

The South Korean Health Care System

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Background: Improvement of living quality¹

The quality of Korean people's lives has been increasingly improved in general due to the development of medical technology. The average life expectancy for males increased from 51.1 in the 1960s to 75.7 in 2006. The change in average life expectancy for females is even more startling, from 53.7 in the 1960s to 82.4 in 2006. In 2007, the crude birth rate was 10.1 and the crude death rate 5.0. Infant mortality is also decreasing gradually, from 61.0 per 1,000 live births in the 1960s to 5.3 per 1,000 in 2005. The total fertility rate is sharply decreasing, from 1.67 in 1985 to 1.13 in 2006.²

However, the increasing elderly population and decreasing birth rate are changing family structure in South Korea. The aging population is also becoming a social burden due to increasing medical expenses.

Healthcare Personnel: Over 91,000 physicians¹

In South Korea, only authorized healthcare professionals can provide health services. The Medical Law stipulates that only doctors, dentists, nurses, oriental medical doctors, and midwives licensed by the Ministry of Health, Welfare and Family Affairs (MIHWAF) can provide health services. Nurse's aides, acupuncturists, and massage therapists are described as quasi-medical professionals. As of 2007, there were 91,400 physicians, 23,114 dentists, 16,663 oriental medical doctors, 57,176 pharmacists, 8,587 midwives, and 235,687 nurses in South Korea.

A major problem concerning healthcare resources in South Korea is regional disparities

in medical services. Most private medical facilities are located in urban areas, and around 90% of physicians are concentrated in cities while 80% of the population lives in urban areas.

Healthcare Delivery System: Korean patients have freedom of choice¹

Korean patients can go to any doctor or any medical institution, including hospitals, which they choose. The referral arrangement system is divided into two steps. The patient can go to any medical practitioner office except specialized general hospitals. If the patient wants to go to a secondary hospital, he/she has to present a referral slip issued by the medical practitioner who diagnosed him/her first. There are some exceptions: in the case of childbirth, emergency medical care, dental care, rehabilitation, family medicine services, and hemophiliac disease, the patient can go to any hospital without a referral slip.

Three Arms of Healthcare Security

South Korea's healthcare security system has three arms: the National Health Insurance Program, Medical Aid Program, and Long-term Care Insurance Program.

National Health Insurance Program³

History: Universal coverage for all citizens

The first health insurance law in South Korea, the Medical Insurance Act, came into force in December 1963. From July 1977, all companies with more than 500 employees were required to provide a health insurance program and separate health insurance societies were established. In January 1979, the insurance coverage requirement was expanded to companies with more than

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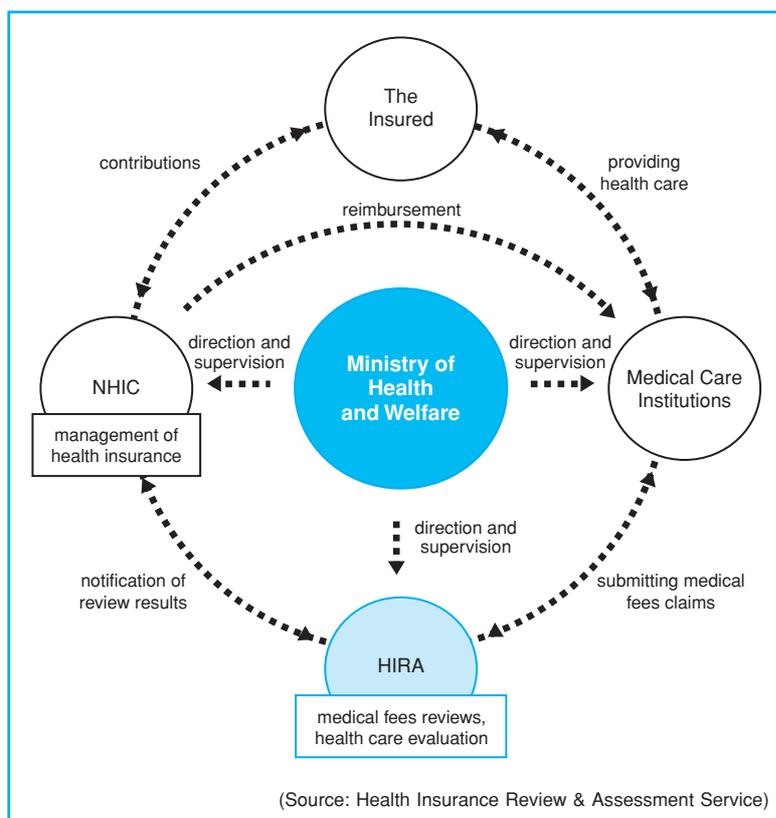


Fig. 1 The structure of the National Health Insurance Program

300 employees, public servants, and private school employees. In January 1988, self-employed people in rural areas were included under this system.

The year 1989 is the most important year in the history of South Korean National Health Insurance Program. In July, the health insurance program for urban areas was expanded to include the self-employed. It took 12 years from the establishment of the Medical Insurance Act to achieve universal health insurance coverage for all citizens. About ten years later, in 2000, all health insurance societies were integrated into a single insurer, the National Health Insurance Program.

Structure and operation

The National Health Insurance Program is broadly divided into four parts (Fig. 1). Firstly, the MIHWAF is in charge of supervision and policy decisions. It supervises the operation of the National Health Insurance Program through the formulation and implementation of policies.

Secondly, the National Health Insurance Corporation (NHIC) is in charge of managing

National Health Insurance Program, namely the enrollment of insured people and their dependents, collection of contributions, and setting of medical fee schedules.

Thirdly, the Health Insurance Review Agency (HIRA) is in charge of reviewing medical fees and health care evaluation. After receiving medical care, the patient can submit a claim to HIRA requesting a review of his/her medical fees, and the NHIC may reimburse the claim.

Fourthly, medical care institutions provide healthcare services. They are directed and supervised by the MIHWAF.

Population coverage and payment of contribution^{4,5}

All people in South Korea are eligible for coverage under the National Health Insurance Program (Table 1). In 2006, the total number of covered people was over 47 million, or over 96.3% of the total population. The insured are divided into two groups: employee insured and self-employed insured. The “employee insured” category includes

Table 1 Number of covered population, 2006

(unit: person)

Classification	Coverage	(%)
Total	49,238,227	100
Subtotal	47,409,600	96.3 (100)
NHIC Employee insured	28,445,033	57.7 (59.9)
Self-employed insured	18,964,567	38.6 (40.1)
Medical Aid	1,828,627	3.7

(Source: National Health Insurance Corporation^{4,5})**Table 2 Co-payment system**

Classification	The portion of health care costs
Inpatient	10–20% of total treatment cost
Outpatient	
Tertiary care hospital	Per-visit consultation fee + 50% of treatment cost
General hospital	50% of (treatment cost + Per-visit consultation fee)
Hospital	40% of (treatment cost + Per-visit consultation fee)
Clinic	30% of treatment cost
Pharmacy	30% of total cost

(Source: National Health Insurance Corporation)

the insured person's spouse, descendants, brothers or sisters, and direct lineal ascendants. Insured employees pay 5.08% of their average salary in contribution payments. Contribution rates change every year.

The self-employed insured category includes people excluded from the category of insured employee. Their contribution amount is set taking into account their income, property, living standard, and rate of participation in economic activities. The remaining 3.7% are supported by the Medical Aid Program.

Overseas Koreans must reside in Korea for at least three months before they apply for National Health Insurance Program in South Korea. Foreigners working in South Korea are required to apply for coverage under the program.

Co-payment system

The insured individual is required to pay a certain portion of the health care costs. The co-payments differ according to the level and type of medical care institution (Table 2). When an insured individual pays more than the co-payment ceiling threshold (3 million won or 2,400USD, 1USD = 1,250 won) within a period of six consecutive months, he or she is exempted from any further

co-payments incurred.

Funding sources⁶

The National Health Insurance Program has three sources of funding: contributions, government subsidies, and tobacco surcharges.

The first source of funding is the payments (contributions) made by the insured. Employee insured individuals are required to contribute 5.08% of their salary. The employer and employee each pay 50% of this amount. The contributions of self-employed insured individuals are based on their level of income. To calculate the income, the insured person's property, income, motor vehicles, age, and gender are taken into consideration. For the insured living on islands or remote rural areas, there is a system of reduced contributions.

The second source of funding is the government. The National Government provides 14% of the total annual projected revenue, which is comprised of the contributions paid by the insured of National Health Insurance Program.

The third source of funding is the surcharge on tobacco. This provides 6% of the total annual projected revenue.

Medical Aid Program³

Around 3.7% of the total population is covered under the Medical Aid Program. As of 2006, the number of people enrolled under the Medical Aid Program is 1,828,627 (3.7%) out of the total national population of 49,238,227. The number of people enrolled in the National Health Insurance Program is 28,445,033 (57.7%) Employee Insured and 18,964,567 (38.6%) Self-employed.

The Medical Aid Program was established in 1979 for low-income households after the promulgation of the Medical Aid Act in 1977. Under this program, the Government pays all medical expenses for patients who are unable to pay for health care. After 2004, the Medical Aid Program was expanded to cover patients with rare, intractable, and chronic diseases as well as children under the age of 18.

The Medical Aid Program is jointly funded by the central and local governments. The MIHWFA sets and annually modifies the criteria for beneficiaries. Local governments select the beneficiaries based on the conditions set by the Ministry.

Recently the Government has faced financial difficulty in providing the needed medical services for low-income people, and changed the system so that the National Health Insurance Program provides partial funding for the Medical Aid Program.

Long-term Care Insurance Program³

Recently life expectancy in South Korea has increased sharply, rising more than eight years over the past 20 years. Traditionally, taking care of elderly people had been a major family burden in South Korea. To solve this problem, the Government introduced a Long-term Care Insurance Program in July 2008 in several locations around the country as a pilot implementation study. It is a social insurance system and currently covers 3.8% of elderly Koreans.

Elderly people with serious limitations in performing activities of daily living (ADLs) are

qualified to apply for the program. For example, those aged 65 years or older, or those aged less than 65 years old but suffer from an age-related disabling condition such as Alzheimer's disease, Parkinson's disease, or paralysis due to stroke, can apply for the program. If they are qualified as a beneficiary, they receive medical treatment services including baths, laundry, and nursing care.

Long-term Care Insurance Program is funded by long-term care insurance contributions paid by the insured, government subsidies, and co-payments by beneficiaries. The Government finances 20% of total long-term care insurance, which is based on a co-payment system. Users of the services pay 15% (in-home services)–20% (institution services) of the expenses for care services.

The national government hopes to expand the program to include coverage of elderly people with less serious limitations in performing ADLs.

Challenges for the Health Care System¹

Access and coverage

Regional inequalities in access to medical care services in South Korea should be addressed. Due to medical profit maximization strategies, most private medical facilities are located in urban areas, and 92.1% of physicians and 90.8% of hospital beds are in urban areas, while 79.7% of the population lives in urban areas.

Increase in the elderly population and health financial deficit

South Korea is becoming an aging society faster than any other country. In line with the increase in the elderly population, there has been an increase in medical expenditure for chronic degenerative diseases, which has become a large social burden. The South Korean Government is endeavoring to reduce the financial burden, especially for the younger population, through comprehensive health care reform. The MIHWAF is taking various measures for the aged, such as the expansion of health care facilities and introduction of Long-term Care Insurance Program.

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