ISSN 2348-3156 (Print)
International Journal of Social Science and Humanities Research ISSN 2348-3164 (online)
Vol. 5, Issue 1, pp: (12-16), Month: January - March 2017, Available at: www.researchpublish.com

The Implementation of Mandatory National Health Insurance System in South Korea: Some Successes and Challenges

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Abstract: **Countries implementing health insurance schemes as social security systems are constantly confronted with the issue of long term sustainability as citizens continue to reap the enormous benefits of such healthcare financing systems. A review of existing literature and data were used to assess the benefits of the mandatory national health insurance system in the Republic of Korea (ROK) and the potential effects of its intrinsic tenets on the long term sustainability of the system.**

Methods: The paper was conducted through an exploration of literature on electronic databases such as PubMed, WHO discussion papers and Google Scholar in December, 2014/January, 2015. The thematic areas for the search included 'health insurance in Korea', effects of Korea's health insurance' and health insurance challenges in Korea. Abstracts from discussion papers, and descriptive studies were reviewed and an extensive review of full papers were further conducted.

Results: Findings from nine publications from the year 2001 to 2012 met the criteria for this narrative review. It was observed that mandatory subscription and rigorous government interventions have led to a 99% health insurance coverage in (ROK). The benefit packages include benefit in kind which focuses on medical treatment components and benefit in cash which focus on reimbursement and rehabilitation to avert catastrophic health expenditure. The health insurance system has contributed to general improvement in health conditions, effective resource allocation and it has become a benchmark for multi-payer health insurance implementation in other countries. However, the long term sustainability might be hindered by a rapidly ageing population, growing health expenditure and dominance of private healthcare providers.

Conclusion: Though the successes gained by the health insurance system cannot be underrated, it is downright misleading if not completely false to assert that there are no threats in terms of long term sustainability.

Keywords: **Countries implementing health insurance schemes, Republic of Korea (ROK).**

1. INTRODUCTION

In response to changes in social and economic development, the Republic of Korea extended its National Health Insurance System (NHIS) to cover the entire population in 1989. The aim was to grant every individual access to healthcare at all medical facilities nationwide. In 1980, the initial publicly mandated NHIS that was enjoyed by employees at large companies which was introduced in 1977 accounted for only 20% of health expenditure (Jones, 2010). Jones (2010), further indicated that it was the lowest health spending in the Organization for Economic Co-operation and Development (OECD) area in 1980. However, Kwon (2008) and Jeong (2010), illustrated that it took only 12 years for Korea to achieve universal coverage for its population after the introduction of the mandatory social insurance for industrial workers in 1977.

Major institutional changes were carried out in the year 2000 in order to harmonize the separate insurance societies for government employees and self-employed people and also to put the sector at par with the centralized claim review and payment to care providers' components. (Kwon, 2008: Goldsmith 2012).

According to Anderson (1989), the intrinsic tenets of the Korean National Health Insurance at its inception were to provide a mandatory universal coverage, establish beneficiary contributions based on income levels and the assurance that benefits offered does not correlate with the amount contributed (Anderson, 1989: cited in WHO, 2009). It is therefore imperative to outline some benefits of the NHIS and at the same time consider the potential effects of the outlined tenets on the long term sustainability of the NHIS.

1.1 Benefit Packages and Financing Policy:

Generally, health insurance is said to be a program that enhances a nation's health and social security system. It entails the payment of benefits to the insured and their dependents in instances of disease prevention, treatment of sicknesses and injury obtained through daily activities, childbirth, health promotion, rehabilitation among others.

Efforts that have been made towards the expansion of the initial health insurance benefits in Korea include the October 1989 introduction of payment for medication at pharmacies (Kwon and Reich, 2005). In addition, the National Health Insurance Act (NHIA) of the year 2000, broadened the benefit packages and clearly defined them to include benefits in Kind and Cash benefits (NHIC, 2001). The benefits in kind include health care and medical services for childbirth, health care services for payable diagnosis, pharmaceutical or medical treatment materials, surgery, in-patient admission and nursing. Health examination and maternity benefits were also included. On the other hand, cash benefits include reimbursements for health care expenses, delivery expenses, expenses paid by the insured or their dependents and fixed amount for funeral expenses. As part of the cash benefits, compensatory grants are also paid when the insured exceed an expenditure level of 1,000,000 won in thirty days (NHIC, 2001).

A co-payment system has also been established to curtail over-use of facilities and also to take into account rural and urban differentials.

The Korea NHIS is powered by multi-faceted institutional and financial approaches and spear-headed by the National Health Insurance Corporations (NHIC). The broad branches are National Health Insurance Program (NHIP), Medical Aid Program (MAP), and Long-term Care Insurance (LCI) Program (Song, 2009: cited in Goldsmith, 2012).

Within the NHIP, the NHIC has been mandated to manage health insurance enrollment, collect contributions, determine medical fees and there is also the Health Insurance Review Agency which reviews fees and evaluates care. All other care institutions are supervised by the government ministry. Medical Aid Program covers the poor while LCI covers disabled older adults (Song, 2009: cited in Goldsmith, 2012).

According to the World Health Organization (WHO) (2009), the general government expenditure on health as a share of general government expenditure stood at 12.5% with a total of 7.5 trillion won going to the NHIC. WHO (2009), indicated that in 2007, 5.1 trillion won were transferred from the government budget to NHIC as government subsidies. Subsidies for the NHIS system alone constituted 71.9% whiles government contributions for its employees and private school teachers constituted 28.1%.

In order to sustain the universal health delivery coverage, it is imperative to discuss the successes of the Korea NHIS while at the same time placing emphasis on the existing bottlenecks in implementation. This paper therefore seeks to examine the achievements of the Korea NHIS and also investigates the existing and potential challenges and make policy recommendations.

1.2 Methods:

This paper was written through an exploratory study by relying on secondary data. Statistical data from the WHO and OECD reports on global and Korea NHIS were used in the paper. Both internal and external publications on topics such as Korea health financing system, health care reforms in Korea and national health insurance policies were also reviewed. The writer took these data into account and drew conclusions by combining data from various sources.

2. SUCCESSES OF THE KOREA NHIS

This section presents three key successes that have been achieved by the Korea NHIS since its implementation. It include an improvement in health conditions, effectiveness in resource allocation and the establishment of a global benchmark for multi-payer health insurance implementation.

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2.1 General improvement in health conditions:

Regardless of the fact that economic development may be followed by an improvement in health condition, remarkably across the globe, the Korea NHIS attained the fastest universal coverage as indicated by Kwon (2008). Table 2.1 shows the introduction of NHIS and the consequent health indicators.

Table 2.1 Introduction of NHIS and health indicators

Indicator	1977	1989	2005
GDP per Capita	1042	5430	16,306
Life Expectancy	64.8	71	77.4 (year 2003)
Mortality (per 100,000 person)	690	542.3	504.3
Infant mortality (per 1000 births)	38 (1970-75 average)	12	3.8 (2000-5 average)
No. of doctors per 10,000 persons	5 (1981)	8	16 (2004)
No. of beds per 10,000 persons	17 (1981)	30	73
No. of physician visits per capita	3.7	6.2	10.6 (2002)
No. of admission per capita	-	0.06 (1990)	0.12
No. of hospital days per admission	12	14	13.5 (2003)

Source: Kwon (2008).

Table 2.1 depicts a remarkable improvement in health conditions since the introduction of the NHIS. Although the improvement cannot be solely attributed the existence of the NHIS, it has been asserted by Mathauer *et al* (2009) that the Korea NHIS is cited as a success story due to its rapid achievement of universal coverage. According to Jones (2010), the expansion of access to health care through the NHIS in Korea has contributed to an improvement in health spending, as its life expectancy which was the second lowest in the OECD area in 1960 has increased by 28 years to match the OECD average of 70 years in the year 2007.

2.2 Effective Resource Allocation:

Studies have shown that the NHIS which is a public non-profit organization provides insured health services for the entire population. Studies by Jones (2010), also reviewed that the NHIS mobilizes funds from social insurance contribution (38.6%), government sources (16.9%), out-of-pocket payments for non-covered services (21%) and co-payments on covered services (13.7%). Table 2.2 further illustrates the trends in health care financing in Korea from 1980 to 2008.

Table 2.2 Trends in health care financing in Korea

Sources	1980 (%)	1990 (%)	2000 (%)	2001 (%)	2005 (%)	2007 (%)	2008 (%)
Total public sector	20.1	36.5	44.9	51.7	52.1	54.9	55.5
Government Sources	15	13.5	19.3	24.1	15.9	18.3	16.9
Social Insurance Payment	5.1	23.2	25.6	27.7	36.1	36.6	38.6
Employers & Employees	5.1	15.8	14.7	17.1	26.4	27.9	29.7
Self-employed & Others	0	7.4	10.9	10.6	9.8	8.8	8.9
Total private sector	79.9	63.5	55.1	48.3	47.9	45.1	44.5
Payments by patients for non-covered services	72.1	47.8	31.4	25.4	25.1	22	21
Co-payments by patients for covered services	3.4	10.4	14.5	14.4	13.9	13.7	13.7
Private insurance	0.7	2	4.7	3.8	3.9	4.1	4.4
Payments by firms	3.2	2.7	4.1	4.2	4.6	4.8	4.6
Non-profit institutions serving household	0.5	0.6	0.5	0.4	0.4	0.4	0.7
Total	100	100	100	100	100	100	100

Source: Jones (2010) p.7.

Table 2.2 depicts a consistent increase in government health expenditure from 1980 to 2008. However, it is important to note the effectiveness in the mobilization of resources has played a double role by first enhancing the implementation of the NHIS whiles also contributing significantly towards an improved health conditions and prolonging lives.

2.3 Serves a benchmark for multi-payer NHI implementation in other countries:

According to Mathauer *et al* (2009), Korea has successfully operated a multi-payer health insurance system from its initiation in 1989 by consolidating nearly 370 insurance programs into one single insurance in the year 2002. It has also successfully provide an NHI coverage of 97% of the country's population and a 3% of the population being catered for through the Medical Aid Program. This has led to a growing global research interest into the Korea NHIS.

3. CHALLENGES IN THE NHIS

This section presents a review of the inherent challenges facing the successful and sustainable implementation of the NHIS in Korea.

3.1 A rapidly ageing population and its ramifications:

Globally, the dangers associated with a rapid improvement in life expectancy on one hand and at the same a decline in fertility has a potential to reduce taxation base, affect NHIS contributions and the demand for health services in any country. Korea cannot be excluded from the predicaments of these two conditions.

Lu *etal* (2005), has indicated that despite the achievement of universal coverage through NHIS in Korea, households still pay for 37.3% as out-of-pocket contributions based on figures from OECD in 2004. There has been a consistent improvement in life expectancy from 64.8 years in 1977 to 77.4 years in 2003 as seen table 2.1. This implies that aged people might have a difficulty to contribute financially and also increase the health expenditure due to the natural tendency to demand for additional medical services as a person age increases.

3.2 Growing health expenditure:

There has been a consistent increase in government sector contributions towards health care as seen in table 2.1. There has been a rise from 20.1% in 1980 t0 55.5% in 2008 and this phenomena has serious budgetary implications on the country (Kwon, 2008).

The WHO (2009), asserted that although Korea has successfully demonstrated a strong political will and financial support from government to achieve universal population coverage within a short period of time, the percentage of catastrophic expenditure has increase for the past several years. This can be attributed to the high out-of-pocket cost and the fact that drug expenditure has been high in Korea as compared to other OECD countries. For instance, expenditure on drugs rose at a 10% annual rate between 2001 and 2006 and this led to the introduction of the Drug Expenditure Rationalization Plan in 2006 (WHO, 2009: Jones, 2010).

3.3 Dominance of private providers:

Looking into the future, the issues around needed service and desired service may play a key role in health expenditure as competition rises among private providers. Extra cost may arise since fierce competition within the dominant private providers will lead to a general improvement in service quality on the positive side and at the same time negatively drive a demand for price increase by service providers on another side.

The element of competition among private providers in the health care delivery sector might have huge financial implications on the NHIS in the long-run and the huge financial burden might also be shifted to the end user which is the household if not curtailed.

4. RECOMMENDATIONS AND CONCLUSION

From the above discussions, the successes gained by the Korea NHIS cannot be downplayed. However, it is downright misleading if not completely false to state that it has no challenges. There is therefore the need to adopt a measured pro-natal approach whiles at the same time encouraging healthy ageing to curtail the problems associated with ageing population in the long term. In the short term, targeted migration and economic policies can be adopted to reconcile for

shortages in taxation and workforce if the need arises. Thirdly, there is the need to continuously strengthen the institutional policies guiding the NHIS and conduct continuous research on the NHIS for regular improvement.

In conclusion, the limitations in the exploratory research method calls for an extensive research based on a combination of secondary and primary data to provide in-depth knowledge on the above discussed subject.

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