The Role of Health Insurance in the Growth of the Private Health Sector in Korea

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I. Introduction

Korea introduced public health insurance for a small portion of the population in 1977 and gradually expanded its coverage to cover the total population. In 1989, 12 years after its initiation, national health insurance (NHI) was born and the system is now fully operational. Along with it came a conspicuous change in the pattern of health service provision and in the composition of providers. The number of for-profit providers has been growing rapidly and they have become a dominant force in the health sector.

Health care policy-makers of some countries are looking for ways to increase the involvement of private providers in health service delivery. They believe that health services can be strengthened through the private sector by providing better access to health care, better quality of care, new impetus for innovation, sources of new capital, efficient use of inputs, improved technology, more responsiveness to the desires of physicians, and more consumer choices. Proponents of the private approach to health care delivery also believe that national health policy goals can be achieved through greater private participation.

Their basic contention that personal health care is much like other consumer goods and therefore privatization in the health sector is largely beneficial to all parties concerned needs to be tested empirically. Perhaps a proper combination of the public and private, with some regulatory features attached, could attain the objectives of a nation’s health care system. However, a good example of such a proper private/public mix has yet to evolve in the real world.

The case of Korea, unfortunately, does not support the argument made by the supporters of the private approach. Rather, it shows that neither efficiency nor equity can be attained when the health sector is excessively privatized. It demonstrates that the type of ownership does affect the performance of a health care system. It could be a case study of a system in which underregulated privatization brings undesirable outcomes as regards the public’s health and health politics. Health care should be the right of all citizens, but this view has never prevailed in Korean public policy.

This chapter addresses issues related to private sector growth in health care in the Korean context. It briefly describes the Korean health delivery system and provides some data on trends in private sector growth. Next it discusses some of the factors that underlie such trends. The impact of private sector growth on health care delivery is then analyzed. The policy agenda required to attain a balanced health sector is discussed, as well as the resource requirements and the processes involved in achieving this balance.
II. The Korean Health Care System

2.1 Health service delivery

The Korean health service delivery system has been basically a market-oriented, private sector-dominated, fee-for-service payment system. The role of the government has been limited primarily to the public health area. There has been very little regulation or monitoring of the ever-growing number of private providers to preclude excessive technology acquisition, excessive provision of services, unethical behavior (selective abortions, for example), fraudulent insurance claims, and income tax evasion.

It is a market-oriented system in the sense that health care is viewed, in general, as an economic good, but not as a social good. Access to health care is selective, guided by the willingness and the ability to pay. How much and what level of care one receives depends largely on one's income level. For example, there are the so-called special treatment charges (STCs).\(^1\)

The private sector, which was dominant in Korea before the insurance plans, has been growing further with the increase in per capita income and with the expansion of health insurance coverage. A detailed analysis of the private health sector in Korea is provided later in this chapter.

Patients pay a fee for service (FFS) for all services at all referral levels. FFS has been the dominant method of payment for physicians (both Western and traditional), clinical services, and pharmacists.\(^2\) However, physicians at hospitals are paid salaries, and occasionally they are paid bonuses based on their performance.

In most cases, patients are given a choice of providers: they can choose among various providers at multiple referral levels. Because there is no patient referral channel, they can go directly to the outpatient departments of general hospitals. In 1989, some regulatory provisions were enforced in the choice of providers under the NHI. However, most patients do not abide by the rules, and hospitals, for fear of losing revenue, do not enforce these rules. As a result, the provisions have become ineffective.

Within the system, a gatekeeper—someone who could guide the patient to a proper provider or proper level of care—is virtually unknown. Since most patients prefer to be treated in general hospitals, both the outpatient and inpatient departments in general hospitals are overcrowded. Many local clinics suffer from lost revenue. Consequently, when patients prefer to be treated by regular staff physicians (board specialists) in a general hospital, they have to pay STCs in addition to the scheduled fees. If they cannot afford the STCs, interns or residents are automatically assigned to them.

A experiment with a case payment structure began in late 1995. It is the first time that a payment structure other than FFS is being used in the Korean market.
the concept of primary health care hardly exists. For many Koreans and even for some health bureaucrats, primary health care is considered a synonym for public health or low-quality care for the poor.

2.2 Health insurance system

In 1989, the government of Korea launched a compulsory health insurance program for the entire population. It was the result of a gradual expansion of insurance plans from corporate employees to the self-employed and farmers. The steps toward expansion were taken without much resistance politically, economically, or socially. As of 1992, 94 percent of the population is covered by health insurance plans and the remaining 6 percent is covered by the Medicaid program.

2.2.1 Structure and payment

In most cases, as mentioned above, patients are given a choice of hospitals and clinics. Providers are paid by FFS in return for providing services that are covered by insurance. Part of the remuneration is made by the insurance funds, and the rest by patients’ out-of-pocket payments. Two types of cost-sharing features are incorporated into each service utilization. The first feature is a deductible applied to each unit of service. For example, a flat fee of about US $4 has to be paid by a patient for each physician visit. On top of the deductible, a patient pays co-insurance rates of 30 percent for clinic outpatient services, 50 percent for hospital outpatient services, and 55 percent for general hospital outpatient services. The co-insurance rate for inpatient services is 20 percent across all types of providers.

Under the NHI, for insurance-covered services, providers (hospitals and clinics) are reimbursed according to a set of fee schedules. The government plays a major role in setting the fee schedules, although the level of fees is negotiated at the national level by all parties concerned.

2.2.2 Administration

As of December 1994, there were 417 insurance funds. Each fund is financially autonomous. The size of each insurance fund is small, covering 30,000 to 200,000 people. With the current structure of a large number of small insurers in which each fund covers only a small fraction of the population, two problems arise. First, the system can hardly realize economies of scale and, second, there is inequitable risk pooling among beneficiaries. The proportion of administrative costs to total expenditure is 10 percent on average, and as high as 15.6 percent. This high figure is an indication of the high degree of inefficiency compared to 1.5 percent in Canada, 2.6 percent in the U.K., and 10 percent in the U.S.
2.2.3 Coverage

Not all health services are covered by the NHI in Korea. This is the most controversial part of Korean health insurance plans. The extent and the level of insurance coverage are determined by the government. Figure 1 shows the division of health services into insurance-covered and noncovered services, and their payments. Most of these noncovered services are new or expensive high-technology medical services. Examples of services not covered by the NHI system are CT scanning, magnetic resonance imaging (MRI), most nuclear scanning, some chemotherapy, PET, and ultrasonography. CT scans were covered only beginning in January 1996.

In sum, insurance coverage under NHI is limited in several respects: the rate of out-of-pocket payment is still high, even with covered services; some of the expensive services are outside the domain of health insurance; STCs come along with both covered and noninsured services in general hospitals. In addition, there is an upper limit on insurance coverage in terms of the number of days of hospitalization and care covered (180 days per year, 210 days for the elderly), including all prescription days. With highly limited coverage, most of the insurance funds have a financial surplus and its magnitude is getting larger year after year. By 1993 the accumulated surplus was 3,402 billion won (the equivalent of US $4,418 million). As of December 1994, the surplus was roughly equal to two years' premium contributions by all insured people in Korea.

III. Private Sector Growth

The profit-oriented private sector, which is dominant in Korea, has been growing rapidly during the last three decades.

3.1 Providers

Private physicians and pharmacists are the dominant providers in Korea. Although there are physicians and pharmacists in the public sector, their share of the market is relatively small.

There are two types of physicians: Western and traditional. Physicians in each category...
are trained by their own medical school system. They compete with each other for patients at all levels: the general hospital level (hospitals with more than 200 beds), the hospital level (with 20 to 200 beds), and the local clinic level. There is a third type of provider, the pharmacists. Pharmacists provide a wide range of health services by selling Western drugs and many traditional drugs, without doctors' prescriptions. Both Western and traditional physicians can also sell drugs for profit where they practice. Role differentiation between Western physicians and pharmacists, between traditional physicians and pharmacists, and between Western physicians and traditional physicians is not clear in Korea. All these providers have strong financial incentives to prescribe and sell more drugs.

Midwifery is another form of service provision, though the role of midwives is restricted to prenatal and delivery care. Most midwives are in the private sector.

Over time, utilization patterns have changed. Data (USAID 1983, KIHSA 1993) enable us to compare the percentage distribution of treatment by providers before the introduction of health insurance plans (1976), when some health insurance plans were available (1981), and after the NHI (1991). The following changes can be observed. First, there has been a significant substitution of hospitals and clinics for pharmacists, both in urban and rural areas. In the past, with low per capita income and no health insurance, people sought care mostly from nearby pharmacists. With the expansion of health insurance and the increased availability of hospitals and clinics, people depend more on physicians in seeking health services. Such a change is more significant in rural areas than in urban ones. Second, rural residents go more frequently to health centers and health posts (where community health practitioners work as providers) for their health services. This is a notable change for the Korean health care system because people now rely on the public sector for some services.

3.2 Facilities

Health care in Korea is provided by a mixture of for-profit, not-for-profit, and public institutions. Acute general hospitals, acute hospitals, and local clinics have been predominantly proprietary, for-profit institutions. However, there are some general hospitals and hospitals that are classified as not-for-profit. Many nonprofit hospitals, although legally so, are in fact profit seekers. Not-for-profit organizations based on volunteers and charity are rare. Because of public health and safety concerns, government ownership is typical among certain types of institutions, such as tuberculosis, psychiatric, and leprosy hospitals.

In 1977, the year when a health insurance program was first introduced, 53.2 percent of all beds were either public or nonprofit (see Table 1). Seventeen years later, the share dropped to 23 percent. Seventy-seven percent of total hospital beds are in private hospitals. Beds in for-profit local clinics, whose number is estimated to be around 37,000, are not included in the private bed category. Lee (1995) asserts that if that figure
were included the share of private beds out of the total would reach as high as 82.3 percent for 1994. In 1975, two years before the health insurance programs started, 34.5 percent of all hospitals were public. In 1994, the share dropped to 4.9 percent and the remainder (95.1 percent) is now owned and operated by private or nonprofit organizations (Figure 2). Hospitals specializing in traditional medicine are not included in the figures. The shares of the private sector would be even greater if their numbers were taken into account, because most of the facilities and human resources in traditional medicine are in the private sector. The change has been dramatic, and the trend will continue at least in the near future.

Between 1982 and 1984, a total of 34 city and local government hospitals were transformed into financially autonomous nonprofit hospitals. The transformation lowered the percentage of public hospitals from 14 percent to 5 percent. This change was part of the health policy-driven privatization that took place in Korea during the 1980s.

Since the urban areas have been growing faster than the rural areas both in population and in income, the economic demand for health services has been rising faster in urban areas and the returns to health facility investment have been higher there. As a result, many private health facilities are concentrated in the urban areas, although this trend has been eased recently as some private general hospitals are located in rural areas adjacent to cities.

IV. Stimuli for the Growth of the Private Sector

Growth in the private sector has been spurred by many factors, some on the demand side, some on the supply side, and others on the government side. On the demand side, the rapid increase in demand for health services has contributed to the growth of the private sector. The increasing demand is attributable primarily to growing per capita income. It has also been affected by other factors, such as changes in the age structure, expansion of health insurance plans, a higher level of education, and people's perception of the importance of good health.

On the supply side, profitability in the health care market, more than anything else, has induced considerable private investment in facilities and equipment. With sizable returns on investments in health service provision, the private sector has quickly responded and filled the gap between growing demand and short supply.

On the government side, with the great success of market economic policies in the past decades, advocates of private enterprise have been gaining steadily over those favoring government involvement. Their ideas have influenced health policy-makers to favor private services.

Another factor that has contributed to the growth of the private sector is the philosophy underlying government health policy. Few politicians have emphasized the importance
of equity in health care and the role of the public sector in pursuing the equity goal. During the late 1970s, the NHI was pushed forward by politicians simply because it was a popular political subject. However, they failed to fully grasp the interactions among the payment mechanisms, market forces, and the public sector’s role in pursuing equity in health care. Politicians were not bothered by the growth of the private sector. Rather, some politicians, swayed by political lobbying, have supported a stronger role for the private sector.

V. Issues Arising from Private Sector Growth

The growth of the private sector, in conjunction with the gradual expansion of health insurance plans, has resulted in increased demand for services and higher-quality care. The nationwide coverage of health insurance has contributed to increases in health service utilization and to upgrading the level of health of the people. The growing private sector imported new medical technologies aggressively and competitively, resulting in an apparent increase in the (technical) quality of health care.

Annual health insurance statistics reveal that with the expansion of health insurance, the utilization of both inpatient and outpatient services has been increasing continuously over the last two decades, and that consumers, who believe private general hospitals provide better services, prefer care at general hospitals rather than at government hospitals or clinics.

However, these changes involved costs in the form of inefficiency and inequity, which stemmed from mishandling of the evolving system during the last three decades. As the market share of the profit-oriented private sector rose, many undesirable aspects developed in the system, over which the government has had very little control. Some issues arising from the growing private sector include cost increases, a two-tier health care system, commercialized health care, dependency on high technology, low priority of primary health care, and the lack of a referral channel.

5.1 Cost Increases

Rising health costs are now viewed as a growing problem in Korea. The health care system of Korea is inflationary by choice. It is inflationary not simply because people demand more health care services, but because of the way the system is structured; it induces an expanding amount of service provision and consumption and, furthermore, of more expensive services.

Figure 3 shows that from 1975 through 1992 the health care share of the total economy has grown from a mere 2.8 percent to 5.3 percent, with an annual rate of increase of around 28 percent. Many factors contributed to the rapid increase in the national health

between 1975 and 1992, the Korean economy recorded unprecedented high growth rates. The increasing share of health costs as a portion of GDP, therefore, signifies how fast the health sector expanded during this period.
expenditure. A substantial part of the total cost escalation is attributable to the increase in cost per case. The treatment cost per case has gone up 470 percent for inpatient services and 240 percent for outpatient services during the last 13 years, whereas the consumer price index has gone up only 125 percent during the same period (KMIC, Statistical Yearbook, various years).

Increases in the cost per case can be explained by several factors: providers inducing more patient visits per case (supply side); more complex cases, and insured patients paying less out-of-pocket and asking for more expensive and presumably higher-quality services (demand side).

The increase in the supply of private providers, as well as the incentives created in the payment mechanisms, may have caused cost increases, as suggested by the data in Tables 2 and 3. Table 2 shows the difference in Caesarean section rates among general hospitals under different ownership. It suggests that because surgery generates greater revenues, private ownership has resulted in higher Caesarean section rates. The data in Table 3 on out-of-pocket payments for four major clinical departments in three types of general hospitals indicate that the extent of private ownership is positively correlated with higher rates of user charges.

5.2 Two-tier health care system

Korea has a classic two-tier system of health care, one for the rich and another for the poor. While some people can enjoy sophisticated, expensive services provided by private general hospitals, there is a group of people who do not receive adequate services simply because they are not able to pay for them. Those who cannot afford to pay the STCs, copayments, or the charges for services not covered by insurance have to endure low-quality services. The situation is even worse for the public assistance Medicaid program beneficiaries, to whom care is often denied or who are grudgingly provided poor care.

5.3 Commercialized health care

With the presence of strong profit-seeking private providers, health care in Korea is overly commercialized. A ample evidence of the loss of a medical care ethos and the gain of medical entrepreneurship is found in daily practice. A n example of such a trend is found in the rapidly increasing rates of Caesarean section deliveries, which provide greater revenues. Caesarean section deliveries have increased from 6 percent of all deliveries in 1984 to 21 percent in 1994 for one insurance scheme (see Table 4).

Another example of highly commercialized health care is the practice of one- or two-day prescriptions provided during visits to clinics. This practice encourages patients to visit the clinic repeatedly for a single episode of illness.

Like that of many other countries, Korean culture has a strong preference for boy
children. Korea's ratio of male-to-female births is recorded to be the highest in the world, followed by that of China (Choong-ang Ilbo 1993). While the high rate of male births in China is the result of government policy, in Korea it is reportedly due to improved medical technologies and their misuse. Evidence of selective abortions is clear in data from recent years: a higher ratio of male-to-female births is associated with later births in a family (see Table 5). For example, in 1992, for all births that represented the first child in a family, there were 106.4 males born for each 100 female live births. But for births that year where the child born was the fourth in the family, the rate was 232.4 males for each 100 females born.

5.4 Dependency on high technology

Providers are keen not only to increase provision of noninsured services but readily invest more in them. A good example is the active acquisition of expensive high-technology products and equipment by hospitals in recent years. These acquisitions represent wasteful depletion of technology in the health system.

The diffusion of selected technologies over time is shown in Table 6. A significant jump in the rate of technology adoption is observed in 1989 and 1990, when the NHI was fully implemented. The marked difference in the rate of diffusion between 1987 (before NHI) and 1990 (after NHI) can be noted in the table. This rapid adoption of medical technology has resulted in Korea having more magnetic resonance imaging machines per million population than European countries and more lithotripsy machines per capita than the U.S. (see Table 7). Adoption of such technology results in cost increases for the system.

5.5 Low priority of primary health care

With the strong presence of private providers, curative care has been emphasized over preventive care, and specialist care over primary care. No matter what the physical condition, many believe rightly or wrongly that primary health care is a form of low-quality care.

5.6 Lack of a referral channel

The Korean system lacks a proper referral channel. There is neither a vertical nor a horizontal referral network. Patients have unrestricted choice of providers at different referral levels as long as they can pay. They also have a choice among multiple kinds of providers at a certain referral level. There is no gatekeeper who could guide the patient to a proper provider or a proper level of care.

In the absence of gatekeepers in the system, there is inefficiency and a lack of cost effectiveness. Simple illnesses are treated expensively; for example, common colds are often treated by internists in general hospitals and simple headaches are treated by
neurosurgeons in general hospitals. Moreover, patients often seek care from both Western and traditional physicians, and sometimes also from pharmacists, for the same episode of illness, increasing the revenues of the providers but not necessarily giving the patients the proper care.

VI. The Policy Agenda

The recent Korean experience shows that affordability and access are much affected by the growth of profit-driven corporations in the health care field. Health care has become a business. Providers refuse to serve those who cannot pay, will only promote services with a reasonable monetary return, raise prices to the extent the market will bear, increase utilization to maximize income, and aggressively promote excessive and irrelevant services that may not address patients' basic health needs but do generate profits. The very ethos of health care is being threatened by these recent changes in the delivery of health care.

Health policy will have to deal with these trends and the consequences of the growth of the private health sector. Further privatization, especially when it is carried to the extreme, will not be helpful in addressing the problems of Korean health care. This does not mean that curtailing the size of the private sector is the only option Korea has. Politically, downsizing the private sector may not be feasible, at least in the near future. Given the strong presence of the private sector, Korea must respond to two important questions: first, what is the role of government in making the private sector comply with national health policy objectives? And second, which organizational and financing mechanisms (such as health insurance) meet, or do not contradict, the equity objective of Korean policy?

6.1 Government health policy

There are two ways to organize the delivery of health care: government planning and cost control versus reliance on market forces and competition. Korea has leaned toward the market approach, with a two-tier system based on the ability to pay. As others have pointed out, the market approach is acceptable only when market failure is properly corrected by public policies (see Chapter 2). The behavior of profit-seeking organizations and the economically based ethic that emphasizes competition produce efficiency only if they are adequately regulated by market failure-correcting public policies.

There have been public policies to achieve national health policy goals in Korea. For example, the government tried to strengthen health services in rural areas. However, these policies were directed mainly toward public providers and the public health domain. In addition, there have been erroneous policies, including making low-interest loans to for-profit providers, allowing STCs in general hospitals, and offering little financial and organizational support for public health facilities. Little has been done to induce the dominant private sector to help achieve public health goals.
As a result, Korea has failed to ensure the attainment of both efficiency and equity in health care. In order to attain these goals, the government must play a role in making market forces work and in correcting market failures. Six areas of health care that are in need of strengthened public policies are discussed below.

First, the government has to provide the financial means that would allow destitute people who need care to obtain it. Korea has the Medicaid Class-I Program that provides free care for the poor. But only a very small fraction of the total population, 1.6 percent as of 1994, benefited from the program, compared to the estimated population under the poverty line of 9.8 percent (Park 1994). Even worse is that not all health services are provided free to the beneficiaries of Medicaid Class-I and then only from those providers who join the Medicaid Program. Korea has no special programs for the elderly poor or for the disabled.

Second, a strict patient referral channel should be enforced for allocative efficiency. An increased allocation of resources for primary health care ought to be made. Also, since for-profit health care providers are keen to follow economic incentives, incentive structures should be put in place for providers to meet relevant goals for quality, access, and cost.

Third, there is a need for a corporate body to take responsibility for or establish principles of management with regard to technology diffusion and the utilization of existing technologies. Such an organization would ensure that technology assessment keeps pace with the introduction of new modalities of care. A health care network for utilizing existing technologies is necessary, at least at the regional level, so that the appropriate use of technologies can be ensured.

Fourth, there is a need for regulation of the pharmaceutical industry, especially practices such as pricing, marketing campaigns (which produce large payoffs for physicians and hospitals), and excessive advertising. Despite some of these practices, drug companies have brought major advances to medicine and their efforts in research and development should be encouraged and supported. A good public policy will guide the industry to fair competition, efficiency gain, and long-run growth.

Fifth, a public policy of defining the roles of the various health care providers is imperative. Lack of role differentiation among providers causes many problems, such as confusion among consumers, excess utilization, and cost inflation. For example, in prescribing and selling drugs, role differentiation between Western physicians and pharmacists and between traditional physicians and pharmacists does not exist. This provides a strong incentive for all of them to prescribe and sell more and more drugs. The result is that a high proportion of health care expenditures, averaging about 30 to 35 percent annually, is being allocated for drug consumption (KMIC, various years). The lack of role differentiation brings about conflicts among providers themselves. A
example is the battle in 1994 between traditional physicians and pharmacists over the right to dispense herbal drugs. This conflict persists and is not likely to end soon.

Sixth, some measures have to be taken to reduce fraudulent medical claims and tax evasion by providers. Government investigations show that both the health insurance system and the Medicaid system are widely abused by providers. Two policy alternatives can be considered: (1) change the payment and reimbursement structure from the current FFS to a form of prospective payments, or (2) monitor claims and income reporting by providers more stringently. A prospective payment system (PPS), if successfully implemented, will not only solve the problems of medical fraud and tax evasion but will also have enormous impact on the incentive structure of the system. Because of this potential impact, providers in fear of losing revenues oppose it. Therefore, the adoption of PPS is not likely in the near future. In the short run, careful monitoring of provider claims and behavior may be the only plausible option for solving these problems.

In summary, the government and decision-makers should not view health care as just another marketplace but must intervene to correct market failures and promote appropriate incentives in the system for use and payment of services.

6.2 Health insurance reform

6.2.1 Feasibility of health maintenance organizations

In terms of organizational changes to bring about appropriate incentives for both consumers and providers, one could consider having a payment system other than FFS. As pointed out in the previous discussions, FFS in Korea entails a great deal of waste and inefficiency. Considering the similarities in health care delivery between Korea and the U.S., and therefore the similarities in underlying incentive structures and behavioral responses, the applicability of health maintenance organizations (HMOs) to Korea can be considered as one option.

One major obstacle in applying the HMO concept to Korea, however, is the existence of NHI as social insurance. Although NHI in its structure and financing mechanism is similar to private health insurance, it is still a statewide form of guarantee of basic health services. In addition, the role of government in health care delivery is recognized within the NHI. Borrowing the U.S.-type HMO (in the form of nonprofit or for-profit proprietary institutions) would mean a regression in Korean health care, in the sense that the minimal social responsibility that has thus far been achieved with the establishment of NHI would be abandoned.

One can think of a modified version of an HMO in which a regional government becomes an insurer and public and private practitioners join as provider entities. It would be state-owned and state-managed care. Every citizen would be entitled to be a
member through a compulsory premium payment. One drawback of a single HMO structure in one region, though, is the lack of competition among multiple HMOs. One can be skeptical of how efficient the performance would be and how well the built-in incentives would be kept alive in the absence of competition among HMOs.

6.2.2 Expansion of insurance coverage

An alternative would be a reform in the structure of existing health insurance plans. As was previously noted, health insurance in Korea is distinguished by one feature: high user fees stemming from high co-insurance arrangements within the plans and also from full direct payment for noninsured services and of STCs. If equity is considered to be one important goal of the Korean health care system, the priority of reform should be to lower user charges through extension of coverage.

The three most important policies for expansion of coverage are: (1) to broaden health insurance coverage by limiting the range of noninsured services and also by eliminating the 180-day-per-year limit in insurance coverage; (2) to abolish the STC system completely; and (3) to introduce an income-related co-insurance feature in health insurance, which would replace the current flat rate among all income classes. The strategy for comprehensive coverage and its possible outcome is depicted by three diagrams in Figure 4.

First, it is suggested that the STC system be eliminated. The major impact of this change would be a loss of revenue by most general hospitals. To compensate for this loss, the fee schedules of general hospitals should be adjusted upward so that total revenue for an average general hospital remains intact. The adjustment of fee schedules would be made in such a way that the net financial impact on general hospitals is close to nil. In Figure 4, after the change, depicted by moving from Phase A to Phase B, areas (1) and (2) would be incorporated into areas (6) and (7), without net loss to providers. Patients and insurers pay, in total, the same amount of money as long as consumer utilization of general hospital services is not changed.

However, this change is not neutral to consumers and insurers. Cost shifting takes place between patients and insurers: formerly noncovered charges (STCs) would now be covered and would be subject to the cost-sharing features in the insurance plans. Financially, consumers become winners and insurance funds are losers, although in the long run, all of the shifted costs will be reshifted, mostly toward the premium payers (consumers) and some to the government.

This change will bring about an additional indirect benefit, again to the consumers, especially to the poor patients who were formerly not able to pay for special treatment in general hospitals. With lowered payments for general hospital services, those in need of specialist care can have better access to it. Moreover, poor patients should feel less discrimination.
Second, it is recommended that all health services, except for cosmetic and beauty-related services, be covered under NHI. Traditional medicine should also be brought under the NHI umbrella, with some time lags and very careful preparation. However, priority should be given to comprehensive coverage of Western medicine, which absorbs the majority of health expenditures.

By adjusting the controlled fee levels, one can make the size of the aggregate pie that the providers receive (that consumers and insurance funds together pay) the same as before. In Phase A of Figure 4, the segmented elements in the current system (1), (2), (3), (4), and (5) will be merged into one and then divided into only two segments, shown in Phase B of Figure 4 as areas (6) and (7). The respective sizes of segments (6) and (7) depend primarily on the cost-sharing features of the NHI.

Through utilization of health services, there will be cross-subsidization among income groups, from the rich to the poor. The combination of higher (income proportional or progressive) premiums and lower (income regressive) user charges will certainly bring about monetary transfers from the rich to the poor, compared to the reverse case of low premiums and extensive user charges. The more direct user charges are replaced by premium payments, the greater cross-subsidization will be.

In sum, what the proposed health policies do is first, bring most health services under the NHI umbrella; second, maintain the size of the aggregate pie that providers receive; third, restructure income-related cost-sharing features; and finally, make upward adjustments in fee schedules and premiums so that the system can be sustained. A major impact of this reform is cost shifting between insurers and consumers, which will make the whole system considerably more equitable than before.

After the health insurance reform, changes can occur in the conduct, behavior, and performance of the system as a result of a reformed incentive structure. The most important of all is a gain in efficiency through an expected change in provider behavior. As insurance coverage becomes comprehensive, the misleading incentive to provide noninsured services will be removed. Excessive adoption of some high technologies will be eased, as profit opportunities from noninsured high-technology services disappear. Ignoring the dynamic aspect of increasing utilization rates due to growing household income, population, aging, and other social factors, the portion of savings from corrected provider incentives is shown as areas (8) and (9) in Phase C of Figure 4, resulting in a reduced total spending of (6) and (7) to (6') and (7'), respectively.

Another indirect benefit of having comprehensive coverage is that health insurance can act as the basis for adequate government monitoring of providers. Information on utilization, revenues, and costs of formerly noninsured services will be revealed and readily available to policy-makers and researchers. They can be used as guidelines for regulation and be the basis for monitoring of pricing and supply behavior. Medical fraud
and tax evasion can be checked with improved accuracy.

Additional resources are not required for the system to move toward comprehensive coverage, unless utilization patterns are affected by coverage changes. On the contrary, as explained before, there could be some saving of resource [(8) and (9) in Phase C of Figure 4] with reformed provider incentives. This prediction is based on the assumption that there is already a significant amount of supplier-induced demand in the Korean market (for example, one-day prescriptions, a high prevalence of Caesarean section delivery, and frequent use of technologies such as CT scanning and MRI). A possible increase in demand from coverage change may well be offset in quantity by a decrease in supplier-induced demand stemming from corrected provider incentives, as long as fees for services are set at the right level. With the same quantity and lowered (controlled) charges, total expenditure would be reduced by (8) and (9).

Regardless of the cost savings, there certainly will be cost shifting from patients to insurance funds. Using Figure 4 and some supporting information, a rough estimate of cost shifting can be made. In the figure, cost shifting = area (7) - area (5) where the actual amount of area (5) in 1993 is reported to be 2,775.4 billion won (KMIC and Federation of Medical Insurance Funds 1994). Our data reveal that the proportion of area (5) in selected general hospitals is about 30 percent and 50 percent for outpatients and inpatients, respectively. The rates could be slightly higher for services rendered by clinics. A another source (Myung 1995) shows that in 1992, for personal health services, health insurance paid 34.2 percent (2,025 billion won) and the rest, 65.8 percent (3,894 billion won), was paid by households. Assuming the overall rate of 40 percent, the combined amount of medical spending [areas (1) + (2) + (3) + (4) + (5)] would be 2,775.4 billion won x 100 / 40 = 6,938.5 billion won.

When all services are covered by health insurance with no STCs, and assuming the average rate of cost sharing, area (6), to be 35 percent [that is, 65 percent of payments are made by health insurers, area (7)], the insurance payment will be as much as 6,938.5 billion won x 0.65 = 4,510.0 billion won. The amount of cost shifting from patients to insurance funds in 1993 terms would be 510.0 billion won - 2,775.4 billion won = 1,734.6 billion won.

This amount does not take the possible savings of areas (8) and (9) into account. When the savings from reformed incentives are taken into account, the shifted costs will be smaller than the estimated amount of 1,735 billion won. Cost shifting, which might trigger an increase in insurance premiums eventually, is important to policy-makers and to some concerned politicians. Whatever the amount would be, extra spending by health insurance funds means premiums would have to increase.

6.3 The health reform process

To realize a change in health care delivery, one needs the support of various sectors: the
general public, providers, health policy-makers, and politicians. The easiest way to have a reform would be to have decision-makers and politicians develop a value concept about health care and have the courage to push it forward. Then many of the current value conflicts and the confusion about the nature of health care itself, the place of health care in society, the role of health care providers, the relationship between providers and patients, and about whether it is legitimate to make profits from the misfortunes of the sick will be resolved.

Unfortunately, the reality is very different from the ideal. Considering the current complicated environment of Korean health care, it will be very difficult for the politicians and decision-makers to share their concerns and to act.

Providers, especially when they are private, pursue economic profits. The principle they follow is simple: they favor a change if it would bring about gains in economic returns, and resist it otherwise. They might follow a different rule if their behavior were effectively regulated by the government or governed by a different incentive structure. Otherwise, their choice is simple and unambiguous.

It is clear that the policy agenda proposed tightening the government's control of the system and reform in health insurance will produce benefits for the general public. The general public is likely to agree with the change, once they are informed about the background and effect of the change. Politicians may support the change if pressed by public opinion. Bureaucrats may back the proposed change once they realize that it is supported by both the public and the Congress. However, providers will be against the proposition. They will lobby both the government and Congress not to have any change. Eventually, the battle will be between the general public and the providers.

However, experience shows that the general public has been losing the battle. Either people do not have a consensus on health reform or they do not have an effective channel for their ideas. For example, in 1988 the government undertook an effort to implement a policy of role differentiation between pharmacists and physicians in drug distribution, making physicians the prescribers and pharmacists the dispensers. The attempt was a failure. Both parties, being afraid of losing revenues since they predicted drug consumption would fall with the new policy, flatly turned down the government proposal, leaving the public as the only loser.

Factors inhibiting public consensus on health care reform are multiple: lack of organization and funds, lack of leadership, the free rider problem, and absence of a core force. On top of these factors there is a perception gap between the public and health care leaders. The perception gap covers a wide array of issues such as what social health insurance is about and what to expect from it, how health care is different from other goods and services, what the health system is aiming for, and how the excluded population group is handled by the system. Therefore, what is necessary is the public's shared understanding of, and strong agreement with, what ails the Korean health care
system. After that, a citizens' movement backed by formal consumers' organizations will help form a consensus on solutions for specific health care problems and express it to the politicians and policy-makers.

VII. Conclusion

Korea faces persistent difficulties with the delivery and performance of its health care system, despite its implementation of NHI in 1989. Nothing is more basic to any government than ensuring adequate care for the poor, the elderly, and the disabled, and yet Korea fails to do this.

While the 1980s and early 1990s saw a rapid expansion of private health care, the story of the late 1990s is likely to be one of consolidation into giant hospital chains. This trend has already been triggered by jabul (business tycoon) hospitals such as Samsung and Hyundai Hospital. This kind of growth can only exacerbate the current problems in the health care system.

Korea needs health reform in many areas. In 1994, efforts were made to reform the health insurance system. Some minor proposals were made to lower the rate of user charges and to expand health insurance coverage. However, no one is certain if the proposals can actually be implemented. Even if all of the proposals are adopted, the user charge rate would be still so high that the objectives of the Korean health care system—adequacy and equity in access to care, income protection, efficiency—can hardly be achieved.

There are many aspects of our life that are best left to market forces to determine without interference from government. Unfortunately, health concerns are not always among them. Consumer health and quality of care are neither protected nor guaranteed by pure market forces. No country has succeeded in having a sound health system by relying solely upon market forces. Some form of regulation of both the public and private health sectors is necessary, with the government and the professional associations as principal actors in the regulation.

Korea must also prepare for a new era when 65 million people, due to the unification of South and North Korea, together demand high-quality health services. Unless an enormous amount of additional resources is put into health care, the current system will not be able to handle the increased basic health needs. The current system should be overhauled for the sake of both efficiency and equity.

Korea missed a good opportunity to have a sound health care system when additional resources were pumped into the system by NHI. Now with NHI fully implemented and providers adjusted to it, it may be difficult to achieve even minor reforms. But, unless basic reforms are tried, resources will be wasted, consumers will not be protected, health care expenditures will continue to rise, insurance coverage will be reduced, and,
consequently, the accessibility of essential care to low-income families will be further reduced. Without reform now, the problems will become more widespread, persistent, and intolerable in the future.
References


Table 1. Number and Percentage of Public and Private Hospital Beds

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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<tr>
<td><strong>Public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>2,564</td>
<td>8,504</td>
<td>10,580</td>
<td>10,642</td>
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<tr>
<td></td>
<td>24.5%</td>
<td>33.3%</td>
<td>12.4%</td>
<td>8.6%</td>
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<td>Local</td>
<td>3,535</td>
<td>5,078</td>
<td>14,759</td>
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</tr>
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<td>government/</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>nonprofit</td>
<td>33.7%</td>
<td>19.9%</td>
<td>17.3%</td>
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<tr>
<td>Total public</td>
<td>6,099</td>
<td>13,582</td>
<td>25,339</td>
<td>28,870</td>
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<td></td>
<td>58.2%</td>
<td>53.2%</td>
<td>29.7%</td>
<td>23.2%</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,378</td>
<td>11,941</td>
<td>59,841</td>
<td>95,727</td>
</tr>
<tr>
<td></td>
<td>41.8%</td>
<td>46.8%</td>
<td>70.3%</td>
<td>76.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,477</td>
<td>25,523</td>
<td>85,180</td>
<td>124,597</td>
</tr>
</tbody>
</table>

Notes:  

a National encompasses national leprosy, mental, and TB hospitals.  
b Private includes for-profit corporate, for-profit proprietary, nonprofit welfare organization, and private university hospitals.

Source: Ministry of Health and Social Affairs, 1963 Yearbook of Health and Social Statistics; and Membership Reports of the Korean Hospital Association; from Lee 1995.
Table 2. Caesarean Section Rate by Type of General Hospital, 1992

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Number of Hospitals</th>
<th>Total Deliveries</th>
<th>Caesarean Sections</th>
<th>Caesareans as a Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>National medical center</td>
<td>2</td>
<td>1,650</td>
<td>464</td>
<td>28.1%</td>
</tr>
<tr>
<td>National university</td>
<td>7</td>
<td>8,253</td>
<td>2,203</td>
<td>26.7%</td>
</tr>
<tr>
<td>Private university</td>
<td>41</td>
<td>68,494</td>
<td>20,548</td>
<td>30.0%</td>
</tr>
<tr>
<td>For-profit proprietary</td>
<td>37</td>
<td>22,831</td>
<td>8,607</td>
<td>37.7%</td>
</tr>
<tr>
<td>For-profit corporate</td>
<td>55</td>
<td>73,995</td>
<td>29,154</td>
<td>39.4%</td>
</tr>
</tbody>
</table>

Source: Hwang, 1994
Table 3. Out-of-Pocket Payments as a Percentage of Total Treatment Costs

<table>
<thead>
<tr>
<th></th>
<th>University Hospital</th>
<th>Private Hospital</th>
<th>Public Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OP</td>
<td>IP</td>
<td>OP</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>63.9%</td>
<td>51.8%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>63.5%</td>
<td>58.0%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>70.7%</td>
<td>49.6%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Obstetrics &amp; gynecology</td>
<td>90.6%</td>
<td>59.9%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Notes: OP = outpatient service, IP = inpatient service

*Cosmetic surgery is not included.
### Table 4. Caesarean Section Rate for Civil Servant Insurance (Selected Years, 1984-94)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Deliveries</th>
<th>Number of Caesarean Sections</th>
<th>Caesarean Sections as Percentage of Total Deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>42,533</td>
<td>2,482</td>
<td>5.8%</td>
</tr>
<tr>
<td>1985</td>
<td>47,726</td>
<td>2,619</td>
<td>5.5%</td>
</tr>
<tr>
<td>1988</td>
<td>44,203</td>
<td>4,146</td>
<td>9.4%</td>
</tr>
<tr>
<td>1990</td>
<td>43,760</td>
<td>6,067</td>
<td>13.9%</td>
</tr>
<tr>
<td>1992</td>
<td>42,555</td>
<td>7,509</td>
<td>17.6%</td>
</tr>
<tr>
<td>1994</td>
<td>40,238</td>
<td>8,356</td>
<td>20.8%</td>
</tr>
</tbody>
</table>

Source: Korean Medical Insurance Corporation, Health Insurance Statistics, various years; from Shin 1995
Table 5. Rate of Male Births per 100 Female Live Births by Birth Order (Selected Years, 1980-92)

<table>
<thead>
<tr>
<th>Year</th>
<th>First Child</th>
<th>Second Child</th>
<th>Third Child</th>
<th>Fourth Child</th>
<th>Fifth+ Child</th>
<th>Overall Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>106.1</td>
<td>104.3</td>
<td>103.2</td>
<td>102.0</td>
<td>96.8</td>
<td>104.3</td>
</tr>
<tr>
<td>1985</td>
<td>106.0</td>
<td>107.8</td>
<td>129.1</td>
<td>148.7</td>
<td>143.9</td>
<td>109.5</td>
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<tr>
<td>1990</td>
<td>108.7</td>
<td>117.2</td>
<td>191.0</td>
<td>224.3</td>
<td>206.2</td>
<td>116.9</td>
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<tr>
<td>1992</td>
<td>106.4</td>
<td>112.8</td>
<td>195.7</td>
<td>232.4</td>
<td>216.7</td>
<td>114.0</td>
</tr>
</tbody>
</table>

Source: Korean Bureau of Statistics, Statistical Yearbook of Population Dynamics, various years

Note: These rates represent the number of male live births for each 100 female live births. The birth order indicates the order in the family of the child born. For example, in 1992, for all births where the child born represents the first child in the family, there were 106.4 male live births for each 100 female live births. In the same year, for all births where the child born represents the fourth child in the family, there were 232.4 male live births for each 100 female live births.
Table 6. Number of Selected Medical Technology Units per Million Population (Selected Years, 1977-93)

<table>
<thead>
<tr>
<th>Year</th>
<th>Whole-Body CT</th>
<th>MRI</th>
<th>Lithotripsy (ESWL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1986</td>
<td>73</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1987</td>
<td>81</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>1988</td>
<td>104</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>1989</td>
<td>159</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>1990</td>
<td>227</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>1993</td>
<td>507</td>
<td>71</td>
<td>53</td>
</tr>
<tr>
<td>Number/ million population in 1988</td>
<td>2.42</td>
<td>0.00</td>
<td>0.70</td>
</tr>
<tr>
<td>Number/ million population in 1990</td>
<td>5.28</td>
<td>0.77</td>
<td>0.98</td>
</tr>
<tr>
<td>Number/ million population in 1993</td>
<td>11.79</td>
<td>1.65</td>
<td>1.23</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Social Affairs, various years
Table 7. Availability of Medical Technology by Country

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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>CT (whole body)</td>
<td></td>
<td>11.79</td>
<td>NA</td>
<td>NA</td>
<td>17.7</td>
<td>40.33</td>
<td>7.20</td>
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<tr>
<td>MRI</td>
<td></td>
<td>1.65</td>
<td>0.46</td>
<td>0.94</td>
<td>8.03</td>
<td>5.91</td>
<td>1.20</td>
</tr>
<tr>
<td>Lithotripsy (ESWL)</td>
<td></td>
<td>1.23</td>
<td>0.16</td>
<td>0.34</td>
<td>0.94</td>
<td>2.30</td>
<td>0.60</td>
</tr>
</tbody>
</table>

Sources:
\(^a\) Ministry of Health and Social Affairs 1993
\(^b\) Rublee 1989
\(^c\) Japanese Ministry of Health and Welfare 1992
\(^d\) French Ministry of Health (1991)
<table>
<thead>
<tr>
<th>Services Covered by Insurance</th>
<th>Deductible &amp; Cost Sharing</th>
<th>Payment by Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market fee (stated service)</td>
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</tr>
<tr>
<td>(Cost Sharing)</td>
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<td></td>
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<tr>
<td>Special treatment charges</td>
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</tbody>
</table>

*Special treatment charges = Out-of-pocket payments to rider beyond stated price of service*
Figure 2. Public and Private Hospitals by Category
Figure 3. Total National Health Expenditure as Percentage of Gross Domestic Product, 1974-92
**Figure 4. Phased Expansion of Insurance Coverage**

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
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<tbody>
<tr>
<td>Market Fee</td>
<td>Non-Insured Service</td>
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<tr>
<td>(3)</td>
<td>Insured Service</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(4)</th>
<th>(5)</th>
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</thead>
<tbody>
<tr>
<td>Cost Sharing</td>
<td>Insurance Payment</td>
</tr>
<tr>
<td>(6)</td>
<td>(7)</td>
</tr>
<tr>
<td>Insurance Service</td>
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</table>

<table>
<thead>
<tr>
<th>(8)</th>
<th>(9)</th>
</tr>
</thead>
</table>

**Figure 4. Phased Expansion of Insurance Coverage**

<table>
<thead>
<tr>
<th>(6')</th>
<th>(7')</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Sharing</td>
<td>Insurance Payment</td>
</tr>
<tr>
<td>(6')</td>
<td>(7')</td>
</tr>
<tr>
<td>Insurance Service</td>
<td></td>
</tr>
</tbody>
</table>