

Health Insurance and the Growth of the Private Health Sector in the Republic of Korea

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This paper analyzes the efficacy of the national health insurance (NHI) system in the Republic of Korea and the role played by the private health sector in the provision of health care services. It identifies four main problems: (i) lack of access to the system for low-income households because of high co-payments and high insurance premia, thereby leading to a two-tier system; (ii) high administrative costs caused by the existence of a large number of small insurers; (iii) excessive use of high technology brought about, in part, by the lack of a gatekeeper and referral system, and in part, by the freedom granted to private health care providers to collect special treatment charges which are not covered; and (iv) low priority given to primary health care. The Korean example suggests that while private sector participation in NHI is important, appropriate institutional mechanisms should be put in place to control system costs and to provide affordable access to low-income groups.

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Foreword

This paper was prepared for a project on Social Development in East Asia. The project was organized by the World Bank Institute under the auspices of the Program for the Study of the Japanese Development Management Experience which is financed by the Human Resources Development Trust Fund established at the World Bank by the Government of Japan.

The principal objectives of this Program are to conduct studies on the Japanese and East Asian development management experience and to disseminate the lessons of this experience to developing and transition economies. Typically, the experiences of other countries are also covered in order to ensure that these lessons are placed in the proper context. This comparative method helps identify factors that influence the effectiveness of specific institutional mechanisms, governance structures, and policy reforms and thereby ensures a better fit between the lessons from East Asia. A related and equally important objective of the Program is to promote the exchange of ideas among Japanese and non-Japanese scholars, technical experts and policymakers.

The outputs of the project on Social Development in Asia include seven papers on topics such as pension systems, health insurance, education, and employment policies which are all published in the WBI Working Paper series. In addition, a set of papers focusing on the social policy experience of Japan over the past fifty years is being processed separately as a book-length manuscript.

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A substantial change has taken place in the Korean health sector with the introduction of a national health insurance (NHI) system. Many issues raised by this new system are of interest to both developed and developing countries. Major questions of interest are (a) how the government of Korea was able to move from the first step of health insurance schemes in 1977 to the completion of the system in 1989; (b) how a predominantly private-oriented health care delivery and financing system could support government-initiated compulsory health insurance schemes; and (c) whether there are any inherent problems with this health insurance system. While there are some positive aspects, this study shows that many basic problems remain unresolved. Unless basic reforms are implemented at the system level, in the long-run neither efficiency nor equity will be achieved. It is important, therefore, for both the government and the health sector to grasp the gravity of the situation and actively pursue better-formulated strategies.

Health Service Delivery

The Korean health service delivery system has been basically a market-oriented, private-sector-dominated, fee-for-service payment system. The role of the government has been limited primarily to the public health area. There has been very little regulation or monitoring of the ever-growing number of private providers to preclude extravagant technology acquisition, excessive provision of services, unethical behavior (selective abortions, for example), fraudulent insurance claims, and income tax evasion.

It is a market-oriented system in the sense that health care is viewed, in general, as an economic good, but not as a social good. Access to health care is selective, guided by the people's willingness and their ability to pay. How much and what level of care one receives depends largely on one's income level. For example, there are the so-called special treatment charges (STCs). When patients prefer treatment by regular staff physicians (board specialists) in a general hospital, they have to pay STCs in addition to scheduled fees. If they cannot afford the STCs, interns or residents are automatically assigned to them.

The private sector, which was dominant in Korea before the introduction of insurance plans, has been growing further with the increase in per capita income and with the expansion of health insurance coverage. A detailed analysis of the private health sector in Korea is provided later in this chapter.

Patients pay a fee-for-service (FFS) for all services at all referral levels. This has been the dominant method of payment for physicians (both Western and traditional), clinical services, and pharmacists. (An experiment with a case payment structure began in early 1997; it is the first time that a payment structure other than FFS is being tried in the Korean market.) However, physicians at hospitals are paid salaries, and occasionally they are paid bonuses based on their performance.

In most cases, patients are given a choice of providers: they can choose among various providers at multiple referral levels. Because there is no patient referral system, they can go directly to the outpatient departments of general hospitals. In 1989, some regulatory provisions were enforced in the choice of providers under the NHI. However, most patients do not abide by the rules, and hospitals, for fear of losing revenue, do not enforce these rules. As a result, the provisions have become ineffective.

Within the system, a "gatekeeper"—someone who could direct the patient to a proper provider or level of care—is virtually unknown. Since most patients prefer to be treated in general hospitals, both the outpatient and inpatient departments in general hospitals are overcrowded. Consequently, the concept of primary health care hardly exists. For many Koreans—and even for some health care bureaucrats—primary health care is considered a synonym for public health or low-quality care for the poor.

Health Insurance

In this section we will explore the nature of Korea's Health Insurance system. First we will look at its evolution; then the stimuli for its establishment; and finally, its structure.

The Evolution of Korea's National Health Insurance

A blueprint for the Korean health insurance system was initiated by the Health Insurance Act of December 1963, when the country's per capita gross national product (GNP) was still under US\$100. This scheme was primarily aimed at voluntary coverage. However, little was accomplished owing to limited financial resources and lack of participation. The government then implemented the first stage of its compulsory social security program for health care in July 1977, by enforcing the observance of a scheme for corporations employing 500 or more workers. In 1983, the corporate health insurance program was extended to firms with 16 or more employees.

A special program for civil servants and private schoolteachers was introduced in January 1979. In January 1980, the scheme was extended to cover families of military personnel and pensioners. An occupational health insurance program was introduced as a voluntary scheme in December 1981 to cover groups of self-employed workers with similar occupations. In January 1988, the rural regional health insurance program was initiated for people in rural farming and fishery areas. Finally, a program to cover self-employed and unemployed populations in urban areas, the urban regional health insurance program, began in July 1989. Until then, they were the only population group excluded from insurance benefits.

In addition to the health insurance schemes, there are government-financed public assistance programs for medical care: (a) Medical Aid for the destitute, and (b) Medical Assistance for the medically indigent. The first category of beneficiaries consists of individuals who are extremely poor, or those living in public facilities—people such as the elderly (especially those without supportive family members) and the homeless. The second category includes individuals whose income and other means fall below a specified standard, but are relatively better off than those in the first category.

Table 1 shows the percentage of the population under each program in the calendar year 1995: 95.7 percent are under health insurance plans and the remaining 4.3 percent are under the Public Assistance Medicaid program. The Regional (Rural and Urban) Health Insurance offers insurance benefits to almost half of the total population (49 percent).

Table 2 shows the process of sustaining NHI by using statistical figures.¹ Three sudden increases in the number of total beneficiaries are observed: the first in 1981 when self-employed workers within the same field were included; the second in 1988 when the rural insurance program was introduced; and the third in 1989 when self-employed and unemployed urban residents were brought under coverage. It is evident that the government has made great efforts to improve and promote health insurance programs during the expansion period of 13 years (1977–89).

¹ In the table, for example in 1995, the total number of beneficiaries (46 million) exceeds that of the population (44.9 million). That is because 1.1 million people belong to both health insurance plans and the Medicaid program. In other words, some people in the Medicaid program voluntarily join the health insurance program by paying premiums, after they realize that they get better treatment under health insurance.

Table 1. Health Care Security Coverage by Type of Program, 1995

Classification		Number of people (1,000)	Percentage
Grand total		46,005	100
Health insurance	Subtotal	44,015	95.68
	Corporate	16,744	36.40
	Civil servant	4,815	10.47
	Regional	22,457	48.81
	Rural	3,877	8.43
	Urban	18,580	40.38
Public medical aid	Subtotal	1,989	4.32
	Class I	619	1.34
	Class II	1,370	2.98

Source: Ministry of Health and Social Affairs (1995).

Table 2. Health Care Security Coverage by Type of Program
(1,000 people)

	1977	1979	1981	1983	1985	1987	1989	1991	1995
Total population (A)	36,412	37,534	38,723	39,910	40,806	41,575	42,380	43,268	44,851
Total beneficiaries (B=C+D)	5,298	9,923	15,134	19,298	21,254	25,643	44,168	43,679	46,005
(B/A)	(14.6)	(26.5)	(39.1)	(48.3)	(52.1)	(61.6)	(104.2)	(100.9)	(102.5)
Health insurance (C)	3,203	7,789	11,407	15,570	17,995	21,257	39,922	40,800	44,016
(C/A)	(8.8)	(20.8)	(29.5)	(39.0)	(44.1)	(51.1)	(94.2)	(94.3)	(98.1)
Public assistance (D)	2,095	2,134	3,727	3,728	3,259	4,386	4,246	2,879	1,989
(D/A)	(5.8)	(5.7)	(9.6)	(9.3)	(8.0)	(10.5)	(10.0)	(6.6)	(4.4)

Note:

1. Numbers in parentheses are percentages of the total population.

2. Numbers of beneficiaries greater than total population imply that some people are registered in both health insurance and public assistance programs. .

Source: Ministry of Health and Social Affairs (various years).

The introduction of compulsory universal health insurance transmits different signals to different economic agents. Many Koreans now regard health (or basic health care services) as one of their basic rights. Unlike attitudes toward other goods or services, the perspective on health care is that everyone is entitled to minimum services for survival, regardless of his or her wealth or social standing.

Providers can no longer enjoy unchecked autonomy as they are subject to the many constraints inherent in the system. Physician and hospital charges are contingent on government-determined fixed-fee schedules, and the acquisition of certain equipment and expansion or establishment of hospitals in certain areas need the express approval of the Ministry of Health and Welfare.

For the government, the transition implies enhanced financial and social obligations. Even with an economy in recession, it would be extremely difficult for the government to cut budgets or reduce benefits in the future, because people are accustomed to the welfare state, and would not accept such a change. On the contrary, it is more likely that the government will face an even greater burden as certain groups, such as the elderly and the handicapped, demand their fair share of the pie.

Stimuli for the Establishment of National Health Insurance

It is interesting to note how quickly the Korean government proceeded from its initial step to the final goal of NHI. Each stage was reached without much political, economic, or social resistance. The expansion of health insurance coverage was a popular issue, and voters indicated a strong preference for insurance. Politicians, especially those in the then-ruling Democratic Justice Party, took the initiative and gradually expanded health insurance coverage. The following are factors that contributed to the establishment of NHI.

First, the fact that the Democratic People's Republic of Korea provided health care free of charge for all citizens, while the Republic of Korea did not, became one of the focal points in politics. The government had to introduce a comparable structure that would guarantee equal access to health care for all social classes. Competition between the two Koreas became one of the contributing factors toward mandatory health insurance legislation in the mid-1970s.

Second, with speedy industrialization in the 1960s, people began to realize that some of their physical suffering was not solely their own responsibility. Exercising their voting rights, people in the workplace demanded health insurance schemes that mandated employers to offer premium contributions.

Third, unilateral government policies promoting economic growth during the period of 1960–76, which resulted in an unequal distribution of wealth among classes, raised social equity issues. To avoid conflicts among classes, the government had to introduce the concept of social welfare into its policy agenda. The first outcome from such changes was the introduction of a health insurance scheme. The government and the leading political party pushed the idea with the hope that it could somehow solve the inequities, the injustice, and the unnecessary burden of being sick, brought about by rapid industrialization.

Fourth, the expansion of health insurance coverage was a popular political subject. As the gap in health care utilization between the insured and the uninsured widened in the early 1980s, the majority of the uninsured pressed politicians to advance the expansion of health insurance schemes. Politicians, especially members of the then-leading Democratic Justice Party, took an initiative to start and gradually expand health insurance coverage.

Fifth, the growing strength of the Korean economy since 1960 was another factor that made the expansion of health insurance programs feasible. With increased GNP and per capita disposable income, the government was able to finance part of the expenditures of the schemes, and people could afford premiums and other related expenses. For example, two sudden jumps in premiums paid by beneficiaries in 1988 and in 1989 were feasible because people were willing to pay premiums² and the government promised it would be responsible for part of the expenses incurred.

Sixth, consumers, faced with swelling expenditures from increased health service utilization and rising medical fees, preferred being insured rather than taking the risk of being uninsured. In general, there was not much disagreement among the public about going to a universal health care security system, though there were some debates on whether the tax-financed national health service system or the premium and user-fees-

² The premium is shared equally between employees and employers in the corporate health insurance program. In urban and rural regional health insurance programs, the government subsidizes about 35 percent of total insurance fund outlays.

financed NHI was appropriate. It had been hoped that every Korean would have health insurance and that the financial burden of the system would be shared fairly among classes.

There are other elements as well that contributed to the establishment of universal health insurance. One is the existence of a strong public executive and the other a “regulation-oriented” intellectual tradition. Finally, since there was no dominating private insurance that could have blocked any reform trial, the government could easily move toward its goal.

The development of Korea from an agrarian into an industrial society was the basis of all these changes. After all, consumers approved the idea of universal health insurance, politicians pushed forward in recognition of public demand, the growing economy helped form NHI financially, and no influential opposing force existed in the market economy. As far as achieving NHI was concerned, fortunately all sectors of the economy worked in a harmonized way.

However, not much analytical work was conducted prior to the introduction of health insurance. The government did not have much information on the various impacts of insurance programs. For example, in setting up fee schedules, Korea borrowed Japanese fee schedules only with slight modifications. Consequently disputes on the appropriateness of relative value scales continue between the government and provider groups.

The Structure of Health Insurance

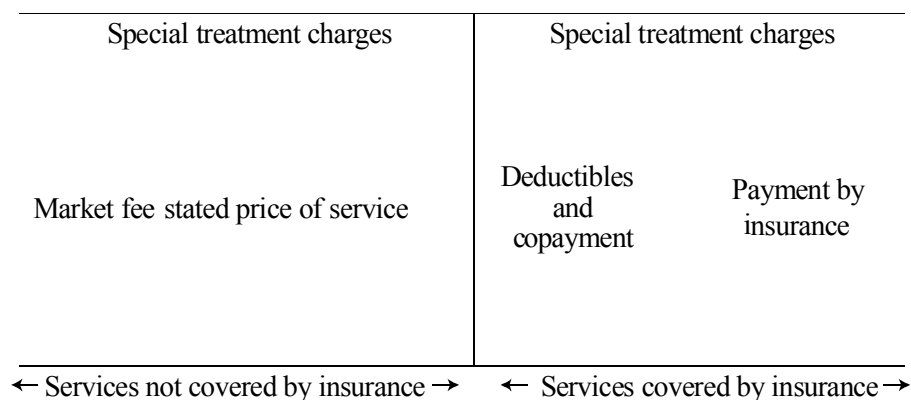
In this subsection we will examine NIH’s structure by looking at its various components.

PAYMENT AND REIMBURSEMENT. In most cases, as mentioned above, patients are given a choice of hospitals and clinics. Providers are paid by FFS in return for providing services that are covered by insurance. Part of the remuneration is made by insurance funds, and the rest by patients’ out-of-pocket payments. Two types of cost-sharing features are incorporated into each service utilization. The first feature is a deductible applied to each unit of service. For example, a flat fee of about US\$4 has to be paid by a patient for each physician visit. On top of the deductible, a patient pays coinsurance rates of 30 percent for clinic outpatient services, 50 percent for hospital outpatient services, and 55 percent for general hospital outpatient services. The coinsurance rate for inpatient services is 20 percent across all types of providers .

Under the NHI, for insurance-covered services, providers (hospitals and clinics) are reimbursed according to a set of fee schedules. The government plays a major role in determining the fee schedules, although fees are negotiated at the national level by parties concerned.

ADMINISTRATION. As of December 1996, there are 373 insurance funds. Each fund is financially autonomous. The size of each insurance fund is small, covering 30,000 to 200,000 people. With the current structure—comprising a large number of small insurers—in which each fund covers only a small fraction of the population, two problems arise. First, the system can hardly realize economies of scale; and, second, there is inequitable risk-pooling among beneficiaries. The proportion of administrative costs to total expenditure is 8.5 percent on average, and in some cases as high as 15.6 percent (KMIC 1996). This high figure is an indication of the high degree of inefficiency compared with 1.5 percent in Canada, and 2.6 percent in the United Kingdom.

COVERAGE. Not all health services are covered by NHI in Korea. This is the most controversial part of Korean health insurance plans. The extent and the level of insurance coverage are determined by the government. Figure 1 shows the division of health services into insurance-covered and noncovered services, and their payments. Most of these noncovered services are new or expensive high-technology medical services. Examples of services not covered by the NHI system are Gamma Camera, Magnetic Resonance Imaging (MRI), most nuclear scanning, some chemotherapy, Positron Emission Tomography (PET), and ultrasonography. Computer Tomography (CT) scans have been covered only since January 1996.

Figure 1. *Components of Total Payments for Services*

Note: Special treatment charges are out-of-pocket payments to providers beyond the stated price of service.

For noninsurance services, providers charge unregulated market prices, while government-controlled prices are applied for insurance-covered services. When prevailing market prices of the services are compared with production costs of such services, one finds enormous differences between the two. The difference is purely the monopoly rent created by factors such as consumer ignorance and imperfect hospital market conditions. This high monopoly rent from noninsurance services acts as a strong incentive for providers to invest more on expensive, non-insurance-covered medical technologies.

In sum, insurance coverage under NHI is limited in several respects: the rate of out-of-pocket payments is still high, even with covered services; some of the expensive services are outside the domain of health insurance; STCs come along with both covered and uninsured services in general hospitals. In addition, there is an upper insurance coverage limit in terms of the number of days of hospitalization and care (270 days). The result is that, as table 3 and figure 1 show, only a fraction of total medical expenditures are covered by health insurance schemes in Korea. User charge rates higher than 30 percent are seldom found in any of the insurance schemes. Based on available information, Korean rates appear to be the highest practically applied rates in the world.

Table 3. *Out-Of-Pocket Payments as Percentage of Total Treatment Costs*

	<i>University hospital</i>		<i>Private hospital</i>		<i>Public hospital</i>	
	<i>OP</i>	<i>IP</i>	<i>OP</i>	<i>IP</i>	<i>OP</i>	<i>IP</i>
Internal medicine	63.9	51.8	63.1	50.6	49.9	23.6
Surgery ^a	63.5	58.0	75.5	54.55	61.0	38.3
Pediatrics	70.7	49.6	83.1	54.55	55.7	23.0
Obstetrics and gynecology	90.6	59.95	93.5	67.4	87.4	47.0

Note: OP = outpatient service; IP = inpatient service.

a. Cosmetic surgery is not included.

Source: Selected hospital survey, School of Public Health, Seoul National University, 1994 Private Sector Growth

Here we will first introduce the private sector as pertaining to health insurance, and then explore the stimuli for its growth.

The Private Sector

In this subsection we will briefly discuss the private sector in terms of its labor force and facilities.

The Labor Force

The profit-oriented private sector, which is dominant in Korea, has been growing rapidly during the last three decades; its primary providers are private physicians and pharmacists. Although these two can be found in the public sector as well, their share of the market is relatively small. There are two types of physicians: Western and traditional. Physicians in each category are trained by their own medical school system. They compete with each other for patients at all levels: the general hospital level (hospitals with more than 200 beds), the hospital level (with 20 to 200 beds), and the local clinic level. There is a third type of provider—the pharmacists. Pharmacists provide a wide range of health services by selling Western drugs and many traditional remedies, without doctors' prescriptions. Both Western and traditional physicians can also sell drugs for profit where they practice. Role differentiation between Western physicians and pharmacists, between traditional physicians and pharmacists, and between Western physicians and traditional physicians is not clear in Korea. All these providers have strong financial incentives to prescribe and sell more drugs.

Facilities

Health care in Korea is provided by a mixture of for-profit, not-for-profit, and public institutions. Acute general hospitals, acute hospitals, and local clinics have been predominantly proprietary, for-profit institutions. However, there are some general hospitals and hospitals that are classified as not-for-profit. Many legally nonprofit hospitals are in fact profit-seekers. Not-for-profit organizations based on volunteerism and charity are rare. Because of public health and safety concerns, government ownership is typical among certain types of institutions, such as tuberculosis, psychiatric, and leprosy hospitals.

In 1977, the year a health insurance program was first introduced, 53.2 percent of all beds were either public or nonprofit (see table 4). Seventeen years later, the share dropped to 23 percent. Seventy-seven percent of total hospital beds are in private hospitals. Beds in for-profit local clinics, whose number is estimated to be around 37,000 are not included in the private bed category. Lee (1995) asserts that if that figure were included, the share of private beds in the total would reach as high as 82.3 percent for 1994. In 1975, two years before health insurance programs were introduced, 34.5 percent of all hospitals were public. In 1994, the share dropped to 4.9 percent and the remainder (95.1 percent) is now owned and operated by private or nonprofit organizations (figure 2). Hospitals specializing in traditional medicine are not included in these figures. The shares of the private sector would be even greater if their numbers were taken into account, because most of the facilities and human resources in traditional medicine are in the private sector. The change has been dramatic, and the trend will continue at least in the near future.

Between 1982 and 1984, a total of 34 city and local government hospitals were transformed into financially autonomous nonprofit hospitals. The transformation lowered the percentage of public hospitals from 14 to 5 percent. This change was part of the health policy-driven privatization that took place in Korea during the 1980s.

Since urban areas have been growing faster than rural areas, both in population and in income, the economic demand for health services has been rising faster in urban areas and the returns of health facility investment have been higher there. As a result, many private health facilities are concentrated in urban areas, although this trend has eased up recently as some private general hospitals have opened in rural areas adjacent to cities.

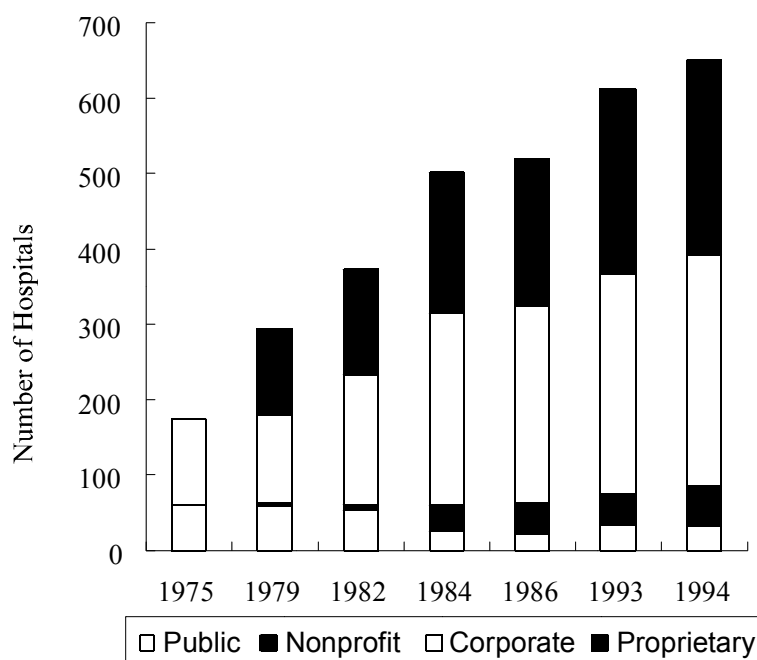
Table 4. *Number and Percentage of Public and Private Hospital Beds (selected years)*

	1962	1977	1987	1994
Public				
National ^a	2,564; 24.5	8,504; 33.3	10,580; 12.4	10,642; 8.6
Local government and nonprofit	3,535; 33.7	5,078; 19.9	14,759; 17.3	18,228; 14.6
Total public	6,099; 58.2	13,582; 53.2	25,339; 29.7	28,870; 23.2
Private ^b	4,378; 41.8	11,941; 46.8	59,841; 70.3	95,727; 76.8
Total	10,477	25,523	85,180	124,597

a. Encompasses national leprosy, mental, and tuberculosis hospitals.

b. Includes for-profit corporate, for-profit proprietary, nonprofit welfare organizations, and private university hospitals.

Source: Ministry of Health and Social Affairs (1963); Membership Reports of the Korean Hospital Association; from Lee (1995).

Figure 2. *Public and Private Hospitals by Category (Selected Years)*

Stimuli for Private Sector Growth

Growth in the private sector has been spurred by many factors, some on the demand side, some on the supply side, and others on the government side. On the demand side, the rapid increase in demand for health services has contributed to the growth of the private sector. The increasing demand is attributable primarily to growing per capita income. It has also been affected by other factors, such as changes in the age structure, expansion of health insurance plans, a higher level of education, and people's perception of the importance of good health.

On the supply side, profitability in the health care market, more than anything else, has induced considerable private investment in facilities and equipment. With sizeable returns on investments in health service provision, the private sector has quickly responded and filled the gap between growing demand and short supply.

On the government side, with the great success of market-oriented economic policies in the past decades, advocates of private enterprise have been gaining steadily over those favoring government involvement. Their ideas have influenced health policy-makers to favor private services.

Another factor that has contributed to the growth of the private sector is the philosophy underlying government health policy. Few politicians have emphasized the importance of equity in health care and the role of the public sector in pursuing it as a goal. During the late 1970s, NHI was pushed forward by politicians simply because it was a popular political subject. However, they failed to fully grasp the interactions among payment mechanisms, market forces, and the public sector's role in pursuing equity in health care. Politicians were not bothered by the growth of the private sector. Rather, some who were swayed by political lobbying supported a stronger role for the private sector.

Potential Problems for Korea's National Health Insurance System

The gradual expansion of health insurance plans, in conjunction with the growth of the private sector, has resulted in increased demand for services and higher-quality care. The nationwide coverage of health insurance has contributed to increases in health service utilization and helped improve people's health. The growing private sector has imported new medical technologies aggressively and competitively, resulting in an apparent increase in the quality of health care.

Annual health insurance statistics reveal that with the expansion of health insurance, the utilization of both inpatient and outpatient services has been increasing continuously over the last two decades, and that consumers, who believe that private general hospitals provide better services, prefer care at general hospitals rather than at government hospitals or clinics.

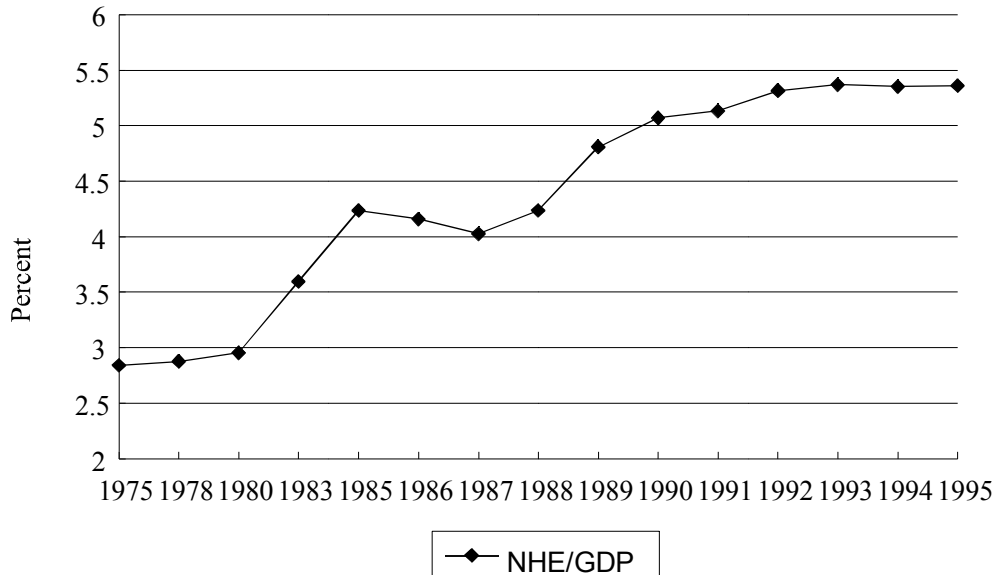
However, these changes involve costs in the form of inefficiency and inequity, which stem from the mishandling of the evolving system during the last three decades. As the market share of the profit-oriented private sector rose during this period, many undesirable aspects developed in the system, over which the government has had very little control. Some issues arising from private sector growth include cost increases, a two-tier health care system, commercialized health care, dependency on high technology, low priority of primary health care, and the lack of a referral channel.

Cost Increases

Rising health costs are now viewed as a growing problem in Korea. The country's health care system is inflationary by choice. It is inflationary not simply because people demand more health care services, but because of the way the system is structured; it induces an expanding amount of service provision and consumption and, therefore, more expensive services.

As shown in figure 3, from 1975 through 1995, the health care share of the total economy grew from a mere 2.8 percent to 5.4 percent, with an annual rate of increase of about 28 percent. (Between 1975 and 1995, the Korean economy posted unprecedented high growth rates. The increasing share of health costs as a proportion of the gross domestic product, therefore, signifies how fast the health sector expanded during this period.) It is expected that upon analysis the rate will turn out to be higher for recent years, as Korea's economic growth rate has slowed significantly since 1996. Experts predict that unless insurance premiums are increased substantially, the entire health insurance system will go into the red in 2000.

Figure 3. National Health Expenditure as Percentage of the Gross Domestic Product, 1974–95



Source: Myung Ji (1995).

Many factors contributed to the rapid increase in the national health expenditure. A substantial part of the total cost escalation is attributable to the increase in treatment costs. Data from health insurance expenditure show that the total increased by 26.6 percent in 1995, and 29 percent in 1996 (NFMI various years). A similar increase is observed in the KMIC data file.

Increases in treatment costs can be explained by several factors: providers inducing more patient visits per case (supply side); more complex cases, and insured patients paying less out-of-pocket and asking for more expensive and presumably higher-quality services (demand side).

The increase in the supply of private providers, as well as the incentives created by the payment mechanisms, may have caused cost increases, as suggested by the data in table 5. The table shows the difference in Cesarean section rates among general hospitals under different ownership. It suggests that because surgery generates greater revenues, private ownership has resulted in higher Cesarean section rates. The data in table 4 (in the previous section) on out-of-pocket payments for four major clinical departments in three types of general hospitals indicate that the extent of private ownership is positively correlated with higher rates of user charges.

Table 5. Cesarean Section Rate by Type of General Hospital, 1992

Type of hospital	Number of hospitals	Total deliveries	Caesarean section	Caesarean as a percentage of total
National medical center	2	1,650	464	28.1
National university	7	8,253	2,203	26.7
Private university	41	68,494	20,548	30.0
For-profit proprietary	37	22,831	8,607	37.7
For-profit corporate	55	73,995	29,154	39.4

Source: Hwang (1994).

Inequity

The combination of the FFS payment-reimbursement system, dominance of for-profit providers, and the current structure of health insurance has made direct payments preferable in Korea. A high coinsurance rate is useful in that moral hazard can be reduced. However, it has a few shortcomings as well. First, a high coinsurance rate is hardly consistent with the principle of social insurance that Korea has adopted (with the Korea Health Insurance Act). One can hardly say that insurance covers health care needs when one pays a substantial proportion of the service charges. Second, a high coinsurance rate raises an equity issue. When the rate is applied irrespective of family income, as is the case in Korea, it represents a greater burden to low-income families than to high-income families. At times necessary care for high-risk, low-income families is blocked by financial barriers, whereas other income groups are rarely affected.

The Two-Tier Health Care System

As a result of high user charges, Korea has a classic two-tier system of health care; one for the rich and another for the poor. While some people can enjoy sophisticated, expensive services provided by private general hospitals, there is a group of people who do not receive adequate services simply because they are not able to pay for them. Those who cannot afford to pay the STCs, copayments, or the charges for services not covered by insurance, are made to put up with low-quality service. The situation is even worse for the public assistance Medicaid program beneficiaries; they are often denied care, or are provided poor care—and that only grudgingly.

Commercialized Health Care

With the presence of strong profit-seeking private providers, health care in Korea is overly commercialized. Ample evidence of how the medical care ethos loses ground and medical entrepreneurship rushes in to fill the void is found in daily practice. An example of such a trend can be seen in the rapidly increasing rates of Cesarean section deliveries, which provide greater revenues. These have increased their share among total deliveries from 6 percent in 1984 to 21 percent in 1994 for one insurance scheme (see table 6).

Table 6. *Caesarean Section Rates for Civil Servant Insurance (selected years, 1984–94)*

	1984	1985	1988	1990	1992	1994
Total number of deliveries	42,53	47,72	44,20	43,76	42,55	40,23
Number of Caesarean sections	3	6	3	0	5	8
Caesarean sections as	2,482	2,619	4,146	6,067	7,509	8,356
percentage of total deliveries	5.8	5.5	9.4	13.9	17.6	20.8

Source: KMIC, Health Insurance Statistics, various years; quoted by Shin and Yang (1995).

Another example of highly commercialized health care is the practice of one- or two-day prescriptions provided during visits to clinics. This practice encourages patients to visit the clinic repeatedly for a single episode of illness.

Dependency on High Technology

Providers are not only keen on increasing the provision of noninsured services; they readily invest more in them. A good example is the active acquisition of expensive high-technology products and equipment by hospitals in recent years. These acquisitions represent wasteful duplication of technology in the health system.

The diffusion of selected technologies over time is shown in table 7. A significant jump in the rate of technology adoption is observed in 1989 and 1990, when the NHI was fully implemented. The marked difference in the rate of diffusion between 1987 (before NHI) and 1990 (after NHI) can be noted in the table. This rapid adoption of medical technology has resulted in Korea having more MRI machines per million population than European countries and more lithotripsy machines per capita than the United States (see table 8). The indiscriminate adoption of such technology increases costs for the system.

Table 7. *Number of Selected Medical Technology Units per Million People, 1977–96*

<i>Year</i>	<i>Whole-body CT</i>	<i>MRI</i>	<i>Lithotripsy (ESWL)</i>
1977	2	0-	0-
1980	8	0-	0-
1983	23	0-	0-
1986	73	0-	1
1987	81	0-	25
1988	104	0-	30
1989	159	10	37
1990	227	33	42
1993	507	71	53
1996	733	194	52 ^a
Number/million people in 1988	2.42	0.00	0.70
Number/million people in 1990	5.28	0.77	0.98
Number/million people in 1993	11.79	1.65	1.23
Number/million people in 1996	16.66	4.41	1.18 ^a

a. 1995 data.

Source: Ministry of Health and Social Affairs (various years); Korean Bureau of Statistics (various years). *Statistical Yearbook of Population Dynamics.*

Table 8. *Availability of Medical Technology, by Country*

	<i>Number of units per million people</i>					
	<i>Korea (1996)</i>	<i>Canada (1993)</i>	<i>Germany (1993)</i>	<i>United States (1993)</i>	<i>Japan (1990)</i>	<i>France (1990)</i>
CT(whole body)	16.66	8.12	12.87	14.54	40.33	7.20
MRI	4.41	1.13	3.65	5.84	5.91	1.20
Lithotripsy (ESWL)	1.18	0.45	1.44	2.00	2.30	0.60

Source: (1) Korea: Ministry of Health and Social Affairs (1996); (2) Canada, Germany, United States: Weil (1995); (3) Japan: Ministry of Health and Welfare (1992); (4) France: Ministry of Health (1991).

The Lack of a Referral Channel

The Korean system lacks a proper referral channel. There is neither a vertical nor a horizontal referral network. Patients have an unrestricted choice of providers at different referral levels as long as they can pay. They also have a choice among multiple kinds of providers at a certain referral level. There is no “gatekeeper” that could steer the patient toward a proper provider or a proper level of care.

In the absence of “gatekeepers” in the system, there is inefficiency and a lack of cost-effectiveness. Simple illnesses are treated expensively; for example, common colds are often treated by internists in general hospitals and simple headaches are treated by neurosurgeons in general hospitals. Moreover, patients often seek care from both Western and traditional physicians, and sometimes also from pharmacists, for the same episode of illness—increasing revenue for providers but not necessarily obtaining for themselves the proper care.

Policy Agenda: Lessons for Other Countries

The recent Korean experience shows that affordability and access are affected a great deal by the growth of profit-driven corporations in the health care field. Health care has become a business. Providers refuse to serve those who cannot pay, will only promote services with a reasonable monetary return, raise prices to the extent the market will bear, increase utilization to maximize income, and aggressively promote excessive and irrelevant services that may not address patients’ basic health needs but do generate profits. The very ethos of health care is being threatened by these recent changes in the delivery of health care.

Health policy will have to deal with these trends and the consequences of the growth of the private health sector. Further privatization, especially when it is carried to the extreme, will not be helpful in addressing the problems of Korean health care. This does not mean that curtailing the size of the private sector is the only option Korea has. Politically, downsizing the private sector may not be feasible, at least in the near future. Given the strong presence of the private sector, Korea must respond to two important questions: first, what is the role of the government in making the private sector comply with national health policy objectives? And second, which organizational and financing mechanisms (of health insurance) meet, or do not contradict, the equity objective of Korean policy?

Government Health Policy

There are two ways of organizing the delivery of health care: government planning and cost-control versus reliance on market forces and competition. Korea has leaned toward the market approach, with a two-tier system based on the ability to pay. As others have pointed out, the market approach is acceptable only when market failure is properly corrected by public policies. The behavior of profit-seeking organizations and the economics-based ethic that emphasizes competition produce efficiency only if they are adequately regulated by market failure-correcting public policies.

There have been public policies to reach national health policy goals in Korea. For example, the government has tried to strengthen health services in rural areas. However, these policies were directed mainly toward public providers and the public health domain. In addition, there have been erroneous policies, including giving low-interest loans to for-profit providers, allowing STCs in general hospitals, and offering little financial and organizational support to public health facilities. Little has been done to induce the dominant private sector to help achieve public health goals.

As a result, Korea has failed to ensure both efficiency and equity in health care. In order to attain these goals, the government must play a role in making market forces work and in correcting market failures. Areas of health care that are in need of strengthened public policies are as follows: providing financial means that would allow destitute people who need care to obtain it; enforcing a strict patient referral channel; managing technology diffusion and its utilization; regulating pharmaceutical industry pricing and marketing; and taking measures to reduce fraudulent medical claims and tax evasion.

Expansion of Health Insurance Coverage

As was previously noted, health insurance in Korea is distinguished by one feature: high user fees stemming from high coinsurance arrangements within the plans and also from full direct payment for noninsured services

and of STCs. If equity is considered to be the one important goal of the Korean health care system, the reform priority should be lowering user charges through the extension of coverage.

To lower user charges, the reform must, first, bring most health services under the NHI umbrella; second, remove STCs in hospital service provision; third, install income-related cost-sharing features; and finally, make upward adjustments in fee schedules and premiums so that the system can be sustained. A major impact of this reform is cost-shifting between insurers and consumers, which will make the whole system considerably more equitable than before. Through the use of health services, there will be cross-subsidization among income groups, from the rich to the poor. The combination of higher (income-proportional or -progressive) premiums and lower (income-regressive) user charges will certainly bring about monetary transfers from the rich to the poor, compared with the present case of low premiums and extensive user charges. The more direct user charges are replaced by premium payments, the greater cross-subsidization will be.

After health insurance reform, changes can occur in the conduct, behavior, and performance of the system as a result of a new incentive structure. The most important of all is the gain in efficiency through changes in provider behavior. As insurance coverage becomes comprehensive, the misleading incentive to provide noninsured services will be removed. Excessive adoption of some high technologies will be eased, as profit opportunities from noninsured high-technology services are largely reduced.

The Health Reform Process

To have a change in health care delivery, one needs to have support from various sectors: the general public, providers, health policy-makers, and politicians. The easiest way to bring about a reform would be to have decision-makers and politicians develop a value concept about health care and have the courage to push it forward. Then, many of the current value conflicts and the confusion about the nature of health care itself, the place of health care in society, the role of health care providers, the relationship between providers and patients, and about whether it is legitimate to turn profits from the misfortunes of the sick will be resolved.

Unfortunately, the reality is different from this ideal. Considering the current complicated environment of Korean health care, it will be very difficult for the politicians and decision-makers to share their concerns and to act.

Providers, especially when they are private, pursue economic profits. The principle they follow is simple: they favor a change if it would bring about gains in economic returns, otherwise they resist it. They might follow a different rule if their behavior were effectively regulated by the government or governed by a different incentive structure. Absent that, their choice is simple and unambiguous.

It is clear that the policy agenda proposed tightening the government's control of the system and reform in health insurance will produce benefits for the general public. The general public is likely to agree with the change, once it is informed about its background and likely effect. Politicians may support the change if pressed by public opinion. Bureaucrats may back the proposed change once they realize that it is supported by both the public and Congress. However, providers will be against the proposition. They will lobby both the government and Congress not to make any changes. Eventually, the battle will be between the general public and the providers.

However, experience shows that the general public has been losing the battle. Either people do not have a consensus on health reform or they do not have an effective channel for their ideas. For example, in 1988 the government undertook an effort to implement a policy of role differentiation between pharmacists and physicians in drug distribution, making physicians the prescribers and pharmacists the dispensers. The attempt was a failure. Both parties, afraid of losing revenues since they predicted that drug consumption would fall with the new policy, flatly turned down the government proposal, leaving the public as the only loser.

Factors inhibiting public consensus on health care reform are multiple: lack of organization and funds, lack of leadership, the "free rider" problem, and the absence of a core force. On top of these factors there is a perception gap between the public and health care leaders. The perception gap covers a wide array of issues such as what social health insurance is about and what to expect from it, how health care is different from other goods and services, what the health care system is aiming for, and how the excluded population

group is handled by the system. Therefore, what is necessary is the public's shared understanding of, and strong agreement with, what ails the Korean health care system. After that point, a citizens' movement backed by formal consumers' organizations would be able to help form a consensus on solutions for specific health care problems and express it to politicians and policymakers.

Conclusion

Korea faces persistent difficulties with the delivery and performance of its health care system, despite its implementation of NHI in 1989. Nothing is more basic to any government than ensuring adequate care for the poor, the elderly, and the disabled—and yet Korea fails to do this.

While the 1980s and early 1990s saw a rapid expansion of private health care, the story of the late 1990s is likely to be one of consolidation into giant hospital chains. This trend has already been triggered by Jabul (named after the business tycoon who owns the enterprise) hospitals such as Samsung and Hyundai. This kind of growth can only exacerbate the current problems in the health care system.

Korea needs health reform in many areas. In 1994, efforts were made to reform the health insurance system. Some minor proposals were made to lower the rate of user charges and to expand health insurance coverage. However, no one is certain whether the proposals can actually be implemented. Even if all of the proposals were to be adopted, the user charge rate would still be so high that the objectives of the Korean health care system—adequacy and equity in access to care, income protection, and efficiency—could hardly be achieved.

There are many aspects of our lives that are best left to market forces to determine without interference from the government. Unfortunately, health concerns are not always among them. Consumer health and quality of care are neither protected nor guaranteed by pure market forces. No country has succeeded in having a sound health system by relying solely on market forces. Some form of regulation of both the public and private health sectors is necessary, with the government and the professional associations as principal actors in the regulation.

Korea missed a good opportunity to have a sound health care system when additional resources were pumped into the system by NHI. Now with NHI fully implemented and providers integrated into it, it may be difficult to pass even minor reforms. But, unless basic reforms are tried, resources will be wasted, consumers will be left unprotected, health care expenditures will continue to rise, insurance coverage will be reduced, and consequently the accessibility of essential care to low-income families will be further reduced. Without reform now, the problems will become more widespread, persistent, and intolerable in the future.

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