Health Care Insurance System and Non profit and Cooperation Sector in Korea

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1. Introduction

Korea has approximately forty-seven million populations and its national health care insurance system has covered almost of the nation in the year of 2003. A rate that occupied for GDP of medical treatment expense is 5.4 percents, which is classified to a low position country group (1999) among the developed and developing countries. National health care expense of Korea has reached approximately 3.7 billion yen (year of 2000), showing a fourth in comparison with that of Japan. Korea has established the national health care system in 1989, after thirteen years of full-scale preliminary period and with thirty years interval its original kick off its preparation of the system from 1976. Korea's national health care insurance system has been promoted based on its rapid social economic development during decades.

National health care system of Korea started formally in 1963 with enacting of "Health care insurance law". However, It was a start that the system could not avoid the negative principle of "low contribution, low service" due to the social and economic lower development level at that time.

At this moment, the ninety percents of a medical and health care organizations or providers are belonged to a private sector. Similarly in Japan, most of them are profit seeking character substantially and there is no legislation for non profit organization. They provide medical services in kind for patients. A ratio of pay for service by patients or users is relatively high. Before changing the pharmacy system in 2001, medical and health care providers supplied medicines and drugs in accordance with the rule of pay for service. Until 2001, all pharmacy which is belonged to a private sector wholly, and a pharmacist also supplied medicine for patients separately from the manipulation of doctors.

Health care policy of Korea government was fundamentally to promote or depend on a private sector; adapting simultaneously government itself took a health care policy to restrict a part of a public medical treatment

At this moment, medical institutions as legal entities defined by the national health insurance are complied such as follows:

State medical institutions are 12, Provincial medical institutions 9, Municipal medical institutions (in county, city and town) 3,600, Local pro-administrative medical institutions 35, special medical legal entities 32, summing 3,698 in total.

According to the classification, they are also classified such as;

General hospital (55), hospital (16), special hospital (17), Public health center and clinics (3,447) which engage in primary care.

At the beginning of the health care insurance system, occupational health care insurance unions were main providers which adopted voluntary membership. Accompanied with reform of Health care insurance act in 1976, provider's two pillars of providers were established, namely, as occupational insurance funds on one hand, those based on area on the other hand. Consequently, it became three different kinds of insurance funds. Firstly, occupational Insurance associations (funds) affiliated by big and medium companies. Secondly, "public servant health insurance funds"

including those of military servants and of teachers, thirdly, "regional health insurance association" affiliated by self employees. They were organized in turn and gradually their cover rate expanded.

Joining rate of individuals in Health insurance system was only 8.6 percents in 1977. Public service personnel after that joined it; moreover it joined it of employees who work the enterprise having more than sixteen people. Joining rate became 44.1 percent in 1985. By enforcement of universal principle target system in 1989, regional self employees also could enter the system.

A cover rate became 97.6 percents in 1990. It was after the settlement of the single government-owned health insurance corporation system in 1998 by integrating three insurance funds.

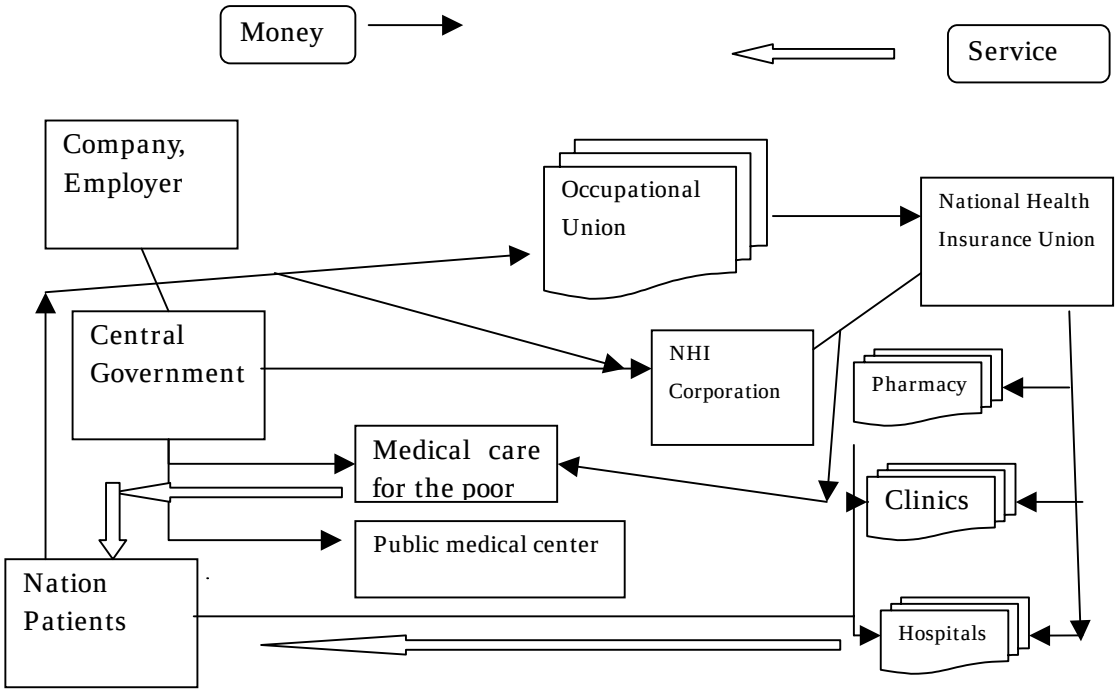
Although a patient could freely choose a provider (medical doctor or medical institutions), there doesn't exist primary care or gate-keeper system. There was no clear distinction between hospital and clinic based on a scale of bed number, so a patient could go any preferable one. A patient was able to receive medicine through either a pharmacy or a medical doctor before the medical system reform in 2000.

Public health care centers which established 1981 in the local area based on the administrative district (minimum five hundred households) has a character of the primary care responsible entities. One of the trial to arrange the obligatory medical doctor who was exempted the military service to implement in the administrative district.

Oriental medical care also is traditionally popular and many patients usually go both of Western medical Orient medical institutions. However, oriental medical service isn't included into health care insurance system.

It is said to that a fundamental character of the starting point of health care insurance system of Korea is "low premium burden, low benefit". “National health care insurance Act” enacted in 1999 had two main directions; first, it aimed to integrate the functions of three funds into one insurer fund; secondly, to split the function of medical treatment and medicine or pharmacy provide service.

Figure. Health Insurance System before a reformation



2. Historic characteristic of Health insurance system of Korea

In comparison with Japan, with tame lag for an around-20-year, Korea has promoted rapidly national health insurance system, in accompany with the rapid change of the civil society from military autocratic governance to democratization.

Table.2. chronology

1962. Start of Five year economic plan.
1977. Start of Health Insurance Act (Funds affiliated over 500 employee companies)
1979. Begin to enter public servants and teachers in a fund.
1988. Begin to enter self employees in a fund.
1989. Begin to enter farmers and fishers in the fund (attain of full coverage or Universality)
1990. Implement of National Health Insurance Act (integration into one insurance fund).
1997. Modification of National Health Insurance Act (establishing Health Insurance Corporation).
1999. Modification of National Health Insurance Act (preparing reorganization plan. partial integration plan of funds)
2000. Integration of the management of National Health Insurance system (establishing Agency of evaluation of health care insurance or HIRA. Act for division of receipt and service of pharmacy: so called Partial integrate method.
2002. Start of complete integrating method.

In the argument of Health insurance system of Korea, one specialist divides the period of the process of establishing National Health Insurance system into three controversy eras; namely, the era of first discussion on integration of insurers (1980-1985); the era of second discussion(1986’1989); the era of third discussion(1993-1999. We see the each characteristics based on these three eras.

(1) The first controversy (1980-1985)

Under the military regime by Chon Dong Hung insurgent of Kwangju city turmoil happened in 1980. In tat time, the argument on the health care system was how to form regional health insurance system. In this case, most important financial problem was how to make pay contribution from local residents whose income relatively lower than employees. On the other hand, there was proposal of integration of the public servants and teachers fund and the regional fund. This aimed at an economy of scale and to cover both local agricultural village and fishing village residents. Insurance fund tried pilot management of local health care insurance program in these areas.

(2) The second controversy (1986-1989)

"Citizen welfare increasing general plan", was announced in 1986, and a proposal of an enforcement of local agricultural and fishing village health insurance being done 1n 1988 and of an urban regional health insurance in1988. Though Nou Te Uh became President in 1988, an election of local municipalities wasn't achieved and only realized prefecture level election in 1995. Although “National health insurance act” was planned to make integration of different funds in 1989, it became a rejected bill by the presidential refusal rightor veto. The points of the Act was (1) establishiment of the insurance pay deliberation council, (2)introduction of prgressibe premium, (3) Introduction of Judges of Medical treatement expense, (4) Using a half price of pension person into medical treatment for pentioners. (5) State subsidies for the premium of self-employees.

A reason of a presidential refusal was that a privilege-like position of wealthy health insurance associations become weak, if the funds integrate in one. It may be to keep the existing privilege of rich funds. However, during this period, many regional or local health insurance associations (funds) were established, consecuently urban self-employees class joined in them. So we can call this period is the era of an establishment a national insurance system or universal principle system based on the union system.

(3) The third controversy (1993 - 1999)

In 1995 health insurance funds started its common financial payment with state subsidies. On the other hand, aiming to promote integration of health insurance system by the power of grass roots movement, "Health care solidarity council” was established by labor union, hospital worker union, insurance medical institutions, farmer group, a female group, and citizen groups.

Based on "National health insurance act" in December, 1997, integration with regional health insurance funds and public servants and teacher’s insurance funds was done in 1998.

Korea was kept under IMF system management due to an economic crisis from 1997 to

2001. This enforced to Korea to effort the preparation of social safety net. President Kim Dae Jung advocated "productive welfare state" and " democratic market economy" and considered to promote a social safety net by state intervention. Though it enacted "citizen health insurance law" to have aimed at integration with occupational health care funds and regional health insurance funds in 1999, in order to make a plan of financial integration through the National health care Act. However, both occupational and regional insurance funds did not change the standard of the contribution, the richer finance of the occupational funds were diverted to the regional insurance funds. This was one of political manipulation to gain the support of local voters.

(4) The reasons of Controversy on Health care system

For a main controversial point of destructuralization of National Health Insurance System were three. First model was a Double pillars model (traditional both occupational and regional insurance fund). The advocators are called Unionist. Second model was to establish unique insurance fund corporation (such as existing Corporation). So called Integrationist supports this model. Third model was a prefecture area insurance fund model supported by local doctor society. After all, second model was adopted. That is an integrationist model. According to the idea of the integrationist, if we integrate functions of each fund, we could dissolve the financial difference among funds and make benefit equal. The state also decided to supply the 50 percent of the cost of benefit.

Some critics exclaimed this model improves the redistribution function in health care supply system and the established independent Health insurance certification institute contributes to promote democratic and independent character of the decision making in medical care cost calculation standard. Moreover, contract system between insurers and medical institutions established through the reform.

Health insurance system originally began as a fund union model. But this model was, according the opinion of integrationist, the cause of the inequality among classes and regional areas.

Health Insurance system began to adopting fund union model. But according to the opinion of Integrationist, this model is a cause of the inequality between occupational fund and regional fund and if it could be possible to appropriate the reserve funds of the occupational funds to the regional funds in order to uniform the benefits; all funds could reduce management cost and realize equality of the contribution standard. In reality, the reform has promoted due to this idea. However, it is not always to stabilize health insurance financial budget as a whole. As the national health care cost has increased, the government must adapt the policy of raising both the contribution by users-patients and subsidies by the state, as applying the unification of different funds into the health insurance Corporation.

Citizens' movement against the raising their contribution in the system has become intensive more and more. On the other hand, there is a problem that the check to the income of self employees is very weak in order to decide the standard of the contribution payment.

The unionist model has been supported mainly by the established organization of industrial sector, labor organizations, namely big enterprises and its related stable trade unions. On the other hand, the group of self employees in the medium

and small enterprise and local residents in agricultural and fishing village areas has supported the integrationist model.

At this moment, there is an alternative plan to reform from the integrationist model (social insurance model) to tax based model. However, in this case, it is said that important thing is to catch the tax obligation for the self-employees or to introduce the consume tax or social security tax, in order to decide the standard of their insurance contribution or premium.

3. Health care reform in 2000 and the actual situation.

Health care reform in July, 2000, has two pillars. Namely, one is so called "Integrate reform" which integrates differences of insure funds into single payment insurer fund and another is "Separate reform" which separates the medicine or pharmacy service from revenue of medical institutions and make pharmacists sell both prescribing medicine prescribed and general medicines. However about an evaluation of these two reformations were still not confirmed.

(1) Division of labor between medical function and medicine function.

Division of labor between Medical and medicine functions was started due to the modification of the Pharmaceutical Affairs Law in 1994 and the Separation of Prescription and Preparation of medicine Act in August 2000. The total sale of medicines of the year of 2001 becomes twice as much as that of 1999, centering the sales in pharmacies over 60 percent. On the other hand, the share of the sales by hospitals declined from 42 percent to 27 percents especially that of the clinics went down drastically from 20 percent to 4 percent. In Korea, the sale of pharmacy has occupied high in the total sale of medical institutions, so the objection of the doctors associations for this separating reform was very strong. Doctors' associations got strike against the reform during 1999 to 2000. The lobbying by the doctors associations was strong. Consequently, the payment for the medical treatment increased by 41 percent by reason of filling a deficiency of the existed back margin of medicine for doctors and the fee for prescription for medicine also increase five times.

Some critics note this is a cause of the deficit of the finance of the Health Insurance system. The government at first intended to decrease the total health care cost through cutting the drug revenue of the medical institutions based on the separation of the function of prescription and provision of medicine. However, on the contrary of the expectation of the government, the cost of the pharmacy increased by 25 percent in 2001 and also increased doctor's fee in comparison of the last year. Moreover, the foreign pharmaceutical companies have increased their sales through the sale of cheaper generic medicines. The public opinion to the result of this reform is not good and 80 percent of the citizens answered to the queasionary in that the health service become worse and or not change than before (Daily Choson, 13.9.2003). We can estimate the plan of making the Medicine distribution corporation offered the function of evaluation of the price than the plan of making free market for medicine.

Table. 3. Evolution of affiliation rate of National Health Care system.

Year	rate	New Main Insurant or condition
1977	8.6%	Companies over 500 employees.
1980	24.2%	Companies over 300 employees, public servants, teachers.
1985	44.1%	Companies over 16 employees.
1990	93.9%	Companies over 5 employees. Self-employees.
1995	97.6%	Payment for 180 days and for High cost care.
1999	96.4%	payment for 365 days.

Resource: "Report on Korean Health insurance reform", Federation of Health Insurance Unions, 2003.

Table. 4. Classification of the medical institutions (2001)

(Hospital: over 30 beds, general hospital: over 100 beds)

Total	2,774
General hospital	278
Hospital	706
Clinic	21,340
Dental hospital	71
Dental clinic	10,790
Chinese (Korean) medicine hospital	139
Chinese (Korean) medicine clinic	7,558
Pharmacy	18,372
Midwife centre	87

Resource: "Report", FHIU, 2003

Table 5. Income of National Health care cost (2001)

Total	30679.9 billion won	share
Public finances	13615.7 million won	44.4%
--Central government	(2217.7 m)	(7.2%)
--Local governments	(876.6 m)	(2.8%)
--Social insurance	(10527.4 m)	(34.4%)
Private finance	17064.2 m	55.6%
--Private social insurances	(1319.9 m)	(4.3%)
Private insurance companies	(1343.3 m)	(4.4%)
Households	(12667.7 m)	(41.3%)
Non profit organization	(121.8 m)	(0.3%)
Private companies	(1611.5 m)	(5.3%)

Resource: "Report", FHIU, 2003.

Table.6. Population adopted in Health Insurance and its affiliated number (2001).

(Unit: thousand)

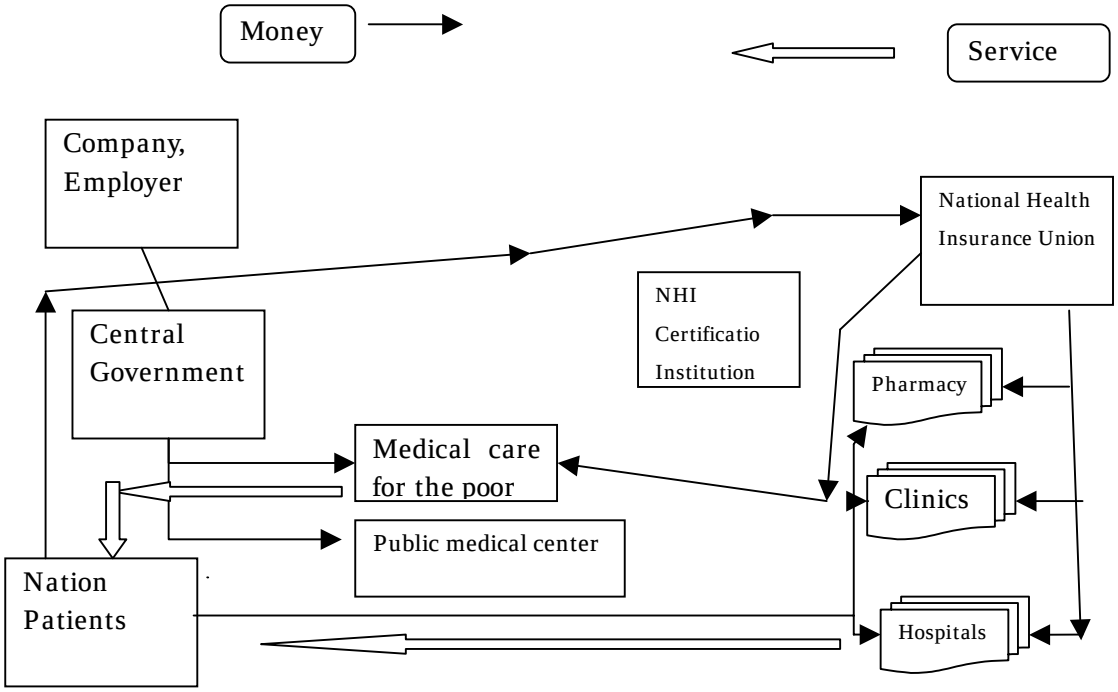
Total Population	47,343		
Population for Health Care System	47,882 (double count)	Member	Average premiums
-Health Insurance	46,379(96.9%)	30,500	11,274won
--Occupational funds	18,503(38.6%)	6,000	26,631WON
--Publics servant			

&teachers funds	4,666(9.75%)	1,400	38,673won
--Regional funds	23,212(48.5%)	23,100	36,253won
-Medical on Agency Assistance	1,503(3.1%)		without a fee

Resources: “Report”, 2003 and NHIC, 2001.

Though a definition of dependants of insurants in Korea are considered as “a person without revenue and supported actually by an insurant”, the range is widely in comparison with Japan including brothers and sisters. Dependants concentrate on occupational insurance funds and the average dependents number is 2.08. On the other hand, a class of self employees occupies approximately a half of population. Medical assistance system has similar ideas as Medicare and Medicaid in USA.

Figure2. New National Health Insurance system in Korea



4. Revenue and payment forms of Health Insurance system.

(1) Medical treatment payment system

Korean Government tries to decide a unit price of medical treatment service based on the total cost calculated resources prices. The Corporation and Health insurance Revision Agency (HIRA) decide a unit price of Medical treatment service with a negotiation every year with representatives of medical institutions. If advancing in a direction of total frame budget cut for a unit price standard of medical treatment pay based on actual results date in the last year, a gradual fall of a quality of services will inevitable. In case of Korea, as well a negotiate bargaining power

of the interest parts are very strong such the case that medical doctor association could attain a rise in a price of medical treatment service, as making the price standard will link highly with a political negotiation. It is a different approach to that of Japan decided unit price standard by the hand of welfare ministry unilaterally with the policy making intention.

Revenue resources of medical practitioners are composed by three factors; (1) medical treatment payment contract (2) patient payment, (3) special arrangement for corrupts of contract negotiation. Presentation of receipts for the HIRA has two types; whether documents or electric data. Receipts are ordered a week. HIRA was established in July of 2000. Director board is composed by 16 persons including 5 persons from Medical and Phamathetical industry, 3 persons from insurance corporations, 5 persons from labor union and civic organizations, 3 persons from public authorities. Their tenure is three years. HIRA has 1,500 staffs, including 40 doctors, 1,000 nursing practioners. The administration cost is derived from the Insurance Corporation as a year budget. However some critics say it is better to receive financial fund from central government directly in order to keep HIRA's independency.

Korean government tried to control the total cost of health care system, but, they found the increasing of the cost after all. The financial crisis of the health care system born deficit of 2.7 trillion won in 2001, as 25% of the governmental budget. Some explain main reason of the deficit after the system reform is that government admitted for doctors to raise care treatment cost instead of taking off the pharmacy payment in the revenue payment agreement. On the other hand, government plans to raise premium of the health care system 9 percent per year by 2006. Doctors have dissatisfaction with low level of their revenue through the treatment payment system. However government also has no power to decide unliterary the standard of payment. So the bargaining by two parts is traditional decision making process. Most critics agree that there is no effect to defend the budget expansion if government decides decreasing of treat payment against doctors. If government does, doctors would increase number of examination for patients in order to keep their revenue.

Medical system develop special committee announced that the fixed number of the students in 41 medical colleges will be decreased by 10 percent during the year of 2004 and 2006.

The crises of the business of medium and small hospitals are making them to advance in the China market, which the total investment has reached 1.75 million dollars by August of 2003. The advanced medical services of Korea including cosmetic surgery, dermatology, dental and obstetrics are planning to get into China market.

Payment system for utilizing efficiently the resources is mixed of two methods: payment for services and payment per capita. In the case of the payment for services, the income will increase if the number of patients increases. However it is apt to increases responsibility of the risk and over medical treatment. On the other hand, the payment per capita system is apt to decrease the risk responsibility for users, because of the income does not depend on the content of the medical treatment.

Korean Government has introduced in 2001 "The relative value standard system" which aims mixed payment mechanism, referring the point system in USA. This system does not explain the real cost of the medical service such as the Managed care in the USA. Moreover introducing of DRG may bring both pre-determination and fixation

of medical treatment cost. DRG already has partially introduced since 1997 and achieved experimental adaptation, but some said that DRG is not necessary to link the improvement of the quality of medical institutions.

Government decided to decrease the benefit of exemption of medical fee of workers from the adaptation for those who pay the sum of over 3 percent of the annual income to those who are that of over the 5 percent. Consequently, the 60 percent of the existing users who had received this benefit will be excluded.

The 73 percent of the nation think that the separation of the medical payment and pharmacy payment brings the increasing of patient payment. People do not estimate this reform successful at this moment.

(2) Insurance premium system

Because that there has been very low to the portion of levy of health insurance contribution among local self employees (about 30 percent of them), the standard how to collect premiums from them based on the total property including income, properties and price of cars. It is very unusual that 89 percent of the self employees are under 5 million won annual income. The average monthly wage of employee belong to professional union is 1.47 million won in comparison that of self-employee is 0.86 million won. However if the rate of the capture of the income for them is only 30 percent, the real income of self-employee can be 3 million won. In Korea, the percentage of the self-employees in the society is 45 percent which is higher than that of Japan. The problem seems to be caused from the mechanism of levy.

In the health insurance system, there are two different standards for the two different insured. Those who belong to the professional union are adapted 3.4 percent of the monthly income and the employers also pay same amount. The minimum income per month of the insured must over 28,000 won per month.

In the case of self-employees, classification of the premium is divided in the line of 5 million annual incomes. The lower group is classified 30 sub-classes and the higher group is classified 50 sub-classes, adding the 50 portions based on property and 7 portions of price of cars.

Patients pay at the service normally 30 percent at the clinic and from 40 – 65 percent at the hospital and normally 30 percent for dugs. The more advantage treatment adapted, the more the payment of patient increase.

It is said that Korean government plans to increase insurance premium from the existing 3.9 percent to 6.7 percent and provision portion from 52 percent to 70 percent by 2008. Government also plans to increase public medical institutions double from existing 15 percent to 30 percent.

(3) The Medical care system for the poor

When the establishment of the health insurance system in 1977, those who is objected to the poor benefit system was exempted the payment of premium. However, in 1997, due to modification of the Poor Act, self- help of the poor become recommended.

At this moment, those who do not reach the minimum income (513 US dollars a month), and special groups are adapted the exemption of premium. However, according to the official statistics, only 3.8 percent of the population is classified as the poor group, the 10 percent of the patients in public hospitals and 1 percent of the patients in private hospital are the poor. So to reform the quality of public hospital or

public health center will contribute equity of access for medical care for the poor.

It is said that the poor groups can not access a private hospital which set high price. So in order to improve the access right, some claims an idea to make private hospitals and clinics a gate-keeper.

In the medical care system for the poor, there are two classifications: class one is for the invalids and over 60 years old person; class two is for the poor who is able to work. At the end, there is no clear distinction between health insurance system and The Medical care system for the poor in the process of access.

(4) Medical NPO & Cooperative institutions in Korea

As parts of traditional Non profit and Cooperation Sector in Korea, agricultural cooperatives, credit unions and foundations are still now subordinated under the control of public authorities, with motivation of private profit, and are seemed to be lack the principle of participative democracy (Kitajima and Bidet, 1999).

Another cause of stamping of the worker welfare movement is that no mutual aide organization, which we can see in Europe, has developed.

At this moment, two types of Non profit and cooperation organization exist in Korea, in which the number of notified NPOs is about 11,000 and non-notified NPOs are about 50,000. The 74 percent of the NPOs are established after Democratization period of 1987. The legal statues which control NPO and Cooperation organization are Civil Code, the NPO establishing Act and relative legislations such as Medical treatment Act for medical institutions, the Social welfare Act for welfare organizations.

The groups of Non profit and cooperation sector in Korea are composed by cooperatives, NGO, NPO, civic movement organizations, foundations, public benefit organization and etc. Under the military regime after the independent since 1948, there was no room to develop such Non profit sector. In stead of them, neighborhood organizations, kinship organizations and rligious organizations are popular as informal sector. During the process of democratization of the era of 1980s, many Non profit organizations are born. In 1999, Nonprofit organization promotion act in 1999 become a tool of public profit activity by civic volunteers.

Medical Institutions has a character as a non profit based on the Medical Institution Act, as equal as in Japan. However, it is not certain whether such medical institutions keep a NPO principle such as “private, autonomy, non distribution of profit and self government” or not. Especially, the principle of Democracy will be a very important one in order to classify the NPOs. Due to the character of NPO, private medical hospitals have received tax benefits of company law, local government tax and donation.

At this moment of 2002, some NPO and cooperative Medical institutions are developing in Korea.

Main actors are six Health care (Medical) cooperatives. Them oldest is Ansong Health Cooperative established in 1999. Rests which are young were established during 2000 and 2002. College Health Cooperative is existed in Pohang University. There is some democratic medical institution which has developed in the community since 1992, especially in poor zone of Seoul City. Another group named Wonjin labor accident protection committee which has established Green Hospital through the movement of protection of medical access right of workers.

Most of the civic medical institutions are created after 1987 through

democratization. Humanitarian practice doctor's council which aims democratic medical practice also started in 1987.

5. Perspective in future

Though Korea has promoted healthcare provision in its social policy since 1980s as a basic condition for economic development, the portion of health care cost in GNP has been lower than that of developed countries. So, Korea has a room for increase several times the total health cost in order to become same portion as Developed countries. Learning from that European countries utilize the NPO and cooperative sector (the third sector) as a tool of provider for welfare and social services, and also as a tool of resolving new needs of unemployment problem and social integration problem, Korea too has a possibility to adapt same policy for the third sector instead of the traditional family system and kinship system, with their own arrangement in the society.

The Health Insurance Corporation plans to improve management, stability of finance, quality of service, restructuring of organization and efficiency of service. OECD report recommends on the health insurance system that Korea should introduce up of premium, establishing total cost plan, the improvement of equality of access right, the introduction of DRG in order to seek cost efficiency, partial build in of liquor and tobacco tax for the health care finance, improvement of governance and accountability of insurers, promotion of regulation and self-regulation of medical institutions and primacy of preventive medicine. Moreover OECD recommends the MAS, Medical Saving Account, now introduced in Singapore; in which individual patient accumulate its own payment account for medical services. However, in Singapore, there exists discrimination policy or division of labor policy that appears critical differences between public hospital which cover ordinary people and private high technological hospitals controlled by foreign investors, which cover the rich people.

So if Korea government will adapt the Singapore model in accordance with the recommendation by OECD, it is inevitable to increase inequity and profit seeking in Medical services and to decrease the public intention, namely it became not a Universal system but a Residual system in Health care system. In this case, main purpose of government policy would be budget cut of the health care system.

Some exclaim based on the principles of public responsibility and equity the introduction of NHS system of Britain financed by taxation into Korea. Some also recommend that French system of Social protection is better because that defines the responsibility of employers in it.

There are many stakeholders in discussing the health care policy, such as medical practioners, patients, employers, self-employees, wage-workers and labor or civic organizations. In comparison with a market in which competition is main principle, Health care industry should be recognized as based on the principle of public interest or cooperation. If so, many different stakeholders can cooperate to realize social solidarity in the field of health care service. Consequently, it promotes the redistribution of resources by the hand by the state.

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