KNOWLEDGE SHARING PROGRAM

2011 Modularization of Korea's Development Experience:

The Operation of Nationwide Health Insurance and its Implications

2012

MINISTRY OF HEALTH & WELFARE

KIHASA Korea Institute for Health and Social Affairs

2011 Modularization of Korea's Development Experience:

The Operation of Nationwide Health Insurance and its Implications

2011 Modularization of Korea's Development Experience

The Operation of Nationwide Health Insurance and its Implications

Title	The Operation of Nationwide Health Insurance and its Implications
Supervised by	Ministry of Health and Welfare (MW), Republic of Korea
Prepared by	Korea Institute for Health and Social Affiars (KIHASA)
Author	Jin Soo Kim, Research Fellow, Korea Institute for Health and Social Affiars (KIHASA)
Advisory	Chang Jin Moon, Former Vice-minister, Ministry of Health and Welfare (MW)
Research Management	Korea Development Institute (KDI) School of Public Policy and Management
Supported by	Ministry of Strategy and Finance (MOSF), Republic of Korea

Government Publications Registration Number 11-1051000-000178-01

ISBN 978-89-93695-32-8 94320

ISBN 978-89-93695-27-4 [SET 40]

Copyright © 2012 by Ministry of Strategy and Finance, Republic of Korea

KNOWLEDGE SHARING PROGRAM

Government Publications Registration Number
11-1051000-000178-01

Knowledge Sharing Program

2011 Modularization of Korea's Development Experience

The Operation of Nationwide Health Insurance and its Implications

MINISTRY OF HEALTH & WELFARE

KIHASA Korea Institute for Health and Social Affairs

Preface

The study of Korea's economic and social transformation offers a unique opportunity to better understand the factors that drive development. Within one generation, Korea had transformed itself from a poor agrarian society to a modern industrial nation, a feat never seen before. What makes Korea's experience so unique is that its rapid economic development was relatively broad-based, meaning that the fruits of Korea's rapid growth were shared by many. The challenge of course is unlocking the secrets behind Korea's rapid and broad-based development, which can offer invaluable insights and lessons and knowledge that can be shared with the rest of the international community.

Recognizing this, the Korean Ministry of Strategy and Finance (MOSF) and the Korea Development Institute (KDI) launched the Knowledge Sharing Program (KSP) in 2004 to share Korea's development experience and to assist its developing country partners. The body of work presented in this volume is part of a greater initiative launched in 2007 to systemically research and document Korea's development experience and to deliver standardized content as case studies. The goal of this undertaking is to offer a deeper and wider understanding of Korea's development experience with the hope that Korea's past can offer lessons for developing countries in search of sustainable and broad-based development. This is a continuation of a multi-year undertaking to study and document Korea's development experience, and it builds on the 20 case studies completed in 2010. Here, we present 40 new studies that explore various development-oriented themes such as industrialization, energy, human capital development, government administration, Information and Communication Technology (ICT), agricultural development, land development and environment.

In presenting these new studies, I would like to take this opportunity to express my gratitude to all those involved in this great undertaking. It was through their hard work and commitment that made this possible. Foremost, I would like to thank the Ministry of Strategy and Finance for their encouragement and full support of this project. I especially would like to thank the KSP Executive Committee, composed of related ministries/departments, and the various Korean research institutes, for their involvement and the invaluable role they played in bringing this project together. I would also like to thank all the former public officials and senior practitioners for lending their time and keen insights and expertise in preparation of the case studies.

Indeed, the successful completion of the case studies was made possible by the dedication of the researchers from the public sector and academia involved in conducting the studies, which I believe will go a long way in advancing knowledge on not only Korea's own development but also development in general. Lastly, I would like to express my gratitude to Professor Joon-Kyung Kim for his stewardship of this enterprise, and to his team including Professor Jin Park at the KDI School of Public Policy and Management, for their hard work and dedication in successfully managing and completing this project.

As always, the views and opinions expressed by the authors in the body of work presented here do not necessary represent those of KDI School of Public Policy and Management.

May 2012

Oh-Seok Hyun

President

KDI School of Public Policy and Management

Contents | LIST OF CHAPTERS

Summary ····· 15

Chapter 1

The Contextual Background of the Introduction of Medical Insurance ····· 19

1. The Socio-Economic Context ····· 20
2. Healthcare Environment ····· 22
3. Major Motivations for the Implementation of Medical Insurance ····· 23
4. The Decision-Making Process Leading to the Implementation ····· 25
5. The Characteristics of Health Insurance in Korea ····· 30
   5.1 The Types of Medical Security Systems ····· 30
   5.2 The Key Characteristics of Health Insurance in Korea ····· 35

Chapter 2

The Medical Insurance Implementation System ····· 37

1. The Legislation and Amendment of Medical Insurance Laws ····· 38
2. The Establishment of the Medical Insurance Cooperative and the Implementation of Demonstration Projects ····· 44
3. Securing Medical Institutions and Building a Collaborative System ····· 48
4. Governmental Financial Support ····· 52
5. Public Promotional Efforts ····· 53

Chapter 3

The Implementation of Nationwide Health Insurance and the Current Status of the Implementation of Key Policies ····· 57

1. Expansion of Eligibility ····· 58

1.1 Eligibility for Employment-based Medical Insurance ····· 60

1.2 Eligibility for Self-employed Medical Insurance ····· 61

2. Changes in the Method of Charging Insurance Premiums ····· 62

2.1 Method of Determining Insurance Premiums for Employment-based Policyholders ····· 63

2.2 Method of Assessing the Insurance Premium for Self-employed Insurance Policyholders ····· 65

3. Expansion of Insurance Benefits ····· 67

3.1 Concepts of Benefits in Kind and Cask Benefit ····· 68

3.2 Benefits in Health Insurance ····· 68

3.3 Cash Benefits ····· 73

4. The Integration of Organizations and Finances ····· 77

4.1. Key Parties of Interest Involved in the Process of Integration ····· 77

4.2. Organizational Integration ····· 80

4.3. Financial Integration ····· 83

Contents | LIST OF CHAPTERS

Chapter 4

The Management and Operation System for National Health Insurance ····· 87

1. The Policy Decision-Making System ····· 88
   1.1 Structure of Management and Operation ····· 88
   1.2 The Decision-Making Structure ····· 90
2. Assessment and Collection of Insurance Premiums ····· 92
   2.1 Insurance Premium Charges ····· 93
   2.2 The Collection of Insurance Premiums ····· 97
3. Financing ····· 100
4. Management of Eligibility ····· 102
5. Management of Benefits ····· 106

Chapter 5

Evaluating the Achievements and Future Challenges of the National Health Insurance System 111

1. Accomplishments 112

1.1 Expansion of Eligibility 112

1.2 Expansion of Coverage 116

1.3 Improvement of Access to Medical Services 118

1.4 The Increase of Medical Resources 121

1.5 Improvements in the Level of Health 123

2. Evaluation 125

2.1 Increasing Coverage Support for Pregnancy, Childbirth and Senior Citizen Treatment Expenses 127

2.2 Strengthening Coverage to the Level of Advanced Countries and Increasing the Percentage of Public Financing 128

2.3 Rational Management of Insured Pharmaceutical Costs 130

2.4 Improving the Treatment Cost Payment Method to Rationalize Cost Expenditures 130

2.5 Reforming the Medical Services Delivery System and Strengthening Primary Care 131

2.6 Project to Strengthen Preventive Measures 132

Chapter 6

Implications 135

References 140

Contents | LIST OF TABLES

Chapter 1

Table 1-1 Comparison of the Features of Medical Social Security Systems According to the Method of Financing ····· 33

Table 1-2 Categorization of the Types of Medical Security Systems ····· 35

Chapter 2

Table 2-1 The Process of Legislation and Amendments to the Medical Insurance Laws ····· 40

Table 2-2 Information on Medical Insurance Demonstration Projects ····· 45

Table 2-3 Statistics on Support through Loan Funding (1978-1992) ····· 50

Chapter 3

Table 3-1 The Sequence of Changes in Medical Insurance Eligibility ····· 59

Table 3-2 Annual Changes in the Insurance Premium Rate for Employment-based Policyholder ····· 65

Table 3-3 The Percentage of Charges Allocated to Each Party for Each Type of Employment-based Policyholder ····· 65

Table 3-4 Types of Insurance Benefits and Their Recipients ····· 68

Table 3-5 Changes in the Period of Coverage for Benefits in Health Insurance ····· 69

Table 3-6 Health Exam Items for Infants and Children by Time Period ····· 73

Table 3-7 The Expansion of Items of Insurance Benefits and their Contents ····· 75

Table 3-8 The Positions of Key Agents Regarding the Integration of Medical Insurance ····· 78

Table 3-9 Trends in the Financial Gap Between Employment-based Cooperatives and Regional Cooperatives ····· 84

Table3-10 Annual Changes in Governmental Funding Support for Regional Medical Insurance ····· 84

Table3-11 The Process of the Administrative and Financial Integration of Medical Insurance ····· 85

Chapter 4

Table 4-1 Comparison of the Method of Assessing Insurance Premiums for Employment-based Policyholders and Self-employed Insurance Policyholders 94

Table 4-2 Method of Computerized Data Linkage for the Assessment of the Insurance Premiums of Self-employed Policyholders 94

Table 4-3 Trend of Changes in Health Insurance Premiums 96

Table 4-4 Changes in the Amount of Health Insurance Premiums Charged and Collected 99

Table 4-5 Changes in Financing for Health Insurance (1977-2010) 102

Table 4-6 Statistics on the Population Eligible for Health Insurance 103

Table 4-7 Components of the Relative Value Units 108

Table 4-8 Annual Changes in the Conversion Factor 109

Table 4-9 Changes in the Annual Increase Rate for Health Insurance Benefits Costs 109

Contents | LIST OF TABLES

Chapter 5

Table 5-1 Current Annual Statistics on the Health Insurance Eligible Population ····· 113

Table 5-2 Current Annual Statistics on Health Insurance Eligible Workplaces ····· 114

Table 5-3 Annual Statistics on Foreigners and Citizens Residing Overseas with Health Insurance Policies ····· 115

Table 5-4 The Coverage of Health Security in Terms of the Type of Treatment ····· 117

Table 5-5 Current Statistics on the Number of In-Patient Treatment Days ····· 118

Table 5-6 Current Statistics on Screening Rates in the National Health Screening Program ··· 119

Table 5-7 Current Statistics on Exam Expenses Paid as Part of the National Health Screening Program ····· 120

Table 5-8 Current Statistics on the Rate of General Health Exams Received Categorized by Type of Profession ····· 120

Table 5-9 Current Annual Statistics on Medical Institutions by Type ····· 122

Table 5-10 Current Statistics on Medical Institutions and Hospital Beds ····· 122

Table 5-11 Current Annual Statistics on the Number of Medical Personne ····· 123

Table 5-12 In Cases of Shifts from an Employment-Based Policy to a Self-Employed Based Policy ····· 126

Table 5-13 In Cases of Shifts from a Region-Based Policy to an Employment-Based Policy ···· 126

Contents | LIST OF FIGURES

Chapter 1

Figure 1-1 The Process of the Emergence of Medical Insurance ····· 30

Chapter 2

Figure 2-1 The Factors Enabling the Implementation of Medical Insurance ····· 55

Chapter 3

Figure 3-1 Method of Assessing the Insurance Premiums of Self-employed Insurance Policyholders ····· 67

Figure 3-2 Chart of Management and Operations under the Cooperative-based Medical Insurance System ····· 82

Contents | LIST OF FIGURES

Chapter 4

Figure 4-1 The Operational Structure of the Health Insurance System ····· 89

Figure 4-2 Annual Trends in Insurance Premiums Charged According to Occupational Categories ····· 96

Figure 4-3 Changes in Insurance Premium Compared to Equivalent Periods in the Previous Year ····· 97

Figure 4-4 Comparison of the Work Procedures Before and After the Integration of Insurance Premium Collections ····· 98

Figure 4-5 Trend of Changes in the Annual Collection Rate for the Self-employed Insurance Premium ····· 100

Figure 4-6 The collection Rate for the First Quarter of 2011 ····· 100

Figure 4-7 Annual Trends in Health Insurance Eligible Populations by Occupational Category ····· 104

Figure 4-8 Annual Changes in the Average Number of Dependent Family Members per Policyholder ····· 104

Chapter 5

Figure 5-1 Time Required by Each Country to Achieve National Medical Insurance for All Citizens ····· 113

Figure 5-2 2010 Statistics for Specific Cities and Provinces on the Number of Foreigners and Citizens Residing Abroad, and Their Percentages in Relation to the Health Insurance Eligible Population ····· 115

Figure 5-3 Statistical Changes in Life Expectancy and Mortality Rates for Males and Females ····· 124

Figure 5-4 Annual Statistics on the Number of Days for Out-Patient Treatment per Individual ····· 125

Summary

Although it has only been three decades since the introduction of the National Health Insurance System in Korea, and two decades have passed since the institution was extended to include all Korean citizens. Korea has achieved notable growth in this field within a short time period, the degree to which has elicited admiration from many other countries around the globe. The National Health Insurance System of Korea has been esteemed by the international community as one of the most efficient systems at providing universal health security for all of its citizens at a low cost.

Korea, however, underwent a process of much trial and error before its National Health Insurance System developed into the successful institution it is today. Moreover, although the health insurance offered in Korea is evaluated as a success, from our current perspective, there are also many unsatisfactory aspects which require improvements. In this light, this study seeks to introduce the experiences of Korea in the field of health insurance, and to share the implications that can be learned, particularly for the benefit of underdeveloped countries striving to implement their own health insurance systems.

To present Korea's experiences during the development of its health insurance, this study first introduces the socio-economic environmental conditions and the major motivators that were prevailing at the time Korea first introduced health insurance, and the process that led to the implementation of health insurance. Related to this, the study also examines the system with which health insurance was implemented, including the legislation and revision processes that were necessary to establish Korea's Medical Insurance Act. We also discuss the establishment of medical insurance cooperatives, the conditions at the time of the demonstration projects, the process of securing the necessary medical institutions and building a system of cooperation, governmental financial support and the method used in the promotional efforts directed toward citizens. Next, we sought to review the current status of key policies implemented in relation to health insurance and the methods being used for its management and operations.

We also analyzed the achievements that Korea's nationwide health insurance system has made thus far, and the problems confronting the system today. Lastly, we derived conclusions regarding the correlations between the choices made by Korea in the early stages of the introduction of health insurance, and their consequent outcomes for the development of Korea's health insurance system. We also sought to identify aspects in which different choices in the past may have prevented certain problems Korea is encountering today. These analyses were intended to assist underdeveloped countries in minimizing the likelihood for trial and error in their own efforts to introduce health insurance, by presenting the lessons that can be learned from the development process of Korea's health insurance.

Korea was able to establish its health insurance for all citizens within such a short period and achieve such notable successes, because the Korean government took leadership in energetically pursuing a series of social reform measures to respond to the demands of citizens, the numbers of whom grew in the context of the country's economic and social development. Another key factor was the country's economic successes, serving as a driving force behind the growth of its social security system. Also, active participation from suppliers of medical services and private companies also made a great contribution to the rise of health insurance. In conclusion, energetic support from the government (political leadership), efforts to secure the institutional infrastructure through research and investigation, economic development, and voluntary participation, along with the effects of promotional publicity for citizens were all factors that combined to enable Korea to consolidate its health insurance system successfully.

Next, it must be noted that Korea adopted an incremental approach in the process of expanding health insurance eligibility, and strengthening benefits to alleviate potential complaints from suppliers as well as from policyholders. We conclude that this method was administratively convenient for management and operations, and also made it possible to set the framework for consolidating the insurance system without incurring excessive strains, in terms of financing or the management of expenditures for benefits costs.

In efforts to secure funding, employment-based policyholders were charged with insurance premium in the early stages of implementing health insurance. It was only later that the government provided financial support, in the process of expanding eligibility to residents in agriculture or fisheries communities. Such financial support allowed the health insurance system to maintain a low premium (low burden) for policyholders in the early years of the health insurance system, providing an incentive for greater participation, and setting the groundwork for a stable expansion into the nationwide health insurance today.

Despite the positive decisions described above, there were nonetheless aspects in which greater deliberation in the early stages of the system's introduction may have further improved the outcome. The first problem pertains to the issue of establishing a fee payment system for medical costs, which Korea adopted from the model used in Japan. This decision has resulted in many challenges that impede efficiency in financial management. Considering that the fee payment system is one of the most important factors among the many policy

issues that need to be addressed in health insurance, it is essential to thoroughly discuss which fee payment system to adopt in the early stages of implementing a health insurance system.

Korea supplied its citizens with medical services through the public sector in the early years of the health insurance system, based on the ideal of providing public medical services. However, as income levels arose in tandem with economic development, and citizens' demands for medical services escalated, it was not surprising that the private sector would grow in proportion as well. Korea failed to anticipate this development, reminding us government should clearly delineate the status and concept of public hospitals in the early stages of implementing health insurance, and set up long-term investment plans on how to realize its public medical system goals.

In regards to financing, we can consider the method based on taxation, and the method by charging insurance premiums. If the method of charging insurance premiums is adopted, countries should avoid the potential for increasing complaints from citizens, arising from the complexity of assessment factors and the dichotomization of the assessment system, as was the case of Korea. This can be achieved by unifying the assessment system with the initial stages of instituting health insurance, and seeking to simplify the determinant factors for premium charges.

In Korea, health insurance was operated by the National Health Insurance Corporation while the insurance benefits for the low income (Medicaid) class was managed by the government, but the latter led to criticisms regarding a lack of efficiency. Also, though in the early years of health insurance the number eligible for insurance benefits was limited to 10% of the national population, the moral hazard arising in a situation where the medicaid beneficiaries receive all of their insurance premiums from the government without almost any co-payments, and the resulting problem of increases in expenditures for medical costs, has made it impossible to increase the number of medicaid beneficiaries, and therefore the percentage of beneficiaries has inversely declined to around 3%. Governments should establish long-term plans on how far to extend the number of medicaid beneficiaries from the first stages of implementing their health insurance system, and should take into consideration that medical beneficiaries are highly exposed to the risk of moral hazard regarding expenditure of medical fees, due to the very low level of insurance premiums compared to ordinary health insurance policyholders. For this reason, mechanisms are necessary for efficiently managing the eligibility for medicaid benefits and controlling the expenditures for benefits costs.

Next, we must note that despite being operated as a form of social insurance, Korea's insurance system is experiencing difficulties in securing revenues, due to obstacles in raising insurance premium levels. For this reason, the amount of governmental subsidies has continued to rise, as well as controversies surrounding the possible misuse of public funds. In light of these experiences in Korea, we advise that the insurance premium should be set low in the early years of introducing health insurance, and require governmental

support in certain areas for the initial stages. However, once the health insurance has stabilized to a certain degree, efforts must be made to actively persuade policyholders of the need to raise the insurance premiums to rational levels, in order to fund the system through insurance premiums, thereby minimizing governmental support. There should also be clear legal stipulations that define how government subsidies will be used.

Regarding the management and utilization of data, there were no efforts to form a database of information in the early years of medical insurance, though Korea's health insurance first began to be implemented at the unit of cooperatives and gradually expanded to include all citizens in the National Health Insurance system. Moreover, though the information pertaining to the period following implantation of a national health insurance has been collected into a database, in actuality this resource has not led to satisfactory results, in terms of utilization for policy decisions. Therefore, it is advisable for countries to strive to organize pertinent information into a database from the early stages of implementing health insurance, and to seek ways to utilize the relevant data for various policy-related purposes, such as the construction of an infrastructure for health and medical related issues.

In terms of the expansion of eligibility and benefits, it is regretful that Korea was not able to take on more initiatives to offer an improved level of benefits corresponding to improvements in eligibility from the initial stages of health insurance. Government must deliberate whether to concentrate on expanding eligibility among the population, or to focus on expanding the range of benefits in tandem with the expansion of eligibility. This decision deserves serious consideration, since the issue is closely linked to insurance premium revenues.

Lastly, we must consider management and operation methods. Korea began operating its health insurance through the cooperative method at the outset, and later, following the integration of the organization, the government's role came to be emphasized to a much greater degree. In operating a health insurance system, there are respective advantages and drawbacks, depending on the agents of the operation. We can consider the example of Taiwan, where the government exercises complete authority in the operation of health insurance, or the case of Germany, where the National Health Insurance Corporation is charged with the responsibilities of an insurer, along with autonomy in governing benefits or financial decisions. If we opt for the method of operation based on cooperatives, where the autonomy of each cooperative is respected as much as possible, methods for pursuing efficiency in management while minimizing discrepancies among the cooperatives in terms of revenue and expenditure will be necessary. On the other hand, systems operated by a single, integrated insurer would demand mechanisms to ensure internal competition in management and operations.

We have hitherto examined the development of health insurance in Korea and the implications Korea's experiences may have for underdeveloped countries. Although Korea has achieved an outstanding institution worthy of the admiration of other countries, it is also true that Korea still faces many challenges ahead.

Chapter 1

The Contextual Background of the Introduction of Medical Insurance

1. The Socio-Economic Context
2. Healthcare Environment
3. Major Motivations for the Implementation of Medical Insurance
4. The Decision-Making Process Leading to Implementation
5. The Characteristics of Health Insurance in Korea

The Contextual Background of the Introduction of Medical Insurance

1. The Socio-Economic Context

The April 19th Revolution of 1960 and the consequent emergence of Korea's Second Republic, followed soon after by the military coup on May 16th, 1961 that led to the establishment of the Third Republic, opened up ground-breaking opportunities for changes in the field of medical social security, along with other fields, including economic development. The administration of the Second Republic that emerged in the wake of the April 19th Revolution in 1960 planned various reforms for economic and social development under the parliamentary cabinet system, but continued political instabilities prevented the implementation of these reforms until the regime was toppled by the May 16th military coup. The military takeover that took place on May 16th, 1961 established the Third Republic, which energetically implemented a series of government-directed social reform measures that sought to respond to the citizens' thirst for economic and social development. These social reform measures, which often took the form of temporary or sporadic expedients, included measures to address the problem of high-interest loans targeting workers in agriculture and fisheries industries, illegal accumulation of wealth by individuals, as well as measures intended to reinforce a strong social ethos and to eradicate delinquent gang organizations. In the first year following the May 16th military coup, the administration enforced various emergency measures, while neglecting to mention or present long-term policy objectives. In 1962, however, discussions regarding these issues began to be addressed in earnest (Medical Insurance Society Association, 1997:24).

Beginning in 1962, the Third Republic implemented long-term and fundamental measures reflected in its "Five Year Economic Development Plan."[1] The basic direction of

1 From 1962 to 1981, Korea sequentially implemented a total of four Economic Development Plans and from 1982, the name was changed to the "Economic Social Development Plan." In this reincarnation, the 5th "5 Year Economic Social Development Plan" was implemented from 1982 to 1986, the 6th from 1987 to 1991, and the 7th from 1992 to 1996.

policy established at this time was founded on the principle of free private enterprise, but with provisions for direct governmental intervention in key economic sectors. The major contents of this policy focused on the development of public sectors under government leadership, accompanied by inducements to encourage voluntary activities from the private sector, industrialization through the modernization of industries, rational convergence in the utilization of natural and human resources, and strengthening national defense through the modernization of the country's armed forces. Since the activities of the private sector at the time were lagging, such policies were regarded to be conducive to stimulating economic activities. Along with these efforts, various policies and institutions regarding social security were introduced and implemented at the government level. In 1961, as part of the poverty relief policy, the National Assistance Act, regarded as the first social security legislation in Korea, was enacted, and relief work, which up to the 1950s and the early 1960s had been haphazardly taken up by foreign religious or aid organizations, was also placed under the aegis of governmental planning and control through the Foreign Nongovernmental Aid Organizations Act, legislated in December 1963.

Articles 30 and 31 of the Constitution of the Third Republic were extensively amended after the military revolution of May 16th. The amendments introduced provisions pertaining to governmental protection to improve social security and citizens' health, launching discussions on the issue of introducing a medical insurance system.[2] Later, in March 1962, the "Provision for the National Advisory Council on the Social Security System" was legislated as Ordinance No. 469 with the support of the Supreme Council for National Reconstruction, and in accordance with this law, the National Advisory Council on the Social Security System and the Social Security Research Center were installed within the Ministry of Health and Social Affairs. These organizations categorized its field of research into general affairs of social security, labor insurance, medical insurance, public assistance and social welfare, and created, prepared and implemented the pertinent laws for the establishment of the system. As a result, the "Act on Social Security" and the "Industrial Accident Compensation Insurance Act" were passed in November 1962 and the "Health Insurance Act" was passed in December 1963. The benefits for the Industrial Accident Insurance became available on July 1st, 1964, functioning as the first ever form of social insurance available in Korea. Meanwhile, health insurance had been scheduled to begin coverage in June of the following year for workplaces with 300 or more employees, but the law failed to function properly, and its implementation ended up becoming deferred (Ok-Ryun Moon et al., 2006:50-51).

This failure was due to the fact that the medical insurance system had been legislated as a voluntary entry system, rather than a compulsory entry system. The government at the time had determined the criteria for the selection of model work sites, according to which it has chosen several companies under governmental management and had recommended

2 Health insurance in Korea prior to 2000 by means of a therapeutic concept was used by medical insurance but the term health insurance was used since 2000 where prevention and health promotion concepts were included.

implementation of this system to the primary candidate work sites. But because of insufficient awareness regarding social insurance, the perceived burden of the insurance premiums, and a voluntary entry system that lacked any institution device for securing implementation, etc. the system was not adopted in the individual work sites. Though negotiations were attempted with candidate work sites in the financial sector as a secondary measure, these efforts also failed. In the midst of these developments, an unanticipated party notified its intention to establish a cooperative, resulting in the birth of the "Central Medical Insurance Cooperative" in 1965. However, the "Central Medical Insurance Cooperative" reached a point of becoming infeasible, due to the indifferent attitudes of both the business owners and the insured parties toward the payment of insurance premiums, and an insufficiency in finances. The administration of benefits de facto ceased after the June of that year. Ultimately, on November 29th, 1965, the Ministry of Health and Social Affairs cancelled the authorization of the establishment through its Notification No. 1394, marking the failure of the first cooperative in Korea within 7 months of its establishment authorization (Medical Insurance Society Association, 1997:44-45).

On August 7th, 1970, the Health Insurance Act was amended to enforce the compulsory entry of laborers, military personnel and public officials, while the voluntary entry provision was maintained for self-employed persons and local residents. Meanwhile, the regulation stipulated that central and self-employed medical insurance cooperative systems must be implemented for military personnel and public officials. The revised Act also enabled the compulsory establishment of medical insurance cooperatives for business owners of workplaces. However, due to the lack of sufficient regulations on the procedures of the law and the difficulty of securing funding, this effort was deferred, and is only remarked upon today for its historical significance as the first regulation requiring compulsory entry. Thereafter, efforts at encompassing implementation was deferred, until various conditions necessary for its successful enactment reached a state of maturation (Ok-Ryun Moon et al., 2006:60).

2. Health Care Environment

Immediately after the end of the Japanese colonial rule in 1945, Korea came under the governance of the U.S. military, and this American influence extended to the health and medical spheres. Korea's health and medical policy was largely modeled after the American system, with the Health and Welfare Department playing the leading role under the U.S. Army Military Government in Korea. The majority of Korean specialists who were in charge of administering policy had also studied health-related disciplines in the U.S. institutions. However, after the outbreak of the Korean War in 1950, almost all policies pertaining to health shifted to a focus on restoration in response to the damages of war, and the management of contagious diseases. This shift prevented the establishment of any long-term plans for the development of health policies.

Beginning in the late 1950s, as the country began its healing process following war, the government emphasized the development of medical resources and the expansion of medical facilities as its key projects. But such projects were stalled by the lagging economic environment following the war. For the most part, Korea could only rely on volunteer organizations, such as religious groups or support from international organizations such as UNICEF to meet its health needs.

With the implementation of the 5 Year Economic Development Plan in the early 1960s, Korea sought to implement health-related projects at the governmental level, by revising its Health Center Law to install health centers for the first time at the level of each city and gun district unit. But the severe shortage of qualified health personnel made it very difficult for this program to succeed. Although provincial hospitals that Japan had established during its period of colonial rule had been ceded to the regional governments and converted into municipal and provincial hospitals, financial constraints resulted in an insufficient number of doctors, as well as dilapidation of facilities, posing severe impediments to performing proper hospital functions. For this reason, municipal and provincial hospitals in the 1960s lost their status and authority as the regional medical centers that they were during the Japanese colonial period. Instead, private hospitals and small-scale individual clinics came to be the primary suppliers of medical services.

At the time of initiating the Second 5-Year Economic Development Plan in 1967, governmental policy focused on the prevention and management of acute infectious diseases, tuberculosis management, expansion of health networks with particular focus on rural communities, and the education and training of medical service personnel. However, in the 1960s and even into the 1970s, Korea's budget for health related fields occupied approximately 1% of the total national budget. As a result, the operating environment for health and medical related fields remained in very inferior conditions during this time (Seung-Heum Yoo et al., 2008).

3. Major Motivations for the Implementation of Medical Insurance

Korea's economic development and successes through the 5 Year Economic Development Plan were the driving forces enabling the development of a social security system. The successful implementation of the "Third 5 Year Economic Development Plan (1972~1976)" functioned as a major contextual factor behind the development of the social security system. In spite of the international oil crisis, the Third 5 Year Economic Development Plan achieved its original objectives and raised the per capita income, providing the foundation necessary to accelerate the implementation of social security policies, including medical insurance. The export-led model of economic development made the achievement of 10 billion dollars in annual government revenue a real possibility for Korea (Medical Insurance Society Association, 1997:75).

In particular, the government's plan to promote the heavy chemical industry at the beginning of 1973 served to further stimulate economic development. As the economic growth made it possible for Korea to accumulate social capital, Korea became capable of implementing systems that would ensure the basic livelihood of its citizens. Empowered by the export-oriented industries, Korean society attained remarkable economic growth in the 1970s. As in all societies, Korea's growth was accompanied by the emergence of a relatively impoverished class. The poor in urban regions and residents from agriculture and fisheries communities did not receive proportionate benefits stemming from Korea's rapid growth. These citizens desired a kind of health security system that would satisfy the fundamental health rights, as they saw them, due to all human beings. The conditions of medical care at the time imposed a great socio-economic burden on the lower-income classes. The government was aware of these contemporary realities and the demand for medical care from the low-income classes. Indeed, the government felt that it was imperative to adopt policies and institutional measures to respond to these demands.

The two social insurance systems that the government pursued at the time were the National Welfare Pension System and the medical social security system. The issue of determining which to implement first, furthermore, had very important significance in the policy implementation and decision-making process. The National Welfare Pension Act was legislated on December 24th, 1973 and was scheduled to be enforced immediately, beginning January 1974. However, the "Presidential Emergency Measure No. 3 for the Stabilization of Livelihoods of National Citizens" adopted in response to the economic recession, resulting from the first oil crisis, caused enforcement to be deferred until December 31, 1974. Moreover, the implementation of the Act became delayed indefinitely for the most part, due to the continued economic stagnation following the oil shock.

The decision to delay the implementation of the pension system was influenced not only by economic reasons, but also by conflicts among governmental departments. At the time, press reports publicized conflicts between the Economic Planning Board, which sought to allocate 10% of the monthly wages of employees to the promotion of the heavy chemical industry, and the Ministry of Health and Social Affairs, which aimed to allocate 3% of the wages for objectives pertaining exclusively to the pension project. The failure to derive a national consensus regarding this conflict was another reason for the policy's failure. For these reasons, the Welfare Pension Office, installed within the Ministry of Health and Social Affairs to implement the pension system, was unable to launch its services. Instead, the office was charged with responsibilities pertaining to projects such as medical insurance, and was later reorganized into the Social Insurance Office in 1977. Since the Medical Insurance Act in 1963, it was the Medical Administration Office's regional medical administration department that oversaw the voluntary medical insurance projects. Thereafter, following the reorganization of public offices in 1970, these services were transferred to the medical system department of the Postal Office and then passed on to the Social Insurance Department that was installed in the Social Affairs Office on March 10, 1973 for the purpose of implementing the pension system. After 1974, this department was expanded

and reorganized, with its responsibilities being transferred to the newly established Welfare Pension Office (Medical Insurance Society Association, 1997:85-86). In consideration of the conditions prevailing at the time, it seems that it was more politically expedient to first implement short-term insurances such as those providing coverage for illnesses, industrial accidents and childbirth, etc., rather than prioritizing long-term insurance plans for income security in old age, such as the National Pension program. The short-term category of insurance was also more feasible to implement, in terms of the receptivity from national citizens. Also, under the historical circumstances at the time, it is apparent that the government was seeking an appropriate policy alternative in the field of social security, in order to secure a political advantage over North Korea in the two regimes' competition with one another. North Korea had exploited the fact that its government offered a free medical care system, in order to promote its ideology as superior to that of South Korea. Confronted with the news of the fall of Saigon, and the ensuing unification of Vietnam by the government in Hanoi in 1975, South Korea's government could not ignore the social security system then being offered by the regime in North Korea.

In conclusion, the institutional foundation for the implementation of medical insurance in Korea was enabled by its economic development. Furthermore, it can be seen that the medical insurance system in Korea originated from its efforts to address the presented by the relatively impoverished classes, a problem overshadowed in the trajectory of growth.

4. The Decision-Making Process Leading to the Implementation

In the course of implementing its "Fourth 5-Year Economic Development Plan (1977~1981)," the Korean government introduced medical insurance as part of its social development policy. In 1975, there was a relatively positive attitude in the National Assembly's Welfare and Social Affairs Committee (Committee on Health and Social Affairs) regarding the introduction of medical insurance. In July 1975, the Welfare and Social Affairs Committee conducted an inspection tour of Seoul, Jeollabuk-do and the Yeongnam region for four days, in order to collect data for deliberation of a new annual budget, including welfare and social policy. The committee prepared and submitted an inspection report proposing gradual expansion of the medical insurance project, and the reinforcement of regional medical facilities. This report was inspired by the Blue Cross medical insurance project in Okgu, Jeollabuk-do to propose that the Labor Welfare Corporation implement medical insurance for the families of miners in the region. The report also proposed that companies over a certain size collaborate with local provincial hospitals at the regional unit level, in order to expand their implementation of medical insurance, constituting a medical insurance system similar to HMO (Health Maintenance Organization)in the United States.

By contrast, high-level officials in the Ministry of Health and Social Affairs, including the Minister himself, were pessimistic. At the 12th meeting of the Welfare and Social

Affairs Committee in the regular session of the National Assembly, the committee head recommended the government implement medical insurance. But, Jae-Pil Go, the Minister of Health and Social Affairs, stated his unwillingness to begin immediate implementation, citing crises occurring in foreign welfare states, in addition to claiming the need to verify outcomes first by implementing demonstration projects, etc. However, the appointment of a new Minister of Health and Social Affairs in December 1975 led to a marked policy shift away from the negative attitude of the incumbent Health and Social Affairs Ministry. At the time, President Chung-Hee Park ordered his Chief Presidential Secretary Jeong-Ryeom Kim to recommend a person capable of implementing medical benefits for the low-income class. As a result, Hyeon-Hwak Sin was appointed as the new Minister. Upon entering office, the new Minister of Health and Social Affairs Hyeon-Hwak Sin was presented with the implementation plan for medical insurance that had been prepared through the work of the Welfare Pension Office at a work report meeting, and as a result, the Minister became aware of the necessity and feasibility of implementing medical insurance in Korea. Following several more sessions reviewing additional reports, the Minister expressed his strong conviction in support of the implementation of medical insurance and undertook a key leadership role in defining how the medical insurance would operate. Thereafter, the Ministry of Health and Social Affairs included a Ten-Year Plan for medical security in the "Fourth 5-Year Economic Development Plan," and confirmed a draft proposal for the revision of the Medical Insurance Act on May 6th, 1976. At the same time, the confirmed draft proposal for the revision of the Medical Insurance Act was circulated through ten governmental departments to collect feedback on its contents.

On June 15th, 1976, when cabinet members including the deputy Prime Minister Deok-Woo Nam reported on the "Fourth 5-Year Economic Development Plan (1977~1981)," President Chung-Hee Park ordered that the government should "forcefully implement measures to provide medical benefits to the low-income class, even if such measures entail 1~2 years of delay in paving national roads. President Park added that a medical system for people in other income brackes should be deferred for the time being" and ordered officials to "research and develop a system of paying for the treatment of people in more unfortunate circumstances, and a plan for patients to compensate for treatment through installment payments." During the decision-making process regarding the medical security system, the government administration at the time allocated 9 billion won of governmental funds. The majority of this funding was used to support the medical protection project. Meanwhile, the cost required for launching the medical insurance system reached 350 million won. Later, in July 1976, the Minister of Health and Social Affairs Hyeon-Hwak Shin announced that the government would adopt a compromise between the method reliant on government responsibility and the method of operating insurance in the manner of a privatized corporation by operating the medical insurance through a cooperative system.

During the process of collecting feedback, the majority of the other departments had not offered any particular views on the issue. The Economic Planning Board was the most vociferous in opposing the revision proposed by the Ministry of Health and Social Affairs.

By early 1976, the Economic Planning Board (Minister Deok-Woo Nam) had already separately prepared its method for improving the medical system, by ensuring equal allotment of medical services for citizens apart from the Ministry of Health and Social Affairs, which diverged dramatically from the plan presented by the Ministry of Health and Social Affairs. The improvement measures proposed by the Economic Planning Board called for the integration of national public hospitals and municipal or provincial hospitals across the country, the installation of a Medical Corporation to address the problems in areas without access to medical services and to expand medical benefits to the low-income class. However, the Ministry of Health and Social Affairs strongly objected to the proposal from the Economic Planning Board on the grounds that the latter plan was premised on autonomous operations, which would risk increases in medical fees and prevent a unified administrative system centered on the Ministry of Health and Social Affairs.

Later, in early September 1976, the Medical Security Plan, including the draft of the Medical Insurance Act, received the final sanction from President Chung-Hee Park. It has been reported that the reason the plan was able to receive the final presidential approval, in spite of the fact that the Economic Planning Board exhibited indifference toward the implementation of medical insurance with the exception of the issue of support for low income classes, was because the Minister of Trade and Industry Ye-Jun Jang submitted a report reflecting the "actively supportive position of corporations" (Medical Insurance Society Association, 1997: 77-82). The formation of political support for the implementation of the medical insurance policy led to social groups with a stake in medical insurance expressing their opinions. Among these groups, the two most prominent were the "Federation of Korea Industries" which spoke on behalf of companies that would become responsible for financing a portion of medical insurance, and the "Korea Medical Association," which reflected the opinions of the medical services industry that would be impacted by the control over medical costs. Beginning in 1974, the Federation of Korea Industries took a deep interest in the issue of medical insurance, from the perspective of welfare for laborers. The organization was particularly active in reviewing problems that may arise from the medical insurance institution, summarizing public opinion through various discussion sessions, board meetings and public meetings, and submitting suggestions regarding governmental policy. This response from the economic sector became one of the critically important factors that helped determine the implementation of medical insurance (Medical Insurance Society Association, 1997:86-89).

Despite differences of opinion in government, the determination of the Ministry of Health and Social Affairs led to the pronouncement of the "Plan to Expand Medical Benefits for the Improvement of National Health" on September 13th, 1976. According to the contents of the report submitted to the 1st Committee on Health and Social Affairs of the 96th Regular Session of the National Assembly on September 27th, 1976, the stipulated objective of the plan was "to institute measures for reinforcing medical benefits for recipients of the livelihood protection program, and for offering medical insurance to diffuse and reduce the burden of medical costs for other citizens, in pursuance of the enhancement of national health by consolidating the foundation for nationwide medical security."

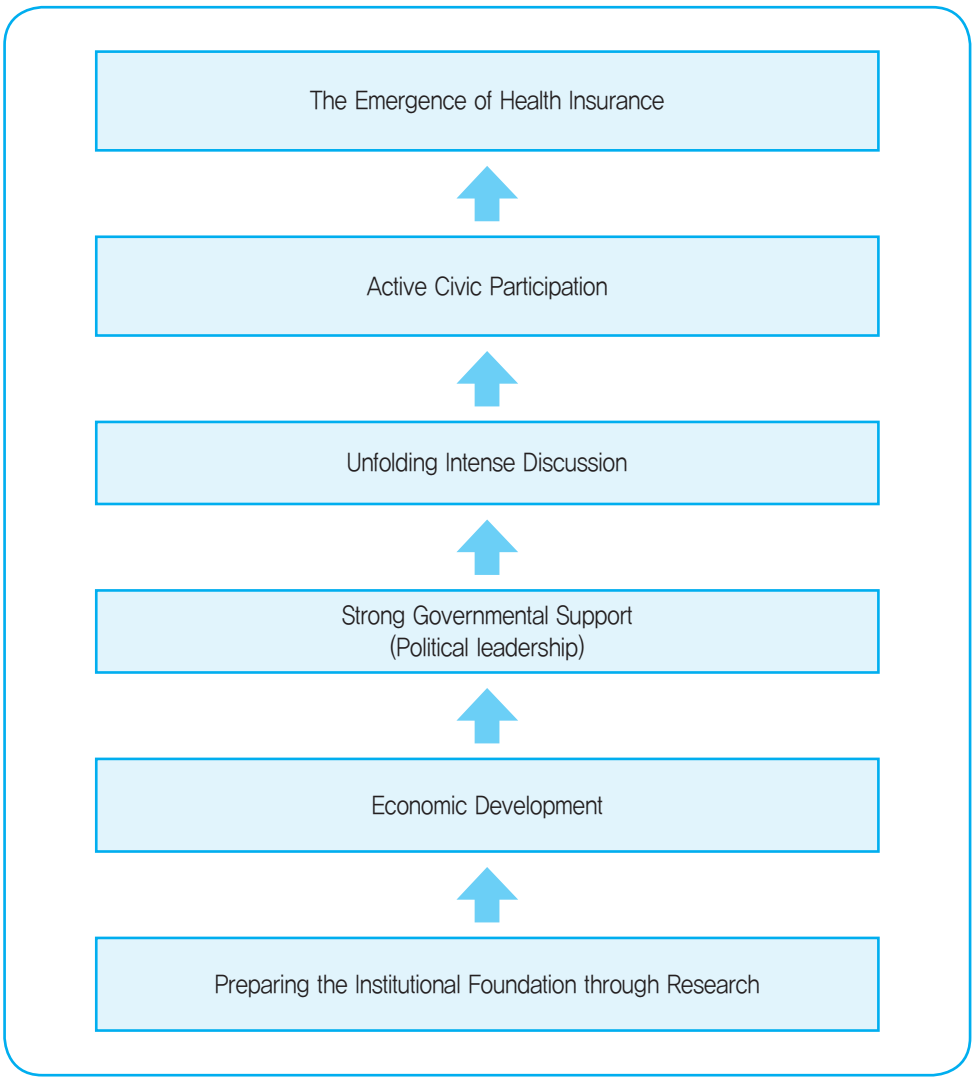
Thereafter, the Ministry of Health and Social Affairs completed the second revision draft for the Medical Insurance Act for the first time in July 1976, and made another round of revisions before submitting the draft to the National Assembly on October 12th, of the same year. In this process, the Economic Planning Board continued to regard the cooperative-based method, as proposed by the Ministry of Health and Social Affairs, as a policy that would risk loss of governmental control and promote faulty administration, resulting in enormous, unmanageable financial losses. To prevent this outcome, the Economic Planning Board continued to object, arguing for an alternative measure based on the principle of governmental supervision. The opinion presented by the Economic Planning Board, with the supporting intervention of the Korea Development Institute (KDI), at first called for a government-led model, but later changed to a limited liability model, then evolved once again into a model based on America's system. These revised plans proposed by the Economic Planning Board, however, failed to have any impact on the draft act submitted to the National Assembly.

The Minister of Health and Social Affairs Hyeon-Hwak Sin explained the proposed draft of the Act at 15th Committee on Health and Social Affairs (Chairman, Yong-Seong Kim) of the 96th National Assembly on November 8th, 1976. He stated that the pre-existing "medical insurance act provided for the compulsory entry into medical insurance of public officials, military personnel and other ordinary workers" but "in consideration of the reality that simultaneous application to all workers would be difficult, the system should also provide an voluntary entry system along with the compulsory system to correspond to actual conditions and supplement and improve upon the unreasonable or insufficient elements of the current law." He also explained that the draft act was being proposed to build the foundation for "national medical security." In addition, he explained the six major revised contents covering the issues of eligibility and the method of its implementation, the system for applying the cooperative method, insurance benefits, insurance premiums, the medical insurance review committee, and the monitoring system. The sub-committee consisting of 4 members of the National Assembly belonging to the Committee on Health and Social Affairs (Chairman Yong-Seong Kim and members Sang-Bong Kim, Hee-Seop Jeong, Yoon-Deok Kim) completed its review of the draft and implemented revisions and submitted the draft to the 14th regular session of the 96th National Assembly on November 30th which passed the proposal. Finally, the Act was promulgated as Act No. 2942 on December 22th, 1976 and the enforcement ordinance was promulgated on March 12th, 1977 as Presidential Decree No. 8487.

We have hitherto examined the socioeconomic conditions and the health and medical environmental conditions that were prevailing at the time Korea first implemented medical insurance. We have looked at the major factors that motivated Korea to implement medical insurance, and the decision-making process involved in its implementation. Although the health and medical environment at the time was extremely challenging, Korea was able to launch this system while avoiding financial reliance on the government, by relying on the insurance premium paid by policyholders as the main revenue for the medical insurance

system. Moreover, the eventual success of the insurance system was the historical outcome of ① efforts to prepare an institutional foundation for insurance through research and investigation; ② economic development; ③ the active support of the government (political leadership); ④ intense public discussion; and ⑤ the voluntary participation of the civic society.

Figure 1-1 | The Process of the Emergence of Health Insurance



5. The Characteristics of Health Insurance in Korea

5.1 The Types of Medical Security Systems

Medical social security is the outcome of institutional and historical processes unique to each country. Its characteristics correspondingly differ in each country, defying any sort of a simplified categorization. Largely, the types of medical social security can be distinguished based on the method of financing and the method of administrative management.

First, when categorizing according to the financing method used to raise revenue necessary for institutional operation, it is possible to distinguish between the Social Health

Insurance (SHI) method, in which the insurance premiums of the policyholders serve as the main source of revenue, and the National Health Service (NHS), in which revenue is mainly from taxation.

Although the Social Health Insurance (SHI) approach is based on the idea that the national government has the responsibility to provide medical social security, the operative principles of insurance is applied and a portion of the medical fees are therefore passed on as the responsibility of the medical services recipient. SHI relies on insurance premiums as the primary source of revenue, while the national government performs the functions of secondary support, direction and monitoring. This is a cost-conscious institution based on the premise that citizens have the primary obligation for the cost, and it minimizes the citizens' dependence on the government. This is referred to as the Bismarck method, since historically it was the German chancellor Bismarck who first implemented the modern form of social insurance.

This Bismarck method is characterized by the following features. First, eligibility for benefits are conferred based on the payment of the insurance premium, and the insurance premium is paid by a fixed rate or fixed amount correlative to income, charged as a co-payment allocated between the employer and the employee (Bonoli, 1997: 357). The majority of the medical service providers belong to the private sector, and the insurer concludes an agreement with these providers to secure treatment for policyholders. Also, policyholders are categorized by self-employed, employed, and type of occupation into organizations with relative autonomy, or cooperatives, which serve as the foundation of a self-governing administration. These features reflect the historical origin of social insurance, which can be traced back to the Middle Ages in Western Europe, when the craft guilds created a sickness fund for the mutual assistance of its members, fostering a culture of social solidarity to take collective measures in the event of illness or injury (Saltman et al, 2004).

Members of cooperatives can participate in the decision-making process for the operation of health insurance through a representative decision-making organization, thereby contributing to the democratic nature of the system's administration. Moreover, this method also emphasizes the cost-consciousness of the citizens, exerting a strong influence to supply relatively high-quality medical care. On the other hand, efforts must be made to overcome the difficulty arising from applying a single set of criteria for insurance premium charges to various members with differing types of income, and the challenge of collecting the insurance premiums themselves.

The National Health Service (NHS) is a method in which the government secures the funding through general taxation and directly administers the health care system, and is sometimes referred to as the Beverage method, in reference to the Englishman who first proposed this method to distinguish it from the Bismarck method. The Beverage method provides universal benefits, and eligibility for benefits is conferred based on citizenship under conditions fulfilling the requirement on needs and residency. In principle, the finances are secured through taxation. However, in actuality, the employer and the user are also

charged with part of the medical social security costs in the majority of member countries, though the percentage charged differs from country to country. Meanwhile in England, the various social security costs including coverage for pensions, medical care, unemployment, and industrial accidents, etc. are aggregated and charged as a single type of contribution fee.

In countries adopting NHS, a significant portion of the medical institutions that are medical service providers are socialized or nationalized, and hence there is a strong control over increases in medical costs. Another advantage of this system is that the effect of income redistribution is relatively strong, since it is funded through taxation. Also, in general this system ensures comprehensive and equal levels of medical care to all citizens, regardless of income level. There are also cases of countries such as Italy, Spain and Ireland where the system is implemented on a limited scope targeting only certain social groups. On the other hand, the socialization of medical care results in less competition between the suppliers, giving rise to the risk of deteriorations in the quality of medical services, and the financing of the medical expenses through taxation may place an excessive burden on the government for welfare costs. Also, some negative effects have emerged, such as the lack of cost-consciousness among the consumers of medical care, and the long waiting periods required for treatment, resulting in a growing need for systematic reforms.

The following table compares the features of the Social Health Insurance (SHI/NHI) method and the National Health Service (NHS) method described above, according to several criteria.

Table 1-1 | Comparison of the Features of Medical Social Security Systems According to the Method of Financing

Category	SHI / NHI	NHS
Management of application to beneficiaries	- Managed by categorizing citizens according to income level, region, type of occupation, employment, etc.	- Uniformly applied to all citizens
Source of Financing	- Insurance premiums - Partially supported from government funds	- General taxation by the government
Method of payment for treatment reimbursements	- The fee-for-service system or the Global budget payment system, etc.	Capitation system for General Practitioners - Salary system for doctors in the hospital class
Managing Organization	- Insurer (Multiple/Single)	- Governmental institutions (Social Security Administration, etc.)
Countries of Implementation	- Germany, France, the Netherlands, Japan, Korea, et al.	- UK, Sweden, Italy, Canada, et al.
Control over medical costs	- Weak functional ability to restraint medical costs	- Exercises strong control over medical costs
Equity for insurance premiums	- Capable of specifically securing equity in the assessment of insurance premiums for a single insurer - Concern regarding the occurrence of financial imbalances among insurers in cases where there are multiple insurers	- Financed by taxation, resulting in powerful income redistribution effects (in the case of advanced countries) (Note that in the countries without advanced taxation systems, regressive income distribution may result)
Management and operation	- Autonomous operations mainly dependent on the insurer (ensures the participation of the cooperative of the policyholders in the operations through representative organizations)	- Direct management by governmental institutions (Excludes the participation of the policyholders in the operations)

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

The medical security systems found in European countries can be broadly categorized into two types. The majority of Western European countries on the continent (Germany, France, Belgium, the Netherlands, et al.) have selected the Social Health Insurance method, whereas countries in Northern Europe and near the Mediterranean (Sweden, Norway, Finland, Denmark, Italy, Portugal, Spain, et al.) have opted for the National Health Service system, with the government providing medical services directly. Although many European countries at first selected the Social Health Insurance method in the process of forming welfare states in the aftermath of World War II, many countries followed the lead of England and transitioned to the National Health Service over the course of the 1970s and the 1980s.

Next, the types of system can be categorized according to the method of managing and operating the medical security system. In this case, we can distinguish the method in which the system is directly managed by the government or is operated by a commissioned public organization, and the method in which non-profit corporations or profit-based private insurance companies are commissioned with the operations to induce mutual competition.

The method of operating the medical insurance system privately (CSM: Consumer Sovereignty Model) encourages mutual competition among multiple non-profit cooperatives or profit-driven private insurance companies. Historically, since the formation of the social security system, the majority of countries offering a medical security system have strengthened the public responsibilities of the government in this field, in consideration of the special character of health and medical services, and only a small number of countries, including the United States, Singapore and Hong Kong, have selected the private insurance method. The United States, which has long maintained the private insurance method, is pursuing policies that seek a transition to the socialized insurance method according to the election platform of the Obama administration. Meanwhile, many countries in Europe have been experiencing a rise in medical costs due to the aging of their populations since the 1980s, and have been suffering from the high financial burden imposed on the government by the needs of the welfare state. The tendency toward neo-liberalism in politics has also resulted in a renewed emphasis on efficiency through competition. These developments have led to a hybrid public and private model for insurance, in order to transfer the responsibilities previously held by the government to the private sector. The Netherlands is a representative case of this transition, where the previous dual structure of public insurance and private insurance has been integrated into private insurance, while requiring compulsory entry for policyholders. However, the Dutch government continues to exercise ultimate control and management. Based on the above explanations, the types of medical security systems can be categorized as in the following table.

Table 1-2 | Categorization of the Types of Medical Security Systems

Management and Operation	Financing	
	Insurance premium	Taxation
Single unified organization/ institution	National Health Insurance (NHI)	National Health Service (NHS)
Multiple organizations/ institutions	Social Health Insurance (SHI)	-
	Consumer Sovereignty Model (CSM)	-

5.2 The Key Characteristics of Health Insurance in Korea

5.2.1 Risk-Pooling through the Compulsory Entry of All Citizens

Social insurance systems operate based on the obligatory application method, in which entry is made compulsory by law. The purpose of this measure is to pool risks by responding to social risks collectively. If the system called for voluntary entry rather than compulsory entry, many individuals would not register for social insurance or choose not to pay the insurance premium. In other words, poor individuals would avoid the payment of the insurance premium due to immediate financial difficulties, while high-income individuals may not register for various reasons, such as the desire to purchase private insurance policies. When there is a large number of citizens avoiding registration, the risk escalates, which can lead directly to social problems. This is the reason that Korea's health insurance system adopted the social insurance approach that includes all citizens as default participants, to disperse the risk which is regarded as belonging to the joint responsibility of the society as a whole, rather than to the responsibility of the government or the individual alone.

5.2.2 Scaled Insurance Premium based on Financial Ability and Provision of Identical Benefits

Diseases and injuries impact the income-earning activities and economic life of the individual, and lead to a vicious cycle in which declining income further deteriorates health. For this reason, Korea's health insurance system takes into consideration the financial ability of each individual when securing its funding through insurance premiums, scaling the amount of insurance premiums assessed and collected based on income, but providing equal benefits according to need regardless of the individual's contribution. This system performs an income redistribution function by reducing the financial burden on the household in the event of illness. The burden of cost is distributed fairly based on circumstance, scaled usually according to income or ability. This has the effect of creating mutual social solidarity among social groups. However, in terms of insurance benefits, the

system ensures an appropriate degree of basic medical care necessary for all the insured to resolve their medical problems. The system is thus characterized by the equal provisions of an appropriate level of benefits to everyone.

5.2.3 Strengthening Social Solidarity through Income Redistribution

The compulsory entry of all citizens, and the scaled contribution of insurance premium according to financial ability accompanied by equal provision of benefits, allow the health insurance system of Korea to perform an income redistribution function, distributing income from high-income class to the low-income class within the same household.

When the health insurance premium charges are compared to the benefits costs, the effect of income redistribution on respective income classes (insurance premium tier) can be clearly observed. Observed at the household unit, the low-income class represented by the low 20% tier for health insurance premiums contributes 18,623 won per household as the monthly insurance premium and receives 97,609 won in benefits costs, which is 5.2 times greater in value. Meanwhile, the high income class consisting of the upper 20% tier for insurance premiums pays 176,707 won of monthly insurance premiums per household, while receiving in turn 212,615 won as benefits costs which amounts to 1.2 times in value. Analyzed in terms of a single individual within the eligible population, a person in the low 20% tier of health insurance premiums contributes 12,167 won of monthly insurance premium per person while receiving benefits costs of 54,965 won, which is 4.5 times greater in value, while a person in the upper 20% tier of the health insurance premiums contributes 57,425 insurance premium while receiving benefits costs of 64,390 won, greater than the value of the insurance premium by 1.12 times (National Health Insurance Corporation, 2011: 2-11).

Chapter 2

The Medical Insurance Implementation System

1. The Legislation and Amendment of Medical Insurance Laws
2. The Establishment of the Medical Insurance Cooperative and the Implementation of Demonstration Projects
3. Securing Medical Institutions and Building a Collaborative System
4. Governmental Financial Support
5. Public Promotional Efforts

The Medical Insurance Implementation System

A prerequisite for properly implementing our medical insurance in the early stages of its introduction was the legislation of the related laws, the establishment of an organization to operate medical insurance, the securement of medical institutions, government support and public promotion efforts. This chapter will focus on these five topics to examine the methods used to implement medical insurance in Korea.

1. The Legislation and Amendment of Medical Insurance Laws

In Korea, the systematic research into a modern social security system began at the governmental and civic levels beginning in the 1960s. The beginning of these efforts focused on the issue of a health insurance system. In October 1959, the medical administration office within the Ministry of Health and Social Affairs hosted meetings under the name of "Research Society for the Implementation of the Health Insurance System." At the time, the research society included eight members, consisting of employees at the medical administration office, its director, and advisors. The society continued to hold regular weekly meetings to discuss issues, publishing their findings in several issues of research reports. These members researched and studied operational conditions and methods used in advanced countries that had already been implemented, and consolidated the medical insurance systems used in European countries and Japan, to review them and their applicability in Korea. The research activities on medical insurance initiated by the medical administration office influenced other departments responsible for social security, such as the Labor Office, which launched its own research into unemployment and labor industrial accident insurances, and the Social Office, which began research into public assistance. Regardless of the degree to which their research activities were reflected in actual, eventual

specific policies, it is clear that these pioneering studies served as the foundation for the implementation of health insurance (Medical Insurance Society Association, 1997: 19~23).

In December 1960, 300 representatives from various sectors of society and regions participated in the "National Comprehensive Economics Conference," a large-scale integrated academic conference that was organized into 7 divisions. At this event, a proposal was made to install a "Deliberation Committee for the Social Security System" under the aegis of the government, to begin researching social security systems and policies in earnest. In March 1962, the "Regulations on the Deliberation Committee for the Social Security System" was established through the provisions of Cabinet Ordinance No. 469. The Social Security Committee appointed the Vice-Minister of Health and Social Affairs as its chairman, and was composed of specialists in the field of social security from the government and academia. According to the fields of research, the committee was divided into four parts, the general affairs team (encompassing all aspects of social security), the medical insurance team, the labor insurance team, and the public assistance team (Medical Insurance Society Association, 1997: 28~31).

In this Social Security Committee, the first project undertaken by the medical insurance team was the "Survey on National Health." In October and November of 1962, over the course of the two months, a survey was conducted on 2,744 individuals in 500 households residing in Seoul, regarding their general conditions, income levels, health conditions and use of medical services. Based on the survey, the committee gained a clearer understanding of the inferior health conditions that citizens were enduring at the time, as well as the status of medical security and facilities in general. Based on this data, an initial draft of the medical insurance act proposal was completed in February 1963, and it recommended that the government apply a compulsory entry system to medical insurance for workplaces with 500 or more employees. However, in the process of reviewing and deliberations by the government-affiliated committee, the contents were revised to propose a system of voluntary entry at workplaces with 300 or more employees. These provisions were then legislated as Act No. 1623 on December 16th, 1963. Thereafter, the Medical Insurance Act underwent several revisions and amendments, and was finally revoked in 2000 when the organizational and financial integration of the National Health Insurance system was accompanied by the legislation of a new National Health Insurance Act.

Table 2-1 | The Process of Legislation and Amendments to the Medical Insurance Laws

Category	Date of revision	Major revised contents
1st Revision	1970. 8. 7 (Act No. 2228)	- Expansion of eligibility to all citizens - Compulsory entry for workers based on the cooperative method - Installation of a medical insurance fund system for the rationalization of medical insurance operations for military personnel and public officials - Voluntary entry for the self-employed based on the cooperative method - The medical insurance cooperative central association is installed to promote mutual support among the medical insurance cooperatives and rationalize operations - New provisions for compulsory collections of insurance premium to secure financial stability for the insurance system
2nd Revision (complete revision)	1976. 12. 22 (Act No. 2942)	- Type 2 voluntary entry medical insurance implemented for regional residents - The medical insurance council is established for security against insurance financial risks in cooperatives and to install and operate medical and welfare facilities - The Type 1insured insurance premium rate is changed (30/1,000 to 80/1,000) - The medical insurance review committee is established in Seoul special metropolitan city, Busan, and other provinces
3rd Revision	1979. 4. 17 (Act No. 3166)	- Improvements in the system of designation of treatment institutions (the designated medical institution or pharmacies cannot refuse service without justifiable reason) - Late payment fees collected at a rate of 0.06 won per 100 won per day when insurance premiums are not paid by the deadline - Strengthened penalties against wrongful treatments (license to practice is revoked for a period of one year or less in cases of wrongful treatment)

Category	Date of revision	Major revised contents
4th Revision	1981. 4. 4 (Act No. 3415)	- Confirmation of the demonstration projects for medical insurance in agriculture and fisheries regions - Confirmation of the jurisdictional districts for Type 2 medical insurance cooperative (the district units for regional cooperatives are limited to the city, gun, and gu units) - Expansion of the scope of eligible dependents (parents of the husband , etc. are included in the category of dependents) - Legal basis is prepared for the establishment of medical insurance cooperative based on occupational categories
5th Revision	1981. 12. 31 (Act No. 3502)	- Strengthened functions for the medical insurance cooperative association (program for the mediation of medical insurance finances, installation of medical and welfare facilities, installation of an operational fund) - Institution of the medical insurance review committee (reviews of insurance benefits costs fees, installed in the payment institution) - Reduction of prescription for the right to collect insurance premiums, etc. (the extinctive prescription on the right of insurance premium collection, right to receive insurance benefits, etc. reduced from three to two years)
6th Revision	1984. 12. 31 (Act No. 3768)	- Expansion of the scope of eligible dependents (Parents of the wife are included as dependents) - Extension of the time period coverage of treatment benefits (The benefit coverage period is extended to 180 days per year regardless of the type of disease, changed from the previous limit of up to 180 days in a lifetime for the same disease) - Establishment of appropriate regulations on the receipt of benefits (a treatment benefit continued after loss of eligibility can be maintained up to 180 days after the start of the treatment benefit)

Category	Date of revision	Major revised contents
7th Revision	1987. 12. 4 (Act No. 3986)	- Confirmation of demonstration projects for medical insurance in agriculture and fisheries regions - The jurisdictional areas for Type 2 medical insurance cooperatives are determined (The jurisdictional areas for regional cooperatives are limited to city, gun, and gu district units) - Extended scope of eligible dependents (parents-in-law are included as dependents) - Establishment of the legal basis for occupation type-based medical insurance cooperatives
8th Revision (complete revision)	1994. 1. 7 (Act No.4728)	- Removal of articles pertaining to voluntary cooperatives and cooperatives based on occupation type - Revision of terminology (treatment providing institution is changed to treatment institution) - Extension of the coverage period for treatment benefits (The period is extended by 30 days to provide for up to 210 days for elderly aged 65 or more) - Expansion of eligibility for childbirth benefits (insured and their dependents are all eligible for childbirth benefits) - Change in the insurance premium rate (changed from 3~8% of wages to 2~8%)
9th Revision	1987. 12. 31 (Act No. 4856)	- Inclusion of legal provisions for privileges granted to Persons of Distinguished Services to Independence
10th Revision	1995. 8. 4 (Act No. 4972)	- Inclusion of legal provisions for privileges granted to Persons of Distinguished Services to Independence - Elimination of limits on the time period for treatment benefits (Elimination of the limits on treatment benefits for elderly aged 65 or above and registered disabled citizens, etc.) - Strengthened legal sanctions against fraudulent claims for treatment benefit costs - Establishment of the legal basis for the health screening program for the early detection of illnesses and the corresponding treatment benefits
11th Revision	1997. 1. 13 (Act No. 5291)	- Act on the Honorable Treatment and Support of Persons, etc. of Distinguished Services to the State
12th Revision	1997. 12. 13 (Act No. 5453)	- Act to readjust certified public accountants, etc. in accordance with the implementation of the Administrative Procedures Act

Category	Date of revision	Major revised contents
13th Revision	1997. 12. 31 (Act No. 5489)	- Adjustments made to the terms of eligibility provided by the medical insurance act, due to the legislation of the National Medical Insurance Act - Establishment of the legal basis for ensuring the autonomy and professionalism of the review/payment institutions - Elimination of certain grounds for limiting benefits, such as arrears on insurance premiums, etc.
14th Revision	1998. 6. 3 (Act No. 5548)	- New institution of separate articles on voluntary continuance policyholders and insurance premium contributions, etc. - Legislation of a special articles on foreigners (strengthened medical security for foreigner workers by extending eligibility to foreign employees at workplaces with 5 or more permanent employees)
15th Revision	1999. 2. 8 (Act No. 5857)	- Complete revision of contents on treatment institutions - Elimination of articles on the treatment institution designation system - Revisions on penalty fees, etc. (revision to impose work suspension for a period of two years or less or penalty fees amounting to less than five times the amount of the wrongfully charged fee, in cases where the insurer has been charged with treatment benefit costs through fraudulence or other wrongful methods or in cases of fraudulent reports, etc. ·)
Legislation of the National Health Insurance Act	1999. 2. 8 (Act No. 5854)	- The Medical Insurance Act is abolished with the legislation of the National Health Insurance Act on January 1, 2000 - Expansion of benefits for prevention/rehabilitation for illnesses&injuries - Installation of the Health Insurance Review&Assessment Service - Integration under a single insurer (The National Health Insurance Corporation) - The contract system for determining treatment benefit costs instituted

Source: Ok-Ryun Moon et al., Health Security Theory, 2006: 57~58.

2. The Establishment of the Medical Insurance Cooperative and the Implementation of Demonstration Projects

In 1965, the first medical insurance cooperatives were established in accordance with the provisions of the Medical Insurance Act. These included the Korea Medical Mutual Fund that was centered around the Jeonju Jesus Hospital and served foreigners, the Central Medical Insurance Cooperative that served workers, the Honam Fertilizer Medical Insurance Cooperative and the Chungwon Medical Association that served the self-employed. The Central Medical Insurance Cooperative was located in Jongno-gu, Seoul, and was as joint cooperative centered on the Hyundai Hospital established by 7 workplaces, including the Sisa Moonhwa Printing Company, Pungjin Industries, the Sosa Religious Settlement 4th Corporation, Samheung Industries, Korea Wasa Industries, Co., Ltd., Daehan Jungseon, and Seoul Smelting.

In May 1968, the Blue Cross medical insurance cooperative[3] was formed with the leadership of the Busan Gospel Hospital to serve the self-employed. The Blue Cross movement that had first begun in Busan became nationally-known through media press coverage, and there were large-scale movements in various regions around the country to establish Blue Cross cooperatives. As a result, in November 1972, 150 parties affiliated with Blue Cross cooperatives across the country gathered to establish the "Central Association of the Korea Blue Cross Medical Cooperatives." However, in July 1973, applications from seven regional cooperatives in Seoul, Suwon, Daejeon, Jeonju, Okgu and Daegu were denied, and the entity failed to develop into a nationwide insurance organization.

To accelerate the establishment of medical insurance cooperatives, the Ministry of Health and Social Affairs notified the Medical Insurance Councils of the workplaces that were applicable by default, and the Council collaborated with economic organizations such as the Federation of Korean Industries, the Korea Chamber of Commerce and Industry and the Korea Employers' Federation to create administrative procedures and materials required for establishing cooperatives. Cooperatives for workplaces with 500 or more members were easy to establish, but the process of establishing cooperatives were relatively more complex and difficult in the case of industrial complexes. As the outcome of this process, on July 1st, 1977, 498 medical insurance cooperatives finally received authorization providing coverage for around 8.2% of the total population at the time [approximately 3 million people (around 1.1 million insured and 1.9 million dependents)] to begin medical insurance. The following table shows the medical insurance demonstration projects that were implemented between 1963, when the Medical Insurance Act was legislated, and 1977, when compulsory medical insurance was implemented.

3 The Blue Cross Medical Insurance Cooperative was modeled on the Blue Cross institution that reflected the "pioneering spirit, deep religious faith, and tolerance of Americans."

Table 2-2 | Information on Medical Insurance Demonstration Projects

Year	Name of cooperative	Target	Date of establishment	Notes
1965	Korea Medical Mutual Fund Central Medical Insurance Cooperative Honam Fertilizer Medical Insurance Cooperative Chungwon Medical Cooperative	Foreigners Employees Employees Self-employed	65. 4. 7	Centered in the Jeongju Jesus Hospital Authorization canceled on November 29, 1965. Changed Name: Korea Integrated Chemical Inc. Based on the Civil Code, located in Chungju
1966	Bongmyeong graphite mining station medical insurance cooperative	Employee		Located in Mungyeong-gun, Gyeongsangbuk-do Province
1968	Blue Cross medical insurance cooperative	Self-employed	68. 5. 13	Centered in the Busan Gospel Hospital
1969	Busan medical cooperative Blue Cross medical Cooperative Blue Cross medical insurance cooperative	Self-employed Self-employed	69. 2. 1 69. 4. 28	Focused on the Sweden Save the Children Federation Integrated establishment of the Blue Cross medical insurance cooperative division and the Busan medical cooperative medical insurance Revised authorization based on law
1970	Blue Cross Korea Medical Cooperative	Self-employed	70. 7. 2	Located in Seoul

Year	Name of cooperative	Target	Date of establishment	Notes
1972	Gwangju	Self-employed	72. 7. 1	Around 1,000 cooperative members
	Incheon	Self-employed	72. 10. 13	Around10,000 cooperative members
	Suwon	Self-employed	72. 11. 3	Around 1,300 cooperative members
	Jeju	Self-employed	72. 12. 1	Around 3,000 cooperative members
	Geojae Blue Cross medical insurance cooperative	Self-employed		
1973	Jeonju	Self-employed	73. 2. 20	Around 2,000 cooperative members
	The Korea Oil Corporation medical insurance cooperative	Employee	73. 3. 3	Changed Name: Okgu
	Okgu Blue Cross medical insurance cooperative	Self-employed	73. 10. 25	Name at the time of establishment: Chunseong
	Chunseong, Chuncheon medical insurance cooperative	Self-employed		
1974	Hyeopseong medical insurance cooperative	Employee	74. 3. 1	Located in Daegu, educational foundation
	Yeongdeok	Self-employed	74. 5. 10	Around 1,000 cooperative members
	Gyeongju	Self-employed	74. 6. 14	Around 500 cooperative members
	Baekryeong Red Cross medical insurance	Self-employed	74. 7. 1	Revised name: Baeknyeong
	Cooperative	Self-employed	74. 8. 13	Located in Pohang, around 1,000 members
	Donghae	Self-employed	74. 9. 9	Around 200 cooperative members
	Daejeon	Self-employed	74. 10. 25	Led by the Youth Chamber at the time of its initial establishment
	Yeongdong medical insurance cooperative	Self-employed		
	Daegu			

Year	Name of cooperative	Target	Date of establishment	Notes
1975	Jeungpyeong Maryknoll Medical Insurance Cooperative Okcheon	Self-employed Self-employed	75. 4. 19 75.	Revised name: Chungbuk Region
1976	Chungbuk Yeongdong	Self-employed	76.	Around 2,000 cooperative members Changed Name: Okgu Name at the time of establishment: Chunseong
1977	Sanhwa medical insurance cooperative	Self-employed	77. 9. 17	

Thereafter, through a loan from the Act for International Development (AID), the Korea Health Development Research Center implemented the "Comprehensive Health and Medical Services Demonstration Project"[4] over the course of five years, from 1976 to 1980. This demonstration project can be regarded as a precursor program, since it took place in the three regions of Hongcheon, Okgu and Gunwi which later became designated as the first demonstration region for the regional medical insurance system. In March 1980, the Korea Health Development Research Center reported the outcome of the Comprehensive Health and Medical Services Demonstration Project in the three regions (Hongcheon-gun, Okgu-gun, Gunwi-gun) and recommended that the Type 2 medical insurance demonstration project should be officially implemented. Accordingly, the demonstration project to implement medical insurance in agriculture and fisheries regions was initiated in the three districts (Hongcheon-gun, Okgu-gun, Gunwi-gun) beginning in July 1981, and six gun districts were designated in 1982, thereby extending implementation to a total of nine districts.

In response, on May 15th, 1981 the government secured regional offices and appointed cooperative establishment committeemen, and followed up on June 2rd by embarking on the

4 The implementation of the Central Health and Medical Demonstration Project, known also as the "Village Health Program," was made possible by the conference of the "International Economic Consultative Organization for Korea (IECOK)" that had took place in Paris in 1972, where the Korean government requested a loan to establish military hospitals. After completing a preparatory process, AID and the Korean government concluded a loan agreement to provide five million dollars in September 13, 1975. The loan program pursued two objectives. The first was to "foster the ability to plan, implement and evaluate the cost-saving model of the comprehensive health and medical services delivery system to serve low-income residents." The other objective was to "successfully demonstrate the cost-saving comprehensive health and medical services delivery system through the implementation in several selected gun districts, to enable the reproduction of the system in other regions" (Medical Insurance Association, 1997:365).

task of electing directors and representative directors. Beginning on June 10, policyholder certificates were prepared and issued, and benefits began to be offered on July 1st. The National Medical Insurance Council printed 42,000 copies of a pamphlet entitled "The Easy Guide to Regional Unit Medical Insurance" and 4,000 posters were distributed in the three regions.

Originally, the second demonstration project was planned for July 1st, 1982 with six target areas, but by September 1982, the target was reduced to three areas. With the exception of Jeongbuk, Gangwon and Gyeongbuk regions where demonstration projects were already underway, regions with relatively high numbers of medical institutions and high income levels were considered as target candidates. Based on research conducted by the Korea Population Health Research Center, the Ministry of Health and Social Affairs selected Ganghwa-gu, Boeun-gun and Mokpo city as the target areas respectively representing the island fisheries model, the agricultural flatlands model, and the small or medium city model. The second demonstration project had a longer schedule than the first, with the period extended to 70 days. The most important challenge of the second demonstration project was to improve upon the problems in the method of assessing insurance premiums, which were exposed during the first demonstration project. The Ministry of Health and Social Affairs dispatched relevant public officials to Japan and decided to directly adopt the "four component method almost identical to the insurance premium assessment method used in Japan's national health insurance system." According to this method, the insurance premium per household was calculating by adding together the basic insurance premium and the basic insurance premium per person, with the earnings-related insurance premium and the assets-related insurance premium (Medical Insurance Society Association, 1997:361-388).

3. Securing Medical Institutions and Building a Collaborative System

To implement compulsory medical insurance beginning on July 1st, 1977, the most urgent priority was to secure medical institutions that would provide the medical services. In order to establish medical insurance as an institution, securing treatment institutions was as crucial as establishing cooperatives. During the period when Korea was colonized by Japan, a limited number of provincial and municipal hospitals were established, but in the following years, especially in the aftermath of the Korean War, the number of medical institutions was severely inadequate. In order to broaden eligibility for medical insurance, which had begun to be implemented in 1977 at the workplaces with 500 or more employees, Korea needed to build a minimal health and medical services delivery system, by extending the scope of medical insurance beyond workplaces, and proceeding to offer regional medical insurance. According to the National Medical Act legislated in 1951, around 500 health clinics had been installed across the country, and health facilities (Health Centers, Public Health Center Branches, Primary Health Care Posts) continued to be reinforced, so that by 1968, 191 Health Centers and 1,354 Public Health Center Branches were installed, almost eliminating

the problem of regions without access to medical care. However, medical facilities and personnel were mostly concentrated in cities, leaving the agriculture and fisheries regions greatly deficient in such resources.

Upon implementing the medical insurance system in 1977, the government responded to this imbalance (reflected in that 80% of medical institutions were located in large cities) by building private hospitals, and supporting the reinforcement of medical equipment in areas with inadequate medical services, such as agricultural/fisheries regions and industrial complexes. The government also sought to modernize medical equipment in national and public hospitals, as part of its policy to create the infrastructure for instituting a nationwide medical insurance system. The government passed a resolution at the Economic Ministerial Council in March 1978 to establish, and invest in hospitals at industrial complexes and underserviced vulnerable regions, and also passed a resolution at the Economic Ministerial Council in December 1980 to implement an investment and loan plan for supporting private hospital facilities. As part of this plan, from 1978 to 1992, Korea acquired loans from Japan's Overseas Economic Cooperation Fund (OECF), Germany's Kreditanstalt für Wiederaufbau (KFW), and the International Bank for Reconstruction and Development (IBRD) to provide financial support for a total of 239 institutions, including 168 private hospitals (Ministry of Health and Welfare Press Release, July 10th, 2006). The following chart shows the detailed amount of loans that constituted this financial support.

From 1978 to 1984, 6 billion Korean won of funding support was provided to a total of 58 facilities, in order to subsidize the interest margins for the loans acquired, and from 1985 to 1987, a total of 2.8 billion Korean won was used to support a total of 29 hospitals in underserved regions.

After designating the business operators in 1978, the government drew in 36.6 billion won in loans from Japan's Overseas Economic Cooperation Fund in 1979 to establish 67 hospitals, and obtained 42.5 million marks in loans from West Germany through Kreditanstalt fur Wiederaufbau (KFW) to construct hospitals in industrial complexes and districts with insufficient medical resources. In sum, the government had invested 100 million marks through loans (1978. 07. 10. Maeil Business Newspaper).

Table 2-3 | Statistics on Support through Loan Funding (1978-1992)

Loan Provider		Date of Implementation	Interest Rate	Terms of repayment	Completion date for repayment	Total amount	Supported institutions
OECF	KO-12	1978	3.5%	7 year grace period13 year repayment	1998	30.7 billion yen	153 institutions
	KO-15	1980	4%	7 year grace period18 year repayment	2005		
	KO-17	1981	4%		2006		
	KO-35	1985	5%		2010		
IBRD	3330-KO	1991	Variable	5 year grace period10 year repayment	2006	76.98 million dollars	83 institutions
	3516-KO	1992	Variable		2007		
KFW		1982	2%	10 year grace period20 year repayment	2012	12.78 million Euros	3 institutions

Note: The variable interest rate charged by the IBRD ranged between 4~7% . KO-15 and 3516-KO supported only national or public institutions

Source: Ministry of Health and Welfare, Ministry of Health and Welfare Press Release Data (2006.7.10).

Next, for medical institutions, the contracts of designation for the treatment providing institutions were delayed more than initially anticipated, and the Ministry of Health and Social Affairs and the Medical Insurance Council therefore collaborated with key representatives of the medical services sector to request each medical institution to conclude designation contracts. As a result, by the late of December 1977, an average of 50 designated medical institutions was secured for each cooperative, launching the system without any great difficulties for policyholders to have access to medical insurance. However, at the time, 14% of medical institutions ranking in the hospitals class and 31% of those ranking in the clinic class did not conclude a contract.

Meanwhile, in determining the medical insurance fees, the medical services sector expressed active interest in the fee payment method, the level of fees, and the method and procedures of participation for the medical industry. In response, the government ensured the medical sector's participation in the policymaking process of preparing the policy proposal regarding specific implementation of the medical insurance program, and undertook the work of determining the level of insurance fees in joint collaboration with the medical

sector. On October 15th, 1976, the Ministry of Health and Social Affairs hosted the first meeting of the Ministry of Health and Social Affairs, the Korean Medical Association and the Korea Hospitals Association, and thereafter the three organizations gathered frequently to conduct the preparations for implementing medical insurance. The task of determining fees was first reviewed by the medical administration office of the Ministry of Health and Social Affairs in February 1976. The Korean Medical Association organized the "Special Committee for the Determination of Medical Fees" and investigated the current statistics on fees in regional medical institutions in March 1976. On July 5th, the committee submitted the "Research Report on Customary Fees to Determine the Criteria for Medical Fees." At the time, the Medical Association presented proposals including a linkage system which would link fee levels with market prices, a scaling system that would differentiated according to the facilities used for in-patients, a system of differentiation according to the physician and region, distinctions between first medical exams and follow-up exams, tax deductions, etc.

Thereafter, the government organized the "Treatment Fee Legislation Mediation Committee" to determine the medical fees, and lead the continued discussions of fees between specialists from various fields. However, when significant progress failed to be made by the Medical Administration Office (which at the time had primary authority over medical fees), Prime Minister Hyeon-Hwak Sin ordered the statistical research department of the Welfare Pension Office to oversee the medical insurance system, and to legislate the criteria for medical fees as they are applicable only to medical insurance patients. The Statistical Research Department reviewed the domestic research materials data that had been collected, and concluded that it would be reasonable to tour Japan, in order to learn about the management and operation methods used there. Accordingly, a medical insurance inspection team organized jointly between the medical sector and the Ministry of Health and Social Affairs set out to tour Japan in November 1976, and submitted a report entitled "The Medical Insur ance Fees and the Insurance System in Japan" on December 16th, 1976. This report would hold decisive influence on the legislation concerning the criteria for medical insurance fee payments and operational methods.[5] The Medical Association, in the course of undertaking the task of determining the medical insurance fees in collaboration with the Ministry of Health and Social Affairs, also argued that the medical insurance fees should be charged according to a fee-for-service method, while maintaining a customary fee level. The fee-for-service system was about the only method available that would sustain the medical security system without a great break from the fee system that was customary at the time. Moreover, the fee-for-service system administered in Japan had been adjusted

5 This report addressed several topics in the following sequence: the method of determining medical insurance fees and the current criteria, the overall conditions of the medical insurance system in Japan and the current conditions in the operation of cooperatives, and the payment fund system. This report on the findings of the inspection tour recommended that Korea should use the principles and criteria for determining points used by Japan as reference when determining the medical compensation point units for use in Korea, but cautioned that the categories should not be sub-divided too specifically. The report also proposed that Korea should install review committees for each specialized field to review the points-per-service.

to the satisfaction of the medical services industry. In the process of implementing medical insurance, the Ministry of Health and Social Affairs had from an early stage promised the Medical Association to consult the opinions of the medical establishment and select measures that it would favor. The fee-for-service system, therefore, was adopted by the Korean government as the method for determining fees, as encouraged by the medical services industry.

However, in the process of establishing the collective fees, the government, which had been overly responsive the medical services industry, set the fee at a lower level than customary fees. As a result, the government instituted a system of differentiating fees by region, a method that the medical industry had opposed (Medical Insurance Society Association, 1997: 100-104). The Medical Association was upset that fees were set much lower than customary levels, and that the regionally-differentiated fees. It has been claimed by some that the medical industry did not actively oppose the policy because the scope of eligibility and the range of benefits were limited, which would allow the industry to be compensated based on its own profitability, i.e., through uninsured benefits and pharmaceutical expenses, from non-insured patients and the fee-for-service system (Seong-Yoon Yoo, 2005). Article 35-1 of the Medical Insurance Act, revised on December 22nd, 1976, provided that "costs for healthcare benefits or childbirth benefits shall be calculated based on the criteria determined by the Minister of Health and Social Affairs, following the deliberation of the Deliberation Committee." Medical fees for insured patients were determined, as stated in the 'medical insurance fee criteria,' publicized by the Ministry of Health and Social Affairs. Thereafter, the percentage of insured patients gradually increased, and revenues of medical institutions grew closer to the break-even point, due to increases in examination participation rates, etc., despite the fact that the absolute amount of revenues also increased (Myeong-Seng Yang, 1999).

4. Governmental Financial Support

In examining the financial support offered by the government in relation to the implementation of medical insurance, we must keep in mind that Korea's medical insurance was based on social insurance, which in principle relies primarily on revenues from the insurance premiums contributed by policyholders. Nonetheless, the insurance system underwent a process of operating with financial support from government. During the early period of medical insurance in Korea, eligibility was limited to employment-based policyholders, a system which was designed to charge both the employers and the policyholders for respectively 50% of the insurance premium, enabling the system to operate without governmental support.

When self-employed medical insurance was introduced between 1988 and 1989, however, policyholders raised complaints about the 50% support for insurance premiums received by employment-based policyholders. Moreover, the difficulty of identifying incomes of self-

employed policyholders, and the impossibility of collecting premiums through a withholding system, created an environment in which the insurance premium burden on the low-income class was concentrated on the agriculture and fisheries industries. This imbalance would inevitably become debilitating if the system were to strain itself just to be financially self-sufficient, and such problematic outcomes would risk the implementation of nationwide medical insurance altogether. In consideration, negotiations were conducted between the interested parties and government (the administration of President Tae-Woo Roh), from which it was determined that governmental subsidies would be provided, without stipulating the size of the subsidy in the related law provisions. The budget would be set by authorities based on the total size of funding, calculated from the estimate of the insurance benefits costs for the current year, and the amount of expenditures for management and operations. 50% of insurance benefits costs and the management and operations expenses would then be subsidized by funds secured from the general accounting budget. The specific amount of the governmental subsidy and the changes that were made to the governmental subsidy will be described in further detail in Chapter 4, under the section on financing.

5. Public Promotional Efforts

In relation to the implementation of medical insurance, public promotional efforts were also launched by the government and cooperatives. In the early years of medical insurance, eligibility was given to employment-based policyholders at workplaces with 500 or more members, a consensus that was reached between management and labor, and financial support had been sufficient since the employer contributed 50% of the insurance premiums. These factors allowed the system to operate without any great problems, and strong promotional campaigns from the government were therefore unnecessary. However, self-employed medical insurance, servicing people in agricultural and fisheries communities, required citizens to understand the unique features of social insurance, increasing the importance of public promotion.

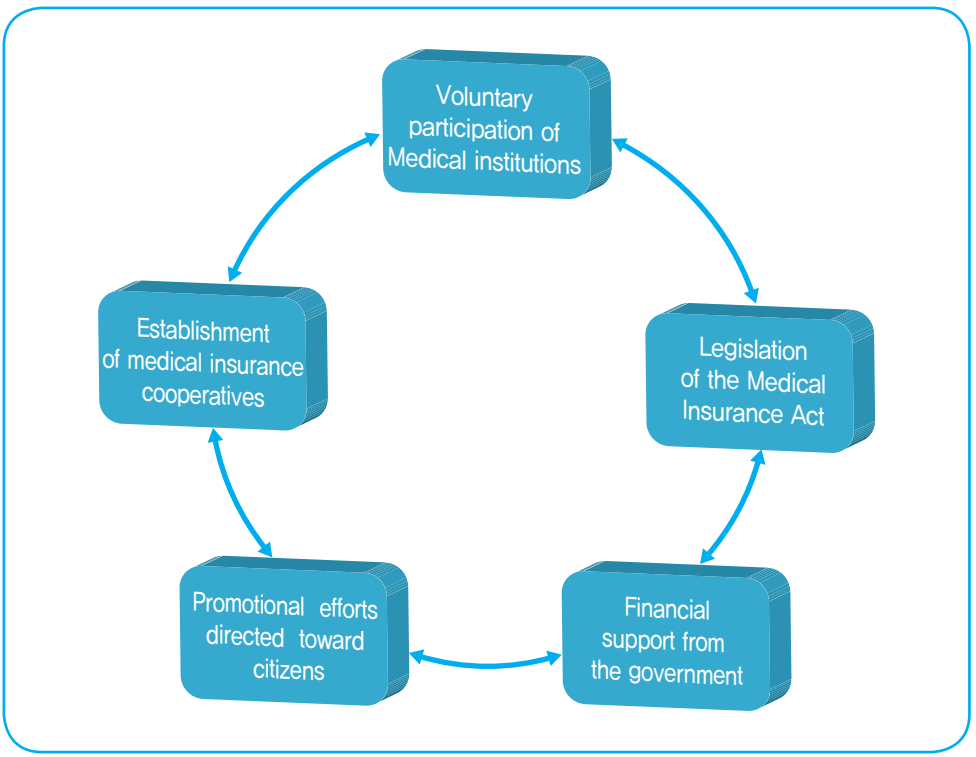
Publicity regarding medical insurance unfolded as a prelude to the national medical insurance, scheduled to be implemented in 1988. At the time the demonstration project was launched in 1981, each demonstration cooperative promoted medical insurance during a number of occasions, including neighborhood meetings, training sessions for members of the reserve forces, and civic defense education sessions. In June 1981, the Medical Insurance Society Association engaged in publicity work by funding posters, handbills and mottos, etc. and in 1982, the Association intensified its efforts by producing and distributing promotional slides, as well as promotional films. The promotional movie was filmed in May 1982 in Duchon-myeon, Hongcheong-gun, being released in July (16mm, 20-minute film-Our Healthy Village (Directed by Yong-Su Yoon, Featuring Il-Woon Lee, Gi-Seon Gwon, Jeong-Hoon Choe, Geon-Il Jang). The completed promotional film entitled "Our Healthy Village" was also produced into 402 video copies, with three copies being distributed to each gun district, starting in late October. 24,952 broadcasting tapes were also made, and one copy was distributed to each li and dong district unit.

At the governmental level, in August 1982, the Ministry of Health and Social Affairs and the Medical Insurance Society Association jointly organized and began operating a "Central Promotions Team" to administer promotional campaigns to strengthen publicity. Their efforts were intended to emphasize that the projects implemented in regional units were part of an official governmental program, as opposed to private insurance or local projects. Also, the Ministry of Health and Social Affairs and the Association organized the promotions team because they wanted to be directly involved in the progress of the project on the site. Along with these efforts, from 1984, writing contests for elementary, middle and high school students, speech contests, and mobile educational programs were hosted to broaden the base of awareness regarding medical insurance at the level of each regional district.

The promotional campaign was intensified from July 1987 to the end of that year. During this period, new regional cooperatives were established, and public officials, school personnel, and industrial complexes were incorporated as members and the national medical insurance system became unified. This gave rise to the need to produce a new symbol to replace the previous one, and a public contest for symbol and poster designs were hosted through media, such as the daily newspaper Kyunghyang Shinmun, as part of the government's effort to standardize the promotional campaign. Also, in 1986, the Medical Insurance Society Association composed a theme song for medical insurance to further boost publicity among citizens. Later, 165,000 copies of posters were printed and two copies were distributed to each town to enlarge the national promotional campaign for medical insurance, along with a total of 2,936 banners. As the date set for launching the National Health Insurance benefits approached, in the late October 1987, 2.41 million leaflets focusing on topics related to insurance premium assessments, the criteria for determining insurance premiums, and governmental support were published and distributed across the country to resident households at the gun district level. The most effective promotional outlets were cartoons and TV advertisements on medical insurance. In December 1987, a cartoon entitled "Medical Insurance in Our Town" was created and used for the campaign, and TV advertisements ran for one month from December 30th to January 28th of the following year, maximizing its publicity effect by concentrated airing during TV programs with high ratings among residents in agricultural and fisheries communities.

We have hitherto examined the systematic approach used in Korea to implement medical insurance. In summary, we can conclude that the introduction of medical insurance in Korea was an outcome made possible by its legal support system, the establishment of cooperatives to take charge of medical insurance, the voluntary participation of medical institutions, the financial support from the government, and active promotional initiatives directed toward citizens.

Figure 2-1 | The Factors Enabling the Implementation of Medical Insurance



Chapter 3

The Implementation of Nationwide Health Insurance and the Current Status of the Implementation of Key Policies

1. Expansion of Eligibility
2. Changes in the Method of Charging Insurance Premiums
3. Expansion of Insurance Benefits
4. Integration of the Organizational and Financial Structure

The Implementation of Nationwide Health Insurance and the Current Status of Key Policy Implementations

1. Expansion of Eligibility

Until nationwide health insurance was implemented for all of its citizens in 1989, Korea's medical insurance system evolved through several revisions of legislation, which incrementally expanded the scope of insurance eligibility. The process by which the eligibility for medical insurance broadened in scope can be summarized as the process of shifting from voluntary entry to compulsory entry, and the process of expanding eligibility from employees of large-scale corporations, public officials, military personnel and school faculty (and personnel who comprised a special category of workers forming the infrastructure of the nation's administration) to the sequential inclusion of employees of small- or medium-sized companies, workers in agriculture and fisheries industries and the urban self-employed, ultimately achieving coverage for all of the country's citizens. The historical timeline of the sequence of legal amendments are presented in the table below.

Table 3-1 | The Sequence of Changes in Medical Insurance Eligibility

Legislation of the Medical Insurance Act (1963)		
	System for Employees	System for Self-Employed Persons
1963	Legal basis for voluntary entry at workplaces with 300 or more members	Legal basis for voluntary entry of self-employed persons
1970	Default entry at workplaces with 500 or more members	
1977 1979	Default entry of Public officials and private school personnel Default entry at workplaces with 300 or more members	Implementation of the 1st demonstration project for regional medical insurance (Hongcheon, Okgu, Gunwi) Establishment of medical insurance cooperatives based on type of occupation
1981	Default entry at workplaces with 100 or more members	Implementation of the 2nd demonstration project for regional medical insurance (Ganghwa, Boeun, Mokpo)
1982	Default entry at workplaces with 16 or more members	
1988		Default entry of self-employed persons in agriculture and fisheries regions
1989	Default entry at workplaces with 5 or more members	Default entry of self-employed persons in urban regions

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

As already examined in Chapter 1, the Medical Insurance Act was legislated in December 1963, scheduled to be implemented in June 1964. This system targeted workers at workplaces with 300 or more employees and members of agricultural and fisheries occupations, providing for voluntary entry rather than compulsory entry. It was in the 1970s that compulsory entry, the key operational principle of social insurance, first became implemented. On August 7th, 1970, the Medical Insurance Act was revised for the first time to change the terms of eligibility from voluntary entry to compulsory entry, but the individuals targeted were limited to employees, military personnel, and public officials. However, due to the insufficient preparation of legal procedures and the difficulty of securing financing, the compulsory entry stipulation failed to be applied in actuality and was deferred, eventually losing effectiveness (Ok-Ryun Moon et al., 2006: 60).

1.1 Eligibility for Employment-based Medical Insurance

On December 22nd, 1976, the National Assembly enacted a complete revision of the Medical Insurance Act, categorizing the insured to apply differentiated requirements regarding compulsory policy entry to each category. Type 1 consisted of individuals with default applicability and Type 2 were individuals with voluntary applicability. Ordinary employees at workplaces were categorized as Type 1, while the remaining others were Type 2. Members of Type 2 were again categorized into those eligible for regional medical insurance offered to local residents and those eligible for employment-based medical insurance targeting self-employed people in specialized occupations. Moreover, in the case of the ordinary employees of workplaces categorized as Type 1 policyholders, it was decided that the compulsory entry requirement would be applied incrementally beginning with workplaces of a certain size, determined by taking into consideration the ability to pay insurance premiums, and the capacity for management and operation. As a result, beginning on July 1st, 1977, 486 cooperatives were established at 19 workplaces with 500 or more employees and work sites within industrial complexes to apply the compulsory insurance policy for the workers.

Meanwhile, it was decided that public officials, military personnel and school personnel at private institutions were separately categorized, and subject to a separately legislated Medical Insurance Act. In the second revision of the Medical Insurance Act in 1976, public officials, military personnel and school personnel at private institutions, etc. were excluded from medical insurance. This measure was taken to enable the individuals of this category to receive medical insurance benefits based on the accident compensation and the short-term benefits offered through the Pension Act. However, the policy objectives of the pension system placed emphasis on long-term benefits of income security, and therefore conflicted in some aspects with the objective of the short-term benefits pursued by medical insurance giving rise to concerns regarding difficulties in financial planning. Accordingly, on December 31th, 1977, the government enacted a separate Medical Insurance Act for individuals of this category, namely the public officials, military personnel and school personnel at private institutions, and following a preparatory period for system operations, insurance benefits began to be offered to 2,665,885 individuals beginning in January 1979 (669,569 insured persons and 2,056,319 dependents). From January 1980, insurance eligibility was extended to include 380,000 people, including military family members, employees of private school management institutions and their dependent family members, and in July 1981, the medical insurance further expanded to apply to pension recipients based on the Public Officials Pension Act and the Private School Employee Pension Act, and this coverage was also offered to military retiree pension recipients in October of the same year. Thereafter, the system underwent a process of incremental expansion to encompass a greater number of insured and their dependents. In December 1998, benefits were being received by a total of 4.954 million citizens, consisting of 1.418 million insured and 3.536 million dependents (Ok-Ryun Moon et al., 2006: 64-67).

In 1981, revisions were made to authorize plans implementing demonstration projects on an extended scope, targeting not only at companies, but also agricultural or fisheries communities. Parentss on the husband's side were included as relations eligible to register as dependents, further expanding the coverage of the system. Meanwhile, foreigners permanently residing in Korea and foreigners employed in Korean workplaces were also designated to receive medical insurance, if so desired. In 1984, the parents of the wife were included as eligible dependents, and in 1987 the status was extended to spouses of lineal descendants and siblings.

Thereafter, medical insurance was applied by default to a greater number of workplaces, finally encompassing even workplaces with one or more members. The insurance system extended to include workplaces with 300 or more workers in July 1979, workplaces with 100 or more workers in January 1981, workplaces with 16 or more workers in January 1983, and workplaces with five or more workers in 1988. In 2000, at the time of the fourth revisions to the National Health Insurance Act, employees at workplaces with five or less workers who had previously been incorporated as self-employed insurance policyholders were reorganized as employment-based policyholders, with the new policy entering into effect in July 2001. This ensured that employees in all workplaces with one or more members were able to receive health insurance benefits. This measure was taken to improve fairness in insurance premium contributions, since these employees, despite also being income-earning workers, had previously been categorized as self-employed insurance policyholders and charged with the entire amount of insurance premiums.

1.2 Eligibility for Self-employed Medical Insurance

The medical insurance system instituted at the beginning of July 1977, based on the principles of social insurance, came to encompass 27.9% of the national population by late 1980. However, among the residents of agricultural and fisheries communities and self-employed people in urban areas who were excluded from eligibility, the number of benefits recipients amounted to only 0.2% of the national population, before complete revisions were made to the medical insurance system. These groups were charged with general fees that were far more expensive than medical insurance fees, and were forced to pay for the entirety of their medical costs, making medical costs a strain on their household budgets. These groups were also placed in disadvantageous conditions that often prevented them from freely using the services of hospitals and clinics available. The lack of social equity between those who eligible for insurance and those who were excluded exacerbated social tensions. For these reasons, the issue of extending medical insurance to these marginalized groups emerged as an urgent policy goal. The National Assembly enacted the fourth revision to the Medical Insurance Act, authorizing the implementation of self-employed medical insurance demonstration projects. Accordingly, beginning in July 1981, the first demonstration project was launched in three regions, including Hongcheon-gun of Gangwon-do Province, Okgu-gun of Jeollabuk-do Province and Gunwi-gun of Gyeongsangbuk-do Province. A year later

in July 1982, Ganghwa-gu in Gyeonggi-do Province, Boeun-gun in Chungcheongbuk-do Province, and Mokpo City in Jeollanam-do Province were added as targets of the expanded second demonstration project (Ok-Ryun Moon et al., 2006:67-68). Later, the revisions to the Medical Insurance Act made in 1987 made it possible to implement medical insurance for agricultural and fisheries regions beginning on January 1st, 1988, and for the self-employed in urban areas beginning in July 1989. This allowed Korea to finally achieve its goal of offering nationwide medical insurance.

2. Changes in the Method of Assessing Insurance Premiums

Prior to the implementation of health insurance, employment-based medical insurance (hereafter referred to as EMI) and regional medical insurance had markedly different ways of charging premiums. The assessment system for EMI was basically an earnings-related method, where a designated value was multiplied to the income to calculate the insurance premium. The actual income was converted to a standardized income through the income standardization method, so that the standardized monthly wage[6] amount established by the insurer was multiplied with insurance premium rates that differed with each cooperative, and the employer and the employee respectively contributing 50% of this amount.

While EMI thus applied a unified system scaled by income level, the regional medical insurance used a method of calculating the premium not only based on income, but also based on a combination of various other assessment items for determining the standard of living, namely items such as assets, the number of household members, car ownership, etc. This approach was adopted due to inadequate information available regarding income, or the absence of accurate data on income amounts. This lack of information would have rendered the practice of assessing the insurance premium charges based only on income inequitable. First, the anticipated amount of expenditures for insurance benefits costs was estimated for each cooperative, and the remaining amount after deducting the amount of governmental subsidy became the total amount of insurance premiums to be charged. Once the total for premium charges was determined, the assessment of insurance premiums was made by broadly distinguishing between the basic insurance premium and the insurance premium, as scaled by ability. The basic insurance premium was a fixed amount per policyholder and per household, agreed upon by the cooperative's articles of association, while the insurance premium scaled by ability was charged by categorization into earnings-related insurance premiums and assets-related insurance premiums. Each item was classifiable into 30 tiers and a tier was assigned when assessing the premium. Among the itemized assets, cars

6 The standardized monthly wage amount was classified into 30 tiers (minimum 22,500 won, maximum 389,000 won) in the early years of the system's implementation, but the classification expanded to 42 tiers in 1981, and then adjusted again to 53 tiers in 1983 (minimum 75,000 won, maximum 1,900,000 won). For each tier, the median amount was set as the standardized monthly wage amount, and in cases where the standardized monthly wage amount was 1.9 million won or more, the amount rounded off to the nearest 10,000 won unit was determined as the amount (Geun-Sik Oh, 2001: 44).

were categorized as "miscellaneous assets" and classified into 5 tiers, based on the car's displacement when assessing the insurance premium (Geun-Sik Oh, 2001: 46-7).

One of the core objectives of medical insurance integration was to ensure equity in the assessment of insurance premiums. In actuality, one of the most acute causes behind the tensions surrounding the integration of medical insurance was the problem of inequity in insurance premium contributions. Under the cooperatives, insurance premiums were charged to each household and each member of a household, regardless of the subject's financial ability to pay the insurance premium. And in cases where the level of income and assets were identical, the insurance premium charges differed depending on the regional cooperative to which one belonged. Moreover, in cases where the income level was identical, the insurance premiums charged to agricultural workers were found to be excessive compared to the charges made to employees at traditional workplaces. This problem also existed not only among the different employment-based cooperatives, but also within a single employment-based cooperative.

The actual insurance premium rates applied to workers with low income was found to be higher than those applied to workers with high income. This was because the amount of income considered to be assessable for insurance premium charges was larger in the case of lower income earning workers, compared to that of workers earning higher incomes.

During the process of integrating medical insurance after October 1998, Korea was able to improve on its fairness in insurance premium charges to a certain degree. In October 1998, the financial integration of the regional cooperatives resulted in a nationally unified assessment system that eliminated the potential for unfairness between self-employed policyholders. Next, the financial integration of employment-based cooperatives in July 2000, and the financial integration of EMI and the Medical Insurance for Public Officials and Private School Personnel in January 2001, ensured equity among wage workers. However, even after the launch of a health insurance system completely integrated in both administrative and financial operations, the criteria for assessing insurance premiums were not integrated and remained in a binary structure, causing problems of inequity between premiums between employment-based policyholders and self-employed policyholders (Byeong-Ho Choe, 2003: 6). For employment-based policyholders, information on earned income was almost entirely transparent, but the incomes of self-employed policyholders remain difficult to determine properly. Hence, Korea continues to develop a separate assessment system to determine the actual abilities of individual self-employed insurance policyholders to pay insurance premiums.

2.1 Method of Determining Insurance Premiums for Employment-based Policyholders

Currently, the insurance premiums of employment-based policyholders are determined through an earnings-related fixed rate system, scaled according to an individual's financial

ability. Insurance premiums of employment-based policyholders are calculated according to the following formula, where the insurance premium is determined by multiplying the current year's monthly wages of the policyholder with the insurance premium rate.

Employment-based health insurance premium =
[Amount of monthly wages × (1/2 of the insurance premium rate × 2)] × 2

The principles for assessing insurance premiums for employment-based policyholders are as follows. Insurance premiums are charged from the month following the date on which the policyholder obtained eligibility, and lasts up to the month that includes the day immediately preceding the day on which the policyholder loses eligibility. However, in cases where the policy eligibility is obtained on the first day of a month, the premium is charged from that date on. Therefore, insurance premiums for employment-based policyholders (including foreigners) are charged based on the monthly wage amounts, calculated for each year, and the total amount of wages for the current year, which is verified the following year, is used to conduct the calculations again for settlement.

Monthly wages refer to the monthly average wage amount received during the current year in the same workplace, calculated by dividing the total amount of wages received during the period of employment by the number of months in that period. Since 2011, the previous assessment tiers were revoked, and the calculation has been made based on the wages received by the employment-based policyholders, but upper and lower limits can be set on the monthly wage amount, according to the criteria set by Presidential Decree. Currently, in cases where the monthly wage amount of the policyholder is less than 280,000 won, 280,000 won can be set as the lowest limit, while in cases where the monthly wage amount of the policyholder exceeds 65.79 million won, 65.79 million won is set as the ceiling.

As explained above, the present insurance premium rate is set at a single rate after deliberation by the Health Security Policy Deliberation Committee. However, prior to the integration of health insurance, insurance premium rates were allowed to be determined independently by the articles of associations of the cooperative, within certain legally stipulated limits. In June 1998, prior to the first integration, the employment-based cooperatives had applied insurance premium rates, ranging from 3.0% at the lowest to 4.4% at the highest, and the national average was 3.21%. The following chart shows annual changes in single insurance premium rates following the integration of health insurance.

Table 3-2 | Annual Changes in the Insurance Premium Rate for Employment-based Policyholders

Period of coverage	Insurance premium rate	Period of coverage	Insurance premium rate
2002.3~2002.12	3.63%	2007.1~2007.12	4.77%
2003.1~2003.12	3.94%	2008.1~2009.12	5.08%
2004.1~2004.12	4.21%	2010.1~2010.12	5.33%
2005.1~2005.12	4.31%	2011.1~Present	5.64%
2006.1~2006.12	4.48%		

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

Comparing insurance premium contribution rates by type among employment-based policyholders, we see that in companies the employer and employee each contribute 50%, while in the case of public officials and military personnel, the government is the employer and contributes 50%, while the employee contributes 50%. Among school personnel, the employer pays 30%, the government 20% and the employee 50%. Overall, the structure of the system requires that the policyholders contribute 50% of total insurance premiums.

Table 3-3 | The Percentage of Charges Allocated to Each Party According to the Type of the Employment-based Policyholder

Category	Total	Policyholders	Employers	Government
Employees	100%	50%	50%	-
Public officials	100%	50%	-	50%
School personnel	100%	50%	30%	20%
Military personnel	100%	50%	-	50%

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

2.2 Method of Assessing the Insurance Premium for Self-employed Policyholders

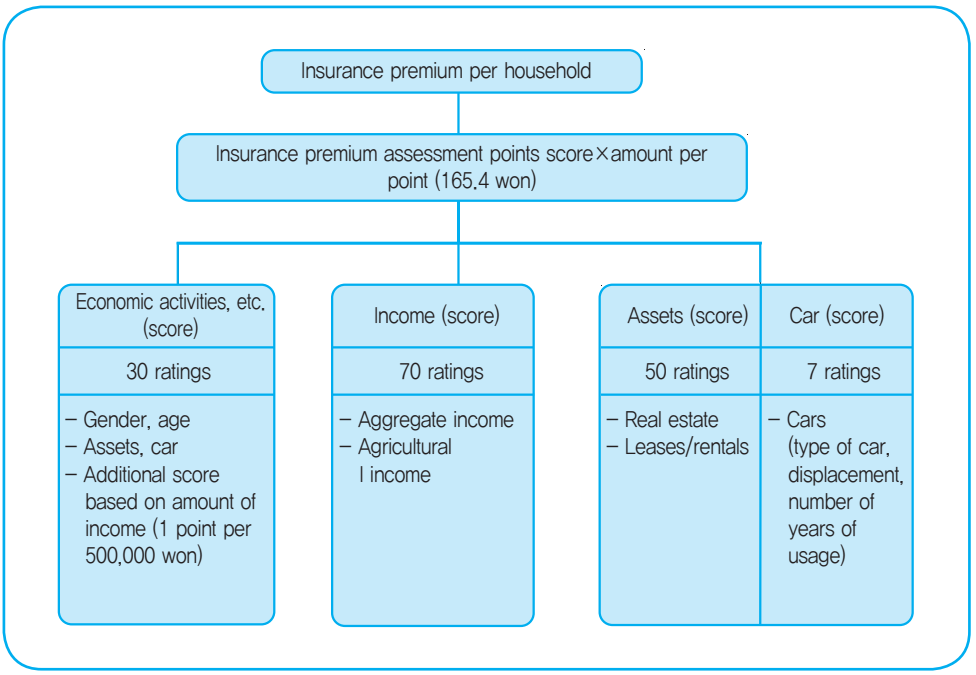
The assessment of insurance premiums charged to self-employed policyholders is determined by taking the "insurance premium assessment score points," which reflect the policyholder's income, assets (including leases, monthly rentals, and cars), standard of living, and rate of participation in economic activities. These score points are then multiplied with the amounts charged per point. Deduction rates and other factors are then applied to calculate the final insurance premium to be charged to the household unit. In other words,

all members of the household to which the policyholder belongs have joint responsibility in paying the premium. However, underage people, as defined according to the criteria stipulated in a Presidential Decree, are exempted from the obligation to pay.

The factors that are used for assessment are differentiated based on whether the annual taxable income is above or below 5 million won. In cases where the annual income exceeds 5 million won, taxable income and the assets are assessed, but in cases where the income is 5 million won or less, the premium is calculated after summing assessable factors, including assets, standard of living (based on an evaluation of assets such as cars, etc.), as well as the rate of participation in economic activities.

First, the income score is classified by the "Score Scaled by Income Level (70 ratings)" and the "Score Scaled by Standard of Living and Rate of Participation in Economic Activities (30 ratings)," while the score for assets is classified according to "Score Scaled by Assets Level (50 ratings)" and the "Score Scaled by Class of Cars (7 ratings)." More specifically, the policyholders who are charged according to the "Score Scaled by Standard of Living and Rate of Participation in Economic Activities" are those in households with no income, or with an annual income of less than 5 million won, and the score per rating as determined by the enforcement ordinance is applied to these policyholders. Policyholders who are assessed according to the "Score Rating by Income Level (70 ratings)" are those with an annual amount of income that exceeds 5 million won when the annual income is calculated by applying the assessment rate, determined by the rules of association of the Corporation concerning aggregate income, pension-based income, etc. The score per rating, determined according to the enforcement ordinance, is applied for these policyholders. Policyholders who are assessed by the "Score Scaled by Assets Level (50 ratings)" belong to households that own assessable property such as houses, buildings, land, ships or aircrafts, etc., or households that are assessed for security deposits and monthly rents gained from leased or rented property. The score per asset rating, as determined by an enforcement ordinance, is applied in these cases. Policyholders who are assessed by the "Score Rating by Class of Cars (7 ratings)" are households with ownership of cars, as defined by the enforcement ordinance, and the annual amount of tax assessed on the car is adjusted with a deduction rate reflecting the number of years used, and based on the displacement or load capacity, a calculation is made according to car type to assign the "Score Rating by Class of Car."

Figure 3-1 | Method of Assessing the Insurance Premiums of Self-employed Policyholders



Source: National Health Insurance Corporation, Homepage of the National health Insurance Corporation , 2011.

3. Expansion of Insurance Benefits

Insurance benefits can be distinguished into cash benefits and benefits-in-kind according to the form of benefits supplied. They can also be categorized into statutory benefits and facultative benefits, depending on whether the benefits are legally compulsory. The following table shows the types of benefits categorized according to these two types of criteria.

Table 3-4 | Types of Insurance Benefits and Their Recipients

Type	Form of benefits	Legal basis	Beneficiaries
Benefits in health insurance	Benefits in kind	Statutory benefits	policyholders, dependents
Health exams			policyholders, dependents
Medical care costs	Cash benefits		policyholders who made direct purchases based on prescriptions, dependents
Prenatal care costs			policyholders, dependents
Benefits for the appliances of the disabled			policyholders who have registered disabilities, dependents
Funeral allowances		Facultative benefits	policyholders, dependents
Reimbursement in the co-payment ceiling system			policyholders, dependents

Source: Gi-Won Kim, Social Security Legistration Theory, 2006.

3.1 Concepts of Benefits in Kind and Cash Benefits

Benefits in Kind is when medical services costs, are paid to medical providers on behalf of the policyholders by a third party insurer. Cash benefits include treatment benefits and health examinations.

Under the cash benefits method, policyholders who cannot earn income because they have ceased work due to injury, illness, childbirth, etc. are compensated in cash in the form of medical care costs, prenatal care costs, funeral allowances, reimbursement in the co-payment ceiling system, and benefits costs to pay for assistive devices for the disabled. Among these, only funeral costs and co-payment compensations are classified as facultative benefits, and the other items are stipulated to be statutory benefits. Although there are more types of cash benefits compared to the types of benefits-in-kind, when compared in terms of the amount of the insurance benefits and the cost, cash benefits barely amount to 1% of the value of benefits-in-kind, indicating that the majority of insurance benefits are supplied in the form of benefits-in-kind.

3.2 Benefits in Health Insurance

3.2.1 Health Insurance Benefits

The largest proportion of cash benefits are composed of healthcare benefits. These healthcare benefits include examinations, medicines and treatment materials, treatment

services such as medical actions and operations, other forms of treatment, preventive and rehabilitative services, in-patient care, nursing and transportation services supplied by medical providers, injuries and childbirth needs of policyholders and their dependents.

Over the course of time, the time period of coverage for expenses charged to the insurer has continued to expand. In 1989, when the nationwide medical insurance system was first launched, the period of benefits coverage was limited to 180 days per year, but Korea began in 1994 to incrementally extend the annual time limit on treatment benefits to reinforce its medical insurance. From July 1994, the time limit was extended to 210 days for elderly citizens aged 65 or over, and from 1996, the time limit on benefits was eliminated for elderly aged 65 or over, citizens with registered disabilities, and designated persons of national merit with injuries, and patients receiving treatment benefits for tuberculosis. The number of days for benefits coverage also increased for ordinary policyholders, expanding by increments of 30 days to 210 days in 1995, 240 days in 1996, 270 days in 1997, 300 days in 1998, and 330 days in 1999, finally reaching 365 days in 2000. The limit on the number of benefits coverage days was eliminated entirely, beginning in 2001. However, after the implementation of the policy separating dispensary and medical services, health insurance suffered from deteriorating financial conditions, and while the limit to 365 days of benefits coverage per year was reinstated in 2002, it was again eliminated completely in 2006 (Seok-Jo Won, 2008: 286).

Table 3-5 | Changes in the Period of Coverage for Benefits in Health Insurance

Year	Details	Amount of annual insurance benefits not limited by the number of coverage days		
		Age 65 or below	Age 65 or over	Registered disability
1977	Benefits were first offered with a limit of up to 180 days for the same disease	-	-	-
1985	180 days for the same disease→ 180 days per year	-	-	-
1988	for the same disease: 180 days per year	300,000 won	300,000 won	300,000 won
1991	for the same disease: 180 days per year	450,000 won	450,000 won	450,000 won
1993	for the same disease: 180 days per year	550,000 won	550,000 won	550,000 won
1994. 7	180 days per year→210 days per year for those aged 65 and over	650,000 won	800,000 won	1.5 million won
1995	Ordinary citizens: 180 days per year→210 days per year	900,000 won	900,000 won	1.6 million won

<table>
<tr><th rowspan="2">Year</th><th rowspan="2">Details</th><th colspan="3">Amount of annual insurance benefits not limited by the number of coverage days</th></tr>
<tr><th>Age 65 or below</th><th>Age 65 or over</th><th>Registered disability</th></tr>
<tr><td>1996.1</td><td>- For those aged 65 or over, those with registered disabilities, people with distinguished national merit: Elimination of the limit on the period of benefits coverage
- Ordinary citizens: 210 days per year→240 days per year</td><td>1.2 million won</td><td colspan="2" rowspan="6">Elimination of the limitations on the number of benefit coverage days</td></tr>
<tr><td>1997</td><td>Ordinary citizens: 240 days per year →270 days per year</td><td rowspan="4">1.5 million won</td></tr>
<tr><td>1998</td><td>Ordinary citizens: 270 days per year →300 days per year</td></tr>
<tr><td>1999</td><td>Ordinary citizens: 300 days per year →330 days per year</td></tr>
<tr><td>2000</td><td>Ordinary citizens: 330 days per year →365 days per year</td></tr>
<tr><td>2000.7</td><td>Elimination of the limitation on the time period for benefits</td><td>-</td></tr>
<tr><td>2002</td><td>Ceiling policy limiting the number of days of treatment benefits per year to 365 days per year
- Prevention of unnecessary treatments or over-medication
- Aims to prevent the practicing of shopping around for medical services or over-abusing examination privileges
- Application to be approved for extension can be submitted to the Corporation in unavoidable cases →Exceptions: 11 types of chronic diseases such as high blood pressure, diabetes, etc.</td><td colspan="3">365-day ceiling policy
(Exceptions for chronic diseases)</td></tr>
<tr><td>2006.1</td><td>→Elimination of the 365-day ceiling policy
- With health insurance financial problem , the policy of 365-day ceiling policy was implemented. .
- Eliminated: the number of exceptional cases with high blood pressure, diabetes, etc. are increased .</td><td colspan="3">Elimination of the 365-day ceiling policy</td></tr>
</table>

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

The objective of health insurance is to ensure basic conditions for a dignified life by supplying an appropriate level of insurance benefits to safeguard against social risks, such as personal illness or injury. In light of this purpose, expanding coverage of insurance benefits is one of the key institutional goals. Since the medical insurance was first implemented, Korea has continued to expand coverage by enlarging the range of insurance benefits, but the most notable developments were made after 2000.

Benefits were extended to include previously uninsured services, such as examinations using high-cost equipment based on advanced technology (ultrasound, MRI, CT). For socially vulnerable groups or individuals with high-cost, severe illnesses or rare or incurable diseases (such as people with low-income, elderly citizens, children, disabled persons, pregnant women, et al.), a policy of providing support for treatment costs or offering deductions have been implemented by means of lowering the rate of their co-payment, or changing the level of ceilings on co-payments.

3.2.2 Health Examinations

As part of the health screening program implemented through government leadership, Korea currently offers health screenings for infants and children, general health exams, cancer screenings, and transitional period health exams. In the following, we explain the evolution and contents of health screening programs, which was first implemented in 1980, following the introduction of medical insurance.

The first ever national health screening program in 1980 targeted insured individuals, consisting at the time of public officials, school personnel, and the members of the Medical Insurance Management Corporation. In 1995, health screenings were extended to employment-based medical insurance cooperatives and regional medical insurance cooperatives, so that the national health screening program came to include all citizens, including employment-based policyholders and their dependents, self-employed insurance policyholders and members of households in the region. Eligibility for screenings, and the items covered by the screenings, continued to be expanded thereafter, and a variety of different programs were introduced. In 2007, the Transitional Period Health Screenings and the Infant and Children Health Screenings were introduced, and on March 22th, 2008, Korea legislated and promulgated the Framework Act on Health Examinations, establishing a legal basis for addressing the problems of the national examinations, such as prevention of faulty examinations, and management of exam quality. The previous system of reporting examining institutions was changed to a system of designation, and it was made possible to cancel designations based on evaluations of the examining institutions. In addition, a National Health Examination Committee (consisting of relevant departments, the consumers, the providers, and specialists in relevant fields) was organized and set into operation.

General health exams were the first to be implemented, and they are currently offered to heads of households in selected regions, employment-based policyholders, household members aged 40 or over, as well as to dependents of employees once every two years. In the case of employees in non-office occupations, the exam is provided on an annual basis. Exceptions from the general health exams policies are individuals between age 40 and 66, who instead receive transitional period health exams. Recipients of medical benefits are also excluded from the general health exams, although they do receive the other remaining forms of health exams. The items included in the examinations have also undergone continual changes. As of 2010, the primary examination consists of 22 components, including interviews and posture exams, chest x-ray exams, blood tests, urine tests, and oral exams, and selective exams are offered for eight types of illnesses, including high blood pressure, diabetes, dyslipidemia, tuberculosis, anemia, renal diseases and oral diseases. A secondary health exam provides consultations on exam results, and health education to individuals suspected of high blood pressure or diabetes and those in high-risk groups for cognitive function disorders (among individuals aged between 70 and 74).

To address the five types of cancer most prevalent among Korean citizens (stomach cancer, breast cancer, colorectal cancer, liver cancer, cervical cancer), an early exam system has been designed, categorized by age (age 30, age 40, age 50) and gender, and has been implemented since 2004. Men and women aged 40 or over are eligible to receive exams for stomach cancer and liver cancer, and men and women aged 50 or over are offered colorectal cancer exams. Women aged 40 (as a dependent) or over and women aged 30 (as a household member) or over are eligible to receive breast cancer exams and cervical cancer exams every two years.

Meanwhile, for the Transitional Period Health Exams that have been implemented since 2007 for those aged between 40 and 66, the exam items, which had previously been separated into primary and secondary exams in the general health exams, have been integrated since 2008 into a primary health exam, with unnecessary items eliminated. Meanwhile, to reflect structural changes in the composition of diseases, a guideline for customized health exams was created to offer superior preventive effects targeting specific groups, categorized by gender and age, and the addition of examination items with high levels of demand. Accordingly, exams for hyperlipemia, waist circumference, and psychiatric conditions were added, and for individuals aged 66, bone density exams and senior citizen health exams were included. Also, all examinees were given secondary physician consultations to help identify health risk factors, and to discuss ways to improve daily habits (Ministry of Health, Welfare and Family Affairs, 2009: 644).

The infants and children health exams that were launched in 2007 currently targets infants and children aged less than 6, and offers interviews and check-ups, development evaluations, consultations, oral exams and parental training on the health of infants and children (on topics including safety accidents, nutrition, sleep, etc.). These exams are organized according to developmental characteristics at specific time periods, scheduled at ages of 4 months, 9 months, 18 months, 30 months, and 5 years.

Table 3-6 | Health Exam Items for Infants and Children by Time Period

Exam Item		Exam Time Period				
		4 months	9 months	18 months	30 months	5 years
Interview&check-up		○	○	○	○	○
Physical measurements		○	○	○	○	○
Development evaluation and consultations			○	○	○	○
Health education	Prevention of safety accidents	○	○	○	○	○
	Nutrition	○	○	○	○	○
	Sleep	○				
	Oral care		○			
	Preparation for school					○
Oral Exam				○		○

Source: Ministry of Health, Welfare and Family Affairs, 2009.

3.3 Cash Benefits

Since the implementation of the health insurance system, the degree of coverage by insurance benefits has continued to increase, and the burden of co-payments charged to health insurance policyholders has gradually decreased. The co-payment rate of ordinary patients is 30% of the treatment fee for in-patients, and for out-patient treatments, the rate is 30% at clinics, 40% at hospitals, 50% at tertiary care hospitals, and 30% for pharmaceutical expenses. In addition, in cases where the co-payment for insurance benefits exceeds 1.2 million won within 30 days, a co-payment compensation system is operated to return 50% of the exceeding amount as a reimbursement. However, the period of application for this system was short, and there were no stipulated ceiling limits, so coverage for patients with high-cost and/or severe diseases continued to be poor. This system was later replaced with a supplemented co-payment ceiling system.

The co-payment ceiling system on treatment fees was implemented in July 2004, in order to respond increases in the number of patients with high-cost, severe diseases, and to alleviate the excessive burden of medical fees incurred by these patients, while improving accessibility for medical services. Under this provision, the time period limit is applied to the total treatment cost, which includes not only in-patient treatments but also out-patient treatments and pharmaceutical expenses. In cases where the statutory co-payment exceeds 3 million won within 6 months, the entirety of the exceeded amount is charged to the Corporation, and in cases exceeding 1.5 million won, 50% of the amount is reimbursed.

Beginning in July 2007, the ceiling limit was lowered to 2 million won. From 2009, the ceiling amount was differentiated according to income level to ensure fairness among income classes when charging medical expenses. The ceiling was set at 2 million won for those in the lower 50%, 3 million won for those in the middle 30%, and 4 million for the upper 20%.

The system for supporting socially vulnerable groups through reductions in co-payments or cash subsidies includes the following measures. To meet the needs of an increasingly aging society, the government has expanded its support for the elderly population. From July 2000, the criterion for reduced co-payments was lowered from age 70 to age 65. At clinics, dental clinics, and traditional herbal medicine clinics, the co-payment is 1,500 won when the treatment fee is less than 15,000 won. At pharmacies, the co-payment is 1,200 won when the pharmaceutical expense is 10,000 won or less.

For a total of 77 types of assistive devices designed for disabled citizens, insurance benefits cover up to 80% of purchase prices, within the range of standards value set by governmental criteria. In 2005, assistive devices including electric wheelchairs, electric scooters, and orthopedic shoes, etc. were added for coverage, while standard values for 58 types of items were raised by an average of 36.6% to expand the benefits for assistive devices. However, in response to a number of fraudulent or wrongful claims, measures were taken to prevent financial waste in 2008 by limiting the qualifications of prescribing and examining physicians, and sub-categorizing the prescription criteria for high-priced equipment such as electric wheelchairs and electric scooters.

Meanwhile, various policies and institutions were implemented to support pregnancy and childbirth. Beginning in December 2004, insurance benefits were offered to cover rubella exams and exams for congenital defects. From 2005, the entire amount of the co-payment required for natural childbirth was exempted. From December 2008, an electronic voucher known as the "Gounmam (Beautiful Mom Card)" have been issued to support the expenses of pre-delivery exams, with a value of 400,000 won per person.

As part of the policy to support medical costs for children below the age of six, complete waivers were granted for co-payments of in-patient children, beginning in 2006. However, there were also some changes that partially resulted in increased co-payments. Beginning in June 2007, only 70% was charged for the out-patient treatment of adults, and from January 2008, the co-payment rate for in-patient treatment was increased to 10% (with the exception of the complete waivers granted for newborn children). Beginning in November 2007, health examinations were offered free of charge, and the dental sealant program to prevent cavities among children was launched in December 2009.

Due to the necessity of continual medication and treatment, patients with rare or incurable diseases are imposed with extreme financial burdens. To ease the financial strain on these households, a special assessment system is administered for their partial co-payments. The co-payment rate for out-patient treatment had once been 20%, but since 2009, the rates for both in-patient and out-patient treatment were reduced to 10%.

Also, to alleviate the strain on household budgets arising from overwhelming treatment costs, measures were taken to radically improve the coverage of health insurance. As a result, the statutory co-payment rate for severe diseases (cancer, cerebrovascular diseases, cardiac disorders) entailing high costs was lowered to 10% in September 2005. Particularly strong support was given to cancer patients, by reducing the rate for both in-patient and out-patient treatment to 5% in 2009. In 2006, the co-payment rate of health examinations for specific types of cancer (gastric cancer, breast cancer, colorectal cancer, liver cancer) was lowered to 20%.

The following table presents the key contents of the changes in insurance benefits tracked from the first implementation of the National Health Insurance system in 1989 up to 2009.

Table 3-7 | The Expansion of Insurance Benefits and their Contents

Year	Expanded Insurance Benefits
1987	· Introduction of medical insurance for traditional herbal medicine
1989	· Introduction of medical insurance coverage for pharmacies
1991	· The rate of co-payment applicable to in-patients applied to out-patient treatment for chronic renal failure or hemophilia patients · Discontinuance of the treatment privilege for hemophilia patients
1992	· Increased adjustment to the payment criteria for childbirth expenses (For mothers in first childbirth 54,000 won→57,000 won, Multiparous mothers 50,000→53,000 won) · Insurance benefits coverage for bone-marrow transplantation
1993	· Inclusion of endoscopic procedures on abdominal cavities · The coverage for external application medicine prescriptions extended from four times per day to six times per day · Increased compensation for childbirth costs: 59,800 won (mothers in first childbirth), 55,600 won (multiparous mothers) · Individuals with arrears on their medical insurance premiums are allowed to retrospectively apply insurance benefits coverage if the insurance premium payments are completed within three days of hospitalization
1994	·I mplementation of childbirth benefits for dependents · Military personnel medical insurance benefits implemented(Above sergeant level with long term contract military service) · Increased compensation for childbirth costs: 62,000 won (mothers in first childbirth), 58,000 won(multiparous mothers) · Inclusion of surgery using lasers in benefits coverage
1995	· Extended period for treatment after loss of eligibility three months→six months · Increased compensation for childbirth costs: 66,000 won (first childbirth), 61,000 won (multiparous) · Benefits coverage for micro endoscopic discectomy

Year	Expanded Insurance Benefits
1996	· Increased compensation for childbirth costs: 70,000 won (first childbirth), 65,000 (multiparous) · Elimination of limitation on childbirth cost compensation to mothers with 3 or more children · Benefits coverage for CT · The co-payment rate for out-patients is applied to co-payment for diagnosis costs · Reduction of co-payment for individuals aged 70 or more as a clinic-class policy: 3,200 won→2,100 won
1997	· Benefits coverage for assisting devices for the disabled: canes for the physically disabled, glasses for the visually impaired, hearing aids for the hearing disabled, artificial larynx, etc.
1998	· Expanded benefits for assisting devices used by the disabled: wheelchairs, crutches, canes for the visually impaired, etc.
1999	· Upper and lower supportive aids for the disabled, assisting devices, artificial eyes, etc. · Contact lenses
2000	· Reduction of co-payments for individuals aged 65 or over · Health exams offered to policyholders aged 40 or over and their dependents
2001	· Implementation of a co-payment compensation system
2004	· Institution of a ceiling system on treatment fee co-payments
2005	· MRI insurance coverage · Co-payment exemption for childbirth · Expansion of benefits coverage on assisting devices for the disabled (electric wheelchairs, etc.) · Extension of coverage period for osteoporosis treatment medicines (90 days→180 days) · 483 items including treatment materials and services previously charged 100/100 to the patient are converted to co-payment system · Strengthened coverage for high-cost severe diseases such as cancer (statutory co-payment reduced 20%→10%)
2006	· Exemption of co-payment for in-patients under age 6 · Organ transplant operations converted into benefits coverage (liver, heart, lung, pancreas) · Reduction of the co-payment rate for examinations for specific types of cancer (gastric cancer, breast cancer, colorectal cancer, liver cancer: 50%→20%, exemption for cervical cancer) · Prison inmates (suspension of benefits→recognition of benefits)
2007	· Insurance benefits for in-patient meals (Note the change from 20%→50% from 2008) · Reduction of co-payment for severe diseases (10% regardless of in-patient or out-patient status)

Year	Expanded Insurance Benefits
2008	· Expansion of reductions for out-patient treatment of rare or incurable diseases (19 items) · Expansion of benefits coverage for leukemia bone marrow transplants · Support for treatment fees prior to childbirth (200,000 won)
2009	· Expansion of coverage for in-patient treatment of newborns in intensive care units · Differentiated ceilings on co-payment according to income · Co-payment reduction for rare or incurable diseases (20%→10%) · Co-payment reduction for cancer patients (10%→5%) · Health insurance coverage for dental sealants and traditional medicine physical therapies
2010	· Deduction of co-payment for heart and brain disease (10%→5%) · Deduction of co-payment for tuberculosis (10%) · Deduction of co-payment for severe scalded (5%) · Introduction of MRI benefit coverage (spine, articulation)

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

4. The Integration of Organizations and Finances

4.1 Key Parties of Interest Involved in the Process of Integration

The fact that the medical insurance system, which had been operated through a cooperative-based method since its introduction in 1977, became financially and administratively unified under a single insurer represented by the National Health Insurance Corporation in 2003 demonstrated one of the most representative cases of reform in Korea's medical system, along with the implementation that distinguished between dispensary and medical practices. Debates surrounding the integration of medical insurance unfolded over the course of two decades, entailing complex entanglements of various social forces and their interests. The following chart summarizes the positions and changes in attitudes by the major agents who played a role in the medical insurance integration process, tracked by the periods in which the debates took place.[7]

7 Yeon-Myeong Kim (2000) divided the course of debates on the issue of the integrated unification of medical insurance into four stages. According to Kim, the first debate took place in the period from 1980 to early 1983, and the second debate lasted from 1988 to 1989 during the administration of President Tae-Woo Roh. The third debate took place from 1994 to 1997 during the administration of President Yeong-Sam Kim, and lastly the period of the fourth debate took place from the time the administration of President Dae-Jung Kim came into power up to July 1, 2003, when the National Health Insurance Act was enacted and enforced to implement the integration of management and operation and finances.

Table 3-8 | The Positions of Key Agents Regarding the Integration of Medical Insurance

Key Agents		1st Debate (1980-82)	2nd Debate (1988-89)	3rd Debate (1994-97)	4th Debate (1998-2003)
Government	Blue House	×	×	×	○
	Ministry of Health and Welfare	○	×	×	○
National Assembly	Ruling Party	○	○	○	○
	Opposition Party	○	○	○	×
Business sector	Federation of Korean Industries	×	×	×	×
	Korea Employers Federation	×	×	×	×
Labor	Federation of Korea Trade Unions	○	○	○	×
	Korean Confederation of Trade Unions	-	-	○	○
Agriculture and Fisheries Workers		-	○	○	○
Urban Self-employed		-	○	○	○
Civic Social Organizations		-	○	○	○
Medical Insurance Association		×	×	×	×

Note: Support for integration (○), Indifference (-), Opposition to integration (×)

The dispute regarding integration of medical insurance began with objections made by pro-integration groups to the then-existing cooperative-based operational method. The pro-integration advocates continually drew attention to the problem of inequity in insurance premium charges, which existed because of separation of operations among the cooperatives, the downward standardization of the level of benefits coverage, and administrative inefficiency. They pointed out that in previous cooperative methods, finances were managed by an independent profit system in each individual cooperative, with the funding for each cooperative primarily supplied through the insurance premium of the cooperative's members, and insurance premiums determined independently within a limit set by the Ministry of Welfare. These critics regarded these features as major causes of financial discrepancies among the cooperatives. They argued that due to the differences in income levels among the cooperatives, there arose differences in the level of insurance premium charges, and the differences in the demographic groups also led to gaps in expenditures, which only further exacerbated the financial discrepancies. Meanwhile, some cooperatives offered additional benefits, resulting in differences in the level of benefits coverage,

depending on the financial conditions of the cooperative. The integrated method would help overcome the phenomenon of downward standardization, whereby the level of benefits had declined to correspond to the inferior conditions in the cooperatives, and the new method would also facilitate the policy of expanding insurance coverage. Also, the cooperatives were subdivided into medium and small sizes with distinct administration systems applied in each cooperative, which critics believed to cause higher administrative costs, compared to an integrated organization. It was emphasized that an integrated administrative system would maximize the scope of risk diffusion, and the size of the management organization to improve equity, while assessing insurance premiums would become consistent nationwide, allowing for greater administrative efficiency.

On the other hand, the pro-cooperative arguments of those seeking to maintain the status quo emphasized the advantages of financial structure and autonomous administration, contributing to stable relations between management and labor. By contrast, the integrated method would lead to over-enlargement, which would weaken the solidarity between labor and management and result in bureaucracy and inefficiency. Considering the gaps in income among different regions, and the fact that medical service resources were concentrated in urban areas, integration would sacrifice fairness in terms of contributions and benefits, which would risk a regressive redistribution of income. These advocates also pointed out that the financial burden on the government would increase, which would make conflicts between government and its citizens more likely, and that without accurate information on income, the integration of regional cooperatives and employment-based cooperatives may encourage distrust and antagonism between different groups of citizens.

The first major debate on the issue of medical insurance integration took place from September 1980 to December 1982. In the first debate, the government, represented by the Blue House and the Ministry of Health and Welfare, differed slightly in their views. The Ministry of Health and Welfare, with the main responsibility for insurance, actively led preparations for integration. In response, the National Assembly, including both the ruling and opposition parties, agreed to integration as well. By contrast, the Blue House, led by the President, sided with the Federation of Korean Industries, the Korea Employers' Federation, and the Medical Insurance Association in their opposition to the integration. During this first debate, the scope of the system's application was still narrowly limited to workplaces with 100 or more employees. As a result, most of the parties involved did not have a direct interest at stake, and did not intervene in an organized manner in the debate. Hence the exchanges of discussion were mostly limited to the elite of the country's leadership.

However, by the second major debate, the scope of eligibility for medical insurance had undergone incremental expansions, so that agricultural and fisheries workers and urban self-employed individuals had direct interests involved, resulting in their entry into the debate on integration as major actors. Until the second debate, labor organizations had not yet actively participated in the integration debate. The Federation of Korea Trade Unions had supported integration from the beginning, but maintained a passive attitude, while the

Korean Confederation of Trade Unions had not yet received legal recognition from the government, and therefore could not mobilize into an organized voice in the debate on medical insurance integration. Meanwhile, the Ministry of Health and Welfare, which had led the movement for integration in the first debate, had shifted to the opposite position.

The debates on integration in the 1990s were markedly different from the discussions a decade before. In the 1990s, the political democratization that had begun in earnest in 1987 intensified, manifested through severe conflicts among various social forces. Labor organizations and civic groups, which had not yet emerged in the 1980s, now participated as new agents in the debate, and antagonism among groups with differing positions became acute. Labor unions for regional medical insurance, the Korean Confederation of Trade Unions, civic organizations and health and medical associations supported integration, while EMI labor unions, the Federation of Korea Trade Unions, and the ruling party took the lead in opposition to integration. The divergent interests pursued by the Korean Confederation of Trade Unions and the Federation of Korea Trade Unions, which both represented labor unions interests, were the outcome of organizational interests involved in the pre-existing cooperative–based system of operation. Regional medical insurance unions, led mainly by the self-employed and the EMI labor unions mostly consisting of wage laborers, opposed each other due to their radically differing interests.

During the period of the fourth debate, which followed the foreign currency crisis in 1997, President Dae-Jung Kim's administration and the Welfare Ministry united in support of integration in the medical insurance sector. Meanwhile, the positions of the ruling party and the opposition party, both of which had maintained a supportive view regarding integration up to the third debate, now diverged. During the financial integration process that took place after 1999, the opposition party changed its previous position, citing concerns about the financial collapse of the medical insurance system, and was joined by the Federation of Korea Trade Unions to oppose integration. Their anti-integration movement succeeded in delaying the planned schedule by six months. However, due to the economic crisis and the change in administration, the political influence of this camp declined, while the pro-integration advocates exercised strong political force by forming a broad coalition, including agricultural organizations, labor organizations, civic society and health and medical associations. Hence, the six month delay notwithstanding, the decision to integrate was nonetheless put into effect.

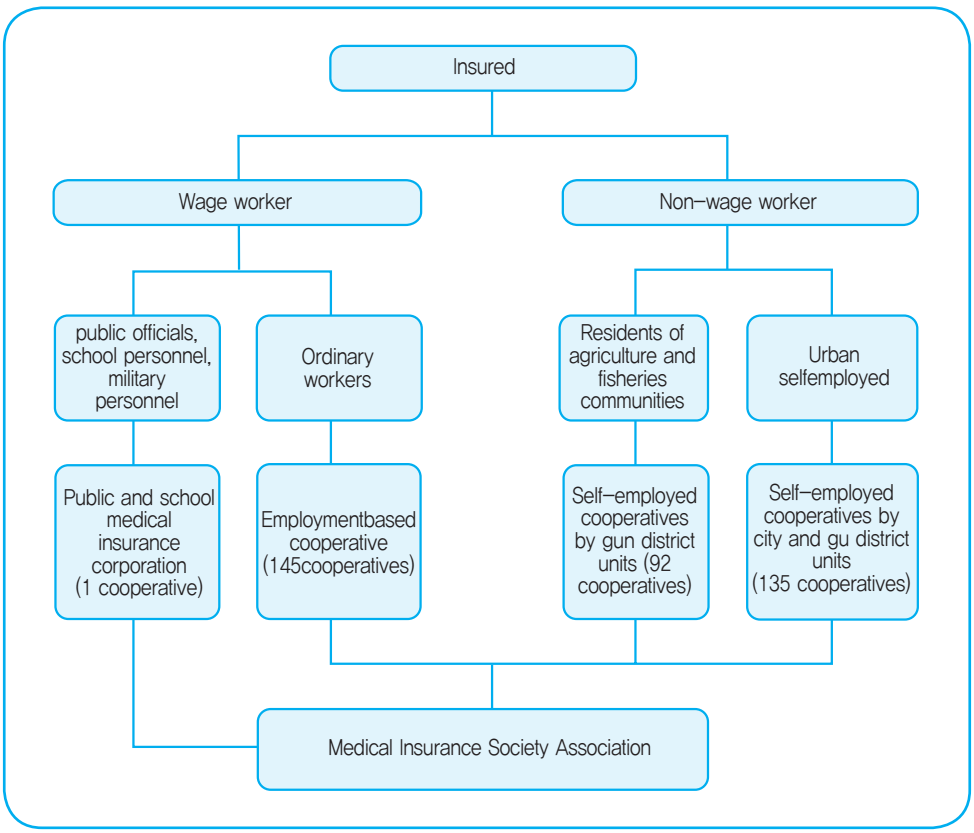
4.2 Organizational Integration

Korea's medical insurance system had been operated through a cooperative approach since its first introduction in 1977. Regarding this approach, Won-Tak Jo (2001) observed that Korea imitated the operation of health insurance cooperatives in Japan when legislating its own medical insurance act, and regarded the cooperative method as a middle ground between the National Health Service (NHS) method and a privatized medical insurance system. Jo also pointed out that Korea considered this approach to be advantageous for

incremental expansions in the future, and for minimizing the financial responsibilities of government. Prior to integrating health insurance, Korea's medical insurance operated by a cooperative method that placed the responsibility for overall management and operations on the medical insurance cooperatives and the medical insurance management corporations that took the form of non-profit, public-interest corporations, while the insured were categorized by occupation type, region and workplace. The following figure illustrates the cooperative-based medical insurance system that existed in 1997, immediately prior to integration.

More specifically, the insured were broadly categorized into wage workers and non-wage workers, and the wage workers were subdivided into: the public and school medical insurance management corporation, which was a category that included public officials, private school personnel, and military personnel. The remaining workers at ordinary workplaces were organized according to the size and location of their workplace, into employment-based medical insurance cooperatives managed by multiple insurers. In the case of employment-based cooperatives, companies with large-sized workplaces formed single cooperatives, while small- or medium-sized companies were combined into units by region, so that multiple businesses formed one joint cooperative. This method of organizing cooperatives created a structure that was highly advantageous for large-sized companies. In joint cooperatives, the cooperative itself exercises right of control over the accumulated funds through the cooperative board members (executive officer), while large corporations were able to operate a large-scale cooperative independently with direct control over funds, allowing the corporation to use the enormous funds collected as insurance premiums at its own disposal, sometimes even using the premiums to finance business operations.

Figure 3-2 | Chart of Management and Operations under the Cooperative-based Medical Insurance System



The public and school medical insurance corporation had 11 branches at the time of its establishment in 1979. But by 1991, it was reorganized with one headquarter office, and 15 branches in various cities and provinces, along with two local stations that managed the insured policyholders and their dependents. At the time of their launching in 1977, there were 494 single employment-based cooperatives, and 19 joint cooperatives, making the number of independent cooperatives overwhelm joint cooperatives. However, after large-scale mergers and closures in 1980 and 1981, the figures were reversed, so that the number of insurers prior to integration consisted of 82 joint cooperatives and 58 independent cooperatives.

On the other hand, non-wage workers were categorized into residents of agriculture or fisheries communities and the self-employed in urban areas. The former were organized by gun district units, while the self-employed were divided into city or gu district units to form regional medical insurance cooperatives. In 1997, there were 92 regional medical insurance cooperatives in agricultural regions and 135 in urban regions, totaling 277 cooperatives.

The Medical Insurance Society Association, established for insures to administer various tasks related to treatment fees such as receipt of invoices for treatment fees, reviews, payment, etc., was first established in 1977 with the name Medical Insurance Society Cooperative Council, changed later into the Medical Insurance Society Association with the incoming membership of the individual cooperatives. Later, with the public and school corporation registering as members, it developed into an associated organization of medical insurers, including public and school cooperatives as well as employment–based and regional medical insurance cooperatives (Geun-Sik Oh, 2001: 38-41).

4.3 Financial Integration

Prior to integration, Korea had adopted the independent profit system for each cooperative, in which each medical insurance cooperative financed itself primarily through the insurance premiums contributed by cooperative members. The main responsibilities of the medical insurance cooperatives consisted of assessing and collecting insurance premiums, processing payment of insurance benefits costs, determining/managing eligible insured and their dependents, and administering preventive programs through training and promotional work, with the exclusion of reviewing treatment fees.

Each cooperative was allowed to determine insurance premiums independently within a certain limited imposed by the Welfare Ministry, and some cooperatives offered additional benefits. Such features were the main cause of financial discrepancies among the cooperatives. For this reason, there were differences in revenues among the individual cooperatives, which led to differences in the insurance premiums charged. The differences in demographic composition also caused differences in the expenditures for insurance benefits, which further exacerbated the financial gaps among the cooperatives. The following table shows the financial discrepancies between employment-based cooperatives and regional cooperatives. In terms of the percentage of reserve funds, it can be seen that employment-based cooperatives were markedly more solvent than regional cooperatives.

Table 3-9 | Trends in the Financial Gap Between Employment-based Cooperatives and Regional Cooperatives

Category		1992	1993	1994	1995	1996	1997
Employ-insured	Cumulative contributions (A)	10,877	12,743	15,576	17,363	19,484	19,494
	Separate contributions (B)	5,301	-	7,012	7,134	6,590	5,532
	Total contributions (A+B)	16,178	-	22,588	24,497	26,074	25,026
	Reserve rate	117.8	119.4	128.7	116.3	103.7	91.0
Self-employed insured	Cumulative contributions	5,492	7,623	9,428	9,424	7,856	8,149
	Reserve rate	48.1	55.8	59.9	46.5	30.9	27.8

Note: Reserve rate = Cumulative contributions / insurance benefits cost for the current year.

Source: Medical Insurance Society Association, Medical Insurance Statistical Yearbook; Cited in Guen-Sik Oh (2001: 68).

As the financial gap between the cooperatives increased, the government sought to reduce the financial disparity between the cooperatives by lending a certain degree of governmental funding support to regional medical insurance cooperatives, and implementing a financial adjustment program for the medical costs of the elderly and high-priced treatment costs. As shown in the table below, governmental funding for regional medical insurance began in 1988, at the time of the launching of medical insurance in agricultural communities, when the government funded 50% of the total finances of the regional medical insurance, on the basis that the state should provide support for wage laborers and their insurance premiums, or the amount of co-payments. Gradually, this percentage declined so that by 1999, government funding was responsible for only 26.4% of the total expenditures of regional medical insurance. With declining support, the regional medical insurance system experienced increasing financial difficulties, and the demand for integration from self-employed cooperatives became louder.

Table 3-10 | Annual Changes in Governmental Funding Support for Regional Medical Insurance

(Unit: 100 million won, %)

Category	1988	1990	1992	1994	1996	1997	1998	1999	2000
Total expenditures	1,733	10,079	13,306	18,164	28,966	33,534	38,163	44,065	48,583
Amount of support	946	3,639	5,924	6,924	8,723	9,954	10,760	11,656	15,527
Percentage of support	54.5	36.1	44.5	38.1	30.1	29.7	28.2	26.4	32.0

Source: Medical Insurance Society Association, Current statistics on settlements by regional medical insurance cooperatives; cited in Geun-Sik Oh (2001: 49).

The process of integrating the management, operations, and finances of Korea's medical insurance began on October 1st, 1998 with the prioritized integration of the medical insurance management corporation, which targeted 227 regional medical insurance cooperatives, public officials, private school personnel and the National Health Insurance Corporation. However, this integration occurred only at the administrative level, and the finances remained separated so that the public and school medical insurance, and the self-employed medical insurance, operated on two different funds. Thereafter on July 1st, 2000 a second integration took place, which combined the National Medical Insurance Management Corporation with the 139 employment-based medical insurance cooperatives to establish the single insurer, the National Health Insurance Corporation, thereby completing unification of management and operations. At the same time, some degree of financial integration was also completed. The public and school medical insurance funds, along with EMI funds, were integrated into a single fund. The regional medical insurance remained separated financially, however, until July 2003, when the regional medical insurance and the EMI merged their finances, finally completing financial integration (Won-Tak Jo, 1999: 227).

Table 3-11 | The Process of the Administrative and Financial Integration of Medical Insurance

<table>
<tr><th colspan="2">Category</th><th>Prior to Oct. 1, 1998</th><th>After Oct. 1, 1998</th><th>After July 1, 2000</th><th>After July 1, 2003</th></tr>
<tr><td rowspan="3">Management</td><td>Self-employed cooperative</td><td>227</td><td rowspan="2">National medical insurance management corporation (1 unit)</td><td colspan="2" rowspan="3">The National Health Insurance Corporation (1 unit)</td></tr>
<tr><td>Public and school corporation</td><td>1</td></tr>
<tr><td>Employment-based cooperative</td><td>142</td><td>142</td></tr>
<tr><td rowspan="3">Finances</td><td>Self-employed cooperative</td><td>227</td><td>1</td><td>1</td><td rowspan="3">Health insurance finances (1)</td></tr>
<tr><td>Public and school</td><td>1</td><td>1</td><td rowspan="2">1</td></tr>
<tr><td>employment-based</td><td>142</td><td>142</td></tr>
</table>

Chapter 4

The Management and Operation System for National Health Insurance

1. The Policy Decision-Making System
2. Assessment and Collection of Insurance Premiums
3. Financing
4. Management of Eligibility
5. Management of Benefits

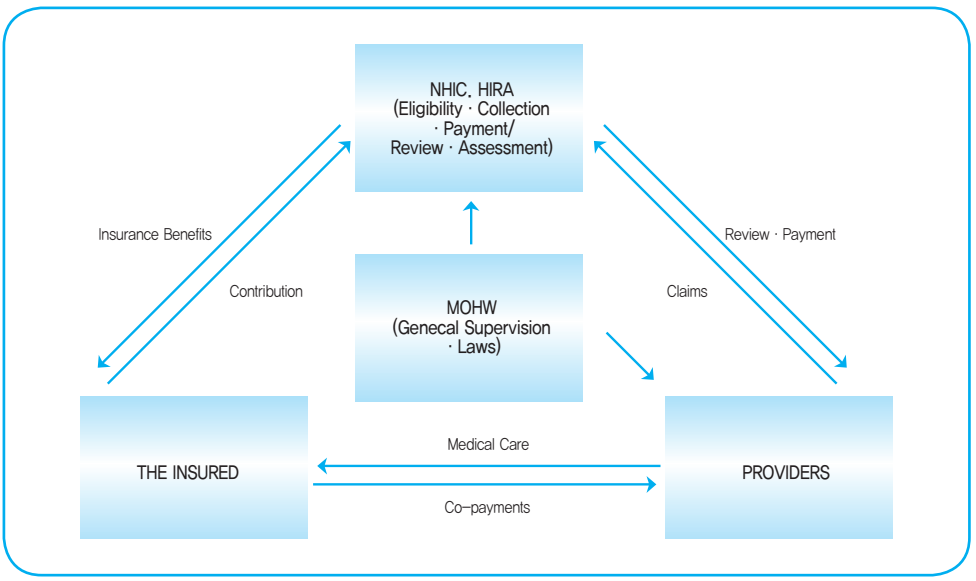
The Management and Operation System of National Health Insurance

1. The Policy Decision-Making System

1.1 Structure of Management and Operation

The management and operational structure of health insurance in Korea can be illustrated in terms of the relations between the interested parties, according to their key responsibilities essential to the operation of the system. Currently, operations of the health insurance system relies on policyholders who may be potential or actual consumers of medical services, healthcare institutions that are medical services providers, the National Health Insurance Corporation (NHIC) serving as the single insurer, the Ministry of Health and Welfare (MOHW) , and the Health Insurance Review&Assessment Service (HIRA), the institution responsible for reviewing and assessing treatment benefits.

Figure 4-1 | The Operational Structure of the Health Insurance System



Source: National Health Insurance Corporation, Internal materials of the National Health Insurance Corporation, 2011.

The Ministry of Health and Welfare is the main governmental body responsible for health and medical affairs and social welfare programs. The Ministry supervises key policies pertaining to the health insurance system, while directing all work operations. The Ministry organizes and operates various pertinent committees under its aegis, which determine insurance premium rates, criteria for assessing insurance premiums, the scope of treatment benefits, etc. The Ministry also approves the budget and regulations for the National Health Insurance Corporation, and the Ministry evaluates new medical technologies, determines the criteria for benefits (methods, procedures, scope, ceilings, etc.) and pharmaceuticals, sets the ceiling on costs for treatment materials, determines the relative values of benefits, and publicizes all information pertaining to benefits.

The National Health Insurance Corporation is currently the sole insurer for the health insurance system, and the agent for operations and management. According to article 13 of the National Health Insurance Act, the Corporation manages the eligibility of policyholders and dependents, assesses and collects insurance premiums, pays and administers post-management of insurance benefits fees, offers health promotion and prevention programs, pursues educational training and promotional efforts regarding health insurance, conducts research and investigation projects, and pursues international collaborations. Work related to benefits, performed by the Corporation, includes decisions regarding pharmaceutical prices (through negotiations with pharmaceutical companies), payment of insurance benefits fees, and the execution of contracts to determine the price per relative value unit (conversion factor).

Another major body is the Health Insurance Review&Assessment Service, which is an organization independent from the National Health Insurance Corporation "for equitably assessing treatment fees charged by the medical institution, securing the suitability of medical services, and evaluating the quality of medical services." According to articles 42 and 56 of the National Health Insurance Act, the Service reviews treatment benefit costs, evaluates the suitability of treatment benefits, develops the criteria for review and assessment, engages in research and international collaborations, confirms eligibility for treatment benefits, and conducts various other works pertaining to benefits to support the functions of the Ministry of Welfare. The Health Insurance Review&Assessment Service performs important functions related to benefits, which include the determination of the relative value scale and amount of reimbursements for pharmaceutical costs, in addition to making decisions regarding the relative value scale and ceiling on treatment material costs and more. The Service also provides the data source for determining the payment method and amount for treatment fees. In addition, the Service is responsible for operating and managing the "Specialized Evaluation Committee on New Medical Technologies," which determine the range of benefits for new medical technologies. When a treatment institution charges the Health Insurance Review&Assessment Service with the fees for benefits, the Health Insurance Review&Assessment Service reviews the claims and reports its findings to the National Health Insurance Corporation, which processes reimbursements after its own review.

1.2 The Decision-Making Structure

Now let us examine the functions, roles and organizational structures of major decision-making institutions. The National Health Insurance Corporation is a deliberative and decision-making body equipped with a board of directors and a Finance Operation Committee. The board of directors consists of 18 members, including the chairman of the board, and makes decisions on key agenda, including the business operation plan, budget and settlements of the Corporation.

Meanwhile, the "Finance Operation Committee" was installed under the aegis of the Corporation, in order to operate the finances of the health insurance in a more democratic and rational manner, and to enable the system to respond more actively to environmental changes. The Finance Operation Committee is composed of 30 members including the chairman, and includes 10 representatives of employment-based policyholders, 10 representatives of self-employed insurance policyholders, and 10 representatives of public interest. The chairman is elected by the public interest representatives. The main roles and functions of the Finance Operation Committee key are to deliberate and make decisions on financial issues that pertain to contracts on treatment benefit costs, changes in insurance premium rates, deficits disposal on insurance premiums, and more. Note, however, that issues related to insurance premiums are deliberated and determined by the Health Insurance Policy Deliberation Committee (Ministry of Health, Welfare and Family Affairs, 2009: 421).

The Health Insurance Policy Deliberation Committee (hereafter referred to as HIPDC) is a committee under the authority of the Minister of Health and Welfare, installed according to Article 4 of the National Health Insurance Act to deliberate and determine key issues pertaining to health insurance, including the criteria for treatment benefits, treatment benefit costs, the level of insurance premiums for policyholders, and more. In fact, this committee has executed final decisions on fees since the transition to the contracts system for determining medical insurance fees.

The precursor to the HIPDC was the "Health Insurance Deliberation and Mediation Committee," which had been installed to integrate health insurance at the time of the National Health Insurance Act (February 8, 1999). At the time, however, this organization was only authorized to deliberate issues pertaining to health insurance, without any decision-making powers. However, after the integration of health insurance, the "Special Act on Sound Finance of National Health Insurance (January 19, 2002)" was legislated to overcome the serious deficits in health insurance financing, and allowed this organization take on its current function as a deliberative and legislative body.

The HIPDC is composed of a total of 25 members, with the Vice-Minister of Health and Welfare serving as the head of the committee, and by 8 representatives of policyholders, 8 representatives of providers, and 8 representatives of the public interest. More specifically, membership consists of ① two members nominated by labor organizations representing the interest of laborers, and two members nominated by consumer organizations, and single members respectively nominated by various citizens' organizations (non-profit civic organizations as defined in accordance with Article 2 of the Non-Profit Civic Organization Support Act, consumer organizations, agriculture and fisheries organizations and organizations representing self-employed persons other than those belonging to the agriculture and fisheries organizations) ② a member nominated by an organization representing the medical services and pharmaceutical industries ③ two members appointed by the head of the central administration organization governing health insurance, from public officials belonging to Class 2 or higher, single members respectively nominated by the President of the Corporation, and the head of the Review&Assessment Service, and four specialists in the field of health insurance. The tenure of the committee members was extended to three years from the two-year term that had been previously stipulated during the operation of the Health Insurance Deliberation and Mediation Committee.

As explained above, from the time of the integration of health insurance in 2000 to the present, the HIPDC has performed a critical role as being the de facto determining body for medical insurance fees. In the past, medical insurance fees had been determined by a consensus between the Ministry of Health and Welfare (Ministry of Health and Social Affairs) and the Ministry of Finance and Economy (Economic Planning Board), but Korea changed to a contract-based system in 2000, when the conflicts surrounding the issue of separating dispensary practices from medical practices were at their peak. However, in 2000, there were not enough actual preparations for the implementation of contracts,

and insurance fees were therefore determined by the Health Insurance Deliberation and Mediation Committee, per the instructions of the National Health Insurance Act. Although negotiations for contracts were broached in 2001, they broke down, with fees being determined again by the same Committee. From 2002 to the end of 2006, the Health Insurance Policy Deliberation Committee was installed, according to the provisions of the temporarily enacted Special Act on Sound Finance of National Health Insurance, but the fee negotiations between the Insurance Corporation and the Council on Treatment Benefit Costs once again broke down, and the final determination of fees were again made by the same Committee for the period from 2002 and 2004, as well as for 2006.

The currently implemented medical insurance pricing system is a relative value resource based system, which confers relative value units on each specifically categorized medical service. These units are then multiplied by the conversion factor (value unit per fee unit). Therefore, the two elements that determine medical insurance fees are the relative value scale and the conversion factor. Until the end of 2006, the most important factor in determining fees was the insurance conversion factor, which was uniformly applied to all items for benefits.

At the present, the conversion factor is determined by a contract based on negotiations between the National Health Insurance Corporation and representatives of each type of medical institution. If an agreement is not reached, the Health Insurance Policy Deliberation Committee (known as the Health Insurance Deliberation and Mediation Committee up to 2001) deliberates and provides an arbitration ruling. However, a decision can be made that insurance fees are ultimately made through negotiations structured between the medical service providers and the insurance policyholders, since: the policies of the Insurance Corporation in the initial agreement stage are de facto determined by the Finance Operation Committee within the Corporation; the policyholders' representatives within the HIPDC are selected from organizations that appoint the representatives of employment-based policyholders and the representatives of self-employed policyholders in the Finance Operation Committee; and the representatives of the public interest within the HIPDC are appointed from representatives within the Finance Operation Committee, which includes the Ministry of Health and Welfare, the Ministry of Finance and Economy, the Health Insurance Review&Assessment Service and the National Health Insurance Corporation, which are all a part of the Finance Operation Committee itself.

2. Assessment and Collection of Insurance Premiums

Insurance premiums are revenue sources that comprise the largest proportion of funding for health insurance systems. Hence, the task of accurately and equitably assessing the premium for each policyholder, and collecting the premium through a reasonable method is of utmost importance. In this section, we will examine the procedures and conditions governing assessment and collection of insurance premiums.

2.1 Insurance Premium Charges

Let us examine the issues pertaining to data sources pertaining to income and assets, which are used when determining insurance premium charges. First, for earnings-related insurance premiums, the taxable income insurance premium is determined, based on the aggregate income tax data provided by the National Tax Service, the farmland income tax data provided by local government figures, and the annuity income data provided by public pension institutions. For aggregate income tax data, the insurance premium is assessed based on real income in the form of business income, earned income, income from rental real estate, and others, as verified by the National Tax Service. The farmland income tax data originally provided information regarding taxes assessed on income generated from farmlands, but the farmland tax is now a cumulative concept for income generated annually, and therefore varies depending on seasonal output, weather conditions and type of crop. Recently, the criteria for basic income tax deductions have been examined closely, and as a result, there are now very few households on which the farmland income tax is assessed. For this reason, the farmland income tax was frequently utilized as the basis for assessing insurance premiums, although in the early stages of the implementation of self-employed medical insurance. Presently, this information is more often than not excluded, and is in actuality converted to other income data for assessment purposes. Next, the assets-related insurance premium is composed of taxable assets, insurance premiums, and other premiums based on assets. This includes property tax data for buildings, land, etc. as well as leases and monthly rental data, in cases where such data is unavailable (Jin-Soo Kim et al. 2009: 64-66).

Calculation of income for the health insurance system is conducted through a method almost identical to that of the National Pension system. The income of employment-based policyholders is reported by the employer, and the insurance premium is withheld every month. By contrast, the income of self-employed policyholders is determined mostly by tax data, as provided by the National Tax Service. For information on other elements, such as assets required for assessing the insurance premium, one must rely on borrowed data collected from external institutions, such as local governments or the Ministry of Land, Transport and Maritime Affairs.

Table 4-1 | Comparison of the Methods of Assessing the Insurance Premium for Employment-based Policyholders and Self-employed Policyholders

Category	Employment-based policyholders	Self-employed policyholders
Adjustment of the insurance premium	Insurance premium rate	Amount per applicable point units
Insurance premium assessment criteria	Earned income from the previous year	Assets and income assessment for the previous year
Insurance premium assessment period	April of the current year~March of the following year	November of the current year~October of the following year
Insurance premium settlement	Yes (April)	No

Source: Yong-Gap Lee et al., Integration of the Assessment and Collection Functions for the 4 Major Social Insurances and Methods of Improving National Health Insurance, 2007: 58.

Insurance premiums for employment-based policyholders are settled in April of each year, based on the 'invoice of withholding tax on earned income' and the 'earned income payment record' submitted to the National Tax Service by the employer on behalf of its employees on December 31 of each year. In other words, the insurance premium of employment-based policyholders imposed for the period from April of the upcoming year to March of the subsequent year are assessed based on the earned income of the previous year. By contrast, the insurance premiums for self-employed policyholders are determined by the Corporation, through computerized data provided by respective institutions, rather than by relying on self-reported household income and assets.

Table 4-2 | Method of Computerized Data Linkage for the Assessment of the Insurance Premiums of Self-employed Policyholders

Name of assessment data		Uniform linkage date revertible year	Period of obtainment	Period of linkage	Data supplying institution
Aggregate income		Amount reverted to the immediately preceding year	October of each year	November of each year	National Tax Service
Annuity income	Public officials pension	current year's annuity income	October of each year	November of each year	National pension

Name of assessment data		Uniform linkage date revertible year	Period of obtainment	Period of linkage	Data supplying institution
Annuity income	Teacher's pension	current year's annuity income	October of each year	November of each year	National pension
	military personnel pension	current year's annuity income	October of each year	November of each year	Ministry of Defense
	National pension	current year's annuity income	October of each year	November of each year	National pension
	Post office	current year's annuity income	October of each year	November of each year	Post Office Association
Agricultural income		Amount reverted to the immediately preceding year	August-September of each year	November of each year	city, gun (eup, myeon) and gu district units
Assets	Assets (land, building constructions, houses)	Current year's amount	October of each year	November of each year	Ministry of Government Administration and Home Affairs, special metropolitan city, city, gun and gu district units
	Data on car changes	Data on changes in the previous month	every month	every month	special metropolitan city, metropolitan city, province

Source: Yong-Gap Lee et al., Integration of the Assessment and Collection Functions for the 4 Major Social Insurances and Methods of Improving National Health Insurance 2007: 58.

The current statistics and trends of changes for the assessed health insurance premiums are as follows. In the first quarter of 2011, the total amount of insurance premiums charged was 7 trillion 538.9 billion won, with 5 trillion 764.9 billion won for employment-based insurance premiums and 1 trillion 774 billion won for regional insurance premiums. A comparison of the monthly average insurance premium shows that per household, the monthly average insurance premium was 74,847 won for employment-based policies and 74,599 won for regional policies. The monthly average insurance premium per individual

was 29,553 won for employment-based policies and 35,911 won for regional policies. This indicates that the monthly average insurance premium per household (charged to the individual) was higher for employment-based policies, while the monthly insurance premium per person was higher in the self-employed policies.

Table 4-3 | Trend of Changes in Health Insurance Premiums

Category	2004	2007	2008	2009	2010	2010.1st Quarter	2011.1st Quarter
insurance premium (100 million won)	156,142	217,287	249,730	261,661	284,577	67,057	75,389
- employment-based	108,283	163,485	190,297	202,377	220,831	50,800	57,649
- regional	47,859	53,802	59,434	59,284	63,746	16,257	17,740
monthly insurance premium per household (won)	47,787	59,278	66,217	66,916	70,989	68,204	74,752
- employment-based	49,675	62,430	69,169	70,250	73,399	68,518	74,847
- regional	45,818	55,054	61,982	61,902	67,168	67,720	74,599
monthly insurance premium per person (won)	17,985	23,690	26,837	27,620	29,765	28,524	31,691
- employment-based	17,752	23,449	26,304	27,049	28,659	26,652	29,553
- regional	18,256	24,065	27,736	28,652	31,899	32,041	35,911

Note: The data for monthly insurance premium per person is based on the insurance premium charged to the individual.

Source: National Health Insurance Corporation, Major statistics on health insurance for the first quarter of 2011 and 2011.

Figure 4-2 | Annual Trends in Insurance Premiums Charged According to Occupational Categories

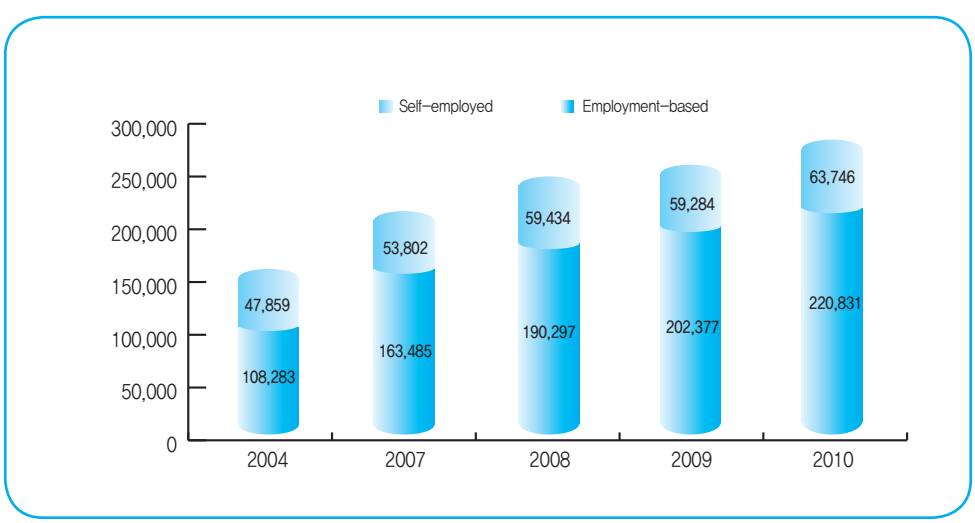
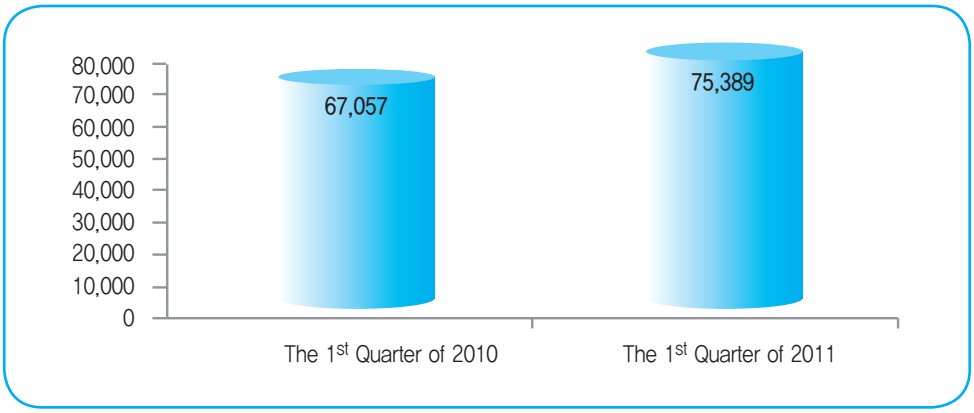


Figure 4-3 | Changes in Insurance Premium Compared to Equivalent Periods in the Previous Year



2.2. Collection of Insurance Premiums

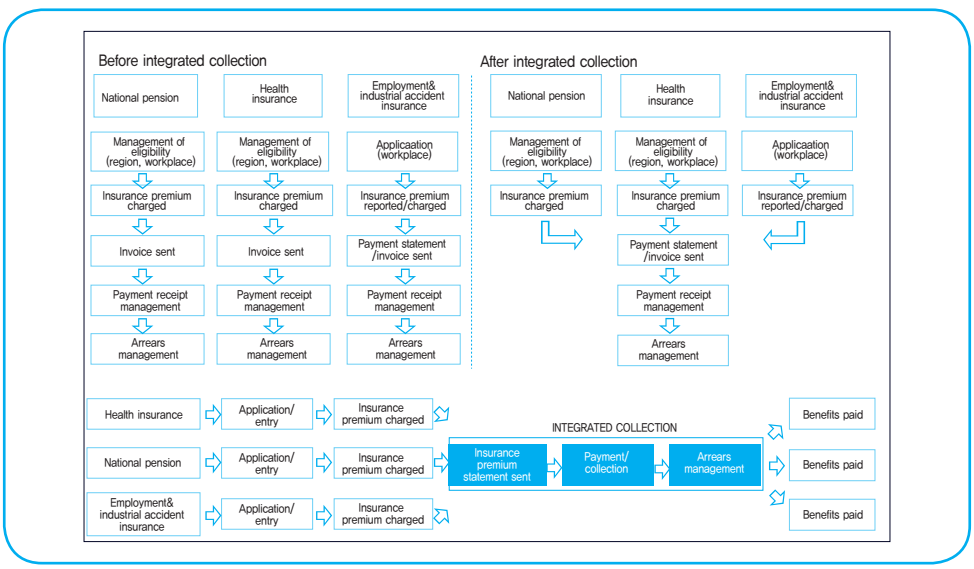
The concept of collecting insurance premiums includes issuance of invoices, the receipt of payments, and the handling of arrears. Currently, the National Health Insurance Corporation integrates collections by receiving data on charges (confirmed invoice data), supplied by the National Pension Service and the Korea Labor Welfare Corporation. The National Health Insurance Corporation has integrated the collection procedures, including tasks pertaining to notification, receipt and arrears for health insurance, national pensions, employment insurance and industrial accident insurance, which had previously been executed by the Health Insurance Corporation, the National Pension Corporation, and the Korea Labor Welfare Corporation. However, eligibility management, assessment of insurance premiums and benefits are still separately processed by each respective organization.

To address the conflicts previous decades regarding the issue of improving efficiency in social insurance, the government in August 2008 confirmed that it would unify collections for the four major social insurance programs under the National Health Insurance Corporation, as part of the government's "Plan for the Advancement of Public Institutions (2008.8.11)." Accordingly, the Ministry of Health and Welfare became the department responsible for the integration of collections, and prepared for integration by organizing a "Preparation Committee for the Integrated Collection of Social Insurances," the "Labor and Management Taskforce Council" and the "Informatization Taskforce Council," and by undertaking legal revisions pertaining to collection integration, redesigning of collection procedures and organizations, reassignment of personnel, and construction of an information system, with collaboration from the Ministry of Labor, each of the Corporations, and labor unions. In

January 2011, the collection integration information system and its services were launched.[8]

In principle, insurance premiums must be invoiced every month on a regular basis. The method of notifying policyholders of insurance premiums differs for employment-based insurance and regional insurance. For employment-based insurance premiums, an individual invoice and a combined invoice for the four major social insurance premiums are transmitted in a single envelope. For self-employed insurance premiums, the invoices are contained in a single envelope, in cases where the head of the household, insurance policyholder, and national pension policyholder are the same person with the same resident registration number and address. But, invoices are transmitted in separate envelopes if the policyholder's information differs. For employment and industrial accident insurance premiums, the method of paying each year through voluntary reporting is no longer allowed as of January 2011. Instead, premiums will be assessed and invoiced each month, as in the cases of health insurance and national pension.

Figure 4-4 | Comparison of the Work Procedures Before and After the Integration of Insurance Premium Collections



Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

8 The integration of social insurance collections progressed as follows. In the current administration, the 1st Plan for the Advancement of Public Corporations determined that the collection work for the 4 major social insurances would be integrated under the Health Insurance Corporation (August 11, 2008), and thereafter the draft Act regarding the integration of social security collections was proposed and underwent revisions before the relevant representatives of labor, management and the government finally signed an agreement that confirmed the legal provisions (June 4, 2009). Afterwards, the National Health Insurance Corporation constructed an integrated collections information system for its demonstration operation (July 31, 2010), established a demonstration plan (June 2010), implemented the demonstration operation (July~December 2010), then completed the training for transitional personnel (October~December 2010) and the reassignment of personnel (November 2011) (Homepage of the National Health Insurance Corporation).

If there are changes in eligibility, settlements may be made on a rolling basis, after retirement or at the end of the year, depending on each situation. In cases of delays in determining eligibility of the policyholder, or the income and assets serving as the basis for assessing insurance premiums, settlement is made on a rolling basis through re-settlements, additional settlements, or conversion processing on insurance premiums. Retirement settlements and end-of-the-year settlements apply only to employment-based policyholders. In cases where the employment-based policyholder retires in the course of the year, the retirement settlement represents the balance between the pre-paid insurance premium and the amount that remains to be paid for the current year up to the time of retirement. The end-of-the-year settlement is charged to the insurance premium in April, after balancing the insurance premium charged to the employment-based policyholder in advance, based on the income of the previous year against the pre-paid insurance premium, once the income for the current year is confirmed at the workplace in February of the following year.

Table 4-4 | Changes in the Amount of Health Insurance Premiums Charged and Collected

Category	2004	2006	2008	2009	2010	2011. 1st Quarter
Amount charged (100 million won)	47,859	49,141	59,434	59,284	63,746	17,740
Amount collected (100 million won)	43,592	45,284	55,526	57,117	62,143	16,913
- current year	40,66	41,584	50,957	51,836	56,372	14,439
- past fiscal year	32,928	3,699	4,568	5,282	5,771	2,474
Collection rate (%)	91.1	92.2	93.4	96.3	97.5	95.3
-current year	85	84.6	85.7	87.4	88.4	81.4

Source: National Health Insurance Corporation, Major health insurance statistics for the first quarter of 2011, 2011

Figure 4-5 | Trend of Changes in the Annual Collection Rate for the Self-employed Insurance Premium

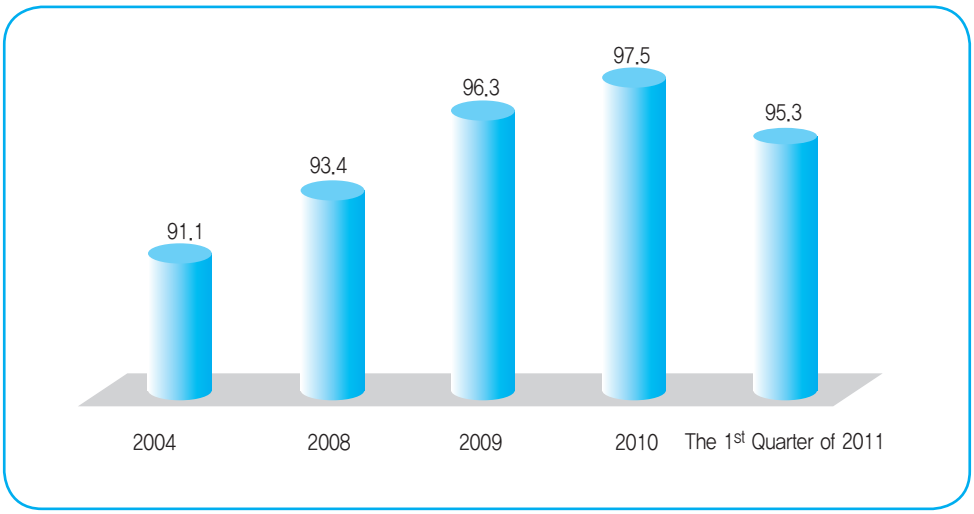
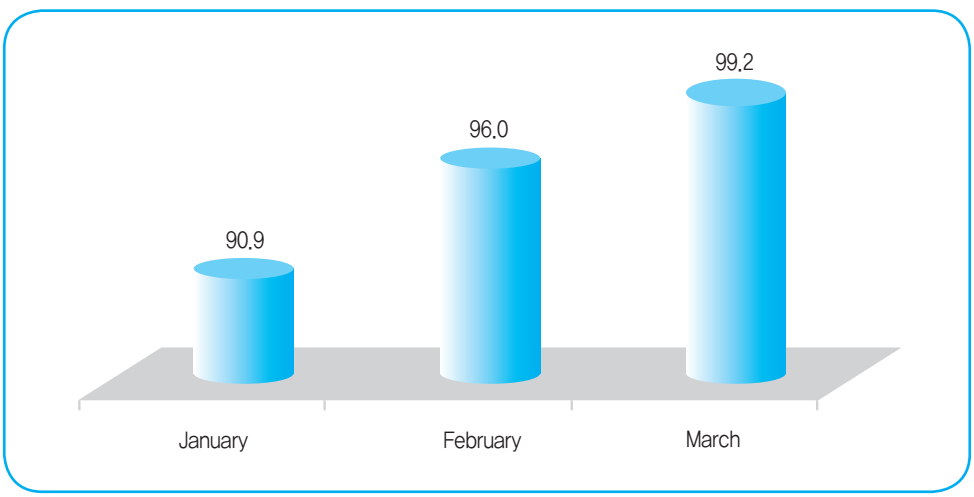


Figure 4-6 | The collection Rate for the First Quarter of 2011



3. Financing

As regards health insurance financing, the revenues consist of insurance premiums paid by the policyholders every month, and the national subsidies provided through governmental taxation. In keeping with the institutional characteristics of social insurance, insurance premiums constitute the majority of this funding. Meanwhile, financial expenditures consist of insurance benefits costs charged by the medical providers as compensation for

the patients' usage of medical services, and the management and operation expenses used to maintain the insurance system. The insurance benefits costs constitute the majority of expenses.

When the self-employed insurance system was designed, the government's plan was to provide support for management and operation costs, but to rely on revenues from insurance premiums to finance insurance benefits costs. However, the results of the demonstration projects illustrated that the self-employed cooperatives continued to incur deficits, with the government having to cover the deficits through governmental loans. Also, self-employed policyholders were responsible for the paying the entire premium, while for employment-based policyholders, employers (including the government) were charged with 50% of the insurance premium, suggesting that administering a social insurance policy based on compulsory entry required inevitable governmental support. Therefore, it was determined that the government would support not only the management and operation costs, but also a part of insurance benefit expenses. Accordingly, at the time the national medical insurance system was launched, the government promised national subsidization for 50% for self-employed insurance. However, since article 48 of the Medical Insurance Act (State Funding) and article 80 of the enforcement ordinance for this act stipulated only that "state funds can be charged with the expenses for the administrative office work of the medical insurance program, for the insurance benefits costs and for financing funding," indicating that such support was not an obligation but rather a recommendation, the policy of providing 50% governmental subsidization could be subject to change, depending on political circumstances.

The public funding was applied beginning with the agriculture and fisheries regions in 1988, and constituted 12.4% of the total insurance revenue. As the application broadened to urban regions, the percentage of governmental funding within the total financial revenues rose to around 18% by 1991.

Thereafter, the amount of governmental subsidy funds continued to increase, but the percentage it represented in total financial revenues continued to decrease, falling to 13% in 1999, immediately preceding integration. In 2000, the financial situation deteriorated with the implementation of health insurance integration, and the separation of the dispensary and medical services, resulting in increased governmental financial support. In 2002, the "Special Act on Sound Finance of National Health Insurance" was legislated. From then on, the governmental funding for health insurance expanded to include not only support for the general budget, but also support through the national health promotion fund, created from a tobacco levy. Also, the size of the governmental funding was clearly stipulated in this legislation. Government funding was fixed at 50% of the funding for regional insurance, within which 35% was allocated to general accounts (as of 2005~2006, 40% for 2002~2004), and 15% was categorized as support through the health promotion fund (as of 2005~2006, 10% for 2002~2004). Thereafter, the governmental support incrementally decreased, falling to 14.4% in 2010.

Table 4-5 | Changes in Financing for Health Insurance (1977-2010)

(Unit: hundred million won)

Category	Revenues	Insurance premium	Governmental subsidies	Expenditures	Insurance Benefit costs	Management and operation expenses	Difference for the current term
1977	149	144	3	51	46	5	98
1978	490	374	10	253	155	24	237
1979	1,131	1,034	17	806	724	87	325
1980	1,789	1,601	21	1,513	1,380	135	276
…							
1988	12,833	10,955	946	10,304	9,144	585	2,529
1989	17,835	14,326	2,205	13,724	11,416	676	4,111
1990	24,321	18,835	3,639	21,640	18,026	1,924	2,680
1991	32,689	23,317	5,868	24,910	19,264	2,326	7,778
…							
1999	88,924	63,056	11,656	96,101	76,656	5,968	-7,177
2000	98,277	72,288	15,527	107,442	92,856	6,956	-9,165
…							
2010	335,265	281,489	49,753	348,989	338,135	10,167	-13,724

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

4. Management of Eligibility

As examined in Chapter 2, individuals eligible for health insurance are categorized as either employment-based or self-employed policyholders. Employment-based policyholders consist of workers and employers at workplaces with one or more hired employees, public officials, school personnel, voluntary continuance policyholders (applicable from July 1, 2007), daily construction contractors, and their dependents. Dependents are defined as those who maintain their livelihood by reliance on the employment-based policyholder, and who do not earn any wages or income of their own. These dependents may include the spouse, lineal ascendants (including the lineal ascendants of the spouse of the employment-based policyholder), lineal descendants (including the lineal descendants of the spouse of the employment-based policyholder), and their spouses or siblings. Meanwhile, self-employed policyholders are individuals other than employment-based policyholders and their dependents, usually consisting of those employed in agriculture or fisheries industries, urban self-employed, and those without any income. The following chart shows the changing statistics on the population groups eligible for health insurance.

Table 4-6 | Statistics on the Population Eligible for Health Insurance

(Unit: 1000 individuals)

Category		2004	2007	2008	2009	2010	2011.3
Medical security		48,901	49,672	50,001	50,291	50,581	50,665
Health insurance		47,372	47,820	48,160	48,614	48,907	49,006
Employ insured	Subtotal	25,979	29,424	30,417	31,413	32,384	32,664
	policyholders	9,283	11,175	11,617	12,146	12,764	12,944
	dependents	16,697	18,250	18,800	19,267	19,620	19,720
	Dependency ratio (persons)	1.80	1.63	1.62	1.59	1.54	1.52
Self-employ insured	policyholders	21,393	18,395	17,743	17,201	16,523	16,342
	No. of households (households)	8,612	8141	8,058	8,111	7,940	7,887
	Dependency ratio (persons	1.48	1.26	1.20	1.12	1.08	1.07
Medical benefits		1,529	1,853	1,841	1677	1,674	1,659
Workplaces (units)		548,714	823,491	901,643	958,899	1,004,557	1,010,183

Source: National Health Insurance Corporation, Major Statistics on Health Insurance for the 1st Quarter of 2011, 2011.

As of March 2011, individuals eligible for medical security, including those covered by health insurance and medical benefits, totals 50.66 million. Among these, there are 1.669 million medicaid recipients, and 49 million health insurance policyholders. Self-employed insurance policyholders constitute 37.6%, with 16.34 million people, and employment-based policyholders constitute 64.4% with 32.66 million people. Since 2004, the number of employment-based policyholders has increased each year by around one million. The number of dependent family members per employment-based policyholder is on average 1.52, which marks a decrease by 0.28 when compared to 2004. The figure is 1.07 for self-employed policyholders, decreased by 0.41 per household when compared to 2004. The number of health insurance workplaces is 1.01 million, 1.8 times more than the 548,714 workplaces in 2004.

Figure 4-7 | Annual Trends in Health Insurance Eligible Populations by Occupational Category

(Unit: 1000 individuals)

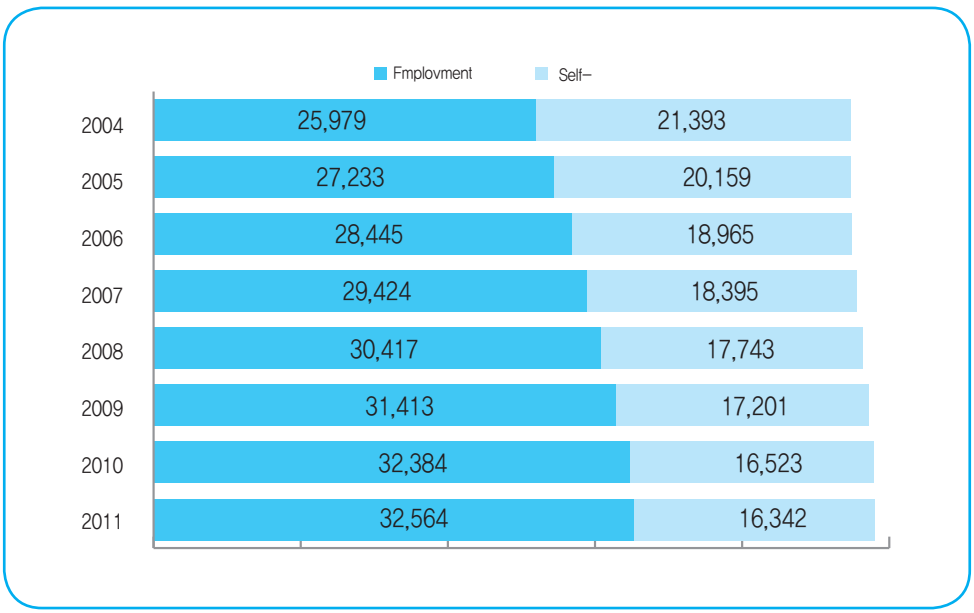
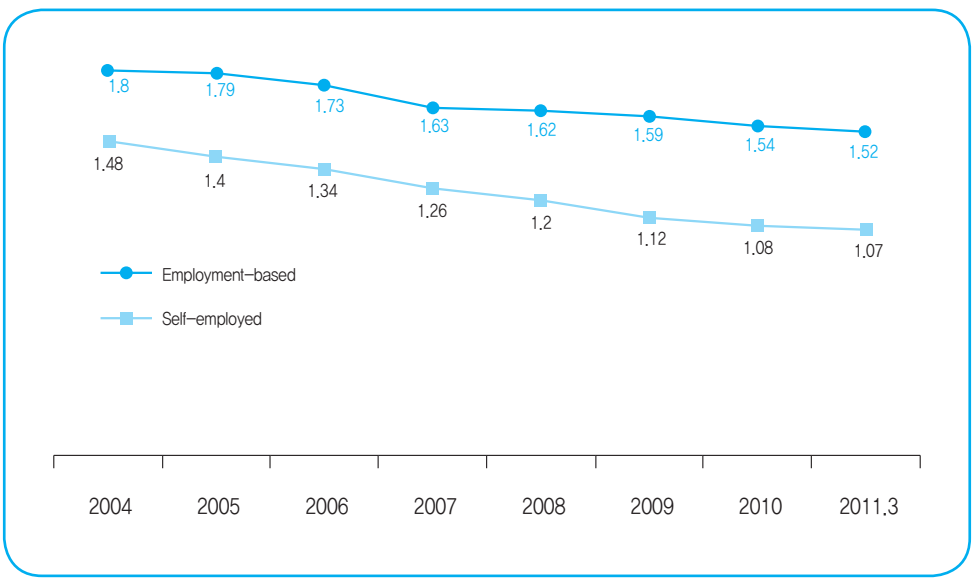


Figure 4-8 | Annual Changes in the Average Number of Dependent Family Members per Policyholder

(Unit: individuals)



Next, let us examine the method used for reporting and managing the eligibility of policyholders. Eligibility for health insurance is based on the reports made by policyholders upon acquisition of eligibility. Employment-based policyholders report their acquisition of eligible status through their workplace, and their dependents report their own acquisition of the status of policyholders. Self-employed policyholders composed of household members have the head of the household directly report their eligible status to the Corporation. The same procedure applies for changes or losses in eligibility. If eligible status changes, the employer of the employment-based policyholder in question, or the head of the household of self-employed insurance policyholders, must report this change to the insurer within 14 days of the acquisition or loss. When the eligibility report has been received, the Corporation for the district confirms the contents of the report regarding the policyholder and their dependents, and determines the eligibility status. The eligibility for health insurance is confirmed by the Corporation headquarters based on public data provided by the Ministry of Government Administration and Home Affairs, the National Tax Service, the National Pension Service, the Korea Labor Welfare Corporation, et al., by verifying information on coverage for medical benefits or citizenship status. To confirm information regarding dependents of an employment-based policyholder, or members of the household of a self-employed insurance policyholder, these organizations refer to information on 'the household members of citizens,' provided by the Ministry of Government Administration and Home Affairs.

The management of eligibility and the assessments, and collection of insurance premiums, is conducted at the unit of the household for self-employed policyholders, and the head of the household is held with certain responsibilities. Also, the head of the household and its members are all categorized as health insurance policyholders, and therefore can be individually charged for insurance premiums. The status of these household members, therefore, differs from the status of dependents of employment-based policyholders, who usually rely on the policyholder for their livelihood.

By contrast, eligibility for employment-based policyholders and their dependents is managed through the workplace of the policyholder. The workplace is first registered, and the employer of the workplace is charged with managing the status of the employees (or public officials and school personnel) as employment-based policyholders. Workplaces are categorized into labor workplaces in the private sector, workplaces of public officials, or private school personnel. At labor workplaces, workers who qualify to be employment-based policyholders are employed by the business owner to provide labor, defined as "a worksite or office in which members continually perform actual business under an organic organization with certain defined relationships." Here, no differentiation is made between whether the workplace is headed by a private or corporate business owner. Regardless of the type of occupation, the concept of labor workplace ultimately includes all workplaces with individuals who live by receiving wages as compensation for their labor. Note, however, that workplaces with laborers who have been hired without the purpose of sustained employment, workplaces without a fixed location, and private workplaces without

employees are excluded from eligibility.[9] For this reason, the problem of non-standard workers without stable employment or income, such as temporary workers who are hired for a period under one month, part-time workers, workers paid by the hour, are excluded from eligibility for employment-based policies.

The eligibility of workplaces is determined by the insurer, namely the headquarters and branches of the National Health Insurance Corporation, and by the workplace itself. The headquarters of the Corporation collects income data and information on workplace management, etc. once a month, and the branch continually identifies unregistered worksites through information from relevant institutions such as the tax office, associations and organizations representing various industries, and others. The head of the workplace is responsible for self-reporting the establishment of the workplace and any changes to confirm its status as an eligible workplace. In the process of verifying the status of the workplace, the Corporation branch checks whether eligible individuals are already registered with health insurance, whether the workplace has been suspended or closed, and whether the workplace belongs under the jurisdiction of another branch.

5. Management of Benefits

The health insurance system is a medical security system formed through the agreement among three parties, namely the policyholders, insurer, and provider. Accordingly, in compensation for the medical services, the insurer pays the provider a portion of the treatment costs on behalf of the policyholders. The payment compensation system refers to the method of compensating the provider of medical services with treatment costs as remuneration for services, and this can broadly be categorized into payment due to the medical service providers (such as doctors) and the payment due to medical institutions. In general, the payment compensation to the medical service provider aims to provide remuneration for the professional skills offered through the medical services, while the payment to the medical institutions indicates compensation for input expenses such as the costs for facilities, equipment, supplies and operational costs. The payment system impacts changes in the treatment behavior of the medical service provider, influencing the quality and fee of the medical services, as well as the method of assessing and managing the treatment costs, and the question of which method is used is therefore of critical importance.

9 According to article 10 of the Health Insurance Act, the following individuals are excluded from eligibility for employment-based policies. a) Daily workers who are employed for a period less than one month, b) Public officials appointed by elections who do not receive monthly wages or payments equivalent thereof, c) employees and employers at workplaces without a fixed location, d) part-time workers or temporary workers who work less than 60 prescribed hours in one month, e) part-time school personnel or public officials and school personnel who work for less than 60 hours in one month, f) individuals who receive medical benefits under the provisions of the Medical Care Assistance Act, g) individuals who receive medical production under the provisions of the Act on the Honorable Treatment of Persons of Distinguished Services to Independence or the Act on the Honorable Treatment and Support of Persons, etc. of Distinguished Services to the State (individuals receiving medical protection such as Persons of Distinguished Services, etc.) who have applied to be excluded from participation in Health Insurance

In the majority of countries today, the payment compensation methods currently used are not unified into a single form. Instead, a variety of forms are combined, according to the characteristics of each respective provider and the particular circumstances of the country.

In Korea, the fee-for-service system (FFS) has served as the main method of payment for treatment costs since medical insurance was first implemented in the country. This system is supplemented by the case payment system method, based on Diagnosis Related Groups (DRG) for in-patient treatment of seven sicknesses[10], and a per-diem payment method for psychiatric treatments under medical benefits coverage, long-term care facilities and home-based benefits services.

The fee-for-service system operates by separately determining the cost of medicines or materials, and assigning a fee for each respective treatment item provided by the medical personnel to pay the treatment cost. The method of calculating the fees of medical services under the fee-for-service system is as follows.

Service practice fee = Relative value units for each item of practice × conversion factor × [1 + (classified addition rate*/100)]

* The classified addition rates applied are 15% for clinics and traditional herbal medicine clinics, 20% for hospitals, long-term care hospitals and traditional herbal medicine hospitals, 25% for general hospitals, and 30% for tertiary care hospitals

The relative value unit is one factor that constitutes the fee-for-service system, and it expresses the relative point value assigned to each item for the value of the treatment benefit by taking into comprehensive consideration factors, such as the amount of work required for the treatment benefit including time and effort, the amount of resources including personnel, facilities and equipment, and the degree of risk and the survival rate involved in the treatment benefit. The currently adopted fee-for-service system based on Resource Based Relative Values (RBRVS) was first proposed by the "Medical Security Reform Committee" in 1994. The determination of the relative values and the development of the conversion factor were completed in 1997, and the system was finally implemented in 2001. However, various problems continued to be identified thereafter, and a series of reforms were implemented, with the current system reflecting new relative values based on research results from 2006. This new relative value unit system distinguishes doctor expenses and treatment expenses, separately allocating the cost for treatment materials. This system also reflects the degree of risk involved in treatment. The components and detailed contents of the relative value units are as follows.

10 The treatment fee is not paid based on a single treatment service. Instead, the treatment fee is paid based on the fixed amount set by pre-determined criteria that has been classified according to the group of disease (or the group of patient). This classification is referred to as the DRG (Diagnosis Related Groups). The pre-payment compensation system based on DRG was developed in the United States beginning in 1983 to restrain the rapid increase in medical costs, and this is used as the method of payment for the treatment fees of patients in the Medicare system operated by the federal government. This system makes medical costs more predictable, and therefore has the advantage of eliminating incentives to long-term hospitalization (homepage of the Health Insurance Review and Assessment Service).

Table 4-7 | Components of the Relative Value Units

Category	Detailed contents
Amount of work (medical services)	Compensation for the professional efforts of the main practitioner (doctor, pharmacist), indicating the relative value reflecting time and intensity
Treatment cost (clinical personnel, medical equipment, treatment materials)	Relative value reflecting the wages for clinical personnel other than the main practitioner (doctor) including physician assistants, nurses, and medical technicians, facilities used for treatment, and treatment materials
Degree of risk (Cost for resolving medical disputes)	Relative value reflecting the cost of resolving disputes pertaining to medical accidents.

To adjust the relative value unit, the treatment institution or medical organization submits a request for the adjustment of the relative value unit publicized by the government, and applies for the assessment of the relative value of a medical practice based on new technology. Upon receiving the request, a review is conducted by the "Specialized Committee on Fee Service" within the Health Insurance Review&Assessment Service, and a decision is made and publicized by the Health Insurance Policy Deliberation Committee.

Another component of the fee-for-service system is its conversion factor, which refers to the unit fee for each single relative value unit point. Since 2001, the conversion factor was based on the agreement between the organization of providers and the Corporation specifying the unit fee. But beginning in 2008, the conversion factor has been determined by agreements between the Corporation and each specific medical institution type. Accordingly, each year, representatives of seven provider organizations (clinics, hospitals, dentists, traditional herbal medicine institutions, pharmacies, midwifery clinics) conclude contracts through negotiations with the President of the Corporation. In cases where negotiations fail, the 'Health Insurance Policy Deliberation Committee' deliberates and reaches a decision as a final resort, which is then published by the Minister of Health and Welfare. To make this assessment, business profit and loss analysis, cost analysis, index models and SGR, etc. must be reviewed. There have been difficulties in reaching agreements, however, due to differences of interests between the providers and policyholders regarding the level of fees. The following table presents the annual changes in the conversion factor since 2001 when contracts began to be implemented.

Table 4-8 | Annual Changes in the Conversion Factor

(Unit: Korean won)

Categorization by Type	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
General hospitals, hospitals and long-term care hospitals	55.4	53.8	55.4	56.9	58.6	60.7	62.1	62.2	63.4	64.3
Clinics								62.1	63.4	65.3
Dental hospitals, Dental clinics								63.6	65.8	67.7
Traditional herbal medicine hospitals, Traditional herbal medicine clinics								63.3	65.6	66.8
Midwifery clinics								80.7	88.2	93.5
Pharmacies, Korea Orphan Drug Center								63.1	64.5	65.7
Health Centers, Public Health and Medical Centers, Public Health Center Branches, Primary Health Care Posts								62.1	63.7	64.8

Source: Health Insurance Review&Assessment Service , Homepage of the Health Insurance Review&Assessment Service, 2011

Despite several advantages, the fee-for-service system also poses various problems. The greatest issue has been that the system cannot control treatment costs. As a result, the cost of health insurance benefits has continually increased, as shown in the table below.

Table 4-9 | Changes in the Annual Increase Rate for Health Insurance Benefits Costs

(Unit: trillion won)

Category	2004	2005	2006	2007	2008	2009
Total	17	19	22.5	25.6	27.5	31.2
Insurance benefits cost (Percentage of increase from the previous year)	16.3	18.4 (13.1%)	21.6 (17.4%)	24.6 (13.8%)	26.7 (8.5%)	30.0 (12.7%)
Management and operational cost	0.8	0.8	0.9	1	1	1
Other expenditures	0.08	0.04	0.08	0.02	0.06	0.07

Source: Health Insurance Review&Assessment Service , Homepage of the Health Insurance Review&Assessment Service, 2011.

To overcome problems arising from the fee-for-service system, beginning in 2002, a case payment system based on Diagnosis Related Groups has been applied to seven types of illnesses (intraocular surgery, tonsillectomy, anal surgery, herniotomy, appendectomy, uterine surgery, Caesarean sections). Currently in Korea, the case payment system is not applied compulsorily, but through the voluntary adoption by the treatment institutions, and as of August 2010, 2,321 institutions (69.4% of the applicable institutions) are voluntary participants.

Meanwhile, Korea is in the process of developing a new model for the case payment system that addresses the problems of the previous system based on Diagnosis Related Groups. The National Health Insurance Corporation implemented an initial demonstration project for 20 diagnosis groups at Ilsan Hospital from April 2009 to June 2010, and in July 2010, the system was expanded to 76 illnesses and implemented for a second demonstration project. In the near future, a decision will be made whether or not to expand the implementation of a new case payment system, based on the results of these demonstration projects.

Next, let us examine the procedures and stages for claiming and paying treatment benefit costs. First, the treatment institution issues its claim for payment and claim for review to the Health Insurance Corporation and the Health Insurance Review&Assessment Service, according to article 43-1 and 43-2 of the Health Insurance Act. To simplify the cost claim, the treatment institution attaches a statement of treatment benefits cost issued to the treatment benefits cost claim form, and submits these documents to the Review&Assessment Service. The Health Insurance Review&Assessment Service reviews whether the treatment benefits cost is in accordance with the relevant laws and the benefits and review criteria,[11] and determines the amount of payment for benefits to be charged to the Health Insurance Corporation and the patient. Notifications of these results are given to the Health Insurance Corporation and the treatment institution in question. The Corporation, upon being notified of the results by the Review&Assessment Service, conducts its own review prior to payment. It completes payment for the treatment benefit cost to the treatment institution or the provider, based on the treatment benefit cost payment notice form.

11 The reviews can be categorized into general reviews and specialized reviews. General reviews are conducted on general matters, fees, and pharmaceutical prices, etc. through a computerized program. The specialized review is a close inspection conducted by employees of the Review Service or (members of) the Review Committee in cases where detailed verification must be made regarding the contents and costs of the treatment benefits. The Treatment Review and Assessment Committee was established in accordance with article 59 of the National Health Insurance Act, and currently consists of a total of 1,050 review committee members (50 full-time, 1,000 part-time). This Committee develops the criteria for review and assessment and deliberates on key issues pertaining to reviews and assessments. (The homepage of the Health Insurance Review and Assessment Service).

Chapter 5

Evaluating the Achievements and Future Challenges of the National Health Insurance System

1. Accomplishments

2. Evaluation

Evaluating the Achievements and Future Challenges of the National Health Insurance System

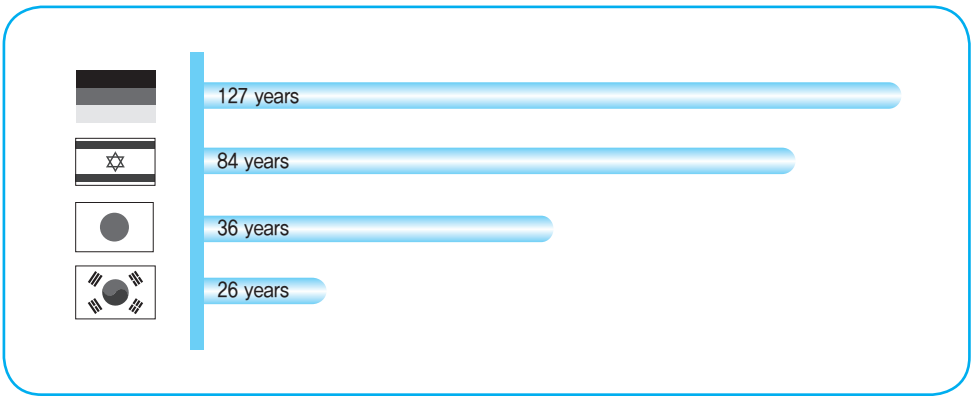
Since the Medical Insurance Act was first legislated in 1963, Korea's health insurance system underwent numerous legal and institutional changes during its growth and development. Presently, Korea's health insurance is regarded as having successfully achieved the objective stipulated in 1977 of "diffusing and reducing the burden of medical fees by means of medical insurance," but the reality is that the system is also insufficient in certain aspects. In this chapter, we evaluate the achievements and remaining challenges in the health insurance system for each sector, and illustrate projects that the government is currently seeking to implement.

1. Accomplishments

1.1 Expansion of Eligibility

When we compare the time that was required in various countries to achieve a medical security system providing universal coverage, Korea can be commended for having attained nationwide medical security in the shortest amount of time. Germany took 127 years to achieve nationwide medical insurance since the time the country first implemented medical insurance, Israel took 84 years and Japan took 36 years. By comparison, Korea required only 26 years from the time of the legislation of the Medical Insurance Act in 1963, and only 12 years from the time of the institution of employment-based medical insurance to reach this objective.

Figure 5-1 | Time Required by Each Country to Achieve National Medical Insurance for All Citizens



Along with building a medical security system for all citizens within an unprecedentedly short amount of time, Korea also achieved remarkable expansions in eligibility. The changes in the population eligible for health insurance from 1977 to 2005 shows that in July 1977, there were 3.2 million eligible, constituting only 8.8% of the total population. Thereafter, the eligible population continually increased, rising to 24.2% in 1980 and 93.7% in 1990. Since the organizational integration of health insurance in 2000, this percentage has remained at around 96~97%.

Table 5-1 | Current Annual Statistics on the Health Insurance Eligible Population

(Unit: 1,000 persons)

Category		1977	1980	1985	1990	2000	2006	2008	2009	2011. 06
Total population		36,412	38,124	40,806	42,869	47,008	48,297	48,597	48,760	50,757
health insurance	Total (eligibility rate)	3,200 (8.8%)	9,226 (24.2%)	17,995 (44.1%)	40,180 (93.7%)	45,896 (97.6%)	47,410 (98.2%)	48,160 (99.1%)	48,614 (99.7%)	49,127 (96.8%)
	employment-based	3,140	5,381	12,215	16,155	17,578	23,724	25,774	26,761	28,426
	Private schools	-	3,780	4,210	4,603	4,826	4,721	4,642	4,651	4,632
	regional	60	65	1,570	19,422	23,492	18,965	17,743	17,201	16,068

Note: Medical benefits are excluded.

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation , 2011.

Along with the increase in the population eligible for health insurance, the number of employers also rose rapidly. As of late 2011, the number of workplaces eligible for health insurance totaled 1,046,998, and among these, workplaces with employment-based policies numbered 1,032,118, constituting 98.5%. Meanwhile, there were 14,880 insured public and school service workplaces, comprising 1.5%. This marks an increase by 139 times compared to the total of 7,523 back in 1979. Since 2001, when small-sized workplaces with 5 or less employees became included as eligible workplaces en masse, the number most notably increased, reaching an annual average increase of 17.1% up to 2011.

Table 5-2 | Current Annual Statistics on Health Insurance Eligible Workplaces

(Unit: number of workplaces)

Category	1979	1985	1990	1995	2000	2006	2011.06
Total	7,523	62,792	123,923	169,825	222,859	706,435	1,046,998
Employment-based	4,364	56,330	116,707	161,444	212,636	693,881	1,032,118
Public and school services	3,159	6,462	7,216	8,381	10,223	12,554	14,880

Source: National Health Insurance Corporation,: Homepage of the National Health Insurance Corporation , 2011.

In addition to the rising totals for the eligible population and workplaces for domestic citizens, there was also an increase in the number of foreigners and Korean citizens residing abroad eligible for health insurance.[12] As of late 2010, the total number of foreigners and citizens residing abroad who hold health insurance policies totaled 481,088, consisting of 456,932 foreigners and 24,156 citizens living abroad. This indicates that the total has multiplied 6.8 times compared to 70,245 in 2001, the year when health insurance eligibility was first extended to these groups.

12 Foreigners or citizens residing abroad who have been appointed or hired to work as an employer in a workplace with employment-based insurance or as a public official or school personnel were given eligibility upon application beginning in June 2001. From 2006, these individuals received default eligibility under the same criteria as domestic citizens without the previous requirement to complete an individual application.

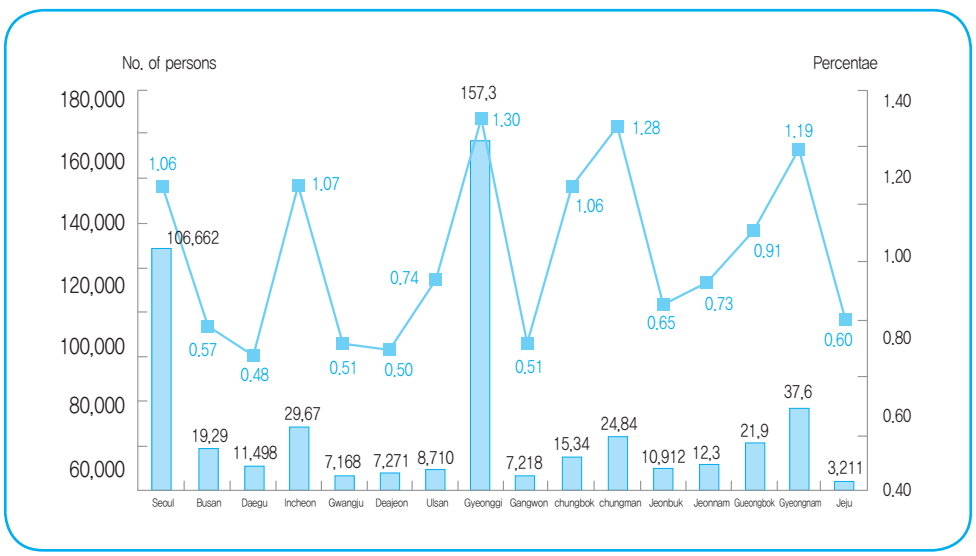
Table 5-3 | Annual Statistics on Foreigners and Citizens Residing Overseas with Health Insurance Policies

(Unit: individual)

Category	2001	2004	2005	2006	2007	2008	2009	2010
Total	70,245	218,580	215,198	271,236	326,085	378,888	422,987	481,088
Foreigners								
- Employment	67,545	204,319	199,082	251,634	303,939	355,523	400,670	456,932
- based	41,876	156,444	143,844	196,343	232,731	270,170	305,489	353,527
- Regional	25,669	47,875	55,238	55,291	71,208	85,353	95,181	103,405
Citizens residing overseas								
- Employment	2,700	14,261	16,116	19,602	22,146	23,365	22,317	24,156
- based	85	9,169	10,681	13,226	15,156	16,181	15,891	17,584
- Regional	2,615	5,092	5,435	6,376	6,990	7,184	6,426	6,572

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011.

Figure 5-2 | 2010 Statistics for Specific Cities and Provinces on the Number of Foreigners and Citizens Residing Abroad, and Their Percentages in Relation to the Health Insurance Eligible Population



Source: National Health Insurance Corporation, Major Statistics on Health Insurance for 2010, 2011.

1.2 Expansion of Coverage

The coverage of health insurance has steadily improved, with the total coverage rate increasing from 61.3% in 2004 to 64.0% in 2009. The improvement has been achieved not only in terms of the total coverage rate, but also in terms of the coverage for high-cost, severe illnesses. The coverage for cancer, in particular, was strengthened even more compared to other illnesses, and the points for this coverage improved from 49.6% in 2004 to 67.9% in 2008, or 18.3%. As the coverage for cancer patients expanded further, the economic burden of the illness on patients gradually decreased. As a result of efforts to categorize cancer patients as severe case patients in order to reduce the number of patients who give up treatment because of cost, the Corporation paid for 62.3 billion won out of the total treatment cost of 86.2 billion won required for cancer patients with health insurance policies in 2001, and in 2007, the Corporation paid for 251.3 billion out of a total of 283.8 billion.

The percentage of Korea's public health and medical expenditures in relation to the national medical expenditure is 55.3% as of 2008, which is markedly lower than the OECD average of 71.4%. However, , this percentage increased by around 22% in the past 25 years from 33.4% in 1983 in Korea, while during the same period the OECD average decreased by 3.7% points from 75.1%.

Next, the coverage of health security can be evaluated in terms of the type of treatment, categorized into in-patient and out-patient treatments. The coverage for the in-patient sector exhibited a slight increase, while the coverage for the out-patient sector improved by a relatively larger margin. In the in-patient sector, while the nominal rate of coverage[13] has been maintained at around 80% since 1995, the actual effective rate of coverage had reached around 65% in the early half of the 2000s, and thereafter fell to around 55. From 1995 to the early half of the 2000s, the gap between the nominal coverage rate and the effective coverage rate narrowed, but expanded again thereafter. In the case of out-patient treatments, both the nominal coverage rate and the effective coverage rate are improving, and the discrepancy between the two is also showing a diminishing trend.

13 Nominal Coverage Rate (Coverage rate for areas included in health insurance benefits) = Statutory Co-payment/(Payment by the insurer + Statutory co-payment)

14) Actual Coverage = (Statutory co-payment + Out-of-pocket payment for uninsured benefits)/(Payment by the insurer + Statutory co-payment + Out-of-pocket payment for uninsured benefits)

Table 5-4 | The Coverage of Health Security in Terms of the Type of Treatment

Year	Category	Health insurance coverage rate	Rate of patient co-payment		
			Total	Statutory contribution	Uninsured benefits
1995	In-patient	54.2	45.8	13.8	32.0
	Out-patient	38.0	62.0	32.4	29.6
1996	In-patient	56.4	43.7	14.5	29.1
	Out-patient	36.4	63.6	36.6	27.0
1997	In-patient	60.7	39.3	15.7	23.6
	Out-patient	38.9	61.1	36.9	24.2
1998	In-patient	57.2	42.8	14.7	28.1
	Out-patient	39.9	60.1	21.1	39.0
1999	In-patient	58.7	41.3	15.2	26.1
	Out-patient	39.5	60.5	19.6	40.9
2000	In-patient	61.0	39.0	16.8	22.2
	Out-patient	30.4	69.6	23.5	46.2
2001	In-patient	65.6	34.4	18.7	15.7
	Out-patient	35.3	64.7	30.9	33.8
2004	In-patient	54.9	45.1	16.4	28.7
	Out-patient	56.9	43.1	26.0	17.1
2005	In-patient	57.5	42.5	14.0	28.6
	Out-patient	58.4	41.6	25.8	15.8
2006	In-patient	64.1	35.9	14.2	21.7
	Out-patient	59.8	40.2	25.4	14.8
2007	In-patient	66.5	33.5	13.5	20.0
	Out-patient	58.7	41.3	24.7	16.6
2008	In-patient	61.7	38.3	15.0	23.3
	Out-patient	57.8	42.2	24.8	17.4
2009	In-patient	64.3	35.7	16.1	19.6
	Out-patient	59.9	40.1	24.3	15.8

Note: The figures from 1998 and after are values obtained after adjustment by type

Source: 1998-2001: Jin-Gyeong Lee, 2004-2005: Jeong-Hee Kim et al., 2006-2008: Gi-Chun Choe et al., 2009:Yeong-Sun Choe et al. , Current status of Treatment Costs for Health Insurance Patients, 2002, 2006, 2009, 2010.

In correlation to increases in coverage rates of health insurance, the rate of individual co-payments decreased, thereby gradually alleviating the burden of medical costs on the household budget. According to the OECD Health Data for 2006, the percentage of the total medical cost expenditures charged as co-payment to the individual decreased in Korea from 56.5% in 1985 to 36.9% in 2004. During the same period, the percentage of individual co-payment in OECD countries increased from 16.3% to 19.8%. Although Korea's co-payment percentage remains high when compared to the OECD average, remarkable progress has been made in narrowing this gap between Korea and OECD countries, from 40.2% in 1985 to 17.1% in 2004 (The National Health Insurance Corporation Health Insurance Review&Assessment Service, 2007:15).

1.3. Improved Access to Medical Services

The increase in the cost of health insurance benefits indicates that the coverage of health insurance has expanded along with greater accessibility to medical services, increasing the rate of usage by citizens. Since the implementation of medical insurance in 1977, the usage of medical services by citizens have surged, and have now reached, inversely, a point of excessive reliance on medical services, a serious concern.

Compared to the situation in 1977 when health insurance was first introduced, the number of out-patient visits per person has risen from 0.7 times to 15.1 times in 2008, more than double the average number of 7.3 times in OECD countries. Moreover, the number of days for in-patient hospitalization per person has also increased from 0.1 days to 1.7 days, exceeding the OECD average level of 1.2 days.

A more detailed examination of the current statistics on medical service usage shows that the population eligible for health insurance benefits has increased 5.26 times from 9.23 million in 1980 to 48.61 million in 2010, but during the same period the total number of days for medical services used increased 3.7 times, with the average in-patient days per person rising from 4.9 days in 1980 to 18.5 days in 2010 and the average number of days for out-patient treatment increasing 5.3 times from 4.6 days to 16.37 days.

Table 5-5 | Current Statistics on the Number of In-Patient Treatment Days

(Unit: Day)

Category		1977	1980	1985	1990	1995	2000	2006	2010
Average Number of in-patient treatment days (per individual within the applicable demographic)	Total	0.75	4.94	7.30	7.72	9.23	11.83	16.04	18.5
	In-patient	0.11	0.39	0.51	0.62	0.76	0.88	1.34	2.12
	Out-patient	0.65	4.55	6.79	7.10	8.47	10.95	14.70	16.37

Source: National Health Insurance Corporation, Homepage of the National Health Insurance Corporation, 2011

The health screening program initiated in 1980 has over the course of the past 28 years continued its expansion to include a broader range of people. The "transitional period health screening" program for citizens between ages 40 and 66 and the "health screening for infants and children" program for youngsters below the age of 6 were both launched in 2007, and compared to previous national health screening programs, these newer programs represented an entirely new type of examination based on the research in medical and health sciences (Ministry of Health and Welfare, 2009: 644).

A review of the changes in the screening rate for the national health screening program shows that the screening rate for general health exams in 2002 was 43.2%. But this figure steadily improved thereafter, reaching up to 66.0% in 2009. The cancer screenings and health screenings for infants and children that were implemented later also continued to improve in terms of the screening rates, and in particular, the rate for transitional period health screenings showed the highest margin of increase, improving from 8.2% in 2002 to 45.3% in 2009.

Table 5-6 | Current Statistics on Screening Rates in the National Health Screening Program

(Unit: %)

Category	2002	2004	2006	2007	2008	2009
General health exams	43.2	51.3	55.7	60.0	65.3	66.0
Cancer screenings				46.1	53.1	56.1
Transitional period health screenings	8.2	14.7	28.6	35.4	40.3	45.3
Health screenings for infants and children					36.7	40.7

Source: Ministry of Health and Welfare, 2010.

The annual statistics on the payments made for examination costs as part of the national health screening program shows that total payments rose from 181.3 billion won in 2004 to 725.1 billion won in 2009, achieving an approximately fourfold increase within five years. As of 2009, the 361.7 billion won in expenses for general examinations made up the largest percentage of the total, followed by the 304.6 billion won paid for cancer screening costs, 38.9 billion won paid for transitional period exams, and 19.9 billion won used for infant and children exams. The cancer screening program was particularly notable for having the largest margin of increase in cost, rising tenfold in the previous 5 years from 31.6 billion won in 2004.

Table 5-7 | Current Statistics on Exam Expenses Paid as Part of the National Health Screening Program

(Unit: 100 million Korean won)

Category	2004	2005	2006	2007	2008	2009
Total	1,813	2,349	3,574	4,273	5,791	7,251
General health exams	1,497	1,798	2,225	2,327	2,873	3,617
Cancer screenings	316	551	1,349	1,615	2,051	3,046
Transitional period health exams				331	679	389
Health screenings for infants and children					188	199

Source: Ministry of Health and Welfare, 2010.

The statistics on changing screening rates for the general health examination program indicates that it is the lowest among self-employed insurance policyholders, while by contrast employment-based policyholders have the highest screening rate. When the screening rate among employment-based policyholders at workplaces with less than five employees is included in the total, we find a temporary fall in the screening rate among employment-based policyholders in 2006 compared to 2005. But overall, the rate has continued to increase each year. The screening rate among dependents of employees increased by a total of 34.7% points over the past 7 years, from 25.1% in 2002 to 59.8% in 2009, achieving the highest annual average increase of 5.0%.

Table 5-8 | Current Statistics on the Rate of General Health Exams Received Categorized by Type of Profession

(Unit: %)

Category	2002	2004	2006	2007	2008	2009
Employment-based policyholders	73.6	80.1	77.2	82.5	84.6	83.7
Self-employed insurance policyholders	17.8	23.9	29.9	32.6	36.0	39.7
Employees' dependents	25.1	34.1	47.6	53.0	56.1	59.8

Source: Ministry of Health and Welfare, 2010.

Meanwhile, the level of satisfaction regarding the health screening program researched through a recent survey also indicated that the program has received a positive evaluation. The results of a survey conducted on 6,000 participants in the transitional period health screening (Ae-Gyeong Lee et al., 2008) showed that 69.8% of the people who received the screening were satisfied with the program. And 55.6% out of the 4,110 people who

previously had not been motivated to improve their daily behavior expressed their will to change their daily habits after completing a second transitional period health screening. Even after six months, 61.7% were found to be maintaining their practice of improvements in daily habits. Moreover, 70.7% of the respondents stated their satisfaction with the newly introduced consultation program. Also, according to an analysis of the effects of the health screenings for infants and children in the first year of implementation (Hee-Jeong Jeong, 2009), a survey with 1,015 respondents found that 73% of the examinees were satisfied with their experience, and the incidence rate was 3.1%. It was particularly notable that 99% of children suspected of development impairments were screened to be abnormal, and that these children were all diagnosed with illnesses requiring speedy treatment, minimizing the potential for future disorders (Ministry of Health, Welfare and Family Affairs, 2009: 644-646).

1.4 The Increase of Medical Resources

Medical resources (medical institutions, number of hospital beds, medical service related personnel, etc.) for providing universally available medical services to all citizens also increased significantly, when compared to the past. Since the 1980s, the number of medical institutions have multiplied 12.3 times by the beginning of the 2000s, the number of hospital beds 8.4 times, the number of doctors 3.6 times and the number of nurses two times. These quantitative increases have enhanced citizens' access to medical care.

First, annual changes in medical institution shows that there were only 6,350 medical institutions in 1979, but by 2010, the number had increased 13 times over 30 years to 81,715 institutions. These statistical increases in the number of medical institutions in 2010 (compared to the end of 2009) can be categorized as follows: there are now 159 more medical institutions of the hospital class or above (2 general hospitals, 141 hospitals, eight dental hospitals, and eight traditional herbal medicine hospitals), 1,174 more medical institutions of the clinic class (443 clinics, 444 dental clinics and 284 traditional herbal medicine clinics), 82 more pharmacies and eight more health clinic institutions.

Table 5-9 | Current Annual Statistics on Medical Institutions by Type

(Unit: Number of Institutions)

Year	Total	General hospitals	Hospi-tal	Clinic	Dental hospi-tal	Dental clinic	Tradi-tional herbal medicine hospitals	Tradi-tional herbal medicine clinics	Health clinic institutions	Mid wifery clinics	Pharmacies
2003	68,075	283	873	23,596	103	11,571	152	8,718	3,407	70	19,302
2004	70,412	283	967	24,314	108	12,086	155	9,171	3,418	63	19,847
2005	72,941	290	1,107	25,180	124	12,553	149	9,760	3,424	52	20,302
2006	75,081	296	1,320	25,780	136	12,994	145	10,293	3,436	51	20,630
2007	76,803	304	1,639	26,141	153	13,339	142	10,859	3,445	51	20,730
2008	78,407	311	1,880	26,521	167	13,719	145	11,321	3,451	51	20,841
2009	80,298	317	2,043	27,036	183	14,245	160	11,789	3,462	49	21,014
2010	81,715	319	2,184	27,479	191	14,689	168	12,073	3,470	46	21,096

Source: National Health Insurance Corporation, 2010 Major Statistics on Health Insurance, 2011.

In tandem with these increases in medical institutions, the number of hospital beds has also increased. The total number of available hospital beds rose from 61,552 beds in 1979 to 498,302 in 2009, growing by 8.09 times.

Table 5-10 | Current Statistics on Medical Institutions and Hospital Beds

(Unit: Number)

Category	1979	1985	1990	1995	2000	2006	2007	2008	2009
Number of medical institutions	6,350	13,413	43,502	53,510	61,836	75,081	76,803	78,461	90,380
Number of hospital beds	61,552	99,950	134,176	196,232	287,401	392,282	450,119	478,645	498,302

Source: Ministry of Health and Welfare, Yearbook of statistics, 2011.

Meanwhile, with the rapid rise in the number of medical institutions, the size of the medical personnel including doctors, nurses and pharmacists also expanded. In 1982, there were 25,097 doctors, but this number increased 3.9 times to 98,434 doctors in 2009, and during the same period, the number of dentists rose from 4,266 to 24,639, while doctors in Oriental medicine rose steeply from 3,268 to 18,401.

Table 5-11 | Current Annual Statistics on the Number of Medical Personnel

(Unit: Number of Individuals)

Category	1982	1985	1990	1995	2000	2006	2007	2008	2009
Doctors	25,097	29,596	42,554	57,188	72,503	88,140	91,475	95,088	98,434
Dentists	4,266	5,436	9,619	13,681	18,039	22,255	23,126	23,924	24,639
Nurses	119,810	165,444	224,746	309,129	160,295	223,781	235,687	246,840	258,568
Doctors of Oriental Medicine	3,268	3,789	5,792	8,714	12,108	15,849	16,732	17,541	18,401
Pharmacists	26,307	29,866	37,118	43,269	50,623	55,831	57,176	58,363	59,717

Source: Ministry of Health and Welfare, Yearbook of statistics, 2011

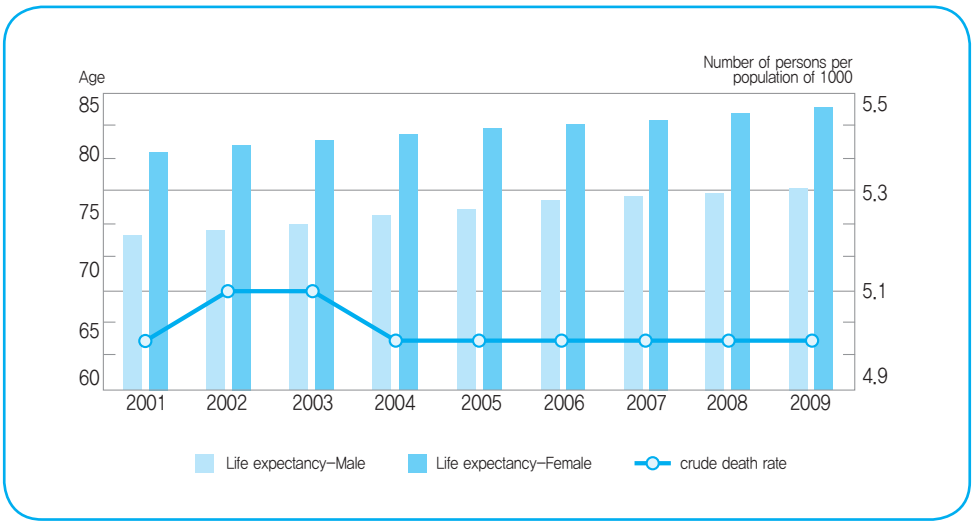
1.5 Improvements in the Level of Health

During past periods, health insurance achieved institutional developments that contributed to raising the health levels of its citizens. Although the health indices for a country are impacted not only by the health medical system, but also by various other factors in the socio-economic environment, a significant portion of the enhancements in health can be attributed to the improved medical security that resulted from the development of the health insurance system.

Firstly, the infant mortality rate in Korea was markedly high in the past, but today the rate has decreased rapidly to one of the lowest levels found in advanced countries. In 1970, the infant mortality rate was 57.5 infants per 1,000 births, but in 2008 the number dropped to 5.3, nearly rivaling the OECD average of 5.2.

Meanwhile, the average life expectancy increased, exceeding the OECD average in 2006. In 1948, the average life span was 46.8 years but this increased to 79.1 years in 2006, which is even higher than the OECD average of 78.9 years. The difference in average life expectancy between males and females was 8.2 years in 1980, but this gap has also gradually narrowed, and in 2006, the discrepancy was reduced to 6.7 years. As of 2008, the average life expectancy for the total population in Korea was 80.1 years, or 76.5 years for men and 83.3 years for women. Compared to 1998, the life span has increased by 5.4 years for men and by 4.8 years for women, and when compared to 2007, the increase has been 0.4 years for men and 0.6 years for women.

Figure 5-3 | Statistical Changes in Life Expectancy and Mortality Rates for Males and Females



Source: National Statistical Office, Statistical Research on Population Trends, 2011

The survival rate for the five major types of cancer in Korea improved greatly in the middle of the 2000s, when compared to the late 1990s. The percentage of cancer patients who survived for five years or more following diagnosis and treatment improved by 16.5% for stomach cancer, 12.1% for colorectal cancer , 10.1% for liver cancer, 6.7% for breast cancer, and 0.5% for cervical cancer during this time period. Even when compared to international statistics, the survival rates for stomach cancer, colorectal cancer, liver cancer, breast cancer and cervical cancer are higher than those in the United States. The margin of improved difference in survival rate is particular high for stomach cancer. The strengths of Korea's health insurance system have been acknowledged in international evaluations. This has been partially confirmed by the results of a recently conducted international comparison of national health and medical systems. According to data published in 2004 by the Conference Board of Canada, Korea's system has been evaluated to be in the upper tier, ranking 5th out of 24 major OECD countries. In 2006, OECD included Korea, along with Japan and the United Kingdom, as examples of countries with cost-effective health and medical systems. Also, the Health Insurance Corporation has offered an international training program for the last five years to share information regarding the achievements of Korea's health insurance system with the international community. 235 representatives from 95 underdeveloped countries who participated in this program were introduced to the health insurance system of Korea, and from 2005 to 2009, 498 guests from 54 countries have visited the Health Insurance Corporation to acquire its know-how regarding the operation of its medical system. These activities reflect Korea's heighted international status in this field.

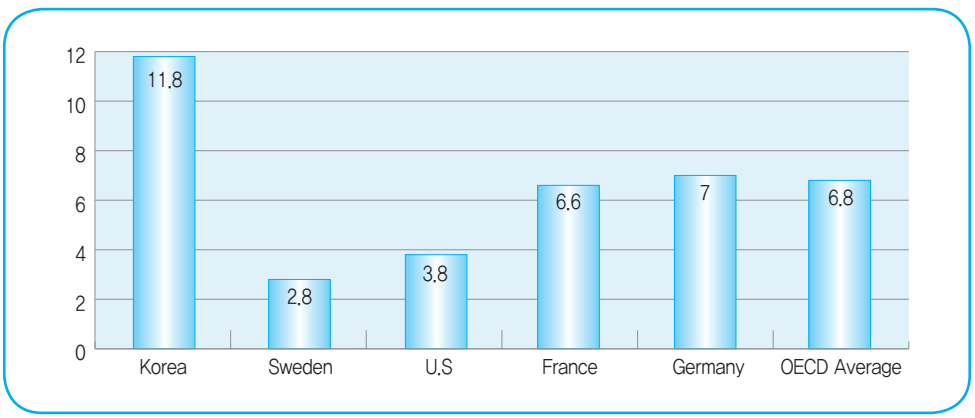
2. Evaluation

As described in the previous section, Korea built a nationwide medical security system within a short period with progress unprecedented anywhere in the world. Korea's health insurance improved the accessibility of medical institutions, playing a major role in enhancing the health of the country's citizens, and creating the institutions necessary for a stable supply of medical services, while contributing to the framework for growth in the health and medical industry. However, in spite of all these achievements, Korea's health insurance system still confronts many issues that will need to be resolved in the future.

The foremost challenge is strengthening coverage. Korea has continually implemented policies to strengthen coverage, and has thereby made great improvements in coverage for patients suffering from high-cost, serious conditions, including cases requiring in-patient treatments. But the rate of coverage in Korea is still assessed to be relatively lagging compared to those of advanced countries, and it will need to pursue a rational policy for improving coverage, which takes into consideration the financial demands of health insurance.

Secondly, the payment system for treatment costs, based on the fee-for-service policy adopted in Korea, is simply not cost-effective. Meanwhile, the cost of health insurance benefits is increasing by large margins each year, and the expenditures for health insurance benefits are anticipated to continue to rise greatly due to the increasing percentage of senior citizens within the composition of the aging population structure, a development which is expected to have a significant impact on the country's future. Although complex effects arising from factors such as the level of demand are driving increases in treatment expenses, the cost-inducing payment system is also acting as a major factor on the supply side, necessitating efforts to reform the payment system for treatment costs to resolve these problems.

Figure 5-4 | Annual Statistics on the Number of Days for Out-Patient Treatment per Individual



Data Source: Internal data of the National Health Insurance Corporation, the National Health Insurance Corporation, 2011.

Thirdly, Korea faces the challenge of improving its system for charging insurance premiums, and securing a stable source of financing. The discrepancies in the factors determining the respective insurance premium charges in the cases of employment-based and region-based insurance policies have given rise to problems of fairness in premium contributions. And the free-riding coverage for dependents of employment-based policyholders and the low level of information identifying the income levels of region-based policyholders have been cited as factors that impede the effective financial management of health insurance. To solve these problems, there have been demands for unification of the system for determining insurance premiums and more diverse sources of financing.

Table 5-12 | In Cases of Shifts from an Employment-Based Policy to a Self-Employed Based Policy

(Unit: Number of households, Korean won, %)

	Total			Households with decreased insurance premiums (policyholders)				Households with increased insurance premiums (policyholders)			
	Number of households	Employed average	Self-employed average	Number of households	Rate of decrease	Employed average	Self-employed average	Number of households	Rate of decrease	Employed average	Self-employed average
2007	912,003	41,414	53,988	414,730	45.5	47,746	27,615	496,891	54.5	36,124	75,973
2008	942,057	46,116	58,648	448,401	47.6	53,229	30,169	493,258	52.4	39,652	84,511
2009	1,293,255	45,013	54,464	649,749	50.3	53,256	27,735	642,917	49.7	36,715	81,519
2010	1,300,999	48,353	57,233	675,300	51.9	56,536	29,200	625,146	48.1	39,546	87,554

Note: Based on insurance premiums charged as co-payment to the policyholder.

Table 5-13 | In Cases of Shifts from a Region-Based Policy to an Employment-Based Policy

(Unit: Number of households, Korean won, %)

	Total			Households with decreased insurance premiums (policyholders)				Households with increased insurance premiums (policyholders)			
	Number of households	Self-employed average	Employed average	Number of households	Rate of decrease	Self-employed average	Employed average	Number of households	Rate of decrease	Self-employed average	Employed average
2007	1,023,400	56,019	37,504	586,757	57.3	79,646	33,506	436,535	42.7	24,265	42,878
2008	1,004,653	60,985	41,440	567,531	56.5	87,525	36,510	437,025	43.5	26,525	47,844
2009	1,304,428	58,147	39,046	739,752	56.7	83,555	33,232	564,400	43.3	24,868	46,680
2010	1,382,751	59,072	42,595	727,919	52.7	89,112	35,599	654,450	47.3	25,686	50,392

Note: Based on insurance premiums charged as co-payment to the policyholder.

The fourth problem is the insufficiency of preventive and promotional programs, and the lagging efficiency of the management and operation of health insurance. Despite the support provided by funds to bolster the finances of health insurance, Korea's insurance system is assessed to have devoted a very low proportion of its expenses on preventive and promotional programs, and the reality is that aside from health screening exams, there are no clear programs for health improvement. Next, the maintenance of a system based on a single insurer also creates challenges. Although this system is advantageous for facilitating management and operations, it lacks incentives for competitiveness, as evidenced by the low level of accountability on the part of the National Health Insurance Corporation regarding the expenditure of benefits costs. For this reason, Korea now needs to prepare countermeasures and seek to deploy a system of internal competition to overcome the limitations of the single insurer method.

Lastly, there is the problem of distortions occurring in primary care. The definition of primary care is not limited to the treatment of simple illnesses, but also assessed to include a system of accountability based on a primary doctor offering a continual provision of comprehensive services, including health promotion, prevention and consultations, while maintaining an intimate relationship with the residents of the local community. In Korea, however, primary care is placed in a structure of wastefulness due to excessive competition and the excessive input of resources, and is often limited to the treatment of illnesses. For these reasons, primary care has failed to meet the expectations of citizens and the demand for health care, and is judged to be in need of improvements.

We have hitherto reviewed the achievements and assessed the future challenges for nationwide health insurance in Korea. In response to these evaluations, Korea is now undertaking active policy measures across all sectors of health and medicine at the national governmental level. Alleviating the cost burdens for pregnancy, childbirth and medical care for senior citizens to meet the needs of an increasing low birthrate and the aging of the national demographic, strengthening coverage to those found in advanced countries, stable management of finances, rational management of pharmaceutical costs, reform of processing payment compensations for treatment costs, reorganization of the medical delivery system, and the reinforcement of preventive programs are some of the important challenges ahead.

2.1 Increasing Coverage Support for Pregnancy, Childbirth and Senior Citizen Treatment Expenses

As an institutional response to decreasing birthrates and Korea's aging demographics through health insurance, it is necessary to implement expanded coverage for treatment costs related to pregnancy and childbirth to assist pregnant women, infants and children, thereby ensuring the driving force for the future of Korea's society. Korea will need to further expand support for pregnancy- and childbirth-related treatment costs, building upon current programs such as the "Goun Mom Card," and further increase benefits for treatment of pediatric congenital diseases.

Next, to prepare for the aging of Korea's population, Korea must build a system to provide high-quality services to senior citizens in urgent need of care, by accelerating the consolidation of the long-term care insurance system for the elderly, and institutionally supplementing and improving this system, which seeks to transition the burden of care from family members to the society-at-large. For this purpose, Korea must improve the system for classifying categories of long-term care and diversify the benefits services, in order to rationalize the management and operation of the system. Korea must also simultaneously develop a performance evaluation index capable of measuring factors such as input, process, calculation, and outcome, which comprise the supply of long-term care services, applying this index to evaluating the quality of services. Also, to bolster preventive activities for senior citizens, Korea must implement activities such as regularly scheduled exams, health-promoting education and management of chronic illnesses, in cooperation with social resources of the local community such as Health Centers, public medical institutions, and volunteer organizations. In the process, Korea can transition the supply system for long-term care services, so that the system will rely more on the foundation of the regional community at each stage (Committee for the Advancement of Health Security, 2010: 60-62).

2.2 Strengthening Coverage to the Level of Advanced Countries and Increasing the Percentage of Public Financing

From 2005 to the present, Korea has pursued a steady expansion of coverage for cancer, rare or incurable diseases, cardio-cerebrovascular diseases, and other serious illnesses. In the future, Korea will need to continue its efforts at structural reform to alleviate the burden of patients in high cost, serious illnesses cases, as well as those involving high cost service items. This can be accomplished by pursuing a policy that focuses on high-cost serious illnesses to help mitigate the burden of medical costs on household budgets.

Korea's health insurance also operates on a co-payment ceiling system, which provides for differentiated levels of limits on the maximum amount of out-of-pocket payments, which can be charged according to income level. In other words, policyholders in the lower 50% tier for insurance premiums are annually waivered 2 million won or more on co-payments for treatment costs, policyholders in the 50~30% tier for insurance premiums are waivered 3 million won or more on co-payments for treatment costs, and policyholders in the upper 20% tier of insurance premiums are waivered 4 million won or more on co-payments for treatment costs. Thus health insurance policyholders with relatively lower income levels are provided with a greater degree of medical security. Those benefiting from this co-payment ceiling system increased from 110,000 people in 2005 to 460,000 in 2009, and the annual amount of payments also rose from 62 billion won in 2005 to 180 billion won in 2009. Hereafter, Korea should conduct multifaceted evaluations of this co-payment ceiling system policy and gradually expand its scope, while further strengthening measures to support vulnerable social groups that may currently be marginalized from the benefits of health insurance. At present, the health insurance system, the local self-government system,

and various non-profit institutions provide some degree of support through programs to assist with insurance premiums and medical costs, but medical services does not remain as accessible as they could be for lower-income classes and socially marginalized groups.

Although the percentage of public funding within the total national medical costs has continued to increase in Korea, it nonetheless remains at a low level compared to advanced countries. As of 2008, the percentage attributable to public funding was 55.3%, which was very low compared to the OECD average of 71.7%. Therefore, Korea faces the challenge of improving the rate of coverage in the public sector.

In order to expand the coverage of health insurance in the future to the level of advanced countries, Korea must secure structurally stable sources for insurance financial revenues. For this purpose, Korea must increase the level of the insurance premiums to a rational level, and seek methods for securing additional financial revenues.

First, Korea must take a new approach to the issue of insurance premiums, which occupies the largest proportion of health insurance funding. Along with efforts to reform the current insurance premium assessment system to improve equity between employment-based policyholders and self-employed insurance policyholders, Korea must incrementally increase the current level of insurance premiums to reach the necessary level. When compared to insurance premium rates imposed in major countries that have implemented a health insurance system, the rate of insurance premiums in Korea is relatively low. As of 2008, the premiums were 14.0% in Germany, 13.8% in France and 8.5% in Japan, where as the rate in Korea remained at 5.64% in 2011.

The process of obtaining a consensus of citizens about incrementally raising the insurance premium rate must be preceded or accompanied by systematic reform for assessing the health insurance premiums. In the previous process of integrating health insurance, the need to rationally improve the insurance premium assessment system has been repeatedly cited as one of the urgent reform challenges for health insurance. Although much research and efforts have yielded partial improvements, the assessment system for insurance premiums is still marked by discrepancies that lead to conflicts between self-employed insurance policyholders and employment-based policyholders, which in turn exacerbate distrust regarding the health insurance system. This is a very difficult challenge because of the direct linkage with the issue of transparency regarding income structure, which also serves as the basis of taxation. Nevertheless, only by continued efforts to offer an integrated insurance premium assessment system will Korea be able to generate a consensus regarding measures to adjust insurance premiums.

However, it will be almost impossible to maintain a stable fiscal balance if Korea relies exclusively on insurance premiums for revenues. Therefore, Korea must identify various new sources of revenue, in addition to the insurance premiums. Currently, the majority of the funding for health insurance consists of insurance premiums, partially supplemented by governmental support. The governmental support amounts to about 20% of the revenue from health insurance premiums, and this consists of 14% from governmental subsidies, and

6% from the levy on cigarettes. As of 2010, 84% of the total funding for health insurance comes from insurance premium revenues, 11% from governmental support, 4% from the tobacco levy, and 1% from other sources.

In addition, adverse factors to health, such as alcohol, tobacco and atmospheric pollution result in socio-economic costs. There are currently discussions regarding the possibility of measures to reduce these social costs, by encouraging reduced consumption of these health risk factors, and assigning economic opportunity costs by instituting or expanding the implementation of health levy charges.

2.3 Rational Management of Insured Pharmaceutical Costs

24.7% of the health insurance treatment cost in 2007 consisted of pharmaceutical expenditures. When compared to other major countries using the OECD Health Data on the percentage of out-patient pharmaceutical expenditures within national medical costs, Korea is found to be expending much more on pharmaceuticals compared to other major countries. The rate of increase in the pharmaceutical expenses is also very high. When the increase rate for pharmaceutical expenses between 2001 and 2007 is compared among countries, the figure was 6.6% for Italy and 29.8% for Japan and the average for OECD was 51.1%, but the rate in Korea was 75.3%. The major causes for the high percentage of pharmaceutical expenses are the medical institutions' lack the incentives to purchase low-priced pharmaceuticals, the inadequacy of systems for identifying accurate data on actual transactions, and the insufficiency of a pharmaceutical price discounting system.

To rationally manage insured pharmaceuticals, Korea needs to transition from a micro-level method of managing drug prices for individual items to a macro-level method of managing pharmaceutical expenses by setting a total target value. Meanwhile, Korea also needs to bring greater transparency to the distribution structure for pharmaceutical products, and track actual transactions to rationalize the criteria for determining pharmaceutical prices. Korea must strengthen the Drug Utilization Review (DUR) to establish a managing mechanism that will enable an appropriate utilization of pharmaceuticals, and these efforts must be accompanied by measures to expand bioequivalence tests, and to prepare an institutional foundation providing incentives to medical institutions, thereby encouraging the usage of affordable and high-quality generic pharmaceuticals.

2.4 Improving the Treatment Cost Payment Method to Rationalize Cost Expenditures

To address the problem of the ever-increasing health and medical costs, Korea can no longer avoid the need to change the payment system, since the quality of the medical services cannot be damaged. As examined above, the cornerstone of Korea's system of payment for treatment costs is the fee-for-service system, with the case payment system and

the fixed per diem system partially applied to illnesses and procedures requiring in-patient treatment. The fee-for-service system includes elements that induce increases in medical fees, and critics have constantly raised the need to revise this system. In the fee-for-service system, treatment costs are compensated based on the amount of services provided, and therefore the costs are compensated, even in cases where the medical providers require unnecessary treatment or cause complications or side effects, leading to a lack of micro-level efficiency and difficulty in controlling treatment costs. The system also makes it almost impossible to predict the total treatment cost and therefore impedes the financial sustainability and stability of the health insurance system on the macro-level (Commission for the Advancement of Health Security, 2010: 52).

In advanced countries, there are almost no cases in which a country relies entirely on the fee-for-service system. As a result, a majority of countries hybridize a variety of payment methods. Based on research and experience gained from past achievements, Korea should also strengthen efficiency on both the macro and micro levels by instituting diverse payment methods, in addition to the existing fee-for-service system and develop a payment system that is best adapted to our local conditions.

First, at the macro level, Korea needs to institute a global budget system that establishes a level of total treatment costs and a rate of increase that is acceptable by social consensus. To make this system feasible, it is imperative to develop a system to suit particular local conditions by applying a method that systematically sets expenditures targets for each sector, or a method of setting a ceiling on total costs. Moreover, in cognizance of the importance of social consensus, structural efforts must be made to encourage discussions among the interested parties, including the various medical service providers, consumers, civic society, insurer, and government.

Next, to bolster efficiency at the micro-level, Korea needs to supplement shortcomings in the relative value system, as reflected in the current fee-for-service system, while building a more inclusive system for governing payment units through a more appropriate distribution of the financial responsibilities between the medical providers and insurer. As regards the in-patient sector, Korea should expand the implementation of the new case payment system that is currently applied to the demonstration projects centered on the Ilsan Hospital, under the aegis of the Corporation. Korea can also develop and apply a capitation pricing system to the field of primary care in the out-patient sector. These measures, of course, must be predicated on a clearly established medical services delivery system.

2.5 Reforming the Medical Services Delivery System and Strengthening Primary Care

The amount of health and medical resources, and the level of usage of medical services in Korea, have both increased rapidly. From the perspective of the consumers of medical services, this development improved the accessibility of medical services. However, this

excess may lead to inefficiency and financial wastefulness. When compared to other countries, Korea exhibits an inefficient pattern in the usage of its medical resources, illustrated by its relatively longer periods of hospitalization, lower levels of hospital bed occupation rates, and the reduced number of days of usage for personnel and hospital beds.

In principle, to enhance the macro-level efficiency in the utilization of resources, we need to establish a policy for the management of medical resources on the governmental level that will encourage or mandate a balanced distribution of high-quality medical resources, by type and by region. For this purpose, Korea can review possible measures such as building a system for evaluating service quality, organizing a training and dispatching system for medical personnel, instituting a total quota system on hospital beds to correspond to the level of demand for medical services in particular regions, and providing a fee incentive system targeting medical institutions located in areas with shortage in medical services or institutions that supply essential services.

Meanwhile, to reconstitute the collapsed medical delivery system, Korea should to develop and institute a referring doctor system to perform a gate-keeping function, so that citizens can be provided with lifetime health management service centered on primary care. Concurrently, Korea needs to provide incentives to induce incremental reductions in the reliance on clinic-level hospital beds and out-patient treatment at hospitals, and establish obligatory provisions regarding patient referral and patient transference among medical institutions.

2.6 Project to Strengthen Preventive Measures

In addition to treatment-focused applications, health insurance coverage can be expanded to encompass all stages, including health promotion and preventive projects, preventive care against illnesses and rehabilitation. It is very important to provide care after the occurrence of a disease or injury to ensure appropriate treatment, and to prevent further deterioration. However, preemptive care to prevent the occurrence of illnesses in advance can be more effective than ex post facto treatments for maintaining a healthy life for individuals, and it is also the most cost-effective method for reducing medical expenses on the national scale. It is therefore necessary to adopt a new method for managing illnesses, namely the method of advanced prevention, which allows early detection of illnesses and health-promoting approaches to improve the health-related behaviors of individuals. To expand and reinforce efforts building upon the current practice of national health screenings to develop a lifelong health screening program for all age groups, it will be necessary to further systematize the contents and screening processes to bolster their substantial value, and also to integrate the screenings that are currently administered by each respective management agent, to improve the efficiency of the screening system's management and operations.

Chronic diseases are caused by a diverse array of causes, but they are frequently caused by the health-related behaviors of the individual, particularly those pertaining to eating

and exercise. According to research by the American Public Health Association, smoking, drinking alcohol, insufficient exercise, bad nutrition and diet, high blood pressure and hyperlipemia are well-known risk factors that can cause chronic diseases.

Chapter 6

Implications

Implications

We have hitherto discussed the circumstances surrounding the emergence of National Health Insurance in Korea, including the process of its development, the evolving changes in policies, and the method of its current operations. We have also explained how Korea's National Health Insurance has been evaluated, and analyzed possible problems confronting it for the future.

In this chapter, we will examine the implications that may be drawn by underdeveloped countries seeking to implement their own health insurance system, by reviewing the development of Korea's National Health Insurance system. We intend to examine these implications in three aspects. First, we will discuss how certain choices made in the early stages of the implementation of medical insurance have enabled the growth of Korea's health insurance system. Secondly, we will describe how certain contemporary problems could have been avoided if certain issues had been deliberated with greater care in the earlier periods of health insurance implementation. Lastly, we will address the issues that should be deliberated upon in the early stages of in the introduction of health insurance, taking into consideration the characteristic circumstances of each country.

Looking back on the actions taken in the early stages that made it possible for the health insurance system to develop in Korea, the government's strong leadership in undertaking a series of social reform measures to respond to the citizens' demands regarding economic and social developments and the successful economic development in Korea were the key factors that propelled the development of the social security system. Also, the active participation of the medical service providers and private corporations played a significant role enabling the emergence of health insurance. Ultimately, the implementation of Korea's health insurance program was the combined outcome of the energetic support of its government (political leadership), the preparation of the institutional groundwork through investigations and research, economic growth, the voluntary participation of the private sector, and a successful promotional campaigns directed at citizens.

Secondly, as regards the efforts to expand the base of policyholders, in the early stages of its health insurance program, Korea first targeted employment-based policyholders at large companies with 500 or more employees. It thereafter expanded eligibility to self-employed policyholders located in agriculture and fisheries communities. Korea's health insurance was first launched with limited benefits. In other words, Korea adopted an incremental approach in the process of expanding eligibility and the range of benefits, which made it possible to alleviate potential dissatisfactions among policyholders and providers, and facilitated management and operation by ensuring convenience in administration. Korea also avoided large burdens in financing and managing the expenditure of benefits costs, which allowed the country to build the groundwork for a soft landing when transitioning from health insurance to the universal form of National Health Insurance today.

Thirdly, to secure funding, Korea initially charged a user contribution fee to employment-based policyholders in the early years of the health insurance system, and thereafter underwent the process of mobilizing governmental financial support when the system was expanded to agricultural and fisheries communities. Such financial support ensured that in the early stages of health insurance implementation, the policyholders were offered low premium rates as an incentive to participate in the insurance, which allowed Korea to consolidate the basis for stably expanding the health insurance to a nationwide scope.

Next, we consider the current problems of the system and how they may have been avoided if certain issues were more fully deliberated upon in the early period of implementation. First, the fact that the fee payment system was adopted without more in-depth discussions of systems used in other countries (aside from Japan) is pointed out as problematic. Because Korea is now facing difficulties in efficiently managing medical care costs because it simply imitated the Japanese system, it is necessary to engage in a wide-ranging discussion of the various systems available for handling fee payment systems in the early stages of implementing a health insurance system. For example, Taiwan offers an excellent example to follow by stipulating how its payment system will be transitioned stage-by-stage into a global budget system.

Secondly, regarding the issue in the supply of medical services, the early stages of health insurance Korea was reinforced by the public sector, with the rationale of providing public medical services in certain areas. But, since the 1980s, the percentage occupied by the public sector has declined to 20% in comparison to the private sector. This outcome reflects the rise in income fueled by economic development, and the increase in demands for medical services resulting in the expansion of the private sector. Therefore, it appears that in the early stages of implementing health insurance, it is necessary to define the status and concept of public hospitals, and determine a long-term plan indicating how to maintain a system of public medical services, determining the investments necessary for such an agenda.

Thirdly, Korea has adopted the method of charging insurance premiums to finance its insurance system, and the factors that determine insurance premiums differ between employment-based policyholders and self-employed insurance policyholders. The complexity

of this method of charging insurance premiums, and the discrepancies in the amount of insurance premiums that arise when employment-based policyholders change to a self-employed insurance policy (or vice versa), have exacerbated complaints from citizens. Two representative methods for financing insurance are the method of financing through taxation, and the method relying on insurance premiums, and in cases where the latter method is adopted, there needs to be efforts to unify the system for charging premiums from the initial stages of the implementation of health insurance, and efforts to simplify the components for determining charges.

Fourth, health insurance is managed and operated by the National Health Insurance Corporation in Korea, while the Medicaid benefits for the low income class is handled by the government. But this approach has been criticized for its shortcomings in operational efficiency. Also, in the early period following the introduction of health insurance, the group eligible for medicaid benefits comprised 10% of the total national population. But under conditions in which the beneficiaries of these medical services receive support for insurance premiums from government with virtually no responsibilities for co-payment, the problem of moral hazards leading to increases in expenditures for benefits costs may become prevalent. For these reasons, it is impossible to increase the number of people eligible for such support, and the percentage of the population receiving this support has declined to around 3%. When first implementing a health insurance system, there needs to be long-term plans established regarding the scope of eligibility for medicaid benefits, and it must be considered that recipients of such medicaid benefits may be highly susceptible to moral hazards regarding the expenditure of medical costs, since the level of co-payment for insurance fees and the level of financial burden on the individual beneficiary is low compared to the premiums charged to ordinary health insurance policyholders. For this reason, mechanisms need to be prepared for efficiently managing eligibility to receive such medicaid benefits, and the expenditures for benefits costs.

Fifth, though Korea's health insurance is operated on the principle of social insurance in which the insurance premium must be the main source of revenue, the difficulty of raising insurance premiums beyond its current level has been an obstacle to securing adequate funding. Also, these problems have resulted in a continual increase in governmental subsidies, and how these government subsidies are being used has been a controversial matter. As the financial viability of health insurance has become undermined, there have been various efforts to secure financing from revenues other than insurance premiums. In light of Korea's experiences, it appears prudent to begin with low insurance premiums in the early years of instituting health insurance to secure the participation of policyholders, and some form of governmental support in certain areas seems necessary. However, once the health insurance system has stabilized, efforts must be made to actively persuade policyholders to raise insurance premiums to a more reasonable level, and to ensure that insurance premiums provide sufficient financing for the system, so as to minimize governmental support. In addition, clear provisions must be made to regulate the purposes for which government subsidies are used.

Sixth, as Korea's health insurance first began at the unit of cooperatives and gradually expanded to include all citizens in the National Health Insurance system, there was an initial absence of efforts to form a database of information during the early period. ,Although information pertaining to the period after national health insurance was implemented has been collected into a database, this resource by itself has not led to satisfactory results, in terms of usefulness for policy decisions. Therefore, it is advisable for countries to strive to organize pertinent information into a database from the early stages of implementing health insurance, and to seek ways to utilize relevant data for various policy measures, such as the construction of an infrastructure for health and medical related issues.

Lastly, given that Korea has implemented various policies in accordance with the country's local conditions, we may point out certain issues that each country must consider in the process of instituting health insurance to befit their local circumstances. First, while Korea aimed to incrementally expand both the scope of eligibility and the range of benefits in the early period of operating health insurance, Korea did not succeed in expanding benefits to the degree anticipated, whereas eligibility did indeed expand to all citizens within 12 years. It is regretful that Korea was not able to take more initiatives to offer benefits that correspond to the improvements in eligibility from the initial stages of health insurance. From this we should note that governments must deliberate whether to concentrate on expanding eligibility among the population, or to focus on expanding the range of benefits in tandem with expanding eligibility. This decision deserves serious deliberation, since the issue is closely linked to insurance premium revenues.

Also, we should note that Korea began operating its health insurance through a cooperative method in the early years, and later, following the integration of the organization, the government's role came to be emphasized to a much greater degree. In operating a health insurance system, there are advantages and drawbacks, depending on the agents of the operation. It is possible to consider the examples of Taiwan, where the government exercises complete authority in the operation of health insurance, or Germany, where the National Health Insurance Corporation is charged with the responsibilities of an insurer along with autonomy in governing benefits or financial decisions. In the cooperatives system, where the autonomy of each cooperative is maintained, methods for pursuing efficiency in management while minimizing discrepancies in revenue and expenditure among the cooperatives are necessary, while on the other hand, single integrated insurer systems would demand mechanisms to ensure internal competition in management and operations.

In conclusion, there is no such thing as the "best" healthcare reform and National Health Insurance system in the world. Learning the healthcare and health insurance systems of one country does not mean that it can be directly transplanted into another. A country's healthcare and insurance system evolves over time, along with its people's choices and national policies. Success and of failures, perhaps similar to those experienced in Korea, will be inevitable for any country that tries to institute its own system.

Commission for the Advancement of Health Security, the National Health Insurance Corporation, Report on the Activities of the Commission for the Advancement of Health Security, 2010

The National Health Insurance Corporation. Health Insurance Review&Assessment Service, A Statistical Review of the Past 30 Years of Health Insurance, 2007

The National Health Insurance Corporation, Major Statistics on Health Insurance for 2010, 2011

The National Health Insurance Corporation, Analysis of the Current Data on Benefit Costs Compared to Insurance Premium Charges in 2010, 2011

The National Health Insurance Corporation, Major Statistics on Health Insurance for the 1st Quarter of 2011, 2011

Kim, Gi-Won, Social Security Legislation Theory, Nanumeujip (The House of Sharing), 2006

Kim, Seon-Hee, "A Morphogenetic Approach to Policy Changes: With a Focus on Medical Insurance Fee Policies", Korea Public Administration Journal 43(2), pp. 227-256, 2009

Kim, Yeon-Myeong, "Interests Involved in the Integration of Medical Insurance, its Significance and Upcoming Challenges" Edited by Jong-Chan Lee, Korea's Great Medical Debate, Sonamu, 2000

Kim, Jeong-Hee, Jeong, Jong-Chan, Ho-Yong Lee, Suk-Ja Choe, Jin-Gyeong Lee. Research of Current Statistics on Treatment Costs Charged to Health Insurance Patients in 2005, the National Health Insurance Corporation, 2006

Kim, Jin-Su, Seo, Su-Ra, In-Deok Choe, Jae-Jin Kim. Comparative Research on Income Identification Systems Used in Korea and Abroad for the Purpose of Stabilizing the Finances of the Health Security System, The National Health Insurance Corporation, 2009

Kim, Jin-Soo, Choe, In-Deok, Dong-Heon Lee, Sang-Yoon No, Hyeong-Jun Sin. Characteristics Analysis on the Data on Income Holdings among Health Insurance Policyholders, the National Health Insurance Corporation, 2007

Ok-Ryun Moon et al., Health Security Theory, Shinkwang Publishers, 2000, 2006

Park, Il-Su, Lee, Dong-Heon, Research on the Mid-term and Long-term Prospects for the Health Insurance System, The National Health Insurance Corporation, 2010

Ministry of Health, Welfare and Family Affairs, 2008 White Paper on Health Welfare and Family Affairs, 2009

Ministry of Health and Welfare, 2009 White Paper on Health and Welfare, 2010

Ministry of Health and Welfare, 2010 Statistical Yearbook on Health and Welfare, 2010

Sin, Hyeon-Woon, "Methods for Reforming the Health Insurance Management System and Reestablishing the Role of the Insurer", Health and Welfare Forum Issue No. 82, Korea Institute for Health and Social Affairs, 2003

Yang, Myeong-Saen, History of Changes in the Governmental Regulation of Medical Fees, Journal of the Korea Hospital Association, 262: pp. 95-103. 1999

Oh, Geun-Sik, "The Accomplishments and Limitations of the Medical Insurance System", White Paper on Health Insurance, The National Health Insurance Corporation. Chung-Ang University Social Sciences Research Institute, pp. 35-89, 2001

Won, Seok-Jo, Theory of Social Welfare Policy, Yangseowon, 2008

Yoo, Seung-Heum et al, 60 Years of Health and Medicine in the 60 Year History of the Republic of Korea … The Direction for the Future Development of Health and Medicine, 2008, Ministry of Health, Welfare and Family Affairs, National Academy of Medicine of Korea

Yoo, Seong-Yoon, Methods of Institutional Improvement to Establish the Fee Contract System, Medical Policy Research Institute, 2005

Lee, Yong-Gap, Kim, Gyeong-Ha, Han, Jun-Tae, Research on Improvement Methods to Reduce Health Insurance Premiums, the National Health Insurance Corporation, 2009

Lee, Yong-Gap, Moon, Seong-Woong, Nam-Gyu Seo.Gi-Chun Choe, Integration of the Assessment and Collection Functions for the 4 Major Social Insurances and Methods of Improving National Health Insurance, 2007

Lee, Jin-Gyeon, "Analysis of the Current Conditions and Trends of Health Insurance Co-Payments", Health Insurance Forum (Autumn Issue), 2002

Medical Insurance Association, The Historical Trajectory of Medical Insurance (Up to 1996), 1997

Jo, Won-Tak, "The Project to Implement Integrated Medical Insurance: With a Focus on the Context Behind the Deferment of the Legislation on Medical Insurance Integration", Social Welfare Policy Volume 9, Korea Academy of Social Welfare Policy, 1999

Jo, Won-Tak, "The Introduction of the Medical Insurance System and the Historical Progress of its Implementation", Health Insurance White Paper, The National Health Insurance Corporation. The Social Sciences Research Center at Chung-Ang University, pp. 1-34, 2001

Gi-Chun Choe. Ho-Yong Lee, Seon-Mi Lee, Research on the Current Status of Treatment Costs for Health Insurance Patients in 2008, The National Health Insurance Corporation, 2009

Choe, Yeong-Sun, Su-Jin Baek. Eun-Sil Im. Ho-Yong Lee. Hye-Jeong Jang, Research on the Current Status of Treatment Costs for Health Insurance Patients in 2009, The National Health Insurance Corporation, 2010

Choe, Byeong-Ho, "New Challenges for Policy Following the Financial Integration of Health Insurance", Health and Welfare Forum, Issue No. 82, Korea Institute for Health and Social Affairs, 2003

National Statistical Office, Nationwide Estimate of the Future Population, 2006

National Statistical Office, Statistical Research on Population Trends

Homepage of the National Health Insurance Corporation www.nhic.or.kr

Homepage of the Health Insurance Review&Assessment Service www.hira.or.kr

G. Bonoli, Classifying Welfare States: A Two-dimension Approach, Journal of Social Policy, 26 (3): 351-372, Cambridge University Press. 1997

R. B. Saltman, R.Busse and J.Figueras, Social Health Insurance Systems in Western Europe, Open University Press, 2004

www.ksp.go.kr

Ministry of Strategy and Finance, Republic of Korea

427-725, Republic of Korea Goverment Complex 2, Gwacheon, Korea Tel. 82-2-2150-7732 www.mosf.go.kr

KDI School of Public Policy and Management

130-868, 87 Hoegiro Dongdaemun Gu, Seoul, Korea Tel. 82-2-3299-1114 www.kdischool.ac.kr

ISBN 978-89-93695-32-8

Knowledge Sharing Program
Development Research and Learning Network

- 130-868, 87 Hoegiro Dongdaemun Gu, Seoul, Korea
- Tel. 82-2-3299-1071
- www.kdischool.ac.kr