Executive Summary

The health status of the population has improved noticeably over the years in the Republic of Korea. In 2011, the life expectancy of males was 77.7 years and 84.5 years for females. The top cause of mortality is cancer, and the number of those who are physically active decreased by more than 20% during the period of 2005–2012. Various indicators of child mortality including neonatal, infant, and under-five mortality rate have shown great improvements due to high rates of prenatal care utilization and facility delivery. Overall, the health status of the Korean population is better than that of many other countries in Asia. The Republic of Korea faces problems of rapid ageing along with low fertility, which is expected to make it the second most aged country by 2050. Though currently stable, the age dependency ratio is expected to increase steeply as the baby-boomers age and as smaller numbers of young people reach productive age.

The Republic of Korea achieved universal health coverage of its population in 1989, just 12 years after the introduction of social health insurance. It was first implemented among formal sector workers in large firms and incrementally extended to workers in smaller firms and finally to the self-employed. Prior to 2000 there were three separate types of insurance schemes (with more than 350 insurance societies). In 2000, all insurance schemes were merged into a single payer with a uniform contribution schedule and benefits package. In contrast to public health financing, health-care delivery relies heavily on the private sector, though some public health facilities provide medically necessary services at the central, regional and municipal levels.

The Ministry of Health and Welfare plays a central role in health planning, policy formulation and policy implementation at the national level. In collaboration with the Ministry, regional governments are in charge of managing regional medical centres while each municipality is in charge of managing health centres, health subcentres and primary health-care posts. The Ministry’s approach to health planning is generally based on the health needs of the population, but sometimes influenced by political
changes. Taking account of the social determinants of health, health in all policies has been emphasized.

The Ministry of Health and Welfare has delegated the task of running the National Health Insurance (NHI) to two quasi-public organizations—the National Health Insurance Service (NHIS) and the Health Insurance Review and Assessment Service (HIRA)—while retaining indirect control over it. Under a single-payer health insurance system, it has become feasible to collect utilization data of the entire population. HIRA has made efforts to improve the quality of health services by providing both health providers and consumers with feedback and information generated from the claims database. Purchasing decisions on health services to be included in the NHI benefit package are centralized.

To regulate health-care providers and improve the quality of their services, the Ministry of Health and Welfare introduced a new hospital accreditation programme in 2011, in which participation was voluntary for most hospitals. A new license reporting mechanism was also recently introduced whereby licensed health professionals are required to report completion of continuing professional education as well as updated employment status every three years.

Health care is financed through National Health Insurance covering the entire population. Other than some very new and costly technologies, most health care services, including medical check-ups and cancer screening, are included in the benefits package with relatively high cost-sharing. The role of voluntary health insurance (VHI) in health care financing is increasing, and its role has been controversial.

Out-of-pocket (OOP) payments still required in social insurance include copayments for covered services and full payment for services not included in the benefits package. Patients pay 20% of the cost for insured services in inpatient care, and differential cost-sharing is applied for outpatient care, depending on the level of health provider. The poor are exempted from cost-sharing at the point of service, and vulnerable patient groups have access to discounted copayment rates. There is a ceiling on OOP payments, with differential ceilings applied to different income groups, but the ceiling applies only to insured services. High OOP payments have been a serious concern and are increasingly driven by payments for uninsured services, most of which involve new technology and medicines with uncertain cost effectiveness.
and the value of property such as houses and vehicles. As a single payer system, health insurance has a uniform contribution formula and benefits coverage nationwide. Population ageing and a flexible labour market with diversified forms of employment or income will be a challenge for revenue collection through social health insurance, which depends significantly on formal sector labour. Other sources of revenue generation for health care seem inevitable in the future, such as an earmarked consumption tax and a surcharge on income (e.g. interest income) other than payroll.

Social health insurance is managed by quasi-public agencies: the National Health Insurance Service (NHIS) deals with premium collection, risk pooling, fund management, and reimbursement to providers, and Health Insurance Review and Assessment Service (HIRA) is responsible for claim review, assessment of appropriateness of health care, technical support to benefit packages and the design of the provider payment system. Health care providers are paid under the fee-for-service system, and fees are negotiated annually between the NHIS and provider associations. Along with the dominance of private providers, fee for service payment has contributed to the rapid increase in health expenditure. Other payment methods include Diagnosis Related Group (DRG)-based prospective payments to acute care providers for seven disease categories and per-diem payments differentiated by 17 disease categories to long-term care hospitals.

Since the introduction of social health insurance, physical and human resources have been increased in response to the growing demand for health care. The numbers of practicing doctors and nurses have been increasing continuously, but they are still less than the average of Organisation for Economic Co-operation and Development (OECD) countries. Most capital investment was made in the private sector, so their share of hospitals and beds has increased over years; and the number of acute beds has increased rapidly, contrary to a downsizing trend in other developed countries. In addition, the increase in hospital beds has been concentrated in metropolitan areas, which in turn resulted in a concentration of human resources in large metropolitan hospitals. Almost all private health facilities have had electronic medical records (EMR) in place because they claim for health care costs electronically. The Government has tried to extend the scope of U-healthcare (ubiquitous health care based on IT) to the elderly and patients with chronic diseases.
While communicable diseases which were prevalent until the 1970s have declined significantly, chronic or noncommunicable diseases (NCDs) now represent the top causes of mortality. The Ministry of Health and Welfare has the function of basic planning, technical support, capacity building, evaluation, and financing for public provision of public health and medical services. In addition, Korea Centers for Disease Control and Prevention (KCDC) is functioning as a specialized agency of the Ministry. Provision of public health services is shared between the public and private sectors, due to the predominance of the private sector in the provision of health care.

Health care facilities are classified into two or four tiers according to two different legal frameworks, namely, the Health Care Law and the NHI Law. The role of primary care in gatekeeping is rather weak, as patients have much freedom in selecting their first-contact provider as well as choosing referred providers. With near-unlimited accessibility of the patients and their preference for high-tech medical care, patients are increasingly utilizing specialized general (usually tertiary care) hospitals.

All therapeutic prescription drugs except injections are to be prescribed by a doctor and dispensed by a pharmacist. Over-the-counter (OTC) medicines are mainly dispensed and provided by a pharmacist at a pharmacy. Advertising prescription drugs has been prohibited while advertising non-prescription drugs has been allowed. The generic substitution rate has been negligible. The NHI financial situation is closely connected to expenditure on medicines, given that more than 20% of total health expenditure is dedicated to pharmaceuticals. A positive list system whereby only drugs included in the formulary can be reimbursed in the NHI was introduced in 2007. After getting market authorization for a new drug, pharmaceutical companies are required to submit a dossier of cost-effectiveness and negotiate its price with NHIS.

In the early 2000s, the Republic of Korea introduced two major reforms: merger of insurance societies into a single insurer system and the separation of medicine prescribing and dispensing. The two reforms benefitted from the paradigm change in health policy-making. Progressive civic groups actively participated in the policy process and supported the reforms whereas physicians went on strike against the pharmaceutical reform. Responding to the rapid ageing of population, a new social insurance for long-term care (LTC) was introduced, principally for the elderly, in 2008. National Health Insurance Service (NHIS) is also
the insurer for LTC insurance. Coordination between health insurance and LTC insurance, and between health care and social care still needs to be improved.

As the level of OOP payments remains high in spite of the universal coverage of population, the extension of benefits coverage has been of high priority. The Government has reduced cost-sharing for catastrophic cases and introduced a ceiling on cumulative OOP payments for insured services. However, providers tend to promote uninsured services to increase profits, resulting in financial burden on patients. For the financial sustainability of national health insurance, reform of the payment system for providers is needed, and prospective case-based payment, which currently applies to only seven disease categories, should be extended.

The Government emphasizes the sustainability of the health system as an objective, including efficiency improvement and coping with new health risks. Financial risk protection and equity has improved but is still challenging. The proportion of households with high health OOP payments had steadily decreased until 2000, but then the trend reversed. Equity in financing varies across different sources, such as tax, the NHI contribution, and OOP payment.

User satisfaction is modest. In a 2011 Ministry of Health and Welfare survey, 63.9% of the respondents reported being “satisfied” with overall health system performance. In terms of socioeconomic status, health care utilization is relatively equitable, but the poor still face barriers in accessing primary care and receiving uninterrupted care. Inequalities in health outcomes are evident in both men and women from birth to death between different socioeconomic strata. Regional health inequalities are observed between Seoul and other areas as well as between rural and urban areas. Between genders, a substantial female excess in ill-health (measured by self-reported health and chronic diseases) was reported.

Personal health expenditure represents 89.1% of total, with limited role of public health. From the perspective of technical efficiency, the number of annual outpatient visits per active medical doctor is much higher than in other OECD countries, and the number of inpatient discharges per active medical doctor is a little higher than the OECD average. However, the length of stay is much longer than other OECD countries and the proportion of pharmaceutical expenditure has been higher than in other high-income countries.
The Republic of Korea has achieved a rapid improvement in health outcomes thanks to economic development and universal health coverage through national health insurance. Although national health insurance provides some protection mechanisms, such as exemption from copayments for the poor, reduced copayments for catastrophic illness like cancer, and a ceiling on cumulative OOP payment depending on income, high OOP payments have remained a key policy issue. The heavy financial burden results from provider behaviour rather than the benefits coverage itself. Private providers induce demand for new, but sometimes not cost-effective, services and technologies not yet included in the benefit package because they are not subject to NHI fee regulation.

The referral system does not function well in the private sector-dominated delivery system, and patients prefer tertiary care hospitals. Tension between private providers and the Government (and the national health insurance system) has been substantial, and health care providers have been a stumbling block to health care reforms such as the prospective payment system. Government needs to increase the role of public financing or to reduce the level of households’ direct payments for health care by raising health insurance contributions and expanding benefit coverage.

The Republic of Korea achieved rapid economic growth in the 1970s and 1980s along with decreasing inequity. However, inequity has been increasing since the 1990s, which has had a big impact on health care system and population health outcomes. Policy to reduce the inequality in health care and health outcomes should be a priority for the Government. Very rapid ageing of population is a key challenge to health care system, too. New long-term care insurance improves access for the elderly to long-term care. However, avoidable admissions to hospitals are still nontrivial, and coordination between hospitals and long-term care facilities along with strengthening of primary health care and gatekeeping can contribute to the continuum of care to meet the needs of the aged population.