h·well NHIS National Health Insurance Service

NHIS Health Promotion Program

Integrated Management of Chronic Diseases

From Primary Care to Health Management Services

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01. Overview

1-1. Key Features of NHIS

Mandatory Subscription

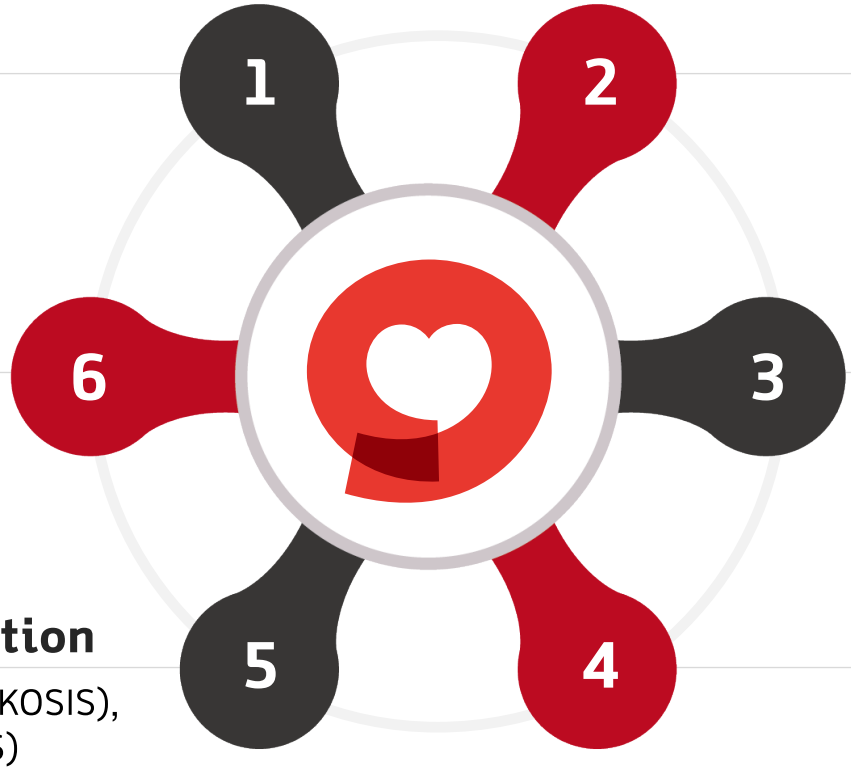
Mandatory under the National Health Insurance Act

Broad Coverage

Medical services, prescription drugs, health screenings, prenatal care, severe illnesses, etc.

Private Medical Care Institution

94.2% of healthcare facilities (Q3 2024, KOSIS), No. of providers: 101,832 (Q3 2024, NHIS)



Contribution Assessment

Contributions imposed based on the ability to pay

Equal Benefits

All citizens receive the same insurance benefits regardless of the amount of contributions they pay

Payment and Collection

The insured pay their contributions and NHIS collects the contributions

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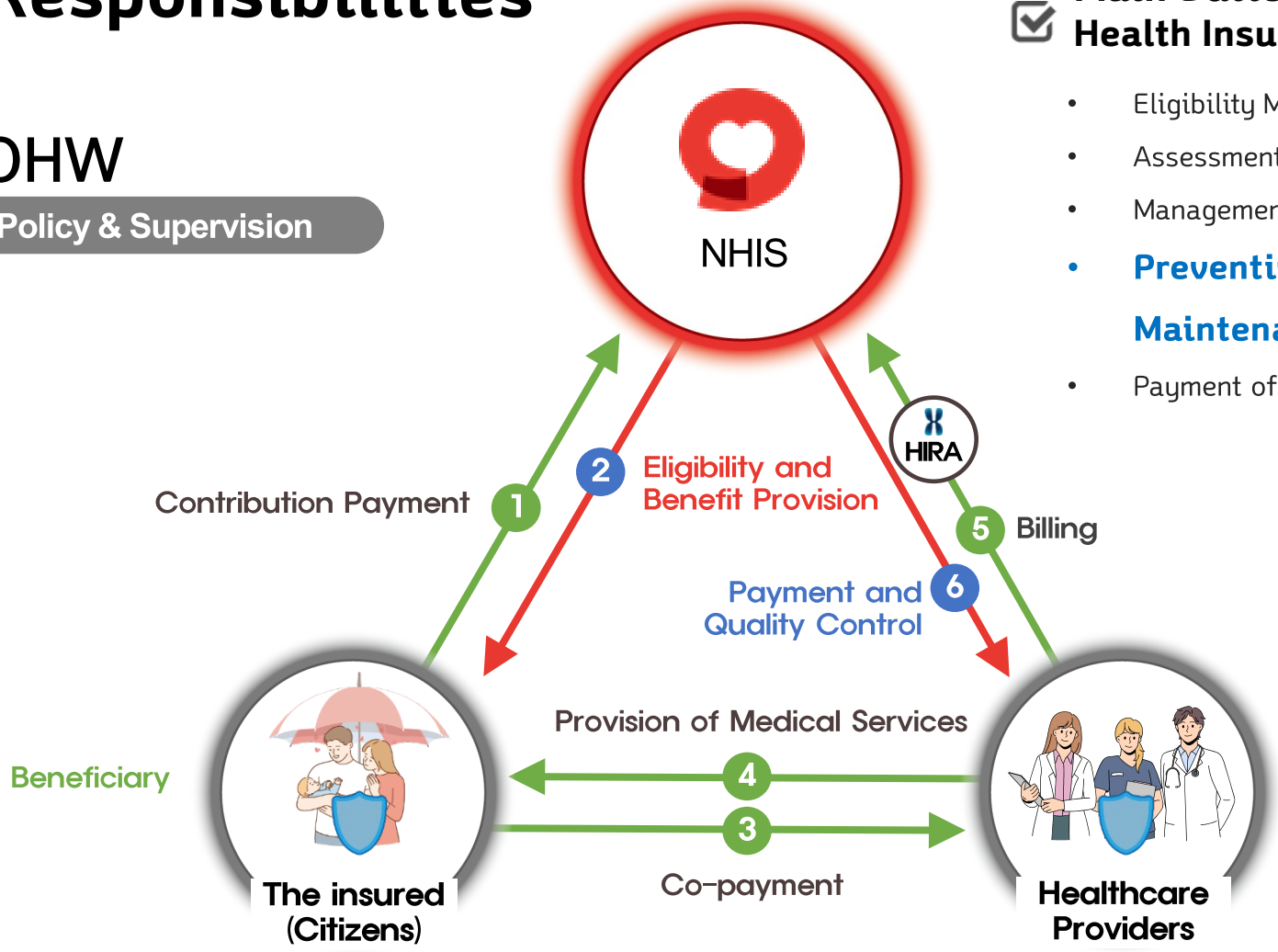
01. Overview

1-2. NHIS Responsibilities

MOHW

Policy & Supervision



Main Duties ··· Article 14 of the National Health Insurance Act

- Eligibility Management for The insured and Dependents
- Assessment and Collection of Insurance Contributions, etc.
- Management of Insurance Benefits
- **Preventive Programs for Health Maintenance and Promotion**
- Payment of Insurance Benefits, etc.

- Healthcare
- Health Screenings
- Long-Term Care

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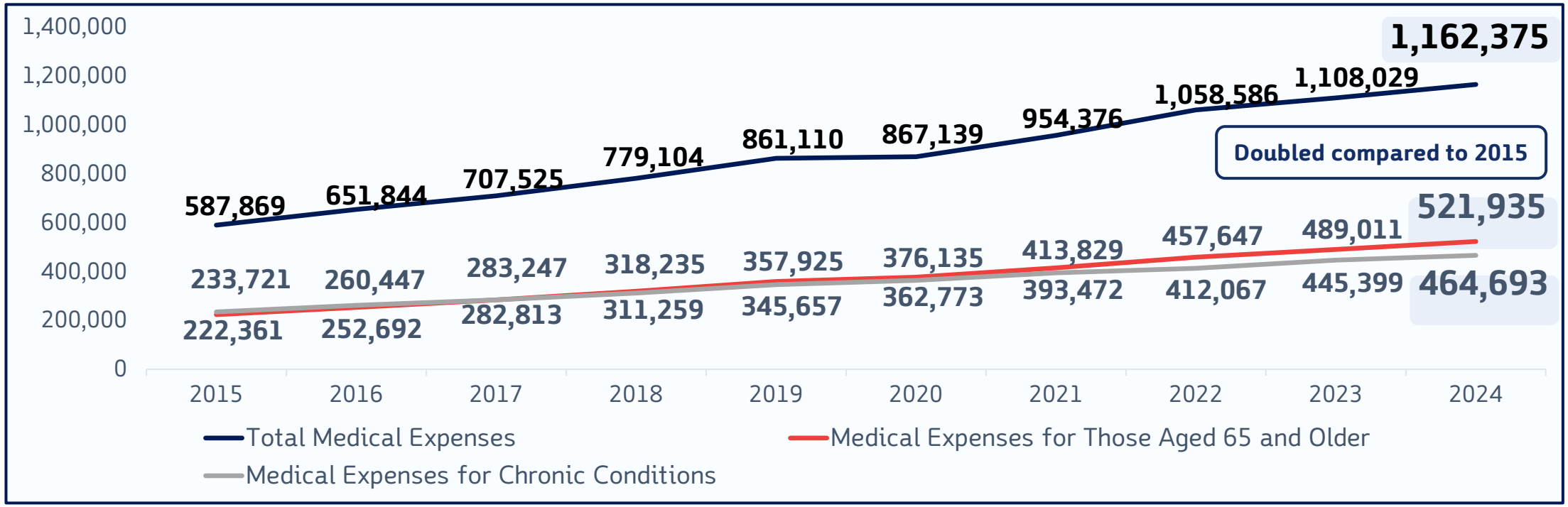
02. NHIS Health Promotion Program

02. NHIS Health Promotion Program

2-1. Background

Medical expenses are on an upward trend each year due to the transition to a super-aged society and the increase in patients with chronic diseases

(Unit: 100 million KRW)



※ Source: National Health Insurance Statistical Yearbook

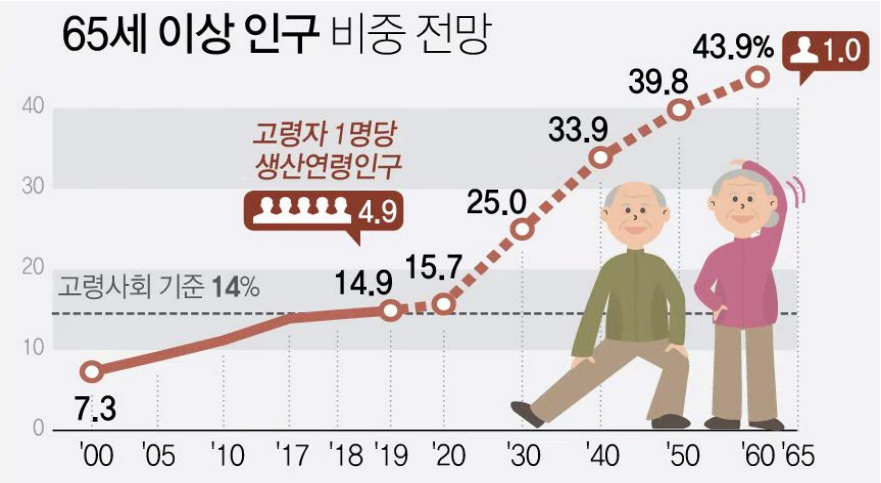
02. NHIS Health Promotion Program

2-1. Background

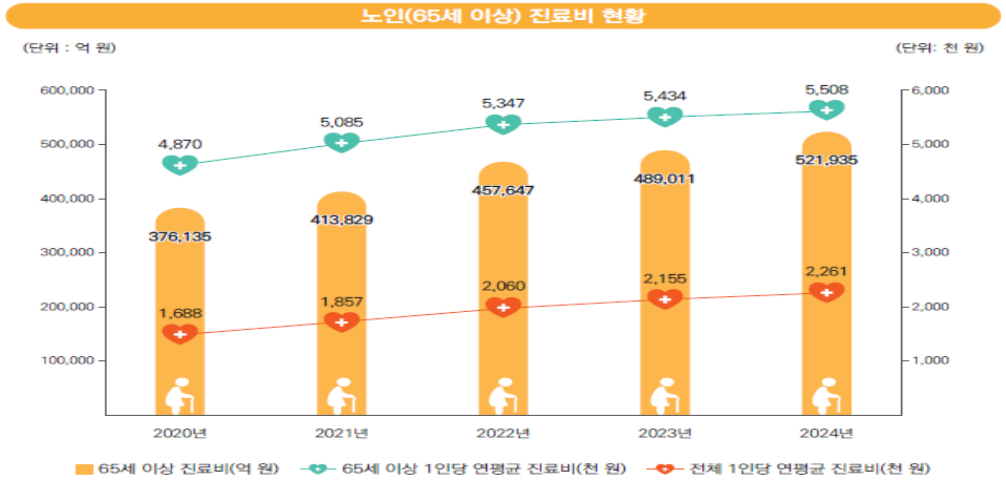
☑ **Medical expenses for seniors aged 65 and older are increasing annually, and the health of the elderly is deteriorating**

- Average annual medical expenses/person: 2,261,000 KRW; Those aged 65 and older: 5,508,000 KRW (2024)
- 86.1% of the elderly suffer from chronic diseases, an average of 2.2 chronic conditions (Survey of Older Korean, '23)

☑ **Health improvement is required by strengthening health promotion programs to enhance the sustainability of NHIS**



※ Source: Statistics Korea, 2020



※ Source: 2024 National Health Insurance Statistical Yearbook(2025)

02. NHIS Health Promotion Program

2-2. Social Responsibility

☑ **Its role is gradually expanding from the treatment of diseases or injuries to prevention and health promotion**

· Implementing evidence-based programs that can drive behavioral change
· Reducing socioeconomic costs through health promotion to ensure its stable operation

☑ **It is legally obligated to provide preventive and health promotion services**

· Article 14 of the National Health Insurance Act: (1) The NHIS shall administer the following affairs:

※ 4. Preventive programs prescribed by Presidential Decree, which are conducted by utilizing information on the current state of providing health care benefits and the results of medical examination for the purpose of early detection and prevention of diseases and health management of the insured and their dependents

☑ **Nationwide network & personalized services by utilizing medical records & results**

· Nationwide organizational network, providing personalized information and services based on individual health status, and operates chronic disease management programs

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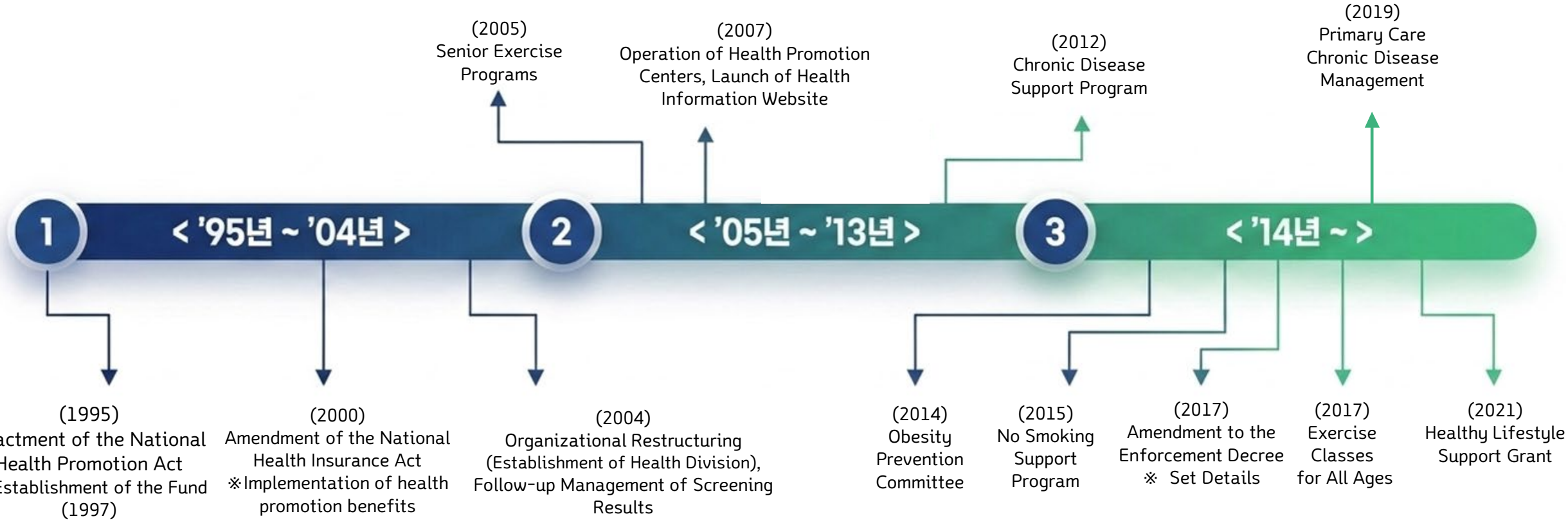
02. NHIS Health Promotion Program

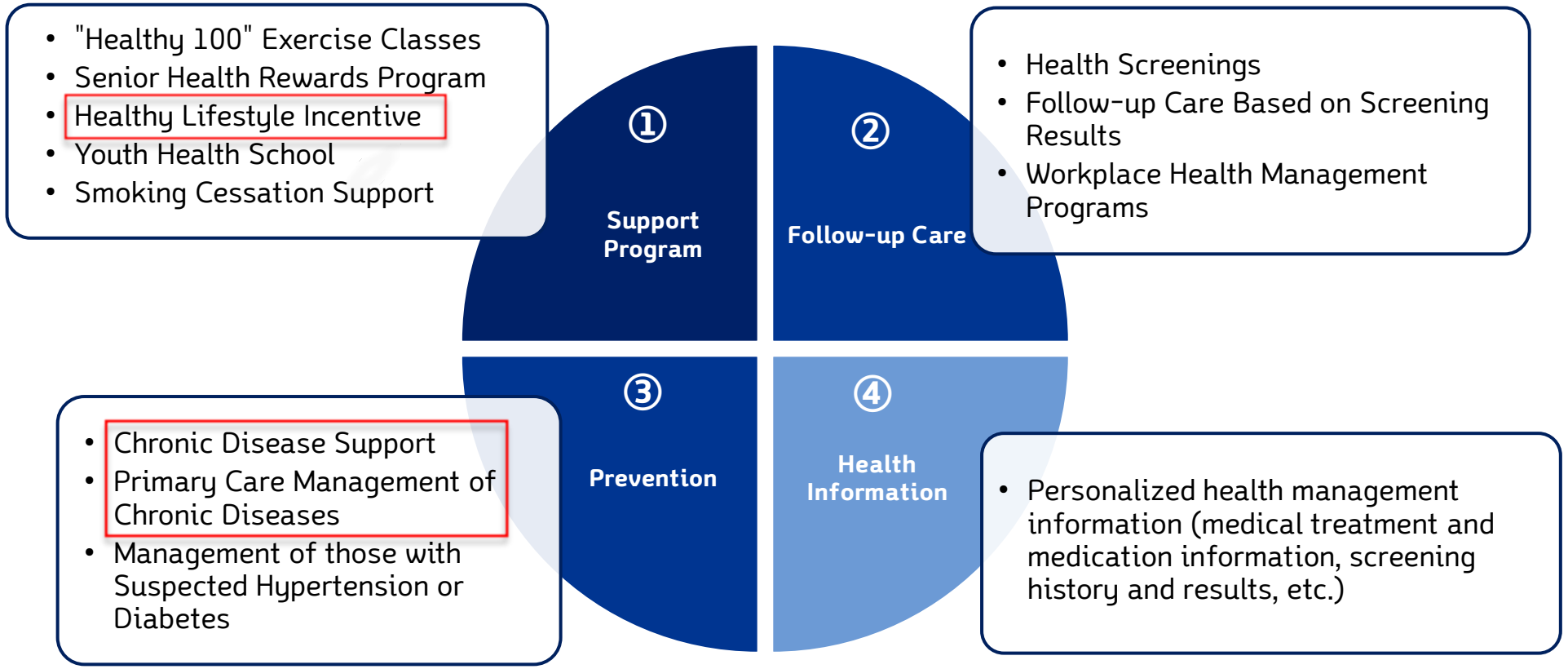
2-3. Development Process

· Health screenings as part of preventive programs
· **Acceleration** after the merger and the enactment of the Act



02. NHIS Health Promotion Program

2-4. Key Services



03. Integrated Management of Chronic Diseases

03-1. Current Status and the Necessity for Management

03-2. Primary Care Chronic Disease Management

03-3. Healthy Lifestyle Grant-Pilot

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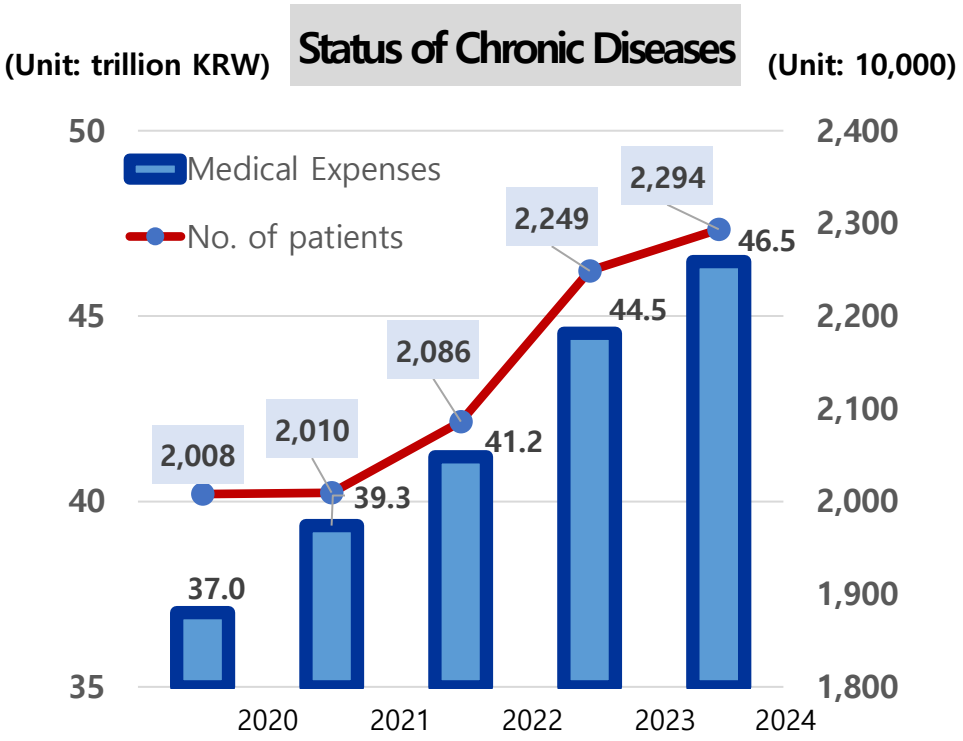
03. Integrated Management of Chronic Diseases

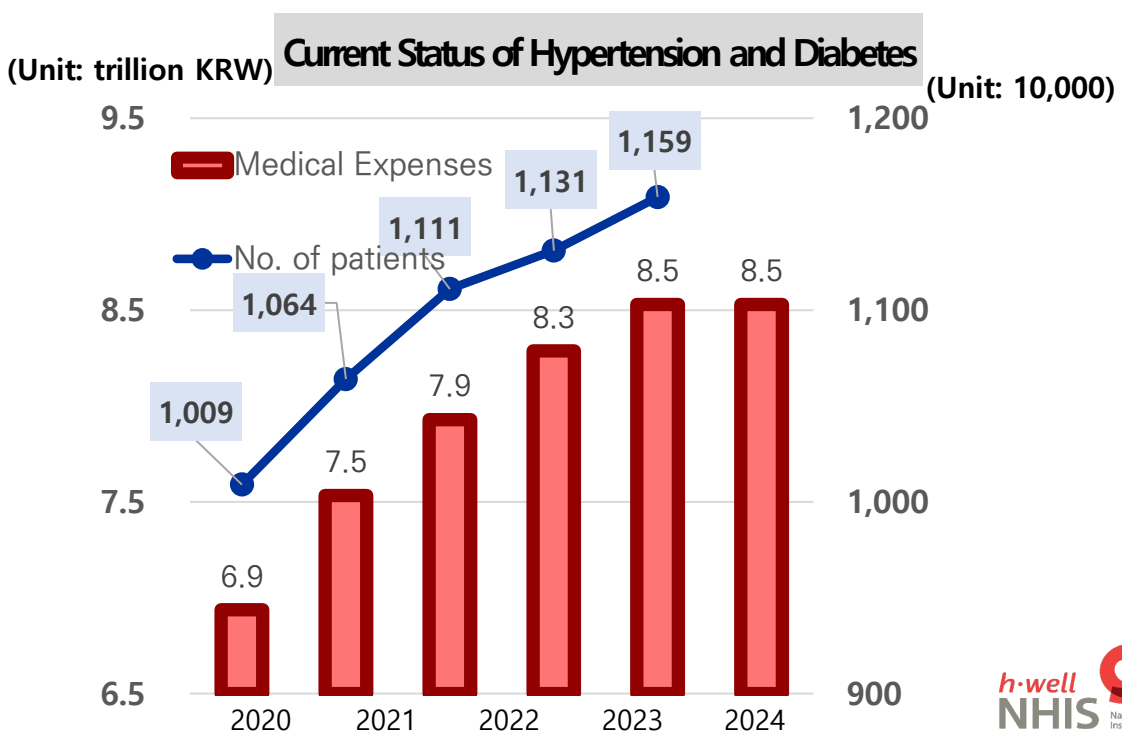
03-1. Current Status and the Necessity for Management

03. Integrated Management of Chronic Diseases
03-1. Current Status and the Necessity for Management

Status of Patients and Medical Expenses

· **(Patients)** 22.94 million with chronic diseases (44.4% of the total population);
11.59 million have hypertension or diabetes (50.5% of all chronic disease patients)
· **(Expenses)** Chronic diseases: 46.5 trillion (40% of total expenses); hypertension and diabetes: 8.5 trillion (18.3%)





Source: 2024 National Health Insurance Statistical Yearbook

03-1. Current Status and the Necessity for Management

"The Growing Need for Chronic Disease Management"

- The rise in chronic diseases due to an aging population and changes in lifestyle poses a threat to individual health, leading to a growing burden of healthcare costs
- Continuous health management, including lifestyle improvements, is crucial for chronic diseases; and management through primary care facilities and public health agencies within the community is effective
- It is necessary to establish a system that provides continuous health management to patients with chronic diseases to provide continuous health management

Strengthening Primary Care & Proper Management of Chronic Diseases

03. Integrated Management of Chronic Diseases

03-1. Current Status and the Necessity for Management

Current Status Comparison Across Chronic Disease Management Programs

Category		Hypertension and Diabetes Registration and Management Program	Chronic Disease Management Program at Primary Care Clinics	Primary Care Chronic Disease Management Pilot Program	Primary Care Chronic Disease Management Program
Start Date		September 2007–	April 2012–	January 14, 2019–September 29, 2024	September 30, 2024–
Target Areas		19 cities, counties, and districts	Nationwide	109 cities, counties, and districts	Nationwide
Participants	**Medical Institutions**	Designated clinics and pharmacies located in the target areas	All clinics	Participating Clinics	Participating Clinics
	Patients	Residents of the target area aged 30 or older with hypertension or diabetes	Patients with hypertension or diabetes	Patients of participating clinics with hypertension or diabetes	Patients of participating clinics with hypertension or diabetes
Support Details	**Clinic**	Support for patient registration fees	Incentives provided based on the results of the appropriateness evaluation	Reimbursement by Medical Service	Reimbursement by Medical Service
	Patients	Reduction of Out-of-Pocket Costs for Medical and Pharmaceutical Expenses for Registered Patients Aged 65 and Older	For patients who have expressed a desire for ongoing care Reduction of out-of-pocket costs for patients	Patient co-payment rate set at 10% during pilot program	Patient co-payment rate set at 20%
Supporting Organizations		Hypertension and Diabetes Registration and Education Centers	NHIS Health Support Center (operated by branch offices)		

03. Integrated Management of Chronic Diseases

03-1. Current Status and the Necessity for Management

☑ Legal Basis

◈ Article 14, Paragraph 1, Subparagraphs 4 and 13 of the 『National Health Insurance Act』

Article 14 (Services) (1) The NHIS shall administer the following affairs: <Amended on Feb. 8, 2017>

4. Preventive programs prescribed by Presidential Decree, which are conducted by utilizing information on the current state of providing health care benefits and the results of medical examination for the purpose of early detection and prevention of diseases and health management of the insured and their dependents;

13. Others determined by the Minister of Health and Welfare as being necessary in connection with health insurance.

◈ Enforcement Decree Article 9-2 (Services of the NHIS)

Article 9-2 (Services of the NHIS)

“Programs prescribed by Presidential Decree” in Article 14 (1) 4 of the Act means the following:

1. Building and operating the electronic health information system for health management of the insured and their dependents;
2. Developing and providing programs or services for health management by life cycle, workplace, and function;
3. Collecting, analyzing, and researching information on major diseases by age, sex, and profession, and providing management plans;
4. Providing information on major chronic diseases, including high blood pressure and diabetics, and supporting health management;
5. Supporting a health management program by region through connection and cooperation with the regional health care institutions under subparagraph 1 of Article 2 of the Regional Public Health Act

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03. Integrated Management of Chronic Diseases

03-2. Primary Care Chronic Disease Management Program

03-2. Primary Care Chronic Disease Management Program

Program Details

• Establish individualized disease management plans for patients with hypertension and diabetes at local clinics, and through continuous management, improve disease control rates and delay or prevent complications

Target

- **(Eligible Patients)**
  Patients with hypertension (I10–13, I15) and diabetes (E10–14) receiving outpatient care at clinics
- **(Healthcare Facilities)**
  Registered medical clinics that meet the eligibility requirements (completion of training)

03-2. Primary Care Chronic Disease Management Program

Progress Report

Sept. 2007–
Hypertension and Diabetes Registration and Management Program
- Pilot project launched in Daegu Metropolitan City (Concluded in 2010)
- Following the establishment of the Comprehensive Plan for Cardiocerebrovascular disease in 2010, KDCA developed a program model in 2011 and expanded it from July 2012

Apr. 2012–
Chronic Disease Management System at Primary Care Clinics
- Established an institutional framework at primary care facilities
- Implemented in April 2012
→ 7,782 clinics (as of Dec. 2017)
→ 8,210 clinics (as of Dec. 2018)

Oct . 2014–Dec. 14, 2018
Community-Based Primary Care Pilot Project
- As a model for clinic-centered chronic disease management, implemented the national policy initiative “Reform of the Citizen-Centered Healthcare System” in May 2013
- Launched in four regions in March 2014
→ Expanded to 16 regions in Nov. 2017,
Changes to the fee-for-service payment system

Sept. 2016–Dec. 14, 2018
Chronic Disease Management Pilot Program
- Verification of health insurance fees and coverage criteria to revitalize service functions at primary care
- Pilot program launched in Sept. 2016 with 1,870 clinics nationwide
→ Oct. 2017: 1,165 locations (41,702 people)
→ Dec. 2018: 1,174 locations (52,000 people)

Jul. 2018–
Preparation of an Integrated Model for Chronic Disease Management
- Development of an integrated model that leverages the strengths of existing programs
- Preparations for service launch in Dec. 2018
- Operated a steering committee comprising the Korean Medical Association, experts, and a medical community-led implementation committee

Jan. 14, 2019–Sept. 29, 2024
Primary Care Chronic Disease Management Pilot Program
- Through five rounds of recruitment and selection processes, 3,559 clinics in 109 regions participated

Sept. 30, 2024
Project Transition

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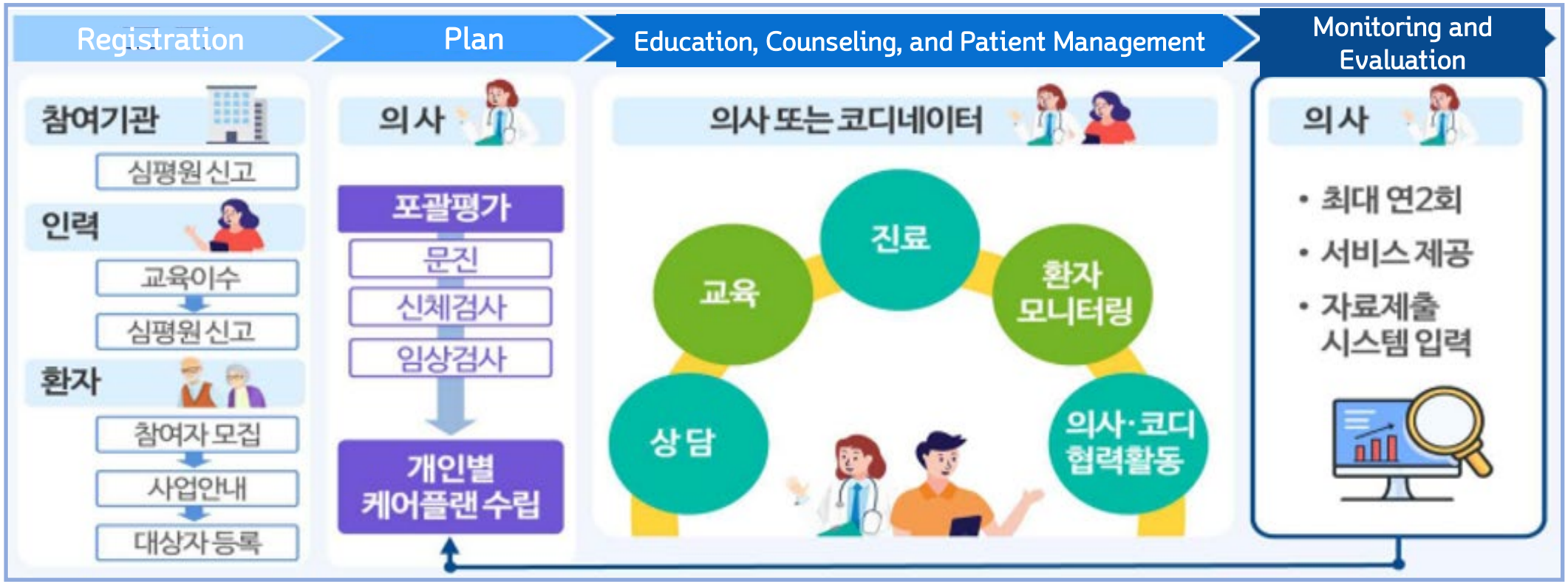
03-2. Primary Care Chronic Disease Management Program

Service Process

Registration → Care Plan Development → Education, Counseling, and Patient Management → Monitoring and Evaluation



03-2. Primary Care Chronic Disease Management Program

1. Registration

Facility Registration

- Submit a report for “Management of Primary Care Facilities for Chronic Diseases” via HIRA’s Integrated Healthcare Resource Reporting Website (www.hurb.or.kr)
- Clinics are selected for participation immediately upon registration

Staff Registration

- Register physicians mandatory staff care coordinators (nurses and dietitians)
- Upload certificates of completion for basic training (initial) and advanced training (annual) to HIRA’s Integrated Healthcare Resource Reporting Website

Patient Registration

- Listen to a presentation on the Primary Care Chronic Disease Management Program, complete the application form and the consent form for the collection, use, and third-party disclosure of personal information, and then register via HIRA’s Healthcare Institution Business Website

03-2. Primary Care Chronic Disease Management Program

1. Registration → 2. Plan&Establishment

☑ Care Plan

- Comprehensive Assessment → Clinical Tests → Care Plan
  - (Comprehensive Assessment) Medical history, lifestyle assessment, physical examination, etc.
  - (Clinical Tests) Test results within 6 months
    - ◈ Mandatory Tests by Condition

General, Hypertension	Diabetes
Blood Pressure, Total Cholesterol, TG (Triglycerides), HDL cholesterol, LDL cholesterol	HbA1c

  - (Care Plan) Development of a comprehensive, patient-tailored health management plan based on test results (annually)

03-2. Primary Care Chronic Disease Management Program

1. Registration → 2. Plan & Establishment → 3. Counseling & Patient Management

☑ Educational Counseling

- (Disease Management and Lifestyle Improvement)
  Physician, 1:1, 10 minutes
- (Lifestyle Improvement)
  : Care Coordinator, 1:1, 20 minutes

※ The initial education and counseling session for the first cycle is conducted by a physician; up to 10 sessions per year

☑ Patient Management (Pilot)

- Blood pressure and blood glucose levels, medication adherence and occurrence of side effects, achievement of lifestyle improvement goals, etc. Checking disease management status
- Provision of online services via phone or messenger

※ Monthly, up to 12 times per year

03-2. Primary Care Chronic Disease Management Program

Monitoring and Evaluation

- Evaluation to be conducted 4 months after the care plan is established

※ Twice annually

◈ Mandatory Tests by Condition

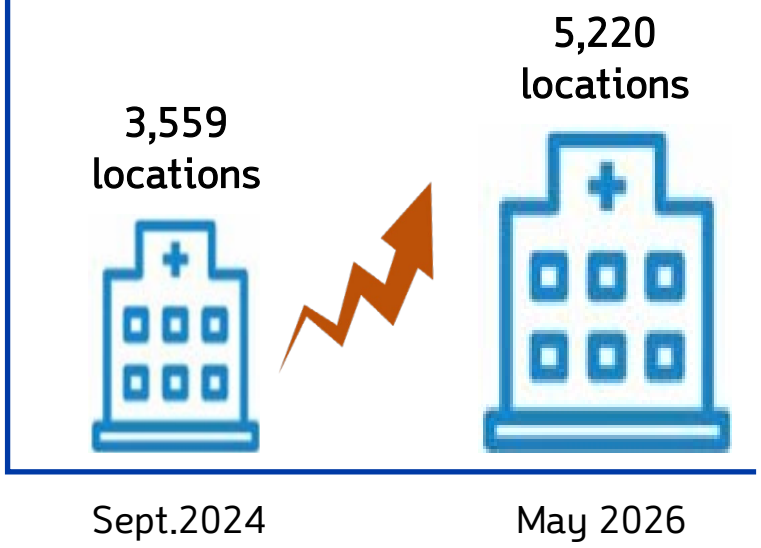
Category	Test Items
Hypertension	Blood Pressure
Diabetes	Blood Pressure, HbA1c

03-2. Primary Care Chronic Disease Management Program

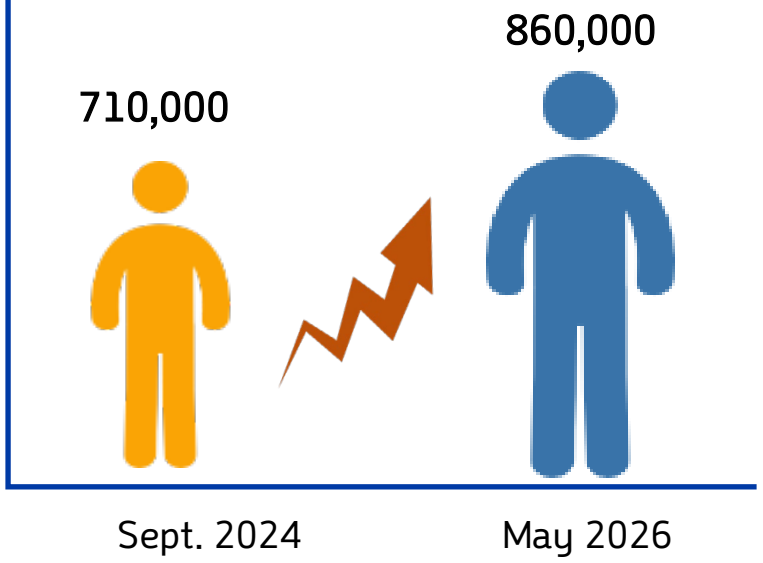
Achievements 1.

Since its launch(Sept. 2024–), no. of participating clinics has increased by 1,661 (46.7% ↑), and no. of patients by 150,000 (21.7% ↑)

Participating Clinics (Cumulative)



Participating Patients (Cumulative)

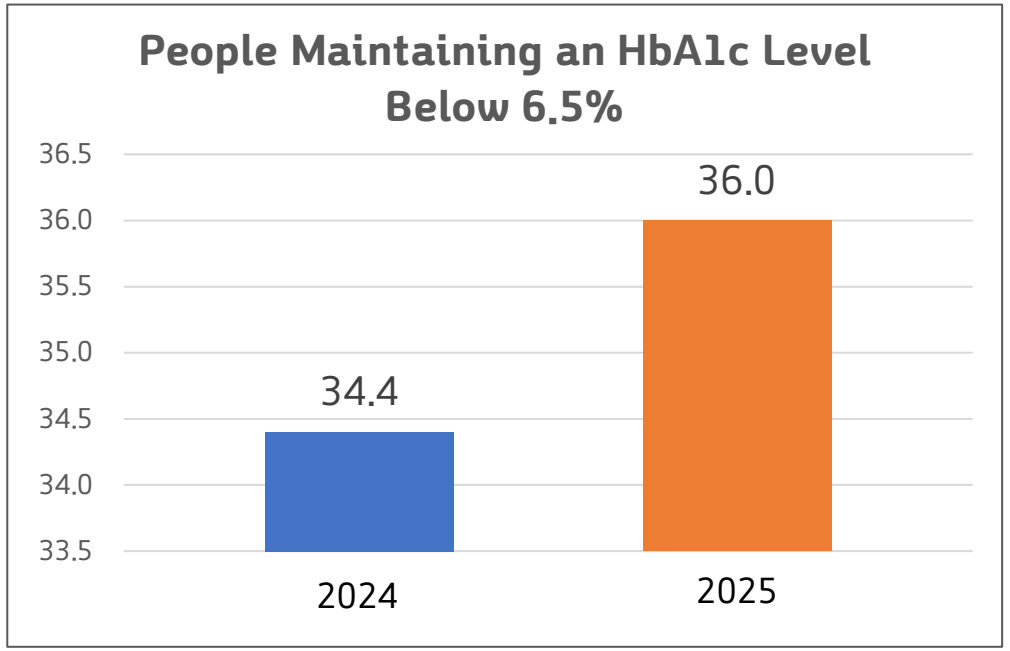


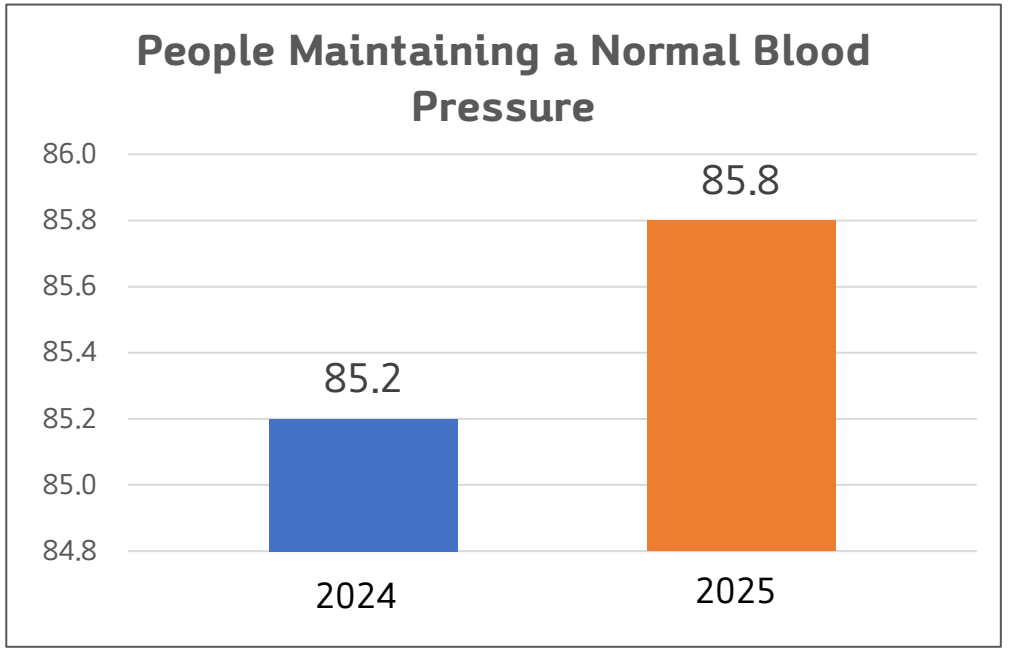
03-2. Primary Care Chronic Disease Management Program

Achievements 2.

Diabetes control rate ('24 : 34.4 →'25 : 36.0%) and hypertension control rate ('24 : 85.2 →'25 : 85.8%) improved compared to the previous year

· (Health Improvements) Increase in the no. of diabetes patients with HbA1c levels below 6.5% (1.6% ↑) and hypertension patients maintaining normal blood pressure (0.6% ↑)





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03. Integrated Management of Chronic Diseases

03-3. Healthy Lifestyle Grant-Pilot

03-3. Healthy Lifestyle Grant Program

Background

- Increasing social and economic losses due to the rise in disease incidence and the growing number of patients with chronic conditions caused by health risk factors
- Strengthening health management by providing incentives for healthy lifestyles to prevent disease and reduce unnecessary medical expenses

Program Details

- A program that provides financial incentives(points) to those practicing a healthy lifestyle and requiring health management (July 2021~)

  * Legal basis: Article 14 (Services) of the National Health Insurance Act and Article 9-2 of the Enforcement Decree of the same Act

03-3. Healthy Lifestyle Grant Program

Key Points

(Target Group) High-risk groups requiring health management

- **(Prevention Care Plan)** those in high-risk groups* after undergoing general health screenings in 50 regions nationwide (ages 20–64)

  * BMI of 25 kg/m^2 or higher, with systolic blood pressure of 120 mmHg or higher (or diastolic blood pressure of 80 mmHg or higher) or a fasting blood glucose level of 100 mg/dL or higher

- **(Management Care Plan)** Participants in the Primary Care Chronic Disease Management Program/ Patients with hypertension or diabetes; implemented nationwide (all ages)

  ※ The “Management care plan” model will be implemented starting Sept. ’24

03-3. Healthy Lifestyle Grant Program

Key Points

- **(Details)** Earn healthy lifestyle points for activities such as walking, participating in health management programs, engaging in health education and counseling, points can be used to purchase health-related items and pay for clinic visit
- **(Saving Points)** Prevention Care Plan: 120,000 points (2 years); Management Care Plan: 80,000 points (1 year)…1 point = 1 won

Type and Amount

(Unit: points)

Preventive Care Plan		Management Care Plan	
Participation Points	5,000	**Participation Points**	5,000
Action Points	100,000 (50,000 per year)	**Action Points**	65,000
Points for Improvement	15,000	**Assessment Evaluation Points**	10,000
Earning Limit	**120,000 (2 years)**	**Earning Limit**	**80,000 (1 year)**

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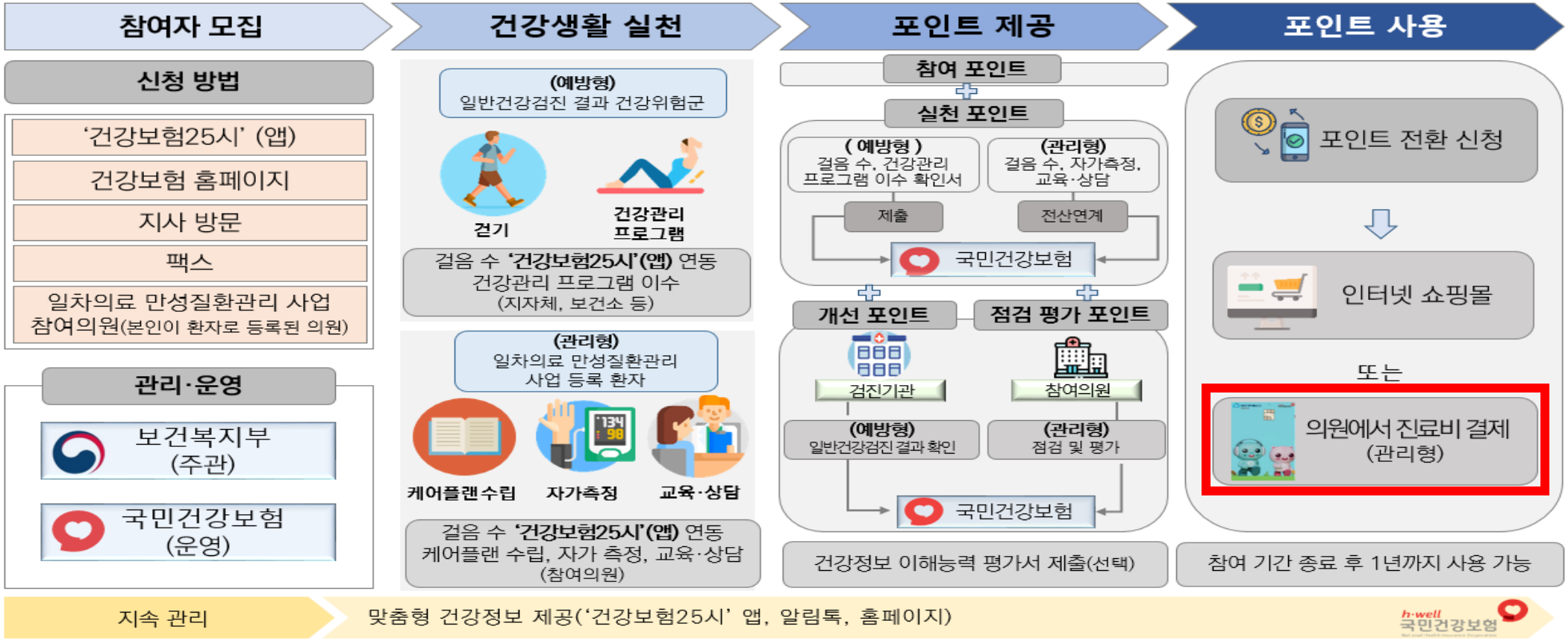
03-3. Healthy Lifestyle Grant Program

Service Process

- Participants are awarded points based on their progress in adopting a healthy lifestyle
  - Points can be used to purchase items at designated online stores or to pay medical bills at clinics



03-3. Healthy Lifestyle Grant Program

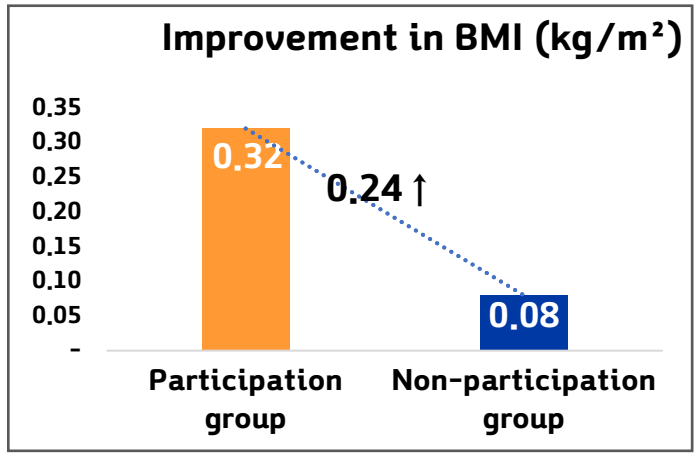
Achievements 1.

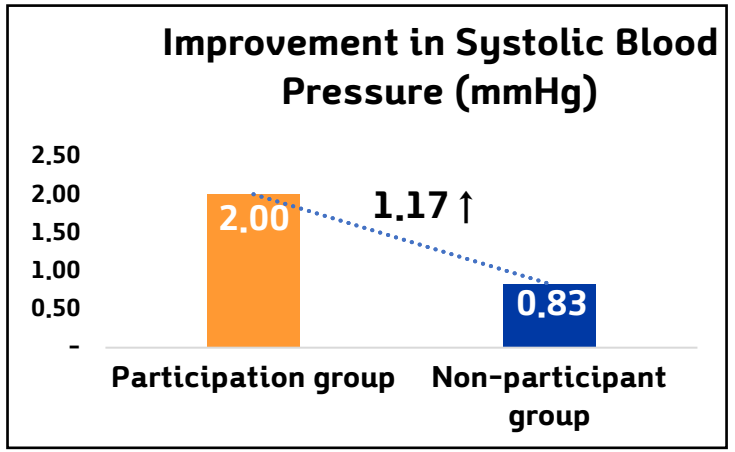
550,000 participants (400K-prevention care plan, 150K-management care plan), **4.6 billion KRW**··· as of May 2026

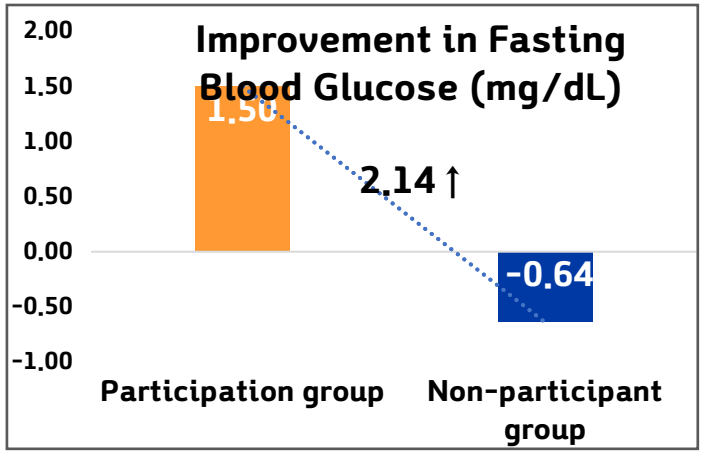
Achievements 2.

Demonstrated reduction in medical expenses due to improved health

- (Improvements) BMI (0.24 kg/m²), systolic blood pressure (1.17 mmHg), and fasting blood glucose (2.14 mg/dL) in the prevention group







- Annual hospital and outpatient days decreased for both the prevention (0.45 days) and the management group (2.43 days)
- Annual per-person medical costs decreased for both the prevention (40,183 won) and the management group (491,422 won)

※ Source: Study on the Effectiveness of the Pilot Program for the Healthy Lifestyle Grant (Health Insurance Research Institute, 2024)

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03. Integrated Management of Chronic Diseases

03-4. Chronic Disease Health Support Program

03-4. Chronic Disease Health Support Program

Background

• With the rising number of patients with chronic diseases such as hypertension and diabetes, a support system is needed to enhance their ability to manage their own conditions

Program Details

• Providing tailored booklets, intensive counseling, and renting self-monitoring devices to patients with hypertension and diabetes to provide supportive services for self-management

Target

• Patients with hypertension (I10–13, I15) and diabetes (E10–E14)
- Patients with a history of reduced out-of-pocket costs for medical consultations (based on claims under the Chronic Disease Management Program for clinics)
- Patients with under- or over-medication for hypertension or diabetes (medication possession rate below 80% or 150% or higher over a 6-month period), etc.

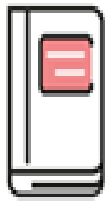
03-4. Chronic Disease Health Support Program

Key Points

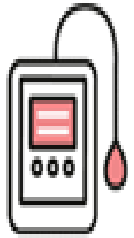
- Health care staff at 178 branches nationwide provide health counseling and run educational programs based on patient needs

Types of Services

문자발송 서비스 (건강정보제공)

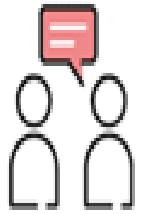


건강관리 책자 제공 (고혈압, 당뇨병)



혈압기 대여

혈당기 대여



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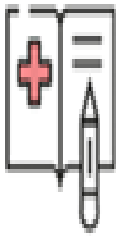
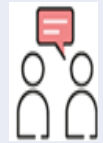


교육프로그램 (건강교실,자조모임)

03-4. Chronic Disease Health Support Program

Details

Service Categories	Details
 **Text Message**	Health information on nutrition, exercise, drinking, and smoking, as well as notifications regarding complications (Weekly for 9 weeks)
 **Health Management Booklets**	Includes guidance on managing hypertension and diabetes
 **Self-monitoring Devices**	Enable patients to monitor and manage their own blood pressure or blood sugar Blood pressure monitors or blood glucose meters (8-week rental period)
 **Intensive Counseling**	Through counseling on disease management, lifestyle improvements, and etc./ Post-intervention evaluation (up to 4 sessions)
 **Health Education Programs**	Lectures and discussions to provide education on disease management and support for self-management

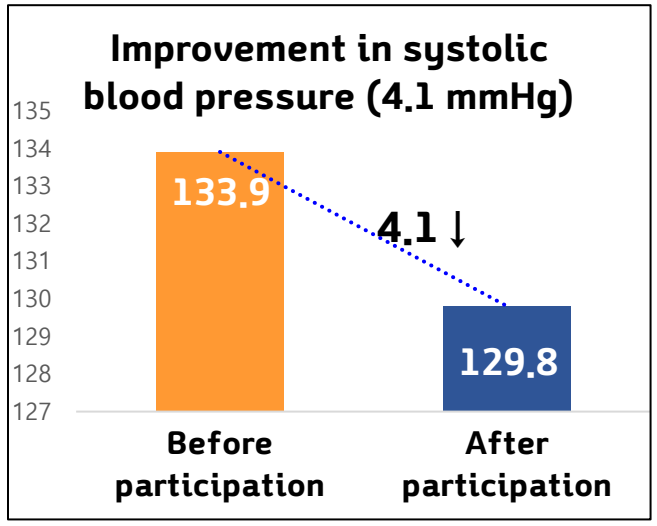
03-4. Chronic Disease Health Support Program

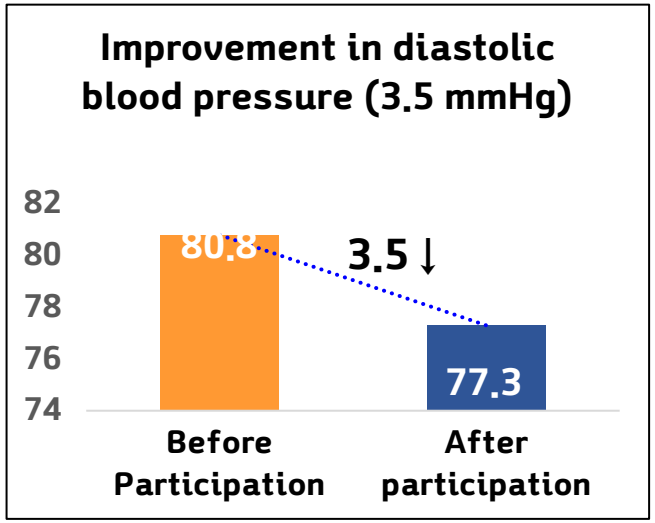
Achievements 1.

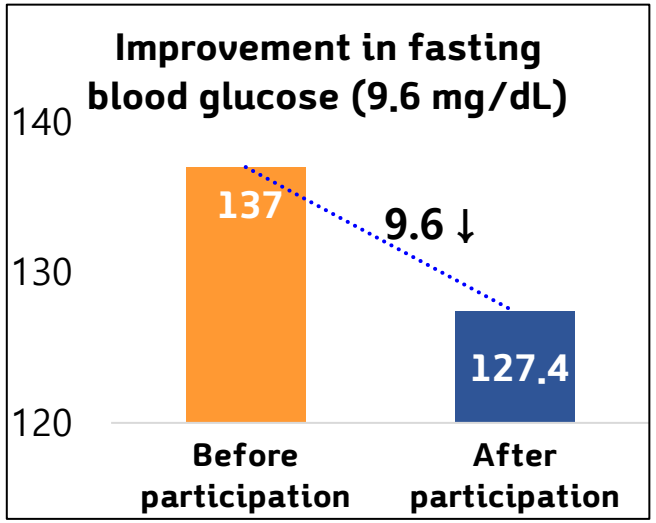
Cumulative participants: 1.95 million (since July 2012) ··· 1.22 million with hypertension, 360,000 with diabetes, and 370,000 with both diabetes and hypertension (as of May 2026)

Achievement 2. Showed reductions in blood pressure and blood glucose levels after participation

- (Improvements) Hypertension patients (systolic blood pressure 4.1 ↓ / diastolic blood pressure 3.5 ↓ mmHg), diabetes patients (fasting blood glucose 9.6 mg/dL ↓)







※ Source: Analysis of Health Promotion Effects of the Chronic Disease Health Support Program 2024 (Health Support Program Department)

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04. Future Plans

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Expand systematic management of chronic diseases, focusing on primary care clinics

Program promotion
Expand participation by clinics and patients through promotional efforts and enhanced support for participating clinics

Integration of Similar Programs
Implement integrated management through coordination by phase with similar chronic disease management programs

Program Enhancement
Identify improvement measures through evaluation on program operations and effectiveness (March–August 2026)

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Thank You

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