The Korean experiences on UHC : Lessons to South American countries

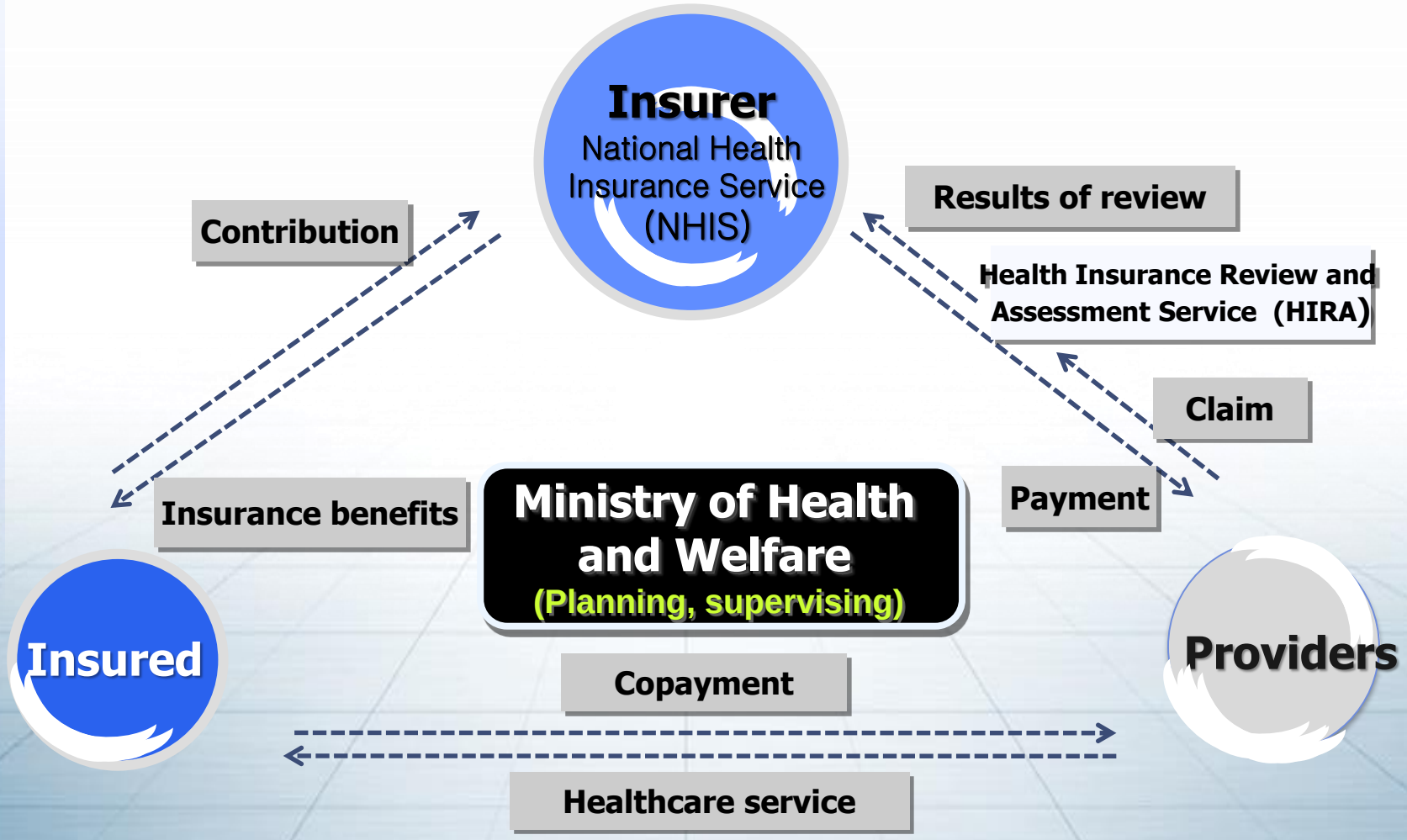
Won Whang
National Health Insurance Service, Korea

Ⅰ. Introduction :

Key elements and international recognition

- Universal population coverage in 12 years
  - shortest record in health insurance history in the world
- Step-by-step approaches in both covering uninsured and extending benefit package
- Low healthcare expenditure compared to average of OECD countries while securing universal and comprehensive HC
  - 7.2% of GDP compare to 9% of average OECD countries(2015)
- Privately dominated providers
  - more than 90% of all hospitals and almost all clinics
- Relatively long life expectancy compared to other OECD countries
  - 82.2 (Korea) vs. 80.6(OECD average)(2015)

Structure of Korea National Health Insurance



Ⅱ. Political and Economic Environment surrounding Health Insurance Policy

☐ **Political environment**

- Political democratization
- Vitalization of civil society and its active engagement in government matters, explosion of civic groups, progressive medical and pharmaceutical professionals.
- Strong demands of civic groups and trade unions for social security and health care reform
- Emergence of diverse kinds of health care-related civic groups

☐ Economic environment

- **1960s-1970s**

- One of the poorest countries
- The government-led economic development plan and top priority on economic growth
- Strong economic leadership and export-oriented economy
- Unprecedentedly high level of economic growth

- **1980s-1990s**

- Simultaneous pursuit of economic growth and distribution, economic and social developments, and growth and stability.
- Affiliation to the OECD and Globalization

Major economic performances in the 1960-70s

	Per capita GNP ($)	Industrial production index (1975=100)	Export (mil.$)	Unemployment rate
1963	100	11.8	86.8	8.1
1965	105	13.7	175.1	7.4
1967	142	21.3	320.2	6.2
1969	210	33.5	622.5	4.8
1971	278	43.1	1,067.6	4.5
1973	386	65.9	3,271.3	4.0
1975	583	100.0	5,003.0	4.1
1977	965	155.6	10,046.6	3.8
1979	1,597	213.5	14,704.5	3.8

Source: Economic Planning Board Statistical Bureau.

□ Emergence of “health rights for all”

- Social equity : people started accepting ‘health’ as a basic rights for all

  - contribute to UHC by covering total population step-by-step strategy

- Equal accessibility in using health facilities by adopting the system that works as incentive to rural-based health providers
- Strong patient voices in policy-making process

  - Innovative new drugs and technologies are enlisted as benefit package

- Differentiated cost-sharing system to light financial burden for catastrophic diseases like cancers

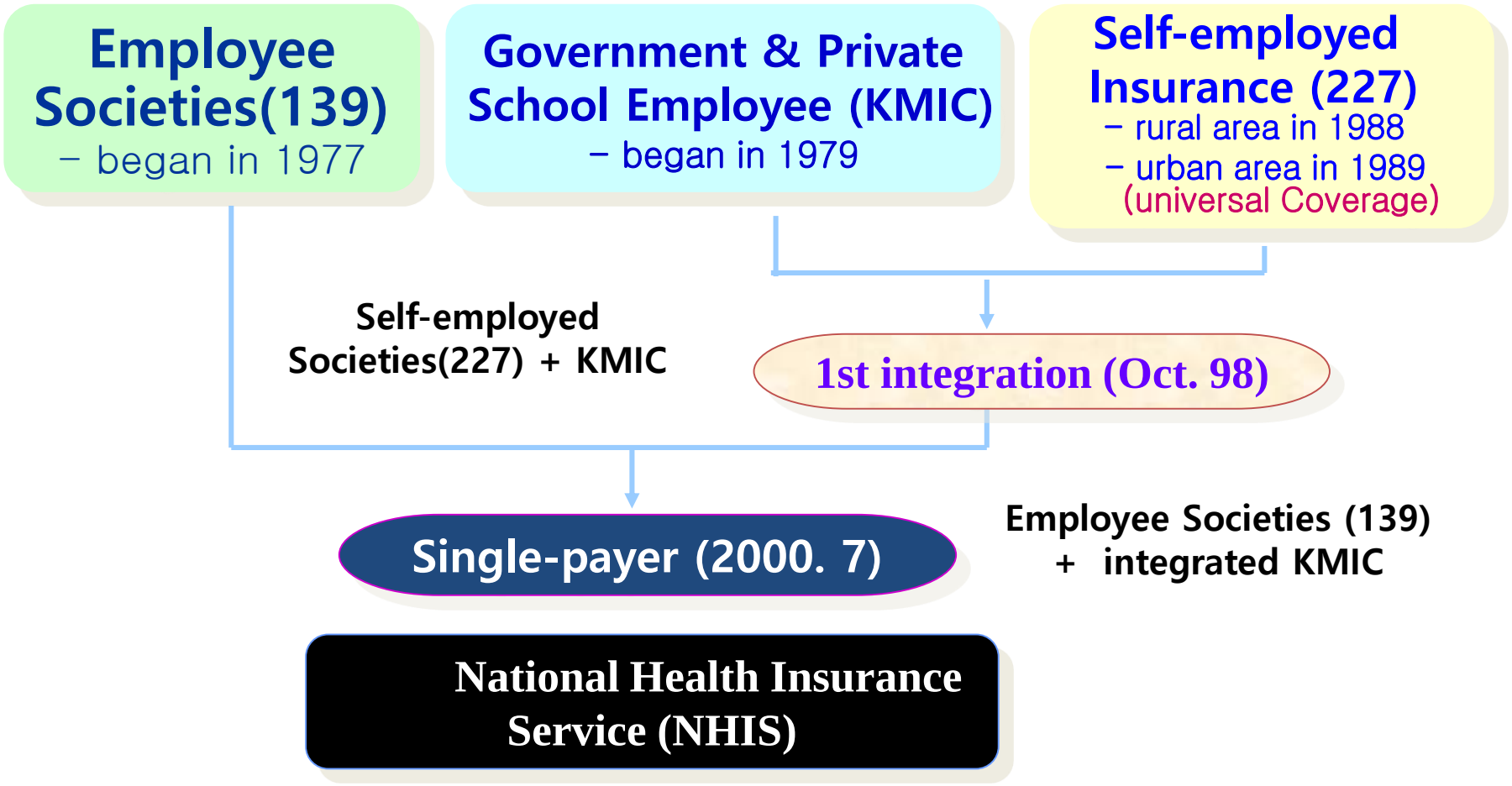
Ⅲ. Health Insurance System of Korea : single –payer system

□ Major characteristics/reforms

- Insurer system started from multi-payer systems (at one time, amounted to more than 600 funds) and transformed into single payer after big debate on ‘pro-and-con integration’
- An independent ‘Review’ Agency, HIRA, was built
- Functions of single-payer are rapidly expanding: collection of all social insurance contributions, management of LTC

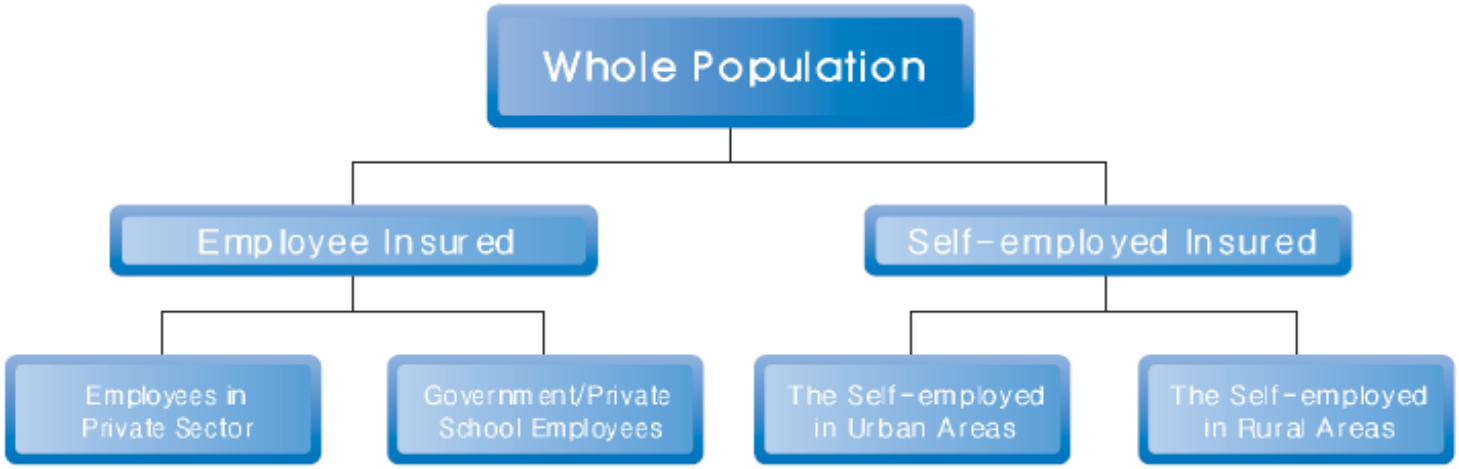
- Outcomes/advantages from Korean health system
  - Monopsonic (purchasing) power in negotiating with healthcare provider groups
  - Efficiency in management of health insurance system : Contributions collection, administration costs
  - Higher customer satisfaction due to standardization of services

Insurer integration process

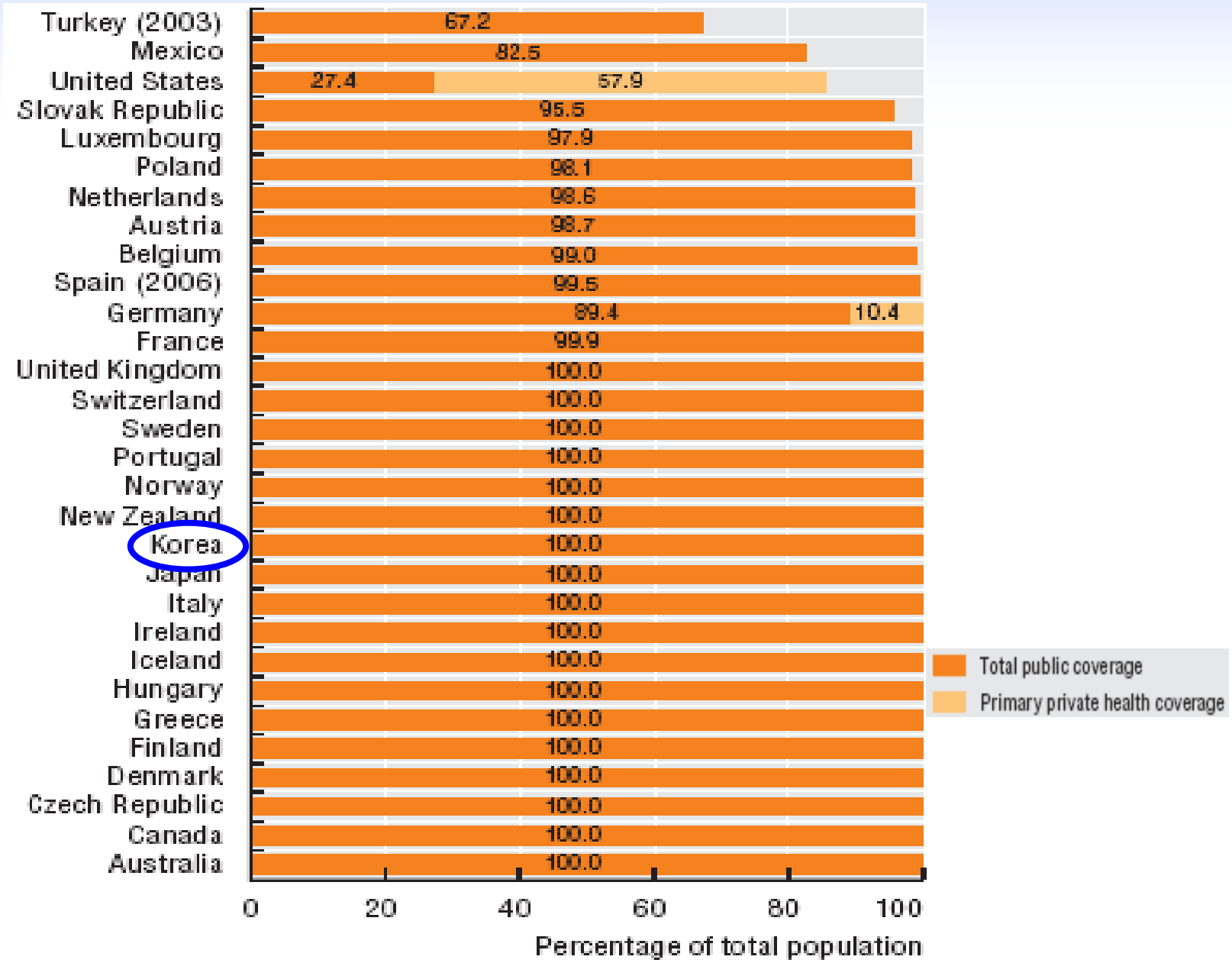


Ⅳ. Coverage expansion to universal health care

- Enrollment is compulsory for those residing in the Korean territory, except of some Medical Assistance recipients
- The insured persons under the National Health Insurance program are duly classified into two categories: the employee insured and the self-employed insured
- Universal coverage was achieved gradually, starting from corporate employees to self-employed persons



Health care coverage rate of OECD countries in 2007



Source: **OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).**

Ⅴ. Benefits

- Benefits in kind
  - Diagnosis, tests, treatments, surgery, and rehabilitation
  - Drugs & medical materials
  - Lifelong-cycle health checkup program, etc.

- Benefits in cash
  - Refunding copayment over ceiling
  - Appliance expenses for the disabled
  - Refunding allowance for healthcare : home oxygen therapy, treatment costs for chronic renal failure, etc.
  - Pregnancy & childbirth examination expenses

* NHI Benefit package is same for all insured regardless of employee-insured or self-employee-insured(NHI contributions are based on insured’s income)

.

Copayment

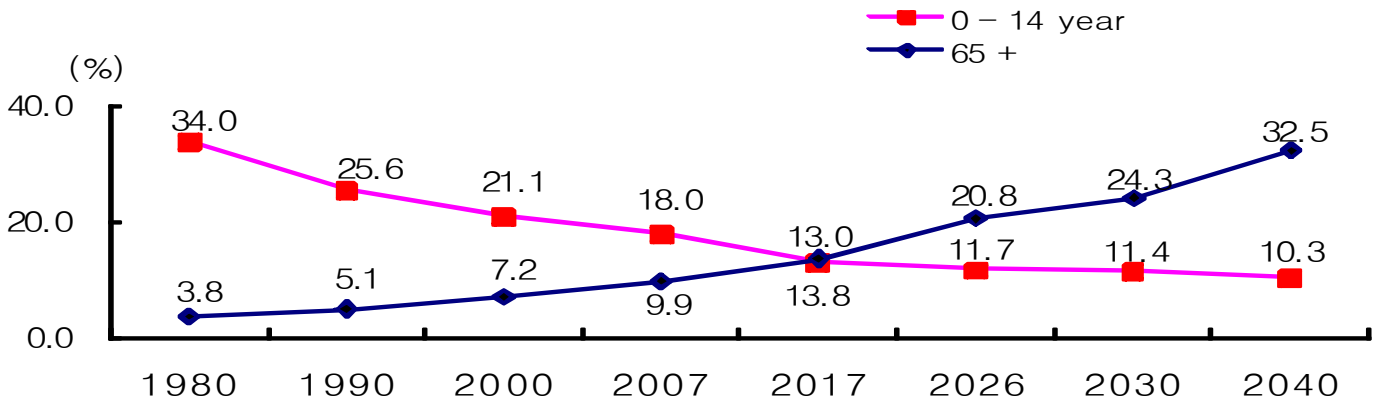
Service	Healthcare Institution	Diseases	Copayment rate of total healthcare cost
Inpatient	-	General Diseases	20%
	-	Rare Diseases[1]	10%
	-	Serious Diseases[2]	5%
Outpatient	Tertiary hospital	-	60%
	General hospital	-	50%
	Hospital	-	40%
	Clinic	-	30%
	Pharmacy	-	30%

1) Rare diseases : hemophilia, chronic renal failure, etc.
2) Serious diseases : cancer, cardiovascular disease, cerebrovascular disease, tuberculosis, and severe burn injuries

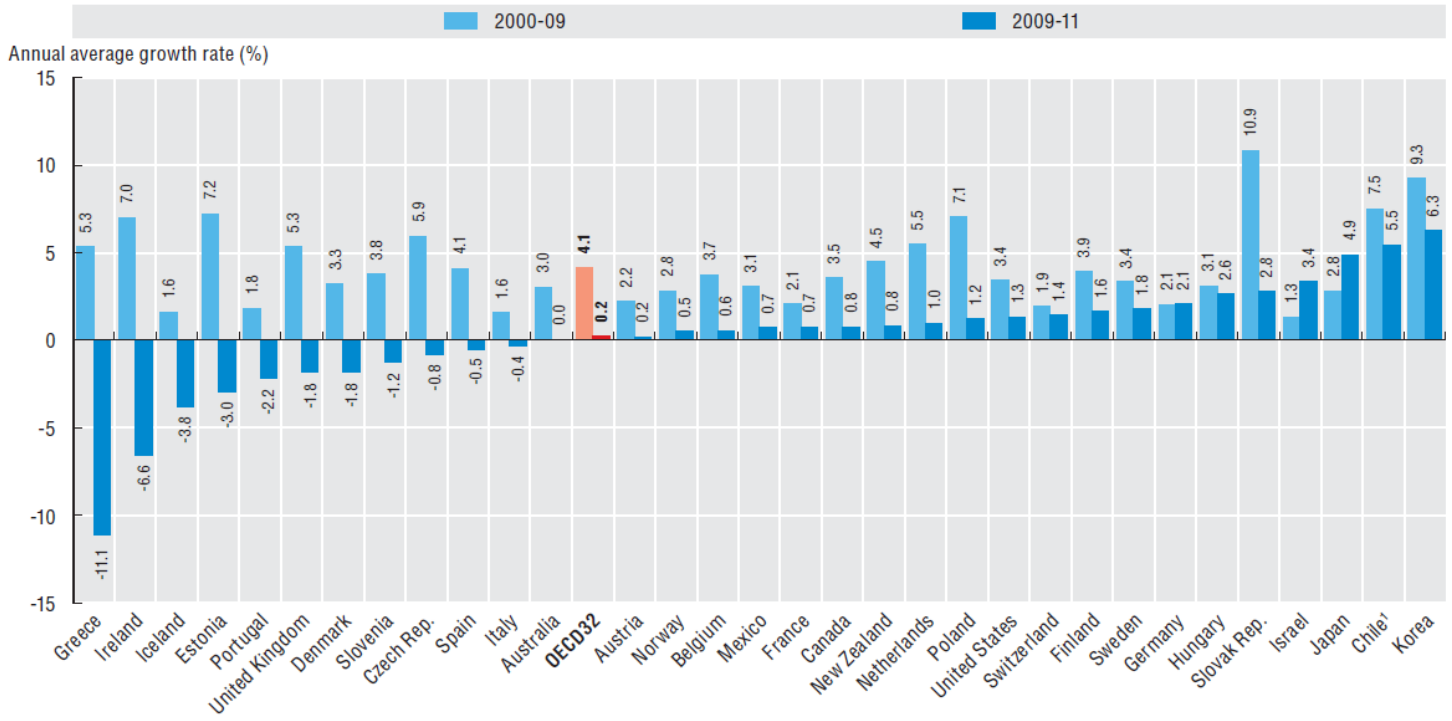
VI. Challenges for Sustainable Health System

☐ Lower fertility, Ageing population

- In 2008, Korea is lowest fertility (1.19) in the world, and it significantly increase health care expenditure.
- In 2015, 13 percent of 65 year older spends 38 % of total health expenditure



☐ Rapid growth of healthcare expenditure



Source : OECD, Health at a Glance 2013

☐ Lower benefit package coverage rate

- Difficult to cope with many new technologies and 'non-covered benefits' developed by providers

* currently benefit coverage rate is 63.2%(2014)

Ⅶ. Lessons from Korean NHI

Lesson 1:
Achieving universal coverage based on step-by-step extension can be exemplary case for developing countries around the world

By adopting these strategies :

- Step-by-step coverage expanding strategy
  - employees first, self-employed second
- Low contribution & higher co-payment to enroll total population
  - population coverage first, then moving to higher protection by expanding benefit gradually
- Managerial capacity and advanced IT technology

Lesson 2:
Grass-root supports from major stakeholders were greatly contributed to achievement of UHC

- Strong support from civic groups while strong oppositions from some interest groups

- Political & social consensus and continued political commitment on UHC

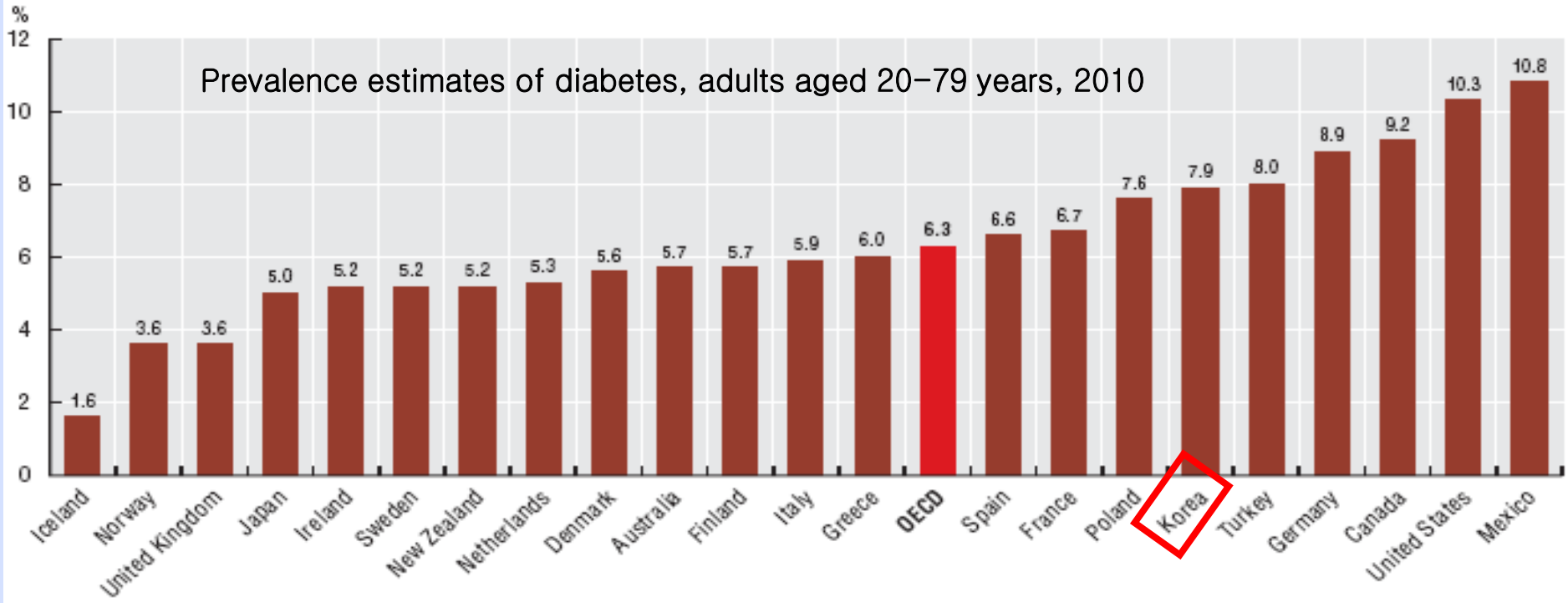
Lesson 3:
Well-designed payment system securing quality of care, reasonable price are primarily important element for sustainable health insurance systems

- Korea's payment system, fee-for-service payment method, causes rapid health expenditure inflation.

- For sustainable health system, these method can be choice:
  - The salary-plus-bonus payment method is superior to salary only.
  - Capitation payment for primary care has much to recommend it,
  - For high- and middle-income countries, per-admission payment and simplified DRG payment to hospitals have desirable incentive effects but also create administrative complexity.
  - For hospitals in low-income countries, global budgets may be preferable because of their more limited administrative requirements

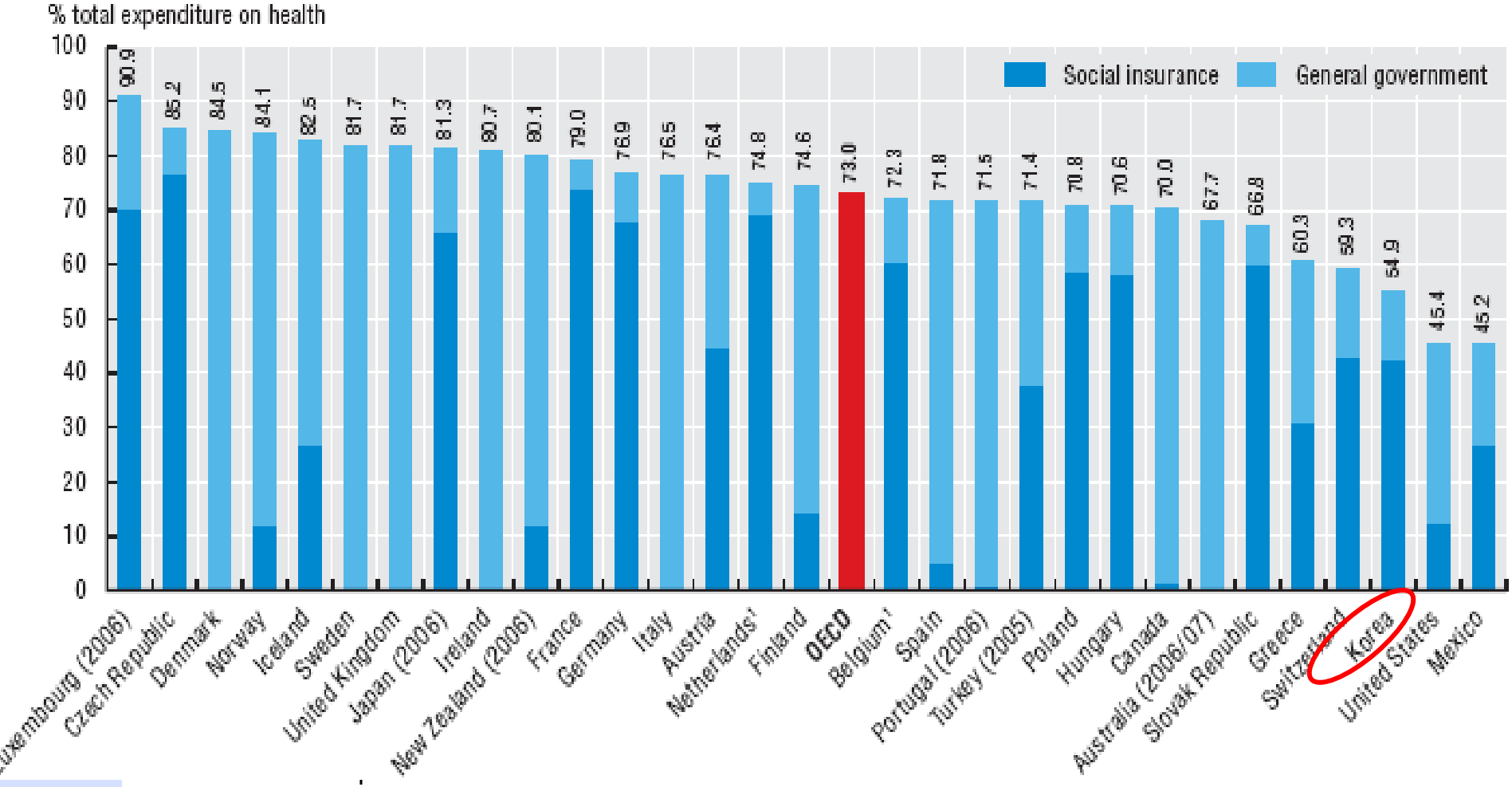
Lesson 4:
Transition of health care paradime from acute-oriendted care to prevention/promotion is urgently considered

- Today, in half of the OECD countries, every second person is obese or overweight. The result has been a sharp rise in chronic conditions that are costly to treat, from cardiac disease and stroke to diabetes and some cancers.
- Great emphasis must be placed on prevention for long-term growth of health care.



***Source*: International Diabetes Federation (IDF) (2009), "Diabetes Atlas, 4th edition".**

Lesson 5:
Mix of public and private provider system is unavoidable, but public-dominance financing is very important in order to keep afforable health care to all population.



Source: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).

Thanks for your attention!