Lessons learned from ...

The South Korean Health Care System

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Inside:

Health care system reform is an ongoing policy issue in almost every industrialized nation.

The United States sponsors a unique health care infrastructure. One component is highly regulated, and the other a "free market." Neither component is coordinated with the other; and they are often in conflict.

Our choices will be to regulate more, create freer markets, coordinate subsystems, or do nothing. Whatever approach is taken, cost control measures will be paramount.

Every industrialized nation has adopted a specific approach to the provision of health care services to the public. Every system has something to teach us. Each is worth examining.

All other nations have adopted a version of compulsory health insurance within a regulatory framework. The most prevalent financing method is income-adjusted premiums or levies.

The most common form of regulation is standardizing professional fees and hospital revenues. Most notably, many countries prefer not to micro-manage the practice of medicine nor the administration of the system.

This series examines the health systems of several nations and the reform actions of three states. They include, but are not limited to:

- ***Oregon***
- ***Hawaii***
- ***West Germany***
- ***South Korea***
- ***Washington***
- ***Canada***
- ***Japan***
- ***Australia***

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Primary Source

The primary reference for this brief is the article "Universal Health Care Coverage in Korea," Gerard F. Anderson, Health Affairs, Summer 1989. This brief abstracts significant portions of this article. It also standardizes the analysis format and creates a context for this analysis.

Historical Origin

The 1988 Summer Olympics highlighted the economic progress made by the Republic of South Korea since the end of the Korean War. The Korean approach toward health care systems and financing is virtually ignored by American policy analysts. The evolution of this system should be very instructive for several reasons:

- The Koreans literally created their system from scratch starting in 1976.
- They made policy decisions that were consistent with the economic growth plans of the country.
- The Koreans were able to model their system after any of the mature systems of theindustrialized nations.

In 1963 the per capita income in Korea was less than $100. In the same year the government permitted larger companies to offer health insurance, and allowed for the creation of "medical insurance societies." These societies resembled the West German "sickness funds" in that they are essentially non-profit executors of self-funded health plans.

The first health insurance program allowing individual health policies was authorized in 1969. In 1976, the government announced a plan and timetable to achieve a universal health insurance plan.

The plan called for the achievement of universal health insurance by 1989. It was met by 1988. The phased-in time schedule is below:

1963	Group health insurance plans permitted for large companies.
1969	Individual health insurance plans permitted.
1976	**Insurance compulsory for firms with more than 500 employees.**
1977	Federation of Korean Medical Insurance Societies established.
1977	Government program for low income individuals established (Medical Aid).
1979	**Insurance compulsory for government workers and school teachers.**
1979	**Insurance compulsory for firms with more than 300 employees.**
1981	**Insurance compulsory for firms with more than 100 employees.**
1981	Societies for self-employed established.
1981	Demonstration in rural areas started.
1982	**Insurance compulsory for firms with more than 16 employees.**
1988	**Insurance compulsory for everyone.**

Organization
The overall purpose is to assure that each Korean is covered by a meaningful health insurance policy.

Individuals are required to possess health insurance. There are no exceptions for seasonal, part-time or unemployed workers. Lower income workers are subsidized to a degree.

The insurance premium amount is income-adjusted. Individuals are required to pay 50% of the income-adjusted family premium. All patients are obligated to pay for their care. There are very high co-insurances that are designed to discourage over-utilization.

The Korean system requires that universal health insurance be provided basically by individual and corporate premiums. The government is involved in setting overall policy, standardizing fees, providing administrative costs and providing for the poor.

Fees and operating budgets are set by the government in coordination with providers consumers and corporations. The operation of the system is essentially within the private sector. The essential fabric of the Korean system are the interlocking mutual obligations of employers, employees, insurers, providers and government. Each has obligations toward the other.

The sources of health insurance are:

Type of Coverage	1977	1988
Corporate	8.6%	33.0%
Government workers, teachers, and pensioners	0.0%	10.7%
Occupational	0.2%	4.2%
Medical Assistance	5.7%	10.0%
Urban Regional Medical Insurance	0.0%	22.7%
Rural Regional Medical Insurance	0.0%	19.4%
Total	14.5%	100.0%

Covered Services
The basic health plan package includes hospital, physician, maternity, and prescription drug benefits. In 1988, limits for physician visits and hospital visits were removed.

All health insurance is sponsored by the adult worker(s) of the family. All dependents are automatically covered when the worker is covered. There are six major populations addressed by the Korean system. Each has a proscribed medical insurance society depending upon employment, income or residence. Regardless of the plan covering the insured, the benefits are essentially the same. The groups are:

- Employed
- Government/teacher/retired workers
- Self-employed
- Other urban residents
- Other rural residents, and the
- Poor.

Dependents (spouse, children and parents of employed person) have always been automatically covered by any of the insurance plans. In 1985, parents-in-law were added. In 1988 siblings, and their children, were also covered if they are dependents of the worker.

Providers of Care
Almost all hospitals and clinics are either for-profit entities or owned by physicians. Korea has a limited number of hospital beds. There are about 67% fewer beds than Japan; 140% fewer beds than the United States and 218% fewer beds than Canada. Rural areas have only one-third of the population adjusted beds that urban areas do.

System Financing
Employers are responsible to pay at least 50% of the income-based premium covering every employee and their dependents; employees are responsible to pay the remaining premium via a payroll tax.

Providers are obligated to care for all patients and the medical insurance societies are required to insure all eligible citizens. The medical insurance societies are obligated to keep health care costs low and to negotiate with providers.

Physician fees and hospital operating budgets are set by the government in coordination with providers, consumers and corporations.

Most health insurance is employer-based. It is financed through the "medical insurance societies" with income-based premiums collected as a payroll deduction. In other words, the premium amount varies with income. Employers and employees share premiums equally.

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There are 144 medical insurance societies in Korea. Some are subsidiaries of large individual corporations while others are the result of smaller companies banding together.

All of these societies are administered by the Federation of Korean Medical Insurance Societies. The Federation processes all claims and provides plan administration for approximately 5% (compared to 18% in the U.S.) of total costs.

The government sets the minimum standard of benefits. Management and labor negotiate the individual corporate benefits. There is little difference in benefits from one corporation to another. The costs range for 3-8% of payroll.

The average cost of the premium is 3.6% of payroll with employers and employees contributing equally. Therefore, the average payroll deduction for employees is 1.8%.

For the societies covering the non-corporate sector, the premiums are based upon family income and the number of family members.

The urban and rural residents that do not fit into other categories are covered by a separate program. In this program, the government pays about half of the expenses, and individual premiums the other half. Premiums are based upon income, assets and family size.

Over 33% of the population is covered by these corporate-based societies. Another 56% of the population is covered by other private medical insurance societies. The remaining 10% (lowest income people) are covered by the government.

In order to be eligible for government assistance, an individual must earn less than 25% of the average per capita income.

Cost Controls

Physician and hospital fees are set by the government in coordination with providers, consumers and corporations. Medical fees have been limited to economic growth, and this has started to become controversial.

Administrative expenses of medical insurance societies are below 5%. The societies, with the help of the 50% premium payment by individuals, have linked utilization with premium in the minds of the insured.

Access to Care

All Koreans possess health insurance. However, access is uneven because of very high coinsurances such as 55% for tertiary care facilities, 50% community hospitals and 20% in physician offices. Korea administers 41 income categories. The utilization rate of the lowest income groups is four times less than highest income groups.

System Limitations

The fairly simple construction of the system is colliding with rising patient expectations. There are no rigid cost controls and little health facility planning. As the system matures, the Korean government will come face-to-face with some of the cost issues being addressed by western nations.

Like Japan, Koreans expend an extraordinary amount on prescription drugs. Almost a third (32.6%) of all health care expenses were for pharmaceuticals, compared to 8.8% in the United States.

South Korea at-a-Glance

Participation	*Compulsory*
Insurance Coverage	*Universal*
Insurance Benefits	*Standardized*
Payer Type	*Single*
Primary Payer	*Government*
Primary Financing	*Premiums*
Secondary Financing	*General Revenues*
Physician Status	*Private*
Physician Fees	*Standardized*
Hospital Status	*Private*
Hospital Revenue	*Standardized*
Balance Billing	*No*
Expense Per Capita	*$115 (1986)*
Dominant Sector	*Public*
Dominant Payer	*Federal Government*
Cost Controls	*Yes*
	Standard Fees
Special Features	*Expanded dependents*

Lessons

The Korean Health Care System has several important lessons to teach as we seek suggestions and ideas for health care reform in the United States. They include:

Economic Growth and Universal Coverage

Compulsory health insurance and economic growth were not incompatible in Korea. Between 1976 and 1989, the Korean economy expanded at a greater rate than any other country in the world. During the same period, Korea installed a compulsory health insurance program within all sectors of the economic society.

Cost Controls

Costs have been restricted to the rate of GNP growth. This was done by the government standardizing physician and hospital fees after negotiations between the corporate, consumer and provider sectors. Cooperative and responsible negotiations concerning standard fees and global budgeting is required in order to achieve cost control.

Subsidies

The Korean system recognizes that some cross-subsidization is necessary and therefore income-adjusts the premium at the workplace, and subsidizes the premium in the absence of an employer.

Of all of the international models, the German system seems closer to what many Americans appear to aspire; the Australian model appears to be closer to what we are likely evolve. In the newly emerging industrialized nations the Korean model is closest to the German one.

Limited Government Involvement

There is limited government involvement in the Korean system. Government adopts the role of setting the fundamental statutory principles and that of a participant in regulation. The actual management of the health care financing and infrastructure lies entirely within the private sector.

Cost Sharing

The United States may have gone too far in subsidizing health care for employees. Any responsible reform must require a meaningful participation by employees to the extent that responsible spending decisions are forced. The Korean system requires that employees pay 50% of the overall insurance costs with the individual premium amount that is income-based. Also very high co-insurances are imposed on hospital services.

Universal Coverage

If one is to achieve universal coverage through the private sector, there must be compulsory insurance provisions for employers-employees; and also compulsory insurance offerings on the part of insurers. There should be no exclusions and no options. Anything less insures less than universal coverage.

Per Capita Health Spending in U.S. Dollars, 1989

The Republic of South Korea is an emerging industrialized nation. The national spending for health care is a fraction of the other industrialized and developed nations. Nevertheless, the principles of health system organization are more important in this analysis than the amounts expended.

Country	Spending
South Korea (1986)	**$115**
Australia	**$1,032**
Austria	$1,093
Belgium	$980
Canada	**$1,683**
Denmark	$912
Finland	$1,067
France	$1,274
Germany	**$1,232**
Greece	$371
Iceland	$1,353
Ireland	$658
Italy	$1,050
Japan	**$1,035**
Luxembourg	$1,193
Netherlands	$1,135
New Zealand	$820
Norway	$1,234
Portugal	$464
Spain	$644
Sweden	$1,361
Switzerland	$1,376
United Kingdom	$836
United States	**$2,354**
Mean All Countries	$1,094

Source: Health OECD, Facts and Trends (Paris: OECD, forthcoming) Health Affairs, Spring 1991, p 113.

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