The Light and Dark of Healthcare in South Korea*1

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I have watched intently the changes in South Korean healthcare from the closest vantage point through my involvement in government, the National Assembly, and the medical association. At the same time, I also participated in invaluable opportunities to devise policies to foster the development of medicine in South Korea. Based on those experiences, I would like to talk today about the rapid progress made in South Korean healthcare and the process of establishing a health insurance system over the past 30 years.

Introduction of a Health Insurance System in South Korea

Deliberation of system adoption

First I would like to give a simple description of the background and process of the adoption of a health insurance system in South Korea.

The 1960s and 70s were a time when South Korean society was gradually recovering from the deep wounds of the Korean War. It was also a time when the healthcare field was gradually normalizing but, as I remember, the nation was still mired in the situation of developing country at the very bottom. Per-capita national income was a meager 1,000 US dollars. At the time, an environment had not been developed in which citizens could freely utilize modern medical institutions because of a serious gap between rich and poor and skyrocketing healthcare costs. Public medical institutions in particular, and especially hospitals and health centers run by local governments were lagging behind significantly.

In such a situation, Japan's success in establishing universal health insurance coverage in 1961 sparked the emergence of Korean interest in a health insurance system. Ruling lawmakers led the way in organizing study groups with the aim of adopting a health insurance system. At the time, when I held a key position in the ruling Democratic Republican Party, myself and two other lawmakers who were physicians plus two lawmakers who were former bureaucrats formed a study group. After a year of lively activity we came to the conclusion that South Korea should also adopt health insurance system. What is more, we prepared a concrete proposal and presented it to the president. The following are the principles that were established at the time in connection with the adoption of a health insurance system:

1) In principle, the market economy would be the basic direction.
2) Coverage would be expanded progressively to each level of the population in parallel with improvement in the Korean economy.
3) Medical facilities nationwide are fragile with municipal and provincial hospitals in the countryside in particular lagging behind prominently. Accordingly, investment would be expanded to modernize facilities in order to implement a health insurance system.
4) Compensation for healthcare covered by insurance would not be set unilaterally by the government based on administrative opportunism, but would rather be adjusted through negotiation with each level.

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Opposing views over adoption

However, more than a few voices of opposition were heard until adoption of a health insurance system and there were many hurdles blocking the way. Resistance was particularly strong from bureaucrats and physicians. Those in charge of financial administration in government agencies took the stance that advancing universal health insurance coverage was impossible with a fragile economic base in which per-capita national income was a paltry 1,000 US dollars.

Physicians, on the other hand, voiced fears that their independence and autonomy would be lost because overall health and medical policies would hinge on unilateral decisions made by the government following adoption of a health insurance system. Considering the government's authoritarian attitudes at the time, such contentions from physicians were understandable.

In this way, the initiative faced many challenges. But, pushed by the determination of then President Park Chung-hee, who understood better than anyone the actual circumstances of people suffering from poverty, it was decided to adopt a health insurance system. President Park, who was born and raised in a poor family, ended up taking a firm resolution to adopt universal health insurance coverage because he was intimately familiar with the condition in which many people were suffering without being able to receive treatment at a medical institution because they could not afford the medical bills.

Step-by-step adoption and expansion

It was in this context that a health insurance system was initiated in South Korea in July 1977. The government started off with employee health insurance (workplace insurance). The initial scope was to cover employees of large companies with 500 or more employees by requiring employers to pay 50% of the premiums. This was a contrivance to minimize failure of the system by establishing a stable structure and guarding against financial problems. In January 1979, coverage was expanded to civil servants and teachers in private schools, who are financially secure, and then to companies with five or more employees in July 1988. Today, even sole proprietors are eligible for coverage, and so it is safe to say that employee health insurance made comparatively smooth progress down the road of expansion.

Community-based health insurance aimed at farmers, fishermen, and the self-employed, on the other hand, faced many barriers in the process of expansion. This was due to the fact that it was not easy to establish a fair premium assessment system because of the difficulty in ascertaining precise incomes.

Nevertheless, the numerous difficulties were overcome and, after conducting pilot programs in 1981 and 1982, Farming and Fishing Village Health Insurance was enacted for farmers and fishermen nationwide, marking a major turning point in the expansion of community-based insurance. Notably, in an attempt to avert failure of community-based insurance, the government set and immediately implemented a policy of subsidizing 30% of the insurance premiums for persons deemed likely to have difficulty making premium payments.

Obstacles to expansion

As the person responsible for expanding the health insurance system to the whole nation, the thing that became the biggest issue for me was the problem of extending coverage to self-employed individuals in the cities. At the time, some 70 or more percent of urban individual proprietors were not paying taxes because of many loopholes in South Korea's tax collection system. This was a major barrier in the way of expanding health insurance coverage.

In 1988, right when there was a need to solve these problems, I was serving as the Minister of Health and Social Affairs. Looking back now, I think that period in my life was the time when I worked most enthusiastically. After I became minister there was strong opposition among government bureaucrats who claimed that the extension of coverage to self-employed people in the cities should be postponed because of problems in the operation of the system. However, I was firmly resolved to make universal health insurance coverage a reality during my term in office without fail in order to relieve the suffering of people without insurance.

The role of unionism (multiple insurers)

Another point to note in the adoption of a health insurance system in South Korea was that unionism was placed in the bedrock of the system like in Japan. Considering the particularities of South Korea in that it has a dense population like Japan and most of the people live within a one-day life

zone, I believe that the fact that health insurance unions based on the spirit of mutual aid became the core of system operation played a major role in firmly establishing the health insurance system. I think that in the extension of coverage to self-employed individuals in the cities as well, unionism fulfilled a major role in fixing the amount of insurance premium payments with regards to income in a comparatively fair way.

Unionism has the advantages that competition between unions increases efficiency and that the system can be operated according to characteristics of the insured persons. Because of this, I rate unionism as having played greater roles in terms of the collection of insurance premiums and system operation during its expansion.

Unionism and Integralism

On the other hand, inequalities in the premium burden and benefits between unions are major shortcomings. Additionally, there is the problem of financial insecurity from limited pooling and the problem that transfers of income are minimally effective. In South Korea, as elsewhere, disparities in insurance finance between unions and gaps in terms of the utilization of healthcare and the assessment of insurance premiums became problematic in the 1990s. After a time of gradual integration, full integration was achieved in 2003 with the change over to the National Health Insurance Corporation (NHIC) being the single insurer. The switch from a union system made up of several insurers to a single insurer system is an unusual move hard to find anywhere else in the world.

With integralism there is financial stability from broad pooling and transfers of income are effective. Plus inequalities in premium burden and benefits can be corrected to a certain degree. Since integration, the problem of unfairness in the assessment of premiums in community-based insurance is viewed as having improved to some extent. On the other hand, it has been pointed out that bloating of the NHIC has caused deterioration in efficiency and that competition has declined. Thus, appraisals are still split as regards integration.

Achievement of universal health insurance coverage

On July 1, 1989, universal health insurance coverage was finally inaugurated. Delivering the line, "From today all South Korean citizens can go to any hospital and receive healthcare," in a televised address was an emotional moment as a physician and politician that I will never forget. Watching the sad, retreating figures of patients and their families leave the exam room having given up the hope of treatment because they could not afford the medical expenses were my most painful moments as a physician. Having solved that for the present through the adoption of a health insurance system and its successful operation was deeply moving.

Outcome of the Adoption of a Health Insurance System

Increased use of medical services

The achievement of universal health insurance coverage in the short span of 12 years from the adoption of an insurance system in 1977 is an accomplishment without parallel in the world. It was an achievement made possible through political determination and will and because of financial backing from a high level of economic growth that was also achieved at the same time.

This year marks the 34th anniversary of South Korea's health insurance system, which is already starting to approach maturity. And so now I would like to briefly explain the accomplishments of these 30 odd years.

As of 2009, medical security covers the entire nation with 50,291,000 people in South Korea, including foreigners, having received coverage. Of these, health insurance coverage excluding people eligible for a healthcare allowance under the Korean version of Medicaid (4% of the populace) is provided to 48,614,000 people, which accounts for about 96% of the whole nation.

The adoption health insurance led to a rapid increase in the use of medical services by the people. The length of hospital stays increased from no more than 0.1 days per subscriber in 1977 to 1.91 days in 2009, and the number of outpatient days rose from 0.7 to 16.07.

Expanded healthcare foundation

Medical expenditures per day at medical institutions also increased from 41,334 won (3,049 yen) to 125,131 won (9,230 yen) for hospital stays in 2006 and from 6,530 won (482 yen) to 17,998 won (1,328 yen) for outpatient visits.

At the same time, the rapid increase in demand

for healthcare was accompanied by remarkable growth in supply. The number of general hospitals increased from 82 in 1980 to 317 in 2009 along with a prominent increase in the size of hospitals. Medical institutions at the level of a clinic jumped from 6,363 in 1980 to 27,036 in 2009.

Personnel engaged in healthcare also increased. The number of physicians per 100,000 people rose from 39.7 in 1981 to 141.1 in 2006. At the same time, the number of sickbeds continued to increase along with the increase in medical institutions, with the increase in the number of sickbeds in hospital class medical institutions standing out. However, compared to the averages in Japan and OECD countries there is still a gap in the population of healthcare providers.

Furthermore, there has been a rapid increase in advanced medical devices, including rapid growth in the number of CT and MRI machines, which symbolize cutting-edge medical equipment. The increase in advanced equipment speaks for the improvement in Korean healthcare and at the same time cannot be ignored as a cause of soaring healthcare cost.

Improved health indices

It is also clear from various health indices that the establishment of a health insurance system has contributed to the improvement in the health of the nation. To begin with, at 52.4 years, the average life expectancy in South Korea was 16 years younger than the 68.37-year OECD average in 1960. In fiscal 2006, it is 79.1, which is longer than the OECD average. Until the 1970s, South Korea had recorded an infant mortality rate that was double that for OECD nations. In 2002 it had dropped below the OECD average of 6.2 deaths per 1,000 live births to 5.3 deaths per 1,000 live births. In these and other ways, South Korea can be judged as having made breakthrough advances.

Challenges in the Health Insurance System

Side effects of freedom of choice of medical institutions

Nevertheless, there have been a variety of side effects on the flip side of health insurance establishment. A characteristic of South Korea's health insurance system is that insured persons freely choose medical institutions without regard to location or type. However, this kind of policy has created an imbalance with patients preferring large hospitals, and resulting in a significant tendency for patients to converge on the most well-known hospitals in Seoul.

An attempt was made to correct the problem by setting different levels of copayments when using a hospital, but a fundamental solution has yet to be achieved. At the same time, a complete solution has yet to be found for the problem of a three-hour wait for a three-minute exam.

Absence of a philosophy about direction

Looking at political problems, one problem in South Korea's adoption of a health insurance system was the lack of sufficient discussion and agreement between the people and politicians regarding a philosophy that sums up the health insurance system. In other words should we hold up the principle of high cost with high benefits as in the UK and Sweden or should we hold up the principle of low cost with low benefits? A direction could not be defined clearly. With no clear direction, the government, labor unions, companies, and civic groups are still locked into the belief that it goes without saying cheaper is better when it comes to medical costs. This kind of fixed thinking, tied to the populism of some politicians, spreads illusions about expanding benefits. Then again, no one even mentioned the rising costs that come with the growth of benefits. Being absorbed in schemes to win people over and chasing after nothing but daydreams of healthcare will likely end in a situation in which bankruptcy of health insurance finance becomes unavoidable.

Confusion over the main constituent in the provision of healthcare

Something else that cannot be ignored is the fact that the introduction of health insurance has led to confusion over who the actual healthcare provider is, and the public is under a strong impression that the role of healthcare provider has been replaced by the government or insurer. Even physicians themselves feel as if they have become mere tools serving the objectives of the government or the insurer groups instead of the welfare of patients...

I will finish my talk about South Korea's health insurance system here. Next, I would like to say a few things about points of contention in Korean healthcare.

Challenges regarding Health Insurance Financing

Non-benefits

South Korea's Health Insurance Act specifies items not covered by insurance as non-benefits. Theoretically, all medical procedures except these are subject to benefits. Main examples of non-benefits include robotic surgery, treatment using MRI and other new medical technology, items that are considered inconsistent with insurance goals (e.g. upgrading to a better hospitalization room), and costs for seeing a designated specialist who meets certain criteria. Non-benefits are to be paid entirely by the patient.

However, while all medical procedures besides non-benefits are theoretically subject to benefits, the existence of separate criteria for benefits in the review of the reimbursement claims creates a category of *arbitrary non-benefits* as a grey area. In other words, arbitrary non-benefits would be treatments that exceed the benefit criteria but are considered necessary by both the patient and medical institution and therefore burdened solely by the patient. Arbitrary non-benefits are caused by the ambiguity in benefits criteria and by the limit of health insurance finance. Principal examples of arbitrary non-benefits include costs for surgery materials and expensive cancer drugs.

Mixed treatment

In South Korea it is possible to combine insurance covered treatment (benefit items) and non-benefit treatment for a single disease. In other words, what could be called *mixed treatment*, which is banned in the Japanese system, has been allowed since the beginning of insurance system adoption. Mixed treatment became widely accepted because providers attempted to meet the needs of patients by complementing limited benefits, since health insurance was structured on low premiums, low benefits, and low compensation.

By authorizing non-benefits and mixed treatment, the government was able to keep a lid on the excessive pressure on insurance finance even while expanding the list of benefit items covered by health insurance. On the other hand, non-benefits and mixed treatment resulted in high out-of-pocket costs for patients. In 2008, the percentage of costs covered under health insurance was 62.2%, which represents a significant gap with the 80% that is the average for OECD countries.

Out-of-pocket costs

In 2008, the percentage of medical expenses paid from insurance finance was 62.2%, the legal out-of-pocket costs (patients' out-of-pocket costs for medical procedures that are subject to benefits) was 22.6%, and the out-of-pocket costs for non-benefits was 15.2% (total out-of-pocket costs: 37.8%). In monetary terms, of the approximately 58 trillion won (approx. 4.3 trillion yen) in total medical costs, about 35 trillion won (apprx. 2.6 trillion yen) is paid from insurance finance and the total out-of-pocket costs are about 23 trillion won (approx. 1.7 trillion yen), of which around 11 trillion won (approx. 800 billion yen) are out-of-pocket costs for non-benefits.

Crisis of health insurance finance

Health insurance finance has been in peril since the major changes of insurer integration and separation of medical and dispensary practice were made in 2000. First of all, in the aftermath of these changes government expenditure increased in 2001, resulting in a deficit of 2.4 trillion won (170 billion yen), which was eventually evened out by raising insurance premiums and with support from national finances.

Shortly after this crisis had settled down, the government decided to strengthen insurance coverage. In 2006 it implemented a policy making hospitalization charges free for children under six years old and covering 80% of the meal charges for hospitalized patients. This policy pushed health finances back into the red. The deficit problem could not be corrected despite raising premiums and so in the end the policy was changed in 2008 to a 10% copayment on hospitalization charges for children under six years old and 50% coverage on meal charges for hospitalized patients. It is estimated that the deficit will reach 48 trillion won (3.5 trillion yen) in 2030 if health insurance finance remains as it is now, and it has been pointed out that premiums will need to be raised at least 3–5% every year to avoid a financial collapse.

Health insurance finance and welfare populism

As we can see from these facts, it is perfectly obvious that increasing the cost burden is abso-

lutely necessary to expand benefits. And yet, right now South Korea is debating free healthcare. This is nothing more than irresponsible welfare populism that gives no thought to sustainability of the health insurance system.

Given that South Korea's population is ageing rapidly and that its birthrate is the lowest in the world, measures to strengthen insurance coverage gradually by strengthening public finance should be discussed before free healthcare. Raising insurance premiums to an appropriate level will be the most important step to strengthen financial resources to fund health insurance. At present, the premium rate in South Korea is 5.64% of income, which is very low level compared to other countries that have adopted a social health insurance system. I think that diversification of funding sources for health insurances should also be considered. Presently there is a health burden tax on cigarettes only, but fiscal resources need to be diversified such as with a health burden charge on alcohol as well.

Computerization of insurance claim and review processing

Lastly, I would like to briefly touch upon the computerization of insurance claim and review process for health insurance-covered reimbursement, which is something Japan is also putting effort into. The computerization of claims in South Korea began with a pilot program using Electronic data interchange (EDI) in 1996. In 2004, the country has achieved a computerized claim rate of 99%.

Moreover, the number of reviewed cases has also increased exceptionally, jumping more than threefold from 410 million cases in 2000 to 1.28 billion cases in 2009. IT has been introduced into these reviews in an attempt to improve specialization and efficiency. In 2010, more than half of the number of claims was processed through electronic reviews. This is credited with paring down medical costs by 93 billion won (approx. 6.8 billion yen) per year and replacing the labor of 150 people.

The Light and Dark of Healthcare—A personal episode

To finish, I would like to mention an episode concerning the light and dark of healthcare through my own personal experience.

In 1958, I returned to Korea from studying abroad in the US and was working as head of the Department of Neurosurgery at Yonsei University Hospital. I would like to talk about a 12 year old boy and his family, whom I had met at that time. A tumor had been discovered in the boy's cerebellum. I explained the situation to his father and recommended surgery. The father, who was a farmer in the countryside, said he would like some time to consult with his family. He then left to speak with the boy's mother, who had been waiting outside. In a little while the father returned and said, "I am a tenant farmer and support my family of five with a cow. Our only asset is the cow, which we need for farm work. If I sell the cow to pay the costs of the operation, there will be no way for us to live in the future. It breaks my heart, but our only choice is to give up the operation." So saying, he walked out of the exam room.

Watching the retreating figure of the father as he went home slouching in grief, I felt seriously frustrated, as a young physician in my early 30s, that there was nothing I could do for him.

Why had I become a physician? Even though I had learned the latest medical knowledge and technology in the United States, what could I do with the entire Korean society in a state of poverty? These kinds of worries and sadness weighed heavily on me.

Thirty years passed and at last the light began to shine in 1988. As I explained to you here today, universal health insurance coverage had finally been achieved in South Korea through a variety of processes. The instant I had declared in a televised address that, "From today all South Koreans can now freely enjoy the benefits of healthcare with no financial burden," on July 1, 1989 was a precious moment that I can never forget, the time when I had succeeded in giving a light to the nation as a physician and politician. In that instant the wall separating physicians and patients had been removed. I am genuinely grateful that I could participate in that process.

It may be impossible for a health insurance system to work perfectly in any country. But I hope that South Korea's experience can serve as a useful reference for poor countries and developing nations.