informal sector to be subsidized

Family-based Membership

Family-based membership (dependents coverage) can more rapidly

- Increase the population coverage through formal sector
- Reduce the size of the informal sector to be covered

-> Effective way to increase population coverage

Family membership can contribute to overcoming the fragmented system such as separate schemes for the school students, the elderly, etc.

Now there is a threshold income, and those who earn more than the threshold cannot be dependents.

2. Role of Information and ID System

Unique national ID since the 1960s

- Management of enrollees
- Family registry: Dependents, family members
- Profiles of health care providers

NHI data with universal population coverage

- Key resources for policymakers and researchers
- Evidence-based health insurance policy: Monitoring and evaluation of the behavior of providers and enrollees
- Research on the impact of health insurance policy/programs

3. Mix of Contribution and Government Subsidy for the Self Employed

Incentive for the informal sector to join

- Thanks to the subsidy, contribution of the self employed was lower than that of employees
- Compromise of pure contribution and pure subsidy

Rapid economic growth and resultant shrinking of the self-employed sector (increase in the formal sector)

-> made subsidies to the self employed affordable and politically palatable

Contribution Setting

Contribution of the employed: proportional to income, and shared equally by the employer and employee

Contribution of the self employed considers

a. Earned income: business/labor and other incomes

b. Property (house, building, land) and vehicles

c. Living standard: income estimation based on gender, age, property, vehicle, income

When annual income>5,000 USD -> a + b

When annual income <5,000 USD -> b + c

4. Single Pool/Purchasing

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

Public employees; Private employees; Self-employed

- Risk adjustment across schemes had limitations before the merger, and rural insurance societies experienced fiscal instability and chronic deficits

- Improved efficiency and equity of single insurer system

- *Single insurer has positive effects on ICT development, including integrated data management*

b. Even before the merger in 2000, Korean NHI had

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

Provider Payment Systems

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

5. Insurer Organization and Governance

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
- *Larger population coverage and more sophisticated information system than other programs*

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

Accountability:
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)

b. Strong role of a *single* ministry, MOHW (and its Bureau of Health Insurance), can avoid the potential coordination problem across ministries

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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

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Health Care Financing in Asia: Key Issues and Challenges

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Abstract

This article examines the major elements of health care financing such as financial risk protection, resource generation, resource pooling, and purchasing and payment; provides key lessons; and discusses the challenges for health care financing systems of Asian countries. With the exception of Japan, Korea, Taiwan, and Thailand, most health care systems of Asia provide very limited financial risk protection. The role of public prepaid schemes such as tax and social health insurance is minimal, and out-of-pocket payment is a major source of financing. The large informal sector is a major challenge to the extension of population coverage in many low-income countries of Asia, which must seek the optimal mix of tax subsidy and health insurance for universal coverage. Implementation of effective payment systems to control the behavior of health care providers is also a key factor in the success of health care financing reform in Asia.

Keywords

health care reforms, heath economics and financing, health insurance, health systems, health care services

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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.

THANK YOU !!!

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