6 Principal health reforms

Chapter summary
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 the population, a new social insurance for long-term care (LTC) was introduced, principally for the elderly. Coordination between health insurance and LTC insurance, and between healthcare 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.

To contain the cost of pharmaceuticals, the positive listing of medicines based on economic evaluation was implemented. The Government also introduced price negotiations for new originator medicines between the insurer and pharmaceutical manufacturers as well as further cuts in the price of generic medicines. More policy measures are required to influence the prescribing behaviour of physicians.

For financial sustainability, 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 premium base for contributions needs to be expanded by charging against all types of income rather than wage income only.
6.1. Analysis of recent reforms

6.1.1 Health reform in the early 2000s

Merger of health insurance societies into a single payer system

Before the health-care financing reform of 2000, the Republic of Korea’s national health insurance system consisted of more than 350 quasi-public insurance societies. There were three types of health insurance scheme that were subject to strict regulation by the Ministry of Health and Welfare: (i) health insurance societies for employees and their dependents, numbering more than 100; (ii) a single health insurance society for civil servants, teachers, and their dependents, and (iii) more than 200 health insurance societies for the self-employed. There was no competition among health insurance societies to attract the insured, and the insured were assigned to insurance societies based on workplace (for employees) or residential area (for the self-employed) (Kwon, 2009a).

By merging all health insurance societies into a single payer, health-care financing reform in 2000 aimed to increase the efficiency of risk pooling, improve equity in contribution, and minimize administrative costs (Kwon, 2003a). Before the merger, differences in the contribution rates across insurance societies, in spite of identical statutory benefits, raised concerns about equity in health insurance contributions. Members of insurance societies in poor or rural areas had to pay a greater proportion of their income or capacity to pay than those in wealthy areas. The Government introduced a risk-pooling/sharing mechanism among insurance societies, based on population structure and catastrophic medical expenses. Insurance societies with a higher proportion of the elderly and greater burden of catastrophic expenditure were cross-subsidized by others. But many insurance societies for the self-employed in poor or rural areas continued to suffer fiscal insolvency because they faced systematic problems of higher demand for health-care by the elderly with limited capacity to pay contributions.

The single payer/multiple payers debate had continued since the launch of health insurance in the Republic of Korea. The National Assembly passed legislation to merge all insurance funds in the early 1990s, but the President vetoed the law. The Government was worried that a single payer system could increase the government (budget) responsibility for financing (compared with the contribution paid by the insured). But the new Government with a progressive president opened a window of opportunity for major policy reform in 2000 (Kwon and Reich, 2005).
Progressive civic groups actively participated in the policy process and supported the reform, maintaining that the merger would improve equity through a nationwide contribution formula and also save administrative costs for the health insurance system.

**Separation of drug prescribing and dispensing**

Before the pharmaceutical reform of 2000, physicians and pharmacists both prescribed and dispensed medicines. This system provided strong financial incentives for physicians and pharmacists to dispense more drugs and to select those with greater profit margins (Kwon, 2003b). Because fees for medical services were strictly regulated, dispensing drugs was a sought-after source of profit for doctors as they purchased drugs at prices that were much lower than the cost reimbursed by health insurance. Perverse financial incentives for physicians and pharmacists contributed to the high proportion of pharmaceutical expenditure in total health expenditure.

Physicians wanted to retain the dispensing of drugs because it was a major source of their income, and pharmacists favoured the status quo as they wanted to keep the right to prescribe. Lobbying by physicians and pharmacists had been influential and effectively blocked reform for a long time. With the active support of civic groups, a progressive Government succeeded in adopting the policy of separating prescribing from dispensing in 2000 (Kwon and Reich, 2005).

However, the pharmaceutical reform faced a series of nationwide strikes by physicians, leading to watering down of some elements of the reform package (Kwon, 2003b). For example, brand-name prescription was implemented due to physicians’ opposition to generic prescription. Doctors also succeeded in pushing the Government to increase their fees to compensate for foregone medicines-related revenues as a result of pharmaceutical reform. The dramatic increase in physician fees, as much as 40%, contributed to a fiscal crisis in the national health insurance system when its accumulated financial reserve was exhausted in 2001 (Kwon, 2007).

The bargaining power of physicians increased as they were able to use a threat of strikes in the negotiations with the Government. In 1997, the Government began the pilot programme of a Diagnosis Related Group-based prospective payment system (DRG) for five disease categories for voluntarily participating providers (Kwon, 2003c). The Government
planned to extend the DRG payment system to all health-care providers in 2000, alongside the financing and pharmaceutical reforms. After doctors’ strikes against the pharmaceutical reform, the Government had to give up on nationwide implementation of the DRG-based payment system.

6.1.2 Introduction of long-term care insurance for the elderly

In July 2008, the Republic of Korea introduced social insurance for long-term care. Along with an increased life expectancy and a rapid decline in fertility, the family structure has also changed. The proportion of the elderly living with their adult children has decreased, and with an increase in labour participation, women have been less able and willing to play the role of informal caregiver to the elderly (Kwon, 2008).

Government reluctance to extend the tax-based public assistance programme for LTC to the poor elderly contributed to the rather early adoption (when the proportion of the elderly was still less than 10% of the population) of a universal LTC financing scheme. LTC insurance, separate from health insurance, has a potential benefit in “de-medicalizing” LTC by reducing the role of medical care, as physicians would tend to play a dominant role if health insurance provided LTC coverage.

LTC insurance had multiple policy goals. From a social welfare perspective, it aims to ease the financial burden of the elderly. It can also decrease the financial burden on the health insurance system by reducing social admissions to acute care hospitals. The Ministry of Health and Welfare has tried to persuade the Ministry of Finance and Economy of the potential of LTC insurance to create jobs, such as LTC workers, by extending social services.

LTC insurance covers long-term care for the elderly aged 65 or above, but it is limited to age-related LTC in the case of those under 65 (e.g. dementia or cerebrovascular disease). As a result, the probability of younger people accessing LTC insurance benefits is low as the benefits are limited only to age-related LTC needs. This is a political compromise, because the Government wants to make the younger pay contributions (for financial sustainability reasons) by making them eligible for the benefits in principle. In contrast, German LTC insurance covers all types of long-term care, while in Japan those under 40 are not covered and those aged 40 to 64 are eligible for age-related LTC only (Campbell, Ikegami and Kwon, 2009).
6.1.3 Expansion of health insurance benefit coverage

In spite of universal coverage, high OOP payment is a continuing concern (see Chapter 3). Following President Kim Dae-Jung’s active expansion of various welfare programmes, President Roh Moo-Hyun (2003–2008), also from a progressive political party, implemented a series of policies to expand health insurance benefit coverage.

The ceiling on cumulative OOP payment, set at about $3000 per person for any six-month period, was introduced in 2004, and this was reduced to about $2000 in 2007. For the financial protection of the poor, however, the ceiling needed to be differentiated to patients’ ability to pay. In 2009, differential ceilings were implemented based on (relative) income: $4000 for those in the top 20% of the income range, $3000 for those between the 20th and the 50th percentile, and $2000 for those below the 50th percentile. The ceiling on cumulative OOP payment has been effective in reducing the financial burden on patients, but its impact is still limited because it applies only to co-payments for insured (covered) services, and not to OOP payments for uninsured services.

The coinsurance rate for patients with catastrophic diseases, mainly cancer patients, was reduced from 20% to 10% in 2005, then further reduced to 5% in 2009. Exemption from co-payment for inpatient care for children aged six or younger was implemented in 2006, although in 2008 the infant coinsurance rate was reimposed at 10%. Health insurance began to provide coverage for meals with a 20% co-payment rate in 2006, but it was raised to 50% in 2008. Although coinsurance rates for meals and children’s inpatient care increased slightly from 2006 to 2008, the current co-payment rates are still lower than those in the pre-2006 era, which were 100% for meals and 20% for inpatient care.

However, the expansion of benefit coverage has not reduced the share of OOP expenditure in total health expenditure as rapidly as expected. Health-care is provided predominantly by the private sector. As central government regulates the price of insured services, private providers tend to increase the provision of non-covered services, for which they can set their own prices and avoid the government fee scheduling. Demand inducement and the rapid increase in the provision of uninsured services have contributed to the slow increase in the public share of total health-care expenditure.
6.1.4 Pharmaceutical cost containment

The Government introduced two major policy measures to contain pharmaceutical expenditure in May 2006: price negotiation and positive listing (Kwon, 2009b). Previously, the reimbursement price of a new drug was based on external reference pricing, which was set as the average price across drugs in seven reference countries (United States, United Kingdom, Germany, France, Italy, Switzerland, and Japan). More specifically, the price of innovative new drugs was set as the average of manufacturing prices (65% of the list price) of those countries plus a value-added tax and the distributors’ margin. This pricing mechanism was criticized because it tended to result in high prices as it depended on the list price, rather than the actual transaction price, in high-income countries. Considering that the Republic of Korea is a rather early adopter of new medicines, it was often the case that same/similar medicines were available in only a limited number of countries, where the price was very high. The NHIS was also criticized for not playing an active purchaser role in pharmaceuticals. There was also a concern that the price of generic medicines was too high compared with other OECD countries (Kim et al., 2010).

Facing rapidly increasing pharmaceutical expenditure, the Government decided to change the pricing rules for new medicines (Kwon, 2009b). Instead of external reference pricing, the NHIS as a purchaser now bargains with pharmaceutical manufacturers over prices. In the price negotiation, the NHIS considers the size of the market, the substitutability of drugs, the budget impact on health insurance, and other factors. Furthermore, the NHIS takes into account the quantity (volume) of drugs to be consumed. If the actual sales volume is greater than forecast (the estimate that the pharmaceutical manufacturer submitted at the time of listing), the drug’s price will be cut. Linkage of price and volume in price-setting makes the manufacturer share the financial consequences of potential over-utilization of medicines, but there is still no risk for physicians, who actually play a key role in pharmaceutical expenditure. Through price negotiation, the NHIS is expected to use its bargaining power as a single payer to obtain better prices for pharmaceuticals.

In the new pricing scheme, when a patent expires and a generic medicine becomes available, the price of the originator brand-name drug is discounted to 80% of the previous price. The price of the first generic medicine is set at 85% of the price of the original brand-name medicine (or 68% of the price of the originator before the entrance of a generic
The price of the second to fifth generic medicines is set at 85% of the price of the first generic one. In 2012, the Government further reduced the price of medicines. In the first year of patent expiration, there is a 30% reduction in the price of originator medicines, 85% of which is set as the price of generic medicines. In the second year, there is an additional 10% reduction in the price of generic medicines.

In the past, health insurance reimbursement for pharmaceuticals was based on negative listing, which resulted in too many drugs being listed for reimbursement (Kwon, 2009b). As of January 2006, 21,740 drugs (5,411 molecules) were listed for reimbursement. To contain pharmaceutical expenditure, the Government decided to introduce the positive listing of drugs for health insurance coverage. Now the listing criteria formally include economic evaluations or cost-effectiveness analysis, submitted by pharmaceutical manufacturers to HIRA.

6.2 Directions for future reform

In addition to policy to address inequities in health-care utilization and outcomes, the Republic of Korea also needs to improve equity in financing and payment for health-care. For the health-care system to remain financially sustainable, policy measures to increase revenue and contain costs should be implemented. Contributions based on wage income are not equitable, because wage income does not truly represent the ability to pay of the insured. Wage-based contributions can also distort labour force participation. Therefore, the base for health insurance contributions should be expanded to include all types of income including financial income.

Health-care providers play a key role in decision-making and expenditure. The provider payment system is crucial for quality of care and the financial sustainability of the health-care system. Prospective case-based payment, which currently applies to only seven disease categories, should be extended. Case-based payment has its limitations, such as the distortion of diagnosis coding and the substitution of outpatient for inpatient care. Therefore a macro-level spending cap should also be considered to control both the price and the quantity of the health-care.

The LTC insurance system faces many challenges, such as finding a balance between institutional care and home-based (community-based) care and ensuring quality of care. There is an excess supply of LTC providers albeit with a variation across localities (there is a shortage in
rural areas, for example), which results in supplier-induced demand and wasteful competition. The size of most LTC residential facilities is too small and these facilities fail to benefit from the economies of scale. Coordination between health insurance and LTC insurance is a key to the continuum of care and to reducing unnecessary LTC admissions. For example, coordination failure between LTC hospitals (covered by health insurance) and LTC facilities (covered by LTC insurance) is a big challenge. Benefit coverage and provider payment of LTC insurance needs to be coordinated with that of health insurance.

Pharmaceutical spending is determined not only by prices but also by the volume of drugs and the mix of originator and generic medicines. Therefore, pricing policy alone has a limited effect on pharmaceutical cost containment. The quantity of pharmaceuticals consumed is determined to a great extent by prescribing physicians, so without regulating physicians’ prescribing behaviour, pharmaceutical cost containment cannot succeed. A provider payment system and financial incentives for physicians to increase the prescription of less costly but equally effective generic medicines are essential. A budget cap on pharmaceutical expenditure is needed, and the Government should make doctors and the pharmaceutical industry share responsibility when pharmaceutical expenditure exceeds the cap. Policy-makers also need to increase the price difference between originator brand-name drugs and generic drugs by further reducing the price of generics.

Health-care reform faces opposition from vested interests. As in 2000, when physicians went on nationwide strikes against pharmaceutical reform, groups with vested interests influence not only the reform process from policy adoption to implementation but also final reform outcomes (Kwon and Reich, 2005). Political strategy and the Government’s capacity to manage these vested interests will be crucial for the success of health-care reforms that aim to improve the efficiency and equity of the health-care system. It will be also important to build a transparent policy process for greater trust in Government and health policy.