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Korea's National Health Insurance—Lessons From The Past Three Decades

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ABSTRACT This study presents data on health care spending in South Korea in the three decades since 1977, the year its national health insurance—enacted in 1963—was enforced. National health insurance in South Korea is currently a single-payer program (that is both publicly and privately financed) that pays for privately provided health care. Universal coverage was achieved in 1989. As a result, the household share of total national health spending fell from 87.8 percent to 54.6 percent during the three decades, and the out-of-pocket share dropped from 87.2 percent to 38.0 percent. Although covered services have gradually expanded, benefits remain relatively low, and public funding is limited, leaving beneficiaries with relatively high copayments. Coupled with the fact that the government manages the schedule of fees paid to providers, the health care share of gross domestic product was a low 6.3 percent in 2007. An analysis such as this may be of particular interest in middle- or low-income countries contemplating expansions of coverage or undertaking insurance reforms.

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Korea has a system of privately provided health services, with more than half of the cost financed by the public sector. Private hospitals and clinics constitute more than 90 percent of the total number of medical institutions and account for nearly 90 percent of all beds. In addition, more than 90 percent of specialist doctors are employed in the private sector.

A system of national health insurance, described in more detail below, was enforced in South Korea in 1977. In 2007, 96 percent of South Korea's population was covered by the national health insurance program, and the remaining 4 percent was covered by a separate program called Medical Aid, which is a public assistance program for the very poor. The system is both publicly and privately financed. Besides financing much of the nation's health care coverage, the public sector—through Parliament, the Ministry of Health and Welfare, and the National Health Insurance Corporation—is involved in regulating the insurance system; specifying the list of national health insurance benefits; and managing the medical fee schedule, which determines how much providers are paid for goods and services.

This study traced the flow of money in the South Korean health care system from the sources of financing—households, businesses, and government—to the financing "agents," or programs that actually pay health care providers to deliver services. These agents include households that pay out of pocket for care, governments and businesses that pay for their own employees' health services, and insurers—both social security funds that administer the national insurance and private insurance firms.

Knowledge of where the resources come from, the channels they flow through, and how they are used is crucial to better stewardship of the system.[1] Such an analysis may be of particular in-

terest in middle- or low-income countries that are undertaking insurance reforms.

The Development Of National Health Insurance In South Korea

The historical development of national health insurance in South Korea can be divided into four periods: prior to 1977, when there was no national health insurance; 1977–1989, when coverage was first offered and—in 1989—finally expanded to the whole population; 1990–2000, when the benefits offered by national health insurance were expanded; and since 2000, a period in which the structure of the insurance system changed.

NO NATIONAL HEALTH INSURANCE Prior to 1977, patients had to pay for all health care out of pocket, except for care covered under a fund that assisted workers in the event of industrial accidents, which was then the only social insurance related to health care. During this period there was no public fee schedule, so providers in different locations could charge patients different amounts for the same health care. Because a visit to a medical institution was expensive, patients preferred to buy drugs at pharmacies, without a doctor's prescription, for the treatment of relatively mild symptoms. This practice was legal until prohibited by pharmaceutical reforms enacted in 2000.[2]

Rapid economic growth in South Korea in the 1970s, together with strong political will to strengthen a social protection system that had lagged behind such economic development, led to the nation's first compulsory health insurance program.

NATIONAL HEALTH INSURANCE INTRODUCED A publicly funded and managed social health insurance system was introduced in South Korea in 1977. Under this national program, a third party (the insurer) pays for health care for the general public. At the start, insurance was available only to a limited segment of the population, particularly workers in large corporations. The Medical Aid Program—a noncontributory, tax-financed program for the very poor—started in the same year. Together, these programs initially provided health insurance for about 10 percent of the population. Universal coverage was achieved in 1989.

For the employed who are insured by the national health program, individual contributions are set at 4.77 percent of gross salary (as of 2007), with the employer and employee each paying half. For the self-employed, contributions are calculated according to income as well as the value of property owned, which is based partly on the horsepower of personally owned vehicles.

The initial program covered businesses having 500 or more employees. Since then, coverage has gradually broadened to embrace businesses with fewer employees: 300 or more in 1979; 100 or more in 1981; 16 or more in 1983; and 5 or more in 1988. Health insurance was also expanded to include the rural self-employed in 1988. By July 1989, health insurance coverage was available to the entire population, including the urban self-employed—the last group to be brought into the program.

EXPANSION OF BENEFITS Once universal coverage was achieved, efforts were made to expand the benefits offered. In October 1989, prescription drugs dispensed at a pharmacy were added to the benefit package. The insurance program also extended the number of days allowed for treatment, from 180 days per year in 1994, and finally eliminated all restrictions in 2000.[3] By the turn of the millennium, major structural reforms were made to the national health insurance system. In July 2000, what had been about 370 insurance entities were integrated into one organization and designated as branches of the National Health Insurance Corporation (NHIC). This consolidation brought together the single insurer for government employees, teachers, and their dependents; 142 insurers for employees and their dependents; and 227 insurers for the self-employed.

In the latter half of 2000, doctors were prohibited from dispensing drugs and were limited to prescribing drugs, leaving drug dispensing to pharmacists. This change marked a drastic transformation in the South Korean health system.[4,5] The benefit package has since expanded, and the public share of financing has also continuously increased.

LOW CONTRIBUTION AND BENEFIT LEVELS A policy of low contributions and low benefits has continued since the introduction of South Korea's national health insurance system. Although covered services have gradually expanded, public funding for these services has remained limited, leaving beneficiaries with relatively high copayments. This has allowed universal coverage without putting an excessive burden on the government. At the same time, the government has exercised strong control over annual negotiations with health care providers about fees. As a result, health care as a share of gross domestic product (GDP) has increased, but from less than 3 percent in 1977 to just over 6 percent in 2007.

FREEDOM TO CHOOSE PROVIDERS From the perspective of users, South Korea's national health insurance system gives patients considerable freedom when it comes to choosing and accessing care providers. According to Organi-

zation for Economic Cooperation and Development (OECD) Health Data 2008 and 2009,[6,7] South Korea's per capita rate of consultations with physicians is relatively high: 11.8 visits per year in 2005, compared with the OECD average of 6.8 visits. This relatively high rate of consultations is notable, considering the fact that the number of practicing doctors per capita in South Korea is the second- or third-lowest among OECD countries: 1.7 doctors per 1,000 people compared with the OECD average of 3.1 doctors. The average length-of-stay in South Korean hospitals (13.5 days) is higher than the OECD average (9.6 days), and the number of acute care beds (6.8 per 1,000 people) is also higher than the OECD average (3.9 beds).

Study Data And Methods

DEFINITIONS South Korea's national health accounts distinguish between "final financing sources" and "financing agents/programs." Households, businesses, and government constitute the final sources. Money from these sources either is paid directly to health care providers or goes to insurers, social security institutions, charities, or other financing agents that in turn pay providers. In this study, all of the data sources and the estimates based on them are in line with the OECD's System of Health Accounts.[8] The term *sources of funding* as used by the OECD was divided into "final financing sources" and "financing agents/programs" as used by the World Health Organization (WHO).[9]

DATA SOURCES The main data sources are shown in Appendix 1.[10] The Health Insurance Statistical Yearbook was the main source of data for estimating final financing sources of health care. Data provided by both the Medical Aid Statistical Yearbook and the Industrial Accident Compensation Insurance Yearbook were used as well. The employer's share of national health insurance contributions for the employed was treated as "business" spending, and the employee's share came from "household" spending. All national health insurance contributions for the self-employed as well as households' out-of-pocket payments were also classified as household spending. The government's subsidy to the National Health Insurance Corporation, which administers the insurance system, was classified as government spending. Most of the premiums for private health insurance were classified as household spending.

Financing agents or programs can be either public or private. Data sources for the public sector included budget documents from all levels of government and various statistics from the national health insurance program, among others. The data on publicly financed health spending are quite reliable, but problems arise when trying to assess the level and composition of private health spending. These can be underestimated; therefore, much effort has been spent to measure them, as shown below.

The national health insurance program in South Korea has adopted a fee-for-service approach to reimbursement. Each medical institution submits details of the health care procedures it has delivered when filing medical fee claims, most of which are in the form of either electronic data interchange or electronic storage media (diskette or CD). These claims, about one billion per year, are reviewed in a computer program for reimbursement purposes. This information is used to produce the National Health Insurance Corporation statistical yearbooks used in this study.

Household out-of-pocket spending can usually be estimated based on three sources: data reported by providers; a general household spending survey; and a household spending survey focused on health care. This study used data from all three sources: the out-of-pocket expenditure survey conducted by the National Health Insurance Corporation for data on hospitals; the household income and expenditure survey conducted by the National Statistical Office, for which each surveyed household records details about its spending in a diary; and the health and nutrition survey by the Ministry of Health and Welfare, which is based on interviews.

Results

South Korea's total health spending as a share of GDP stood at 6.3 percent in 2007, and annual per capita health spending was 1.27 million won, equivalent to US$1,690 in purchasing power parity (purchasing power parity is the rate at which the currency of one country would have to be converted into that of another country to buy the same amount of goods and services in each country). South Korea shows a relatively low, but rapidly growing, level of health spending compared with other OECD countries. The gap between the South Korean level and the OECD average is considerably wider in health spending than in economic development: South Korean per capita health spending amounted to merely 59 percent of the OECD average, although the country's per capita GDP was 77 percent of the OECD average.

FINANCING STRUCTURE The study considered only one year of health spending, or money paid to providers to deliver services. This did not include investment in buildings, equipment, or training of providers, because these expenses

may occur over several years. Furthermore, they could be financed in part directly by government or businesses (but not by households) and in part indirectly from the revenues of provider institutions.

▶ **RECIPIENTS OF FUNDS:** The moneys described above go to various financing agents and programs, which actually pay health care providers (Exhibit 1). In 2007, 57.0 percent of health spending was publicly financed, from either general government funds (11.5 percent) or social security (45.5 percent), which included not only national health insurance (43.3 percent) but also Industrial Accident Compensation Insurance (2.2 percent). In the same year, 43.0 percent of health spending was privately financed (out of pocket, 38.0 percent; private insurance, 4.4 percent; and "other," 0.6 percent). These shares have changed substantially as reform has progressed.

▶ **PUBLIC FINANCING:** The public share of health spending in South Korea ranked as the third-lowest among OECD countries in 2007, after Mexico and the United States.[6,7] South Korea's private financing share is high because of substantial out-of-pocket payments. This is different from the case in other countries that have high levels of private financing, such as the United States, where private financing comes mostly through widespread private health insurance. The large out-of-pocket payments in South Korea relative to total household health spending do not necessarily indicate a high risk of catastrophic expenses for households, although copayments of 20–55 percent are required for services covered by the national health insurance program, and some services—notably, dental care—are not covered.

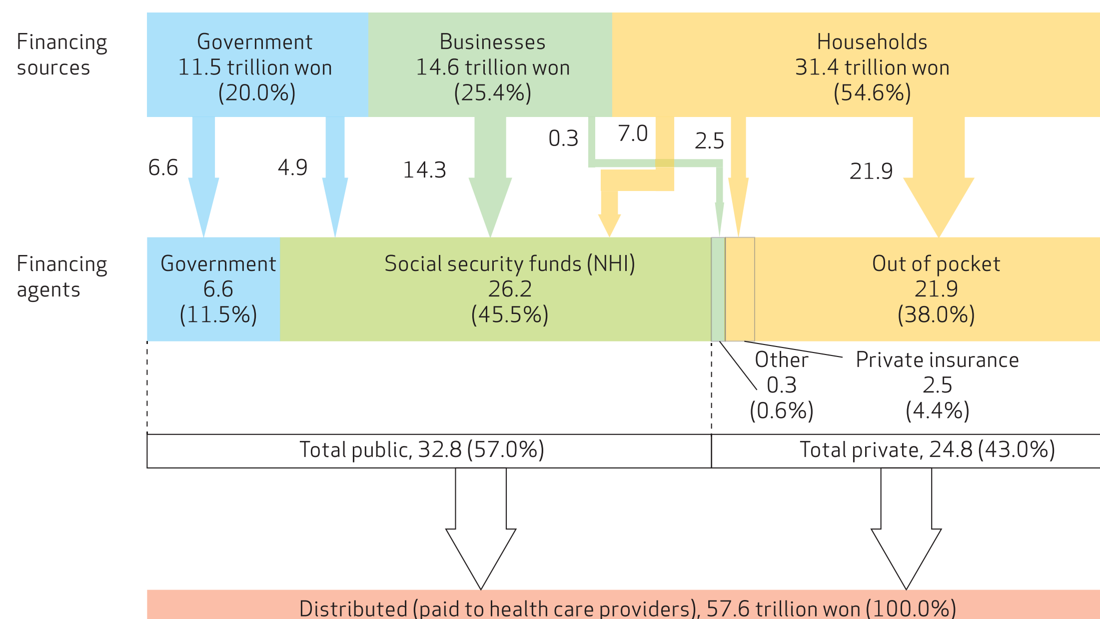
▶ **SOURCES OF FUNDS:** As shown in Exhibit 1, 54.6 percent of health spending in 2007 came from the household sector, with the remainder divided roughly evenly between the business and government sectors. The largest single category of payments by households was out-of-pocket spending, which accounted for 38.0 percent of the total. This included copayments for health care services covered under the national health insurance program and the full payments for services not covered by either national or private insurance. Households also paid premiums for private insurance and made contributions to the national health insurance.

Businesses accounted for 25.4 percent of current health care spending. Most of this represented employers' share of national health insurance contributions. Businesses also paid directly for some of their employees' health care; this spending was included in the very small "other" category (Exhibit 1).

The government's share—20.0 percent—

EXHIBIT 1

Financing Of The Korean Health Care System, Trillions Of Won, 2007



SOURCE Figures are estimated based on data from the sources in Appendix 1 (to access the Appendix, click on the Appendix link in the box to the right of the article online). **NOTE** Width of boxes and arrows is only approximately proportional to the amount of money flows.

included general revenues used to subsidize both the Medical Aid Program and the national health insurance system—8.1 percent and 6.4 percent of current health spending, respectively. It also included dedicated revenue from a tobacco tax, which is paid into the Health Promotion Fund. Introduced in the mid-1990s, this fund is used to pay for both health promotion programs and subsidies to the national health insurance program. In its role as an employer, the government contributed 1.4 trillion won (US$1.87 billion purchasing power parity) for the national health insurance coverage of its employees (data not shown).

HISTORICAL TRENDS IN FINANCING Exhibit 2 illustrates the financing trends of current health spending for 1977–2007 (specific percentages for each year are available in Appendix 2).[10] In general, the household share decreased, while both the business and government shares increased substantially.

Although the share of total health spending by households fell from 87.8 percent to 54.6 percent, the absolute amount of health care financed by households increased. Specifically, the annual average increase in household spending was 15.7 percent, but that was 1.8 percentage points less than current health spending.

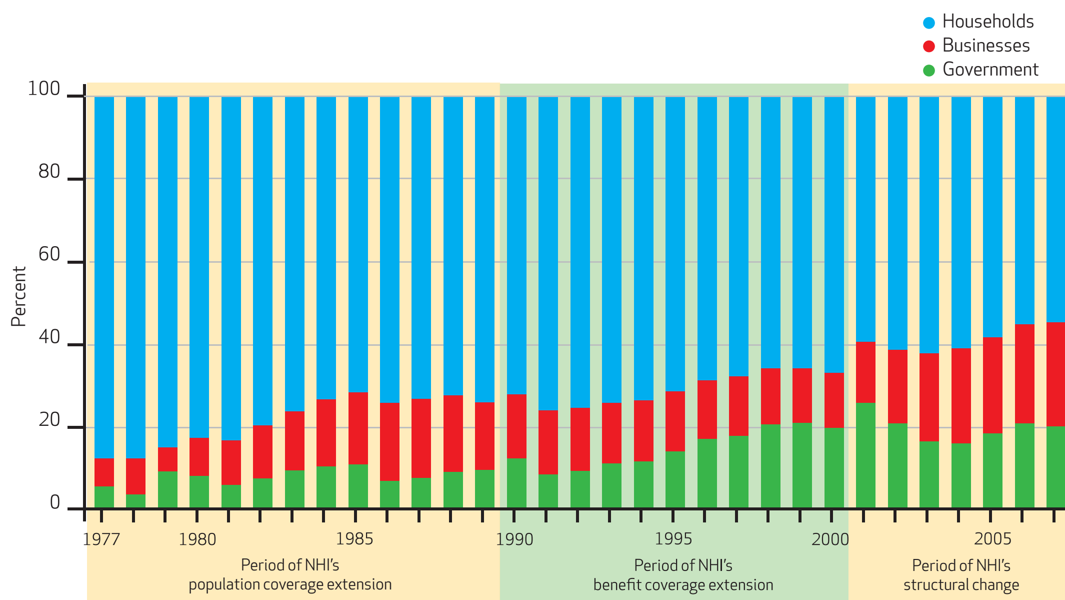
The business sector's absolute burden has increased more rapidly, at an annual rate of 22.9 percent, on average—5.3 percentage points higher than that of current health spending—raising the share from 6.7 percent to 25.4 percent. The share of health care financed by the government also rose more quickly, from 5.5 percent to 20.0 percent. During the same period, government financing increased 22.7 percent annually, on average—5.2 percentage points faster than the growth in current health spending.

Exhibit 3 shows trends in the shares of the different financing agents that actually pay for health services (specific percentages for each year are available in Appendix 3).[10] The household share decreased quickly when out-of-pocket payments alone were considered, and the share of funds coming from social security increased just as quickly. The household share of current health spending fell from 87.2 percent to 38.0 percent; the share borne by social security funds has sharply increased, rising from almost nothing to 45.5 percent.

In contrast to the trends in payments by financing sources, the government's share as a financing agent has risen relatively slowly. Apart from social security, the share rose from 7.6 percent to 11.5 percent. This difference in trends between government as financing source and government as agent is because of the subsidy the government pays to the national health insurance program, which is classified as part of "government" in the financing sources classifi-

EXHIBIT 2

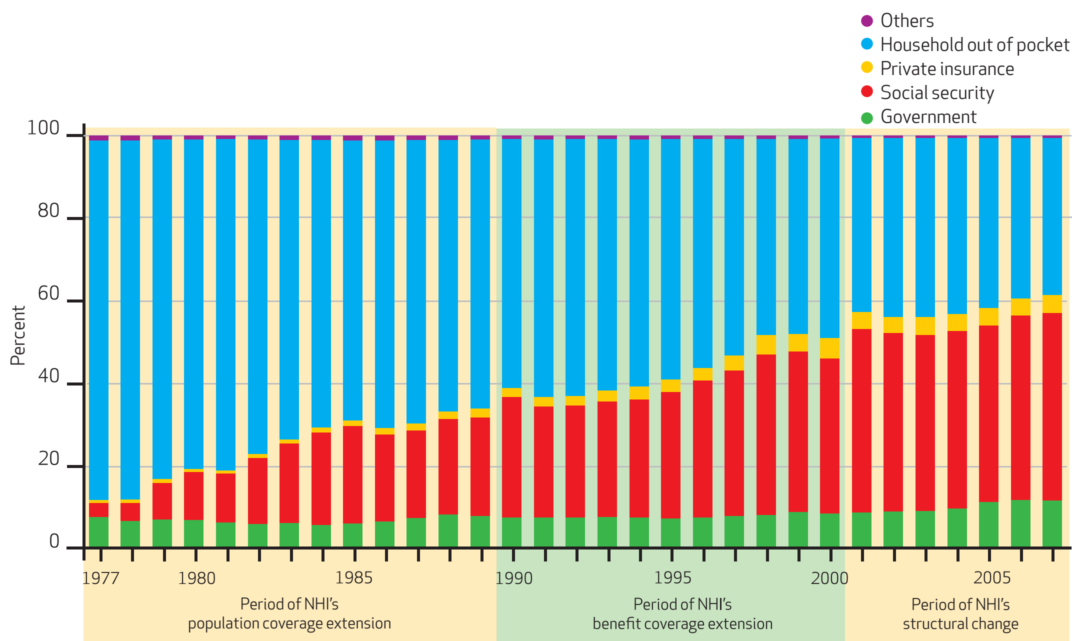
Financing Sources As A Share Of Total Current Health Spending, South Korea, 1977–2007



SOURCE Figures are estimated based on data from the sources in Appendix 1 (to access the Appendix, click on the Appendix link in the box to the right of the article online). **NOTE** NHI is national health insurance.

EXHIBIT 3

Financing Agents And Programs As A Share Of Total Current Health Spending, South Korea, 1977–2007



SOURCE Figures are estimated based on data from the sources in Appendix 1 (to access the Appendix, click on the Appendix link in the box to the right of the article online). **NOTES** "Others" includes corporations as well as nonprofit institutions serving households. NHI is national health insurance.

cation but as part of the "social security fund" in the financing agent classification.[11]

When the national health insurance program expanded its coverage to the self-employed in 1988 and 1989, the government initially subsidized insurance for that population, contributing 35–50 percent of the premiums. Since 2007 the government subsidy has been based on the total contributions from all of the insured, including both the self-employed and the employed. The current rate of subsidy is 20 percent, of which 14 percent comes from general tax revenue and 6 percent from the Health Promotion Fund, financed by tobacco taxes.

THE HEALTH CARE BURDEN ON ECONOMIC ENTITIES As noted above, the household share of current health expenditures has long been dwindling, whether the household is measured as a financing source or as a financing agent. Notably, the financing-agent share of households has been halved since 1977. Exhibit 4, however, reveals that the household financing burden—measured as the share of final consumption spending of households, or spending of all kinds, including health care—continuously increased during 1977–2007. This is true when it is calculated as financing source (from 3.6 percent to 6.6 percent of household consumption) or as financing agent (from 3.6 percent to 4.6 percent). In 2007, health care represented a much larger—but still relatively small—share of a much higher consumption level than it did in 1977.

Exhibit 4 also shows the burden that health care imposes on businesses or employers. Businesses' financing of health care has increased very swiftly in absolute terms, and businesses' share of current health spending increased about fourfold during the three decades examined here. However, this share does not indicate how easy or difficult it is for the business sector to bear this burden. A better indicator is the comparison of employers' health care financing with corporations' total labor cost. This indicator increased about eightfold from 1977 to 2007—more rapidly than employers' share of current health spending—but that level has not interfered with continuing rapid economic growth.

Exhibit 4 also shows that central and local governments' burden for their residents' health care has increased in every aspect. Increases in general revenue subsidies in support of the Medical Aid Program were largely responsible for this change. The burden on governments as financing sources of current health expenditure increased fourfold during the three decades, but the share as a financing agent did not even double. The difference between the two mea-

EXHIBIT 4

Health Care Financing By Households, Businesses, And Government Entities, South Korea, Selected Years 1977–2007

	1977	1987	1997	2007
HOUSEHOLDS				
Financing by households (financing source), trillions of won	0.40	2.9	13.3	31.4
Share of current health spending	87.8%	73.2%	67.9%	54.6%
Share of final consumption spending of household	3.6%	5.1%	5.2%	6.6%
Financing by households (financing agent), trillions of won	0.39	2.7	10.3	21.9
Share of current health spending	87.2%	68.6%	52.4%	38.0%
Share of final consumption spending of household	3.6%	4.8%	4.1%	4.6%
Current health spending, trillions of won	0.45	4.0	19.6	57.6
Final consumption spending of household	11.0	57.7	253.0	476.5
BUSINESSES				
Financing by businesses, trillions of won	0.03	0.8	2.8	14.6
Share of current health spending	6.7%	19.3%	14.4%	25.4%
Share of total labor cost by corporation	0.8%	3.5%	3.0%	6.3%
Total labor cost by corporation, trillions of won	3.5	22.2	94.8	232.3
GOVERNMENT ENTITIES				
Financing by government (financing source), trillions of won	0.02	0.3	3.5	11.5
Share of current health spending	5.5%	7.5%	17.8%	20.0%
Share of total general government spending	0.7%	1.5%	3.1%	4.1%
Financing by government (financing agent), trillions of won	0.03	0.3	1.5	6.6
Share of current health spending	7.6%	7.3%	7.8%	11.5%
Share of total general government spending	1.0%	1.4%	1.4%	2.4%
Total general government spending, trillions of won	3.4	20.7	110.5	279.4

SOURCES Final consumption spending of household and total general government spending derived from Organization for Economic Cooperation and Development. OECD. Stat extracts [Internet]. Paris: OECD; [cited 2010 Dec 13]. Available from: http://stats.oecd.org/WBOS/Index.aspx?QueryId=13602. Total labor cost by corporation derived from an annual labor cost and economy survey by the Ministry of Labor, South Korea. Data for current health spending and for financing by households, businesses, and governments were estimated in this study. **NOTES** One trillion won equals approximately US$1 billion for the period 2005–07. The spending amounts in won are nominal, not adjusted for inflation.

sures comes from the government subsidy to the national health insurance program, as explained above. The burden on the government as financing source—as a share of total general government expenditures—increased much more rapidly, from 0.7 percent in 1977 to 4.1 percent in 2007.[11]

Discussion

SUMMARY OF FINDINGS The introduction and expansion of the national health insurance system increased the burden on the average South Korean paying for health care, not only in absolute terms but also as a share of the household's general consumption spending. Households have been able to absorb this increase because rapid economic growth greatly increased incomes and consumption. However, the shift of the financing burden away from direct payment by households and toward businesses and government indicates that the national health insurance system has successfully done its job by lowering the financial barrier to health care. This suggests that the South Korean national health care system is now funded more equitably than in the past. Out-of-pocket spending as a share of total household spending has increased only slightly.

The South Korean national health insurance system has assumed greater responsibility for health care costs by expanding the guaranteed health care benefit package. To minimize its financial responsibility, the government did not become substantially involved in subsidizing insurance from general revenues at the initial stage of the program.[12] At first—starting in the late 1980s—it used general revenues only to support certain vulnerable groups of beneficiaries.

LESSONS FROM THE SOUTH KOREAN EXPERIENCE South Koreans' health status has improved sharply during the past thirty years, and life expectancy at birth rose from 64.4 years in 1976 to 79.1 years in 2006. Because incomes rose so much during this period, it is not clear how much of the health status improvement can be attributed to increased insurance coverage and reduced financial barriers to care, as opposed to other factors more commonly described as social and economic determinants of health. However, it is clear that the existence of national health insurance in South Korea has had several key

effects.

First, national health insurance has kept health care spending from increasing more rapidly by keeping the cost of health care services under control. The fee schedule, established in 1977, was set at 55–75 percent of the cost of services at that time.[13] Therefore, the cost of services provided to the insured was much lower than the cost of services requiring similar time and skills that were provided to the uninsured public. Medical providers tolerated such a low price level because they underestimated its effect, given that national health insurance was available to less than one-tenth of the population in 1977.

As national health insurance expanded, the rate of cost increases was adjusted so as not to exceed growth in the consumer price index. Such adjustments have continued. Although the Ministry of Finance and Economy could impose prices under the authoritarian government in the past, the National Health Insurance Corporation now negotiates prices with the provider groups, under the guidance of a Committee for Financial Management, which includes representatives from trade unions, farmers, and consumer groups.

Second, national health insurance has played a big role in lessening the direct burden on households of purchasing health care. National health insurance has made additional resources available to the health sector without imposing an excessive financial burden on individual households. Universal coverage and a higher share of the burden on the public purse serve as an inducement for the government to intervene to contain costs.[14]

One important lesson from South Korea's experience is that the strategy adopted by policy makers to support low contributions with limited benefits allowed the rapid introduction of the national health insurance program. However, this strategy resulted in households' bearing a relatively high share of the burden as direct or out-of-pocket payers, even though that burden has continuously decreased over the past three decades as a share of total health spending. Some services are still not covered by the national health insurance program. The prices of these services are higher than the prices of covered services because only fees for the latter are regulated, and providers are inclined to substitute services that are not covered for those that are, in order to increase their revenue.

If private health insurance organizations had been popular before the introduction of national health insurance in South Korea, it would have been extremely difficult to introduce and expand public insurance in competition with them. As evidence of this, recently private insurance companies in South Korea have strongly resisted the introduction of regulations that prohibit full coverage of copayments for services supplied by the national health insurance. The regulations were applied only after several years of conflict. The South Korean approach of applying public health insurance first to employees and only later to the self-employed may have helped achieve universal coverage because it is easier to assess and collect contributions from the employed. ■

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NOTES

1. World Health Organization. World health report 2000. Geneva: WHO; 2000.
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10. To access the Appendix, click on the Appendix link in the box to the right of the article online.
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Hyoung-Sun Jeong, who writes in this issue about health coverage and financing in South Korea, is a professor in the Department of Health Administration, College of Health Science, at Yonsei University, in Wonju. Among other important results, he notes, achieving universal coverage in his country has lowered the direct burden of paying for health care on Korean households.

At the same time, the goal of making that coverage affordable has served as an "inducement for the government to intervene to contain costs"—for instance, by negotiating the fees paid to health care providers. For other countries seeking to expand coverage, he says, a key lesson from Korea's experience is that broadening coverage is an important first step that should probably precede making the benefit package more generous.

Jeong was head of the Health Insurance Review and Assessment Services Policy Institute for more than two years, until August 2009, and he has served for several years as a Korean Focal Point for the Committee on Joint Data Collection for the System of Health Accounts organized by the Organization for Economic Cooperation and Development, the World Health Organization, and Eurostat (Statistical Office of the European Commission). Jeong also serves as the editor-in-chief of the *Korean Journal of Health Economics and Policy* and as an executive board member of the *Korean Academic Journal for Health Policy and Administration*.

He is a member of the Committee on Health Insurance Deliberation Policy and vice president of the Committee on Long-Term Care Insurance, both of which are top-level decision-making bodies in the Korean health insurance and long-term care insurance systems. His major research fields include health reforms—particularly in Asia—expanding insurance coverage, and the public-private mix of health financing.

Jeong holds a doctoral degree in health science from Tokyo University and bachelor's and master's degrees in human science and health science, respectively, from Seoul National University.