International Seminar on
Health Care Financing and Cost-containment

건강보험재정과 비용절감방안에 대한 국제 세미나

일시 2011년 6월 17일(금) 9:00~17:30

장소 한국보건사회연구원 대회의실

주최 KIHASA FRIEDRICH EBERT STIFTUNG

진행순서
PROGRAM

Registration		09:00-09:30
Opening Ceremony		09:30-09:50
Opening Remarks	김용하 (한국보건사회연구원 원장)	
Welcoming Remarks	최원영 (보건복지부 차관)	
Welcoming Remarks	Johannes Regenbrecht, Head of Mission, German Embassy, Seoul	
Congratulatory Address	Christoph Pohlmann, Resident Representative, Friedrich-Ebert-Stiftung, Korea Office	
Coffee Break		09:50-10:10
Session I	Health Care Financing and Cost-Containment in Europe	10:10-12:00
Moderator	사공진 (한양대학교 경제학부 교수)	
Presentation		10:10-11:20
	The European Union and Health Policy: The Logic of the Puzzle – Monika Steffen, Senior Research Fellow, French National Research Center (CNRS), Grenoble University	
	Health Care Expenditure and Cost-Containment in Germany – Franz Knieps, Partner at Wiese Consult, former Director-General at Federal Ministry of Health, Germany	
	Health Care Reforms in France: The Challenge of Regulating a Peculiar System – Monika Steffen, Senior Research Fellow, French National Research Center (CNRS), Grenoble University	
Discussion		11:20-12:00
	이상일 (울산대학교 의과대학 교수) 최병호 (건강보험심사평가연구소 소장) 정형선 (연세대학교 보건행정학과 교수)	

Luncheon		12:00-14:00
Session II	Health Care Financing and Cost-Containment in Selected Asian Countries	14:00-16:00
Moderator	권순만 (서울대학교 보건대학원 교수)	
Presentation		14:00-15:20
	Health Care Financing and Cost-Containment: Japan's Case – Etsuji Okamoto, National Institute of Public Health, Japan	
	Health Care Financing and Cost-Containment in Taiwan – Ming-Chin Yang, Professor, Institute of Health Policy and Management, National Taiwan University	
	Bringing Stability to the Finances of Health Insurance in Korea: Necessary Policy Steps – 신영석 (한국보건사회연구원 사회보험연구실장)	
Discussion		15:20-16:00
	윤석준 (고려대학교 보건대학원 교수) 박민수 (보건복지부 보험정책과장) 김진수 (한국보건사회연구원 연구위원)	
Coffee break		16:00-16:20
Session III	Panel Discussion: Sustainability of Health Care as a Social Insurance Program	16:20-17:30
Moderator	권순만 (서울대학교 보건대학원 교수)	
Discussants	Monika Steffen / Franz Knieps / Etsuji Okamoto / Ming-Chin Yang / 신영석 / 이상일 / 최병호 / 정형선 / 윤석준 / 박민수 / 김진수	

목 차
Contents

Session I

Health Care Financing and Cost-Containment in Europe

건 강 보 험 재 정 과 비 용 절 감 방 안 에 대 한 국 제 세 미 나 1st

EU health policy

- Monika steffen

International Seminar on
« Healthcare Financing and Cost-containment »

KIHSA/FES, Seoul, 17 June 2011

The European Union and Health Policy: the logic of the puzzle

Monika STEFFEN
Institute for Political Studies
University of Grenoble (France)

Common trends

- 1950' – 70': institution building, generalization of access
- After 1973: economic slow-down, early attempts of cost containment
- 1980': retrenchment policies: budget ceilings, health education
- 1990': shifting power: reforming governance
- 2000': management reforms (NPM) : medical computing, PPP, activity based financing

The European Union

- A unique form of federalism
- An « economic » community (EEC).
- « Social Europe » remains the weak part
- Yet, « welfare stateness » is a common commitment and public expectation :
  - Southern Europe
  - Central-Eastern Europe
- 25 different European healthcare systems

Total health expenditure. OECD data: 2007

	% GDP	Per Capita In $PPP	% of public spending	Nb doctors/ 100,000	Years of life expectancy
France	11.0	3,601	79.0	3.37	80.97
Germany	10.4	3,588	76.9	3.50	78.95
Netherlands	9.8	3,837	?	3.93	79.11
Sweden	9.1	3,323	81.7	3.58	80.63
Italy	8.7	2,686	76.5	3.65	79.94
UK	8.4	2,992	81.7	2.48	78.70
Hungry	7.4	1,388	70.6	2.78	72.92
Poland	6.4	1,035	70.8	2.19	75.19

The EU-Health dilemma

- Exclusively national competency, but…
  - "Spill over" effects from other EU policies
  - Mainly market and competition requirements
  - "Coordination" efforts major economic and social policies (OMC, benchmarking)
- Variable impact on the 25 health care systems

Distribution of competency

- Healthcare as part of social security: funding and organization is exclusively NATIONAL competency
- Public health: national, international and growing EU competency
- Transmittable disease: European Center of Disease Control (2004)
- Medical products: under EU regulatory competency and EU competition law

Historical landmarks

- 1957: Rome Treaty. Transportability of Social Security rights, reinforced 1971+72
- 1975: Mutual recognition of diplomas. « White Europe »
- 1980-90s: Public health crises
  - AIDS, plasma, mad cows,
  - Fall of communism: trans-border public health issues
- 1993: Maastricht treaty. Free open market, competition
  - Common safety standards for medical goods, medicines, food stuff
  - Free market for insurances and services. Challenge: applying to health
- 2000s: Eastern enlargement, access+quality challenge

The easy part, Public Health: Institutionalization

- Maastricht Treaty (1993): Art.129 “high level of health”
- Amsterdam Treaty (2000) modifies Art 129, now Art 152 : public health dimension in all EU policies. EU “completes” national action.
- New agencies as policy tools : EMEA 1993, EMCDDA 1993, EFSA 2003, EDCC 2004/data
- European Public Health Programs: Cancer, Aids, transmittable diseases

The complicated part

- EU mainstream policy: four freedoms
  - Free movement for people, goods, capital and services. And free concurrence.
- The meaning for health systems:
  - Mobility of patients, health professionals, and care workers
  - Competition for health services and insurances
  - No public monopoly, no public subsidies, competition for tendering

The main issues
I – Patient’s mobility

- European Court of Justice rulings:
- “country of affiliation has to pay”
- Free will for ambulatory, goods, and urgency
- Prior authorization for non-urgent hospital care
- Countries are opposed, but accepted
- Little real impact. Now promoted as “safety issue” and “rights and protection of patients”

II - Public health insurance

- All insurances are “in principle under the competition law, but…”
- Strong public and political opposition in MS

ECJ rulings defined “Exclusion”:

- Compulsory + solidarity, defined as: no link between risk and premium, no link between contribution and service benefit
- No economic but “clearly social goal”
- Regulation of private complementary Health insurance to avoid cream skimming

III – The Service Directive

- Decision : health services are part of services, under competition law and free market
  - Problem: regulation from “country of origin” would apply to services delivered elsewhere (Bolkenstein–crisis). Refused.
- France fought for the general recognition of “services of general interest” (e.g. public services)
  - Each country can dress its list of “exceptions”. Few do because no change possible
- Finally, “health” was taken out of the service directive in 2008

IV – Replace by: What “activity” is under the competition law?

- A) Recent developments: decision according to the precise “activities”, even part of activity, not the public or private type of organization)
  - In order to avoid cream-scimming, and strengthen the economic viability of public services
- B) Decentralized application of European Law.
  - To avoid MS opposition, return to the traditional principle of subsidiary.

Explaining the puzzle

- UE holds a “general” policy mandate, member states a “specific" mandate
- UE health competency : weakly Treaty-based, multiple ways and tools, hard and soft law
- Three sources, cumulating effects :
  - Public health crises
  - Market integration and compliance
  - Policy coordination and transfer

THANK YOU
for your attention

Further reading:

Scott GREER,

Tamara HERVEY,

Wolfram LAMPING

Elias MOSSIALOS

Health Care financing and Cost-Containment

- Franz Knieps

International Seminar on Health Care Financing and Cost-containment

Health Care Financing and Cost-Containment – The German Example

Remarks by Franz Knieps,
Managing Partner, Wiese Consult GmbH, Berlin, Germany

(former Director-general Health Care, Health Insurance, Long Term Insurance in the
Federal Ministry of Health)

at the International Seminar on Health Care Financy and Cost-Containment,
June 17, 2011, Seoul Korea

1

Health Care Financing and Cost-Containment – The German Example

The main principles of the German health care system (I)

- Public / private mix of insurers and providers
- Shared responsability of federal, state, community authorities
- Dominant role of self-administration
- 10.8% of GDP for health care costs (270 bill. €)
- 100% of population covered

2

Health Care Financing and Cost-Containment – The German Example

The main principles of the German health care system (II)

- 90% of population insured in some 150 public health insurance funds (Bismarck type social insurance)
- 10% of population insured in some 45 private health insurance companies (half of them for profit)
  - Self-employed
  - Employees with salaries above 3800 €/month
  - Civil servants
- Tax money for social and family services and for hospital investments
- 50% of the public insured buy an additional insurance
- Private money for co-payment, additional services and products (e.g. OTC drugs) and Wellness

Health Care Financing and Cost-Containment – The German Example

The main principles of the German health care system (III)

- Wide range benefit package
  - Ambulatory care by 135.000 physicians in private practices and 2.000 medical centers with salaried staff
  - Hospital care given by 2.200 hospitals and rehabilitation clinics (most of them public)
  - All registered drugs except OTC drugs and all medical devices
  - Health related services (e.g. prevention, palliative care, education…)
- Separate long term care insurance
- Comparable low co-payment level (some 15%)

Health Care Financing and Cost-Containment – The German Example

The stearing mechanisms

- Central role for the Joint Committee
  - Funds
  - Providers (physicians, dentists, hospitals)
  - Patients (no decision votes)
- Budgets and sophisticated payment systems for physicians and hospitals (DRG)
- Reference pricing and value based pricing for drugs
- Focus on evidence based decision making
- Independent advice by public institutes, esp. by the IQWIG (Institute for Quality and Efficiency in the Health Care System)

Health Care Financing and Cost-Containment – The German Example

Health policy since World War II

- Restitution of the pre-war structures
- No fundamental reform between 1945 and 1988
- Inclusion of new people (e.g. pensioners, students, handicaped…) into the social insurance
- Inclusion of new services into the benefit package
- Consolidation of the welfare state after the oil crisis and beginning of cost-containment in the late seventies
- Permanent health care reforms since 1988

Health Care Financing and Cost-Containment – The German Example

Health Care Reform Act 1988 (GRG)

- Integration of health insurance law into the social code (SGB V)
- Reference price system for drugs and medical devices
- Co-payments on drugs, medical devices, hospital care
- More money for prevention
- First step to separate long term care insurance (finalized in a special reform act in 1994)
- Improving surveillance over physicians and hospitals

Health Care Financing and Cost-Containment – The German Example

Health Care Structure Act 1992 (GSG)

- Implementing competition between the funds
  - Freedom of choice for all insured and access to all funds
  - Risk sharing scheme between all funds
  - Professionalization of management
- Limitation for the number of physicians
- Allowing hospitals to offer some ambulatory services
- Strengthening primary care

Health Care Financing and Cost-Containment – The German Example

Health Care Reform Act (2000)

- New hospital payment system (DRG)
- Implementation of disease management programmes for cronic diseases
- Allowing experiments and implementing integrated care
- Implementation of competition between providers
- Incentives for patients to visit primary doctors first

Health Care Financing and Cost-Containment – The German Example

Health Care Modernization Act (2003)

- Limitation for drug expenditures
- Co-payments on all services incl. primary care (10 € per visit and quarter)
- Weakening the role of Panel Doctor´s Associacion and flexibilization of ambulatory care (e.g. medical centers with salaried staff)
- Reconstruction of the Joint Committee and founding of the IQWIG
- Reducing the burden of employers and shifting it over to employees

Health Care Financing and Cost-Containment – The German Example

Health Care Competition Act (2007)

- Obligation to be insured for the whole population
- Implementation of a national funds
  - Contribution rate fixed by law
  - Improving risk sharing scheme by morbidity clusters
  - Funds which need additional money must collect an additional premium directly from the insured
- Strengthening competition especially in the field of ambulatory care
- More rights for family doctors
- New payment system and more money for ambulatory care physicians
- Allowing funds to go bankrupt

11

Health Care Financing and Cost-Containment – The German Example

Reform Acts since 2009

- Health Care Financing Act
  - Weakening solidarity
  - Widening additional premiums
  - Freezing employers` contribution
- Drug Reform Act
  - Increasing discounts of pharmaceutical industry
  - Value based pricing for innovative drugs
    - Value Assessment by Joint Committee
    - Bargaining value based price between manufacturer and National Association of Health Insurance Funds
    - Arbitration

12

Health Care Financing and Cost-Containment – The German Example

Common trends through all reforms

- Incremental reform steps instead of a „Big Bang“
- Sophisticated cost-containment approaches
- Focus on
  - Competition (consumers`choice)
  - Primary care
  - Integrated care, managed care, cronic care
  - Drug regulation
- Looking for new financial sources
- Reforming the payment systems (p4p)
- Improving quality and efficiency
- Strengthening the users and patient empowerment
- Flexibilization of institutions and processes

13

Health Care Financing and Cost-Containment – The German Example

Future challenges

- Demografic change
  - Population
  - Health professionals
- Medical, technical, pharmaceutical progress
- Globalization and urbanization
- Ethics
- Acute care and dominant role of physicians

14

Health Care Financing and Cost-Containment – The German Example

Possible answers for Germany

- Common insurance market for public and private insurers
- Focus a public health strategy on
  - Prevention and health promotion
  - Evidence based medicine
  - Cronic care and rehabilitation
  - Out come measurement and pay for performance
- Improving health education and coaching
- Patient empowerment and shared decision making
- Developing new models of integrated and managed care
- E-health
- Professionalization of management and staff
- Using new financial sources (taxes, income with no relation to labor costs)

15

Health Care Reforms in France: The Challenge of Regulating a Peculiar System

- Monika Steffen

Healthcare Reforms in France: the challenge of regulating a peculiar system

- Monika STEFFEN[1)]

(Preliminary draft, not to be quoted)

○ Introduction: Lessons to be learned from France

The French healthcare system is particularly large, in terms of the population covered, the amounts of money spent and the quality of the care delivered[2)] . It is the second biggest healthcare system in Europe, after Germany's. Yet, the French system is not publicized much, and is often misunderstood. The international literature provides few analyses of the French system, being authored mostly by Anglo-Saxon comparatists rather than by French scholars specialized on the subject. This paradox reflects the general problem of international policy transfer and learning: the international diffusion of ideas is a matter of language.

---

1) Senior Research Fellow (CNRS), PACTE - Institute of Political Studies, Grenoble University /France. Contact: monika.steffen@iep-grenoble.fr

2) In 2000, the World Health Organization (WHO) ranked the French healthcare system first, as the world's finest and most efficient one. This first attempts at a worldwide comparative assessment of the overall efficiency of health systems, taking into account multiple data, such as waiting lists, out-of-pocket payments, the progress in medical cover and in general life expectancy, the numbers of years of life in good health, etc., was extensively critiqued, mainly because of the criteria used and the surprising results: the USA ranking 37th and Canada 30th out of 191 countries, Oman being within the top 10 (because of its huge progress in medical cover and life expectancy), and the Italian system ranking 2nd although much critiqued by the Italian users (but it ranked well on progress factors). Criticisms on the ambitious project and the methodology did not however put forward precise arguments against a top position for the French system. A recent ranking from the European Health Consumer Index (2008), established on criteria adapted to high-income countries, ranked the French system 10th out of the 31 countries analyzed (add reference).

There are several good reasons to study the French healthcare system, its organization, functioning and financing. Two of them are of particularly important for policy analysis, from a theoretical as well as practical perspective.

The first reason is that the theoretical models used in the comparison of healthcare systems are not helpful for understanding the French case, which is based on a specific public-private combination, with generous benefits and weak regulation (Catrice-Lorey & Steffen, 2006). In terms of the well-known classification, drawn from the study of welfare states, distinguishing Bismarckian, Beveridgian and liberal healthcare systems (Giaimo, 2001), – re-termed Social Insurance Systems (SIS), National Health Service systems (NHS) and private health insurance systems –the French healthcare system can only be described as a model "half-way between Bismarck and Beveridge" (Palier), or as a mixture of "the Dutch, the USA and the British system" (Kervasdoué, Okma, Marmor 2003). Such conceptualizations call into question either the validity of the theoretical models or the analysis of the case.

The French healthcare system does indeed combine elements of different theoretical models, at all levels: service delivery, regulation, and insurance coverage. The main characteristic is its particular public-private combination, grounded in a unique national history rather than resulting from international policy transfer that might have introduced competition or privatization into a previously public system. The recent French reforms confirm and deepen the specific national characteristics. Today, it is admitted that healthcare systems with a coherent public-private mix may prove to be the most sustainable. The particular French model may therefore be of growing interest to international analysts and observers.

The second reason is that the French healthcare system combines what theory and comparative literature establish as contradictory, and therefore incompatible: universalism and choice. Yet, the French system covers the entire population and it offers a wide range of choice to patients. This unusual combination has been conceptualized as "liberal universalism" (Steffen, 2010a). Patients can use public or private services in often similar financial conditions. They can choose their doctor and their hospital, and doctors are free to prescribe as they see fit. The French medical profession has been able to defend its professional independence from the State as well as from the health insurance system, despite the general context of cost-containment. This opens new perspectives for the comparative assessment of health systems organization and, consequently, for policy-making in countries that undertake to upgrade their medical cover.

To sum up: universalism, choice and professional independence remain important in French health policy. This combination puts limits on the implementation of cost containment. Yet French health spending per capita remains reasonable by international standards. In 2009, it ranked 9th among the 30 OECD countries, with US$ 3,696 PPP against an OECD average of US$ 3,060. Finally, as the French healthcare system offers a positive balance of social costs and benefits, there is a lot to be learnt from it.

The aim of this paper is to explain these evolutions and identify the logic of the often misunderstood French system. The first part will provide the basic economic data. The second will retrace the most important reforms since 1996 in order to assess their successes and failures. The third will analyze the most recent and crucial reform passed in 2009. The conclusion will highlight the new challenges arising from this reform.

1. Health expenditure: a question of economic growth and national solidarity

France has a long tradition of social policy and of redistribution, organized in its present institutional form after World War II. Although social policy has been revised during the last twenty years (activation, evaluation, means testing, etc), the political and social consensus for national solidarity remains strong. The redistribution of national wealth amounts to 30 % (Table 1).

Table 1: Social Protection in France (in %)

	1990	2000	2009
Total amount of social benefits as % of GDP *(Taux de redistribution sociale)*	25.8	27.7	31.3
Part of social benefits in the income of households *(Taux de socialisation des revenus)*	25.1	27.1	28.9
Total of compulsory social contributions or social taxes *(Taux de prèlèvement sociaux)*	27.6	29.6	31.8

Source: INSEE Comptes nationaux annuels, DRESS Comptes de la Protection Sociale (Etudes et Resultats, n° 755, February 2011)

Out of the total expenditure on social protection (€ 597.5bn in 2009, equivalent to nearly €10,000 per capita and per year), the healthcare sector benefits from more than a third (Table 2).

Table 2: Distribution by sector of Social Protection (2009)

	Total in billion €	Part in %
Healthcare	208.8	35.0
Retirement, old age	272.2	45.5
Family, maternity	53.6	9.0
Employment	36.4	6.1
Housing	16.0	2.6
Social exclusion, poverty	10.5	1.8
Total	597.5	100

Source: INSEE Comptes nationaux annuels, DRESS Comptes de la Protection Sociale (Etudes et Resultats, n° 755,February 2011)

The health sector is also a major economic sector. Direct employment is estimated at nearly 10 % of the entire work force, 13 % when adding indirect jobs.

France counts some 219,000 practicing doctors (3.37 per 1,000 inhabitants in 2007), of whom 57 % are private practitioners.

The total number of nurses is 515,700 (7.9 per 1,000 inhabitants). Their employment status is a valid indicator of the circulation of patients within the system: 70.5 % work in hospitals, 14.8 % in ambulatory care as independent professionals, 8.5 % in long term care structures for handicapped or old people, and 6.2 % in other public or private administrations and institutions, mainly for prevention. Within the bulk of the nurses working in the “hospitals”, 75.8 % are employed in public hospitals and an additional 5.9 % in (private) hospitals “participating in the public service”. The private hospitals outside the public-service obligations account for only 11.1 %[3)].

The French healthcare system is extremely expensive in terms % of the GDP, ranking second worldwide, after the USA, and first among the welfare states. This negative picture changes when consider the expenditure per capita, a more realistic criteria for assessing the financial performance of mature healthcare systems. The difference between the two rankings (Table 3) reveals the main problem of the French healthcare system: the health bill is expensive because the country’s GDP per capita is low.

Table 3: Comparative health expenditure, 2009 OECD/France

	Per capita in US $ PPP	Per capita In % of GDP
USA	7,538	16.0
Norway	5,003	8.5
Switzerland	4,627	10.7
Canada	4,079	10.4
Netherlands	4,063	9.9
Austria	3,970	10.5
Ireland	3,793	8.7
Germany	3,737	10.5
France	3,696	11.2
OECD average	3,060	9.0

Source: IRDES

3) Source of figures: ADELI data bank of the Health Ministry, Repertory of healthcare professionals in Metropolitan France.

The source and structure of the financing show a high level of stability (Table 4). The share of the compulsory health insurance has decreased by only 1.6 %, despite repeated reform efforts to reduce this charge ascribed directly to the cost of labor. The contribution from the state and local authorities has increased slightly (+0.2 %), due to a law passed in 2000 creating specific support in order to keep poor populations fully health insured (CMU – couverture médicale universelle: universal medical coverage). The share of the three types of so-called "complementary" health insurance, put together, has increased from 12.2% to 13.8%, while out-of-pocket payments have decreased by 0.2%. In 2009, as in 1995 and before that, the individual/household share corresponds to the goods and services that have always been reimbursed very little (optical and dental care, hearing aids), to the private practitioners who charge over the statutory fee, and to the delisting of "medically inadequate drugs". Table 3 reveals two important facts. First, the shift from public insurance and finance to private complementary insurance and out-of-pocket payments remains very limited, only 1.4 %. Second, the market for commercial health insurance in France is small: its share amount to a maximum of 6.1 % (in 2009, and probably for the next future), when taking the abstract hypothesis that all employers opt, and would continue to opt for commercial companies and none for mutual benefit funds.

Table 4: Financing of current expenditures on medical care and goods, in %

	1995	2000	2005	2009
Social security	77.1	77.1	77.0	75.5
State and local authorities	1.1	1.2	1.3	1.3
Complementary private insurance:	12,2	12.8	13.2	13.8
- Mutual benefit funds	7.3	7.7	7.7	7.7
- Commercial insurance companies	3.3	2.7	3.1	3.6
- Employer-sponsored schemes	1.6	2.4	2.5	2.5
Households	9.6	9.0	8.4	9.4
TOTAL	100.0	100.0	100.0	100

Source: DRESS, Ministère de la Santé, Comptes de la Santé (base 2000),
Comptes Nationaux de la Santé en 2009. Etudes et Resultats, n° 736, Sept 2010

Since 1997, the annual growth of health expenditure is fixed, and therefore limited by a vote in Parliament, each year in december. However, the official target (ONDAM: Objectif National des Dépenses de l’Assurance Maladie: National target for health insurance expenditure) has never been respected, except the year it was introduced, and in 2009, which was also a reform year. Cost containment measures clash with an endogenous dynamic in which doctors, administrative agents and patients counteract the reduction of certain rates of reimbursement. The possibilities allowing for full reimbursement are increasingly used, especially via the ALD (affections longue durée), that is, “chronic diseases”, category. The authorizing list of ALD has grown to over thirty pathologies now, and over seven million patients benefit today from full reimbursement for ALD.

Table 5: Growth rate for health expenditure (in %)

	Targeted growth rate (ONDAM)	Real growth rate
1997	1.7	1.5
1998	2.5	4.0
1999	1.1	2.6
2000	3.0	5.6
2001	2.5	5.6
2002	3.2	7.1
2003	5.8	6.4
2004	4.4	4.9
2005	3.8	4.0
2006	1.8	3.1
2007	1.3	4.2
2008	2.5	3.4
2009	?	3.5
2010	2.9	2.9 (expected)

Source: IRDES 2010

Tables 5 and 6 demonstrate complex trends. On the one hand, there is a strong political will to limit health expenditure, but implementation does not follow, or only slowly (table 5). On the other hand, there has been real progress in recent years (Table 6), especially for pharmaceuticals. Table 6 also shows a more efficient control over growth rates in public hospitals compared to private hospitals.

Table 6: Structure of expenditure, 2009

	Part in %	In billon €	Growth rate: annual average 2000-05	Growth rate: 2009
Hospital care	44.4	78	5.1	3.8
Public	*34.2*	*60*	*5.1*	*3.7*
Private	*1O.2*	*18*	*5.0*	*4.4*
Ambulatory services: GPs, specialists, dentists, nurses, physiotherapists, medical tests	27.5	48.3	5.6	3.0
Transport	2.1	3.6	8.4	6.8
Pharmaceuticals	20.2	34.4	5.9	2.5
Other medical goods	5.8	10.5	8.1	2.8
Total: Consumption of medical care and goods (CSBM)	100	175.7	5.6	3.3

Source: INSEE Comptes nationaux annuels, DRESS Comptes de la Protection Sociale (Etudes et Resultats, n° 755, February 2011)

This slowly developing, because highly contested, but finally now engaged cost-control, had to pass by three major structural reforms: 1996, 2004 and 2009, and an additional reform of hospital financing.

2. Who should regulate the healthcare system? The 1996 and 2004 reforms

French reform politics have a common background: the question of governance.

A long-standing struggle has opposed the social partners (trade unions and employers' unions) and the government over the health insurance system. The system was created after the Second World War and then left to the trade unions, for political reasons. When a reform brought the employers back in (1967), the trade unions refused to collaborate with their class enemy. The mission of national health insurance shrank to a bureaucratic function of reimbursement. No management capacity was built up (this constitutes the main difference compared to the German system). Furthermore, private doctors, who have an official monopoly on the ambulatory care sector and enjoy professional independence, which is granted by law, have continuously refused regulation and cost containment.

Consequently, for years government action concentrated on the public hospitals, which developed considerably, including technical and scientific development. When cost-containment became unavoidable, it was also first focused on the public hospitals, and then extended to the private hospitals "participating in the public service", which is a particular legal status. Cost containment developed only in the hospital care sector, and even there only slowly because of medical and public resistance.

The contradictory evolution deepened the traditional division in the health policy field and actor networks, between the ambulatory care sector, e.g. the traditional private practitioner ("médecine libérale" in French terminology), on the one hand, and the public hospital care sector, on the other. An overall regulation of the care system and expenditure therefore proved extremely difficult, because of a lack of competency, coordination and legitimacy. Still today, private doctors negotiate with the health insurance, and only their tariffs, whilst the ministry governs the hospitals, directly and in detail (including employment, staff careers, and salaries). Private hospitals have gradually gone from the hands of health insurance (as part of "medicine libérale") to the new ministry-led agencies (as part of "hospital care"). For two decades, cost containment was reduced to the marginal adjustment of reimbursement rates for ambulatory care and to global budgets for hospitals.

The 1996 reform, introduced by a conservative government (Lee), was designed to respond to all these problems. The ambitious project can be summarized under three headings: financing, governance, and management.

On the financing front, the previously salary-based contribution from employees was replaced by a "general" social contribution payable on all income. Since 1997, only the employers' share has remained based on the Bismarckian social contribution, that is, exclusively on work-generated income. The affiliates now pay a tax-like contribution, the level of which has been increased several times since 1997. Furthermore, the reform introduced a new contribution, also applicable to all income: the "Reimbursement of the social debts". Originally limited in time (12 years), it has been extended to an "undefined date", and the rates have also been raised.

The reform introduced a limited health budget, for the first time in history, via the annual vote in Parliament on the allowed growth rate of health expenditure. Parliament also votes on the allocation of the budget to the main sectors (hospitals, ambulatory care, care for the elderly and handicapped, etc.). Although the official growth rates have not been adhered to (Table 5), the vote in parliament has provided legitimacy to the highly contested idea of cost containment.

On the governance front, the reform took a middle way, between the modernization the health insurance system and a state-dependent governance via new agencies. The middle way option reflected a political compromise and the composition of the supporting alliance, which included one of the two major trade unions, the employers' union, and the mutual benefit funds for complementary health insurance. Concerning health insurance, the reform organized a redistribution of power within the governing boards of the funds. It also created a specific "surveillance board" in each of the three national health insurance funds. The directors of the funds, at local, regional and national level, previously elected by the respective funds' boards (a highly trade union-dependent procedure) were henceforth nominated by the hierarchy of fund directors, after approval of each candidate by the minister. An agreement was negotiated and signed between the health insurance and the government concerning joint competency. The subject has however remained a source of permanent conflict.

The main achievement of the reforms was the creation of 24 Regional Agencies for Hospital Planning and Management (Agences Régional d'Hopitalisation, ARH), charged with the reorganization, redistribution and reduction of hospital capacities. The directors of the Regional Agencies had to establish "Regional Schemes" for hospitals and other (inpatient) infrastructure, which was a first attempt to integrate short- and long-term care capacities in a common planning proceedure. Care networks for chronic illness were to be organized in collaboration with the hospitals and the professionals from the ambulatory care sector (a vague French adaptation of HMO). Last but not least, regional as well as a national yearly "Health Conferences" had to be set up, in order foster social support and dialogue. The most productive innovation, in terms of tools for cost containment and regulation, was the introduction of contracting: each hospital has to negotiate its budget with the Regional Agency, according to a precise plan for activity and strategic development. All hospitals and inpatient structures, public as well as private, are now obliged to develop their "management" capacity.

On the front of the so-called médecine libérale, e.g. the ambulatory care sector, the reform aimed at reinforcing the position the health insurance system. It provided competency and tools for economic control and for a more coherent organization of services, especially through gate keeping. The medical guidelines were made compulsory, with penalties to be applied to doctors in case of non-compliance. A public agency for the evaluation of treatment was set up, replacing the previous exclusively medical system, with the task to draw up and multiply the compulsory medical guidelines. The high level of pharmaceutical expenditure constituted a reform priority[4]. A list of generics to be prescribed was set up, and chemists were given the competency (and financial incentives) to replace prescribed original medicines by generics. A gatekeeper scheme was set up, but only on a voluntary basis and mainly targeted at patients with chronic diseases. Doctors were urged to organize networks for specific chronic patients. Many other points featured on the reform agenda, such as obliging doctors in private practice to retire at a certain age, to attend further their medical education, and to computerize their office. The latter reform intention aimed at developing the use of electronic cards for the patients' reimbursement, which would improve the statistical computing at the health insurance funds, on patients' circuits within the care system and patterns of consumption, and allow to trace (criminal) abuse. The introduction of the first electronic patient cards was strongly resisted by medical organizations as well as the political left, the media and public opinion, as a threat to privacy and a risk of discrimination, among other things.

The outcome of the ambitious 1996-reform is coherent with the power structure of the policy field. In practical terms, failure predominates. The main success of reform has been to have paved the way for future change[5].

- **Cost containment failed** (Table 5), but it became a legitimate priority on the policy agenda. The financial part of the reform was successful only in so far as contributions were increased, and a door was opened for private complementary insurances to participate in future policy debates.
- **The regional hospital agencies did not succeed** in restructuring the hospital capacities, but the henceforth systematic use of the regional development schemes (SROSS) and of contracting with individual hospitals tested the policy tools, which are today in full operational use.

4) France has an extremely high level of pharmaceutical consumption, and relatively low prices (negotiated by government and industry), which have been compensated by large volumes.

5) In this sense, it can be termed as a "strategic non-reform" (PH: « une non-réforme stratégique » PH)the French system 10th out of the 31 countries analyzed (add reference).

- **Failure was total in the ambulatory care sector**, on all items of the reform. Costs have increased, as has overcharging, which has led to access problems for poor people.
- It took over ten years for action on **pharmaceutical** expenditures to produce its first effects (cf. Table 6). The evaluation of all reimbursed medicines, as to their "level of medical usefulness" took five years, and the delisting of some 800 useless products (out of approx. 4,000) has only been achieved recently, in the late 2000's. The use of generics improved only after the reform in 2004, and remains, by EU standards, low even today[6].

The failure lead to the following reform plans, during the early 2000s, which reflected the changing political context. In 2002, a reinforced conservative majority won the presidential and following parliament election. The employers threatened since 2000 that they would leave the governance system of the health insurance if costs could not be controlled, which they did in 2002.

• Securing access: the universal medical cover (2000).

As long term unemployment grew and shifted people from the health insurance towards a locally administrated medical assistance scheme with geographically variable benefits, a law was passed, in 2000, with a wide political consensus, to unify the medical cover for people with low or irregular income. Henceforth, all beneficiaries of social assistance programs have been affiliated or re-affiliated to the normal health insurance, on the criteria of residence in France and means testing[7]. This scheme, the CMU (Couverture Médicale Universelle: universal medical coverage) is not limited to basic coverage only, it includes a complementary health insurance comparable to that to which most of the population subscribes. This measure is co-financed by the state, the statutory health insurance, and the various "complementary" health insurance organizations (mutual benefit funds, employer-sponsored health benefit schemes, and private health insurance companies). Beneficiaries are free to choose the organization to which they want to be affiliated and can obtain medical care from private practitioners or public institutions, like everyone else. For CMU patients, insurance as well as care is entirely free-of-charge: no patient's contribution, no fixed daily charge for hospitalization and no need to advance costs[8].

The specific achievement of the CMU was not so much to provide care for poor people, which already existed before, but to have normalized the rights and benefits of 5 million people, by integrating them into the mainstream health insurance. In 2004, this was reinforced by the introduction of tax credits for people whose income is just above the CMU-threshold, up to 20%, to help them pay a private complementary health insurance. These tax credit is currently paid out to 2 million people. Public money is thus provided to pay the complementary private health insurance for a total of 7 million affiliates and family members, which represents close to 11 % of the population.

6) In 2007, generics accounted for 10 % of the total sale of medicines, compared to 20 % in Germany, the Netherlands and GB. Source: Etudes et Resultats, n° 634, mai 2008.

7) The monthly threshold for a single person is approximately 600 Euros. This amount is increased for a couple and for each child.

8) In 2007, generics accounted for 10 % of the total sale of medicines, compared to 20 % in Germany, the Netherlands and GB. Source: Etudes et Resultats, n° 634, mai 2008.

• The 2004 reform concerned the health insurance.

It shifted power from inside the institution towards more government control, and introduced new financial charges for the patients, or their respective complementary health insurance. The main changes can be summarized in three points.

First, the boards of the health insurance funds (conseil d'administration), at national, regional and local levels, lost their decision making power. They have been transformed into advisory councils, whilst a new and powerful position has been created, that of the Director General of the Health Insurance. The latter holds competency over the three national funds, which are each heading a specific branch of the statutory health insurance[9]. Nominated directly by the health minister, the national Director General nominates all directors of the local funds. Direct incentives have been introduced in the carrier and the remuneration system of the local directors to motivate for working, at the level of their fund, towards effective cost containment and compliance with the national priorities.

Second, several new national agencies have been created to foster coordination between the three branches of the health insurance on the one hand, and between the statutory health insurance and the complementary private insurances. The evaluation agency created during the 1996 reform has thus been renewed to become the "High Authority for Health", charged with the elaboration of a restrictive basket of reimbursable care and of compulsory medical recommendations. This mission, which concerns the ambulatory care sector, e.g. the private doctors, has failed so far.

Third, a gatekeeper mechanism has been installed, for the first time in France, in order to discourage patients from the direct free access to specialists. Patients can still consult freely as many doctors as they want, but reimbursement rates are lowered if they do not have a transfer from the doctor they officially choose as their "treating doctor" (médecin traitant). Gate keeping thus remains a rather loose obligation.

As doctors refused to participate in regulation and cost containment, the 2004 reform put the burden on the users of medical services. The fixed daily copayment rate during hospital stay has regularly been

9) The three branches for respectively: employees, independent professions, and farmers.

increased. Today it amounts to 18 € per day. The 2004 reform introduced new and non-reimbursable fixed user fees: 1 € for each consultation, 0,50 € for each package of medicines, 0,50 € for each medical service (injections, laboratory analyses, sessions of physiotherapy, etc), and 2 € for each transportation (ambulance or taxi). To prevent heavy charges for very ill people, the total of these non reimbursable copayments has been limited, per person and per day, to a maximum of 4 € for transport and 2 € for paramedical services. The maximum per year and person is 50 €. Only people under the age of 18, CMU beneficiaries, and pregnant women are freed from these payments.

The outcome of the 2004 is mitigated. It shifted the burden of cost containment to the patients, but – by limiting the amounts- it also preserved the principle of solidarity. The reform put an end the to the "Bismarckian illusion" (Catrice-Lorey & Steffen, 2008) and installed the central government at the head of the health insurance. Yet, it did not obtain the collaboration of any intermediate body to actually implement the national policy in the ambulatory care sector. Timid progress however exists. Under the reorganized directorship, the health insurance funds have finally launched, in the late 2000s, an "active health insurance policy". It started with fighting obvious and criminal abuse, in collaboration with the police for the first time in history. It includes a program of socialization targeted primarily towards doctors with atypical prescription profiles, but also more generally towards GPs. It employs specifically trained medical visitors, who organize discussion rounds (Entretiens confraternel) with the aim is to explain to the practitioners what is expected from them in terms of economic awareness, the orientation of patients, prevention and public health. Another priority of the "active policy" is to engage doctors in individual contracting (CAPI program) with the health on such aims, with a priority on the organization of medical availability including during week-ends, holidays and at night.

In fact, although the government is taking over, it relies on the health insurance because the latter alone possesses the necessary data and the computing capacity necessary for the control and the regulation of the ambulatory care sector, which comprises all prescriptions other than indoor-hospital care.

3. The 2009 law: Regionalization as the final step

Lasting failure in cost containment, the 2002-03 financial crisis, and two Presidential elections (2002, 2007) with conservative victory, favored a follow-up of the 1996 options and made the 2009 reform possible. This overarching law, embracing almost all aspects of health administration, including care, prevention and public participation, is in fact centered on two core elements: regionalization and hospital management. The latter discipline is weak in France[10], despite the important infrastructure of public hospitals. Hospitals were administrated, not managed. The ongoing change is considerable for all actors.

Earlier programs prepared the law of the 21 July 2009, entitled "Hospital, Patient, Health, Territory". The law status attests its importance. The previous reforms had only a status of programs, regulations or decrees. The succession of texts illustrates the lengthy learning, political acceptance, and developments of tools.

In 2002, a five years plan for reforming the hospital was announced by the Prime Minister (Raffarin), also known as the "Hospital 2007 Plan". It traced two main directions: the already existing Regional Agencies for Hospital Planning were to organize the cooperation between hospitals, including public and private partnership; and the financing of hospitals was to move from the global budget, dating from 1983, to financing according to activity (T2A). The latter project needed the revision of the various categories on which tariffs footed, especially the construction and tarification of the homogenous groups of patients. Priority was given to investment in information technology and medical computing inside the hospitals. The work needed direct collaboration between the ministry of health and the individual hospitals.

The Regulation of 2nd May 2005 (Ordonnace) completed the earlier provisions for the "Hospital 2007 Plan". It reinforced the competency of the Regional Agencies for Hospital Planning, and focused on an internal reorganization of the hospitals. Henceforth, the regional agency could ask a hospital to submit a plan to absorb or lower its deficit (plan de redressement), and could place a hospital under tutelage of the local public administration. The internal organization of hospitals was to be based on large "Poles", much bigger than the previously existing medical departments. These poles were to become management units. An "Executive Council" (Conseil Exécutif) was to be installed, equally staffed by representatives of the doctors and of the administrators and placed under the presidency of the Director General of the hospital. The mission of Board (CA) was reorganized in order to concentrate on the control and evaluation of the Executive Council's work, and on the strategic development of the hospital.

The 2009 Law confirms these lines and promotes the regional level to the center of health governance. The competency of the regional agencies has been enlarged, they are renamed "Regional Health Agencies". These renewed agencies integrate under their authority the regional level of the health insurance, the entire previously existing public health administration and surveillance systems, the long term care sector, the future regulation of the ambulatory care sector, and of course the entire hospital sector. Health is no longer under the authority of the ordinary administration and the regional prefect, but under the direct authority of the Director of the Regional Health Agency. The nomination of the agencies' directors is the exclusive competency of the Cabinet (Conseil de Ministres). Each nomination is done by a government

10) Health economists constitute a growing community, since the late 1990s, with presence in various commission and think tank like forums, but compared to other European countries, it is still a weak community (Bemouzing). Although management has developed as a major discipline in France during the last two decades, health management is a very marginal discipline, with only very few university teachers and researchers.

decree, and published in the Official Journal (Journal Officiel). The employment is contractual, not a public service position, which constitutes a major change in the French tradition of high-level public responsibility. The specific position of the directors of the health agencies attests to the role of the state, which has now taken over the entire health sector.

The content of the law concentrates on three main issues, with potential for success:

❶ Territorial planning and coordination for investment, activities and care capacities. The specific tools to foster coordination are the "territorialized hospital communities" (Communautés hospitalières de territoire) for the collaboration of several hospitals, and the joint ventures for sanitary cooperation (Groupement de coopération sanitaire). The latter can operate for sharing the use for equipment or to organize common activities. Both these tools can be used for public-private partnerships, or for exclusively public or private partnerships.

❷ Contracting. The latter is now compulsory on two levels. Each care institution has to sign a pluri-annual[11] contract (contrat d'établissement) with the regional health agency covering its planned activities and development strategy. In a similar way, each hospital "Pole" has to sign a contract with the hospital, covering the activities, projects and development strategy of the each single pole. The latter is then responsible for its budget and enjoys the right to manage itself (délégation de gestion).

❸ Internal reorganization of the hospitals: The organization introduced in 2005, based on a board, an executive council and the Director General, has been modified by the 2009 reform, with the aim of reinforcing the power of the General Director. The board was abolished, replaced by council of surveillance; a Directory assists the Director, who is now the "boss" of the hospital. A doctor, assisted by a care manager, however heads the Poles.

Last but not least, the regional agencies have access to any data "needed to fulfill its missions" and contained in the data systems of the health insurance funds, the hospitals, and the long term care institutions and funds (Devreese, 2011, p 108).

The 2009 reform can be summarized in few words: the central state holds now unshared power over the health sector. The regional agencies and the directors of the hospitals are the main instruments of the new governance. Contracting is the main tool for territorial coordination and planning, and for the internal management of the hospital. The projects for the ambulatory care sector remain still vague and constitute the most uncertain issue of the reform.

11) The maximum duration is 5 years (p.110, Devreese)

○ Conclusion

The concluding arguments can be summarized in the form of future perspectives and new challenges.

Despite the structural reforms, the future perspectives seem to follow the same path as previous national tends: The level of health expenditure, compared to the country's modest economic growth, will remain relatively high, because the solidarity is fully maintained. Cost containment has shifted a growing but legally limited part of expenditure towards private financing, and a public scheme has been introduced to protect the economically weak part of the population. People with high and medium incomes pay more, and heavy healthcare consumers see their personal out-of-pocket expenses increase. The basic values of universalism and choice seem to be preserved. Access does not seem to be becoming the major problem in the France, at least not for economic and social reasons. The current problem of access results from the growing geographical disequilibrium of medical staff and infrastructure, with "medical deserts" appearing in rural areas. This issue is not a problem of universalism in itself, but of the still unaccepted regulation of ambulatory care (e.g. the total freedom of private practitioners to set up praxis where ever they like).

The structural reforms carry new challenges. It is too early to assess the outcomes of the 2009 reform, as implementation is still underway, with continual adaptation and negotiation. However, two main challenges can already be identified:

- The first challenge concerns the internal governance of hospitals. Management has now been brought inside the care institutions. Training programs, catering for middle-management and part of the medical elite, accompany the change. However, the empirical content of the "management function", to be carried out by the medical heads of the new and huge hospital departments (Pôles), still needs to be invented in practice – although it is mentioned in the official regulations. What profile of activity, competency and power (and what training) should these doctors have? At what levels is the new "hospital management" to be carried out: inside the Pôles or at the general directorate of the hospitals?
- The second challenge concerns the future role of the health insurance system. Will the social health insurance funds, or the state-dependent regional health agencies, organize the regulation of the ambulatory care sector? So far, reform options have remained limited to lowering reimbursement and to a loose "territorial" regulation. In practice, this comes down to relegating care for the chronically ill and elderly to local authorities. The two main issues, control over prescriptions and over the geographical distribution of doctors, are still not solved, because politically difficult. The problem was clearly illustrated by the political debate in Parliament, in 2004, on the "role" of the High Authority on Health: quality or cost issues? A restrictive "basket" of reimbursable care, its initial mission, has been

put aside and replaced by quality and rights-of-patients issues. However, the newly appointed director (2011) announced that the HAH would “now turn to the cost dimension” (Paris Conference, mai 2011).

The evolution over two decades corresponds to the Jacobin reframing of a Bismarckian illusion. Trade unions and employers have been driven out of the governance of the health sector, for lack of management, after a 50-year struggle with the state authorities. The central state has taken over, by imposing “territorialization” as the main tool of regulation, via agencies under its direct control. The problem is that this government-based governance exposes the unpopular policy of cost containment directly and regularly to electoral politics. Perhaps the health interests of a nation are, after all, best protected by the competition for political power.

○ References (to be completed)

BARBIER Jean-Claude et THERET Bruno, 2009, Le système français de protection sociale, Paris : La Découverte

BEMOUZING

CATRICE-LOREY A., 2009, (Grenoble, text AFS)

CATRICE-LOREY A. and STEFFEN M., 2008, "La protection-santé en France: vers quel nouveau modèle?", in GUILLEMARD A-M. (ed.), Où va la protection sociale?, Paris: Presses Universitaires de France, p. 173-163

DEVREESE, Emmanuel 2011, Droit de la santé et réformes hospitalières, Paris : Editions Demos

GIAIMO, Susan (2001), « Who pays for health care reform? », in Pierson, Paul, ed by, The New Politics of the Welfare State, Oxford/New York : Osford University Press.

HP “Juppé non reforme strategique”

HATZFELD, Henri, 1971, Du paupérisme à la Sécurité sociale, Paris : Armand Collin

HATZFELD, Henri, 1963, Le grand tournant de la médecine libérale, Paris : Economie et Humanisme, Les Éditions ouvrières.

KERVASDOUÉ, J. de, K. OKMA, and T. MARMOR. 2003. “Les gouvernements de quelques pays de l’OCDE et l’Etat providence depuis 1990” (Governments and welfare states, in OECD Countries. An Overview since 1990). In Mututalité Française, Carnet de santé de la France, 2003 (The Health Notebook of the French Federation of Mutual Benefit Societies); ed. Par J. d Kervasdoué, 205-243, Paris: Dunod.

LEE

STEFFEN M., 2010a, « The French Healthcare system : Liberal Universalism. The French health care system and its reforms», Journal of Health Policy, Politics and Law, n° 35-3, pp. 335-365.

STEFFEN M., 2010b, « Social Health Insurance Systems : What makes the difference? The Bismarckian case in France and Germany », Journal of Comparative Policy Analysis, vol. 12, n° 1-2, pp 141-161.

STEFFEN, M. 1987. “The Medical Profession and the State in France”. The Journal of Public Policy, Vol. 7 2:189-208.

Session I
Discussion

이상일 (울산대학교 의과대학 교수)
최병호 (건강보험심사평가연구소 소장)
정형선 (연세대학교 보건행정학과 교수)

Session II

Health Care Financing and Cost-Containment in Selected Asian Countries

건강보험재정과 비용절감방안에 대한 국제 세미나 4th

Japan’s health care financing and cost-containment

- Etsuji Okamoto

Japan's health care financing and cost-containment

Etsuji Okamoto
(National Institute of Public Health)

History

- 1922 Health Insurance Act
- 1938 National Health Insurance Act (+MHW)
- 1961 Universal coverage
- 1973 Free care for the elderly, copayment cap
- 1983 the Elderly Health System
- 1988 Skilled Nursing Facilities
- 1990 Per diem reimbursement for geriatric hp
- 1991 Independent visiting nursing station
- 2000 LTCI

Current status

- ***Fragmented*** insurers (similar to Korea before 2000)
  - 1,497 corporate-based Health Insurance Societies
  - 167 trade-group-based National Health Insurance Societies (NHI societies)
  - 1,788 municipal NHI (cities, towns and villages)
  - 77 Mutual Aid Associations (MAA) for civil servants
  - the giant Japan Health Insurance Association (JHIA) covering small-medium corporations
- Separate insurance system for the elderly >75yo
  - administered by Federation of municipal governments at prefectural level (N=47)
- LTCI
  - administered by municipal governments (N=1,788)

Premium structure

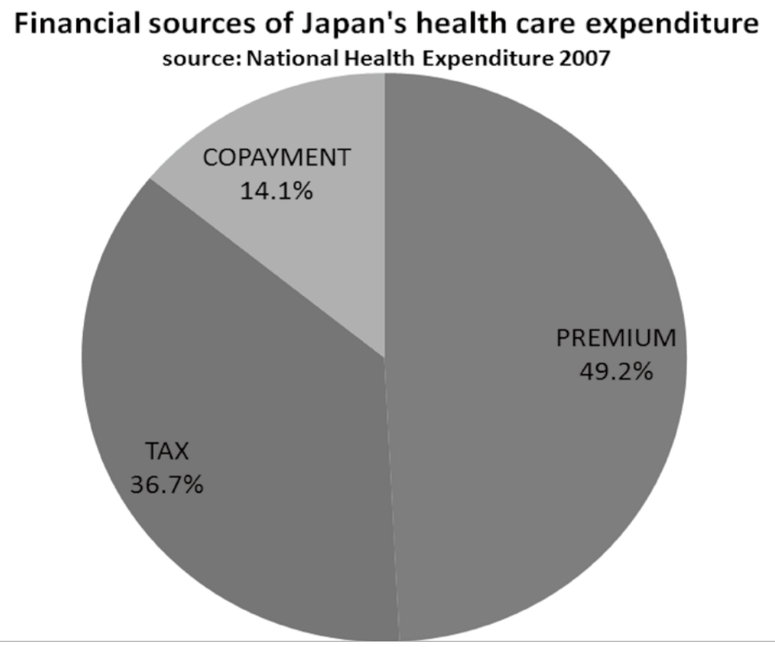
- Employees' health insurance
  - fixed % of monthly wages (up to 1.21 million yen) + bonuses (up to 5.4 million yen/year)
  - ex. JHIA:9.5% (+1.5% LTCI for >40yo)
  - ***NOT RELATED TO N of family***
  - ***Working couple will pay double premium***
- Municipal NHI
  - fixed % of annual ***household*** income + fixed premium/beneficiary (+ real estate tax in some cases)
  - ex. Osaka city: 11.4% of annual income + 25564yenXN +43895 yen (3 million yen, 4 family->488,151 yen/year)

    capped at 560,000 yen/household

Government subsidy

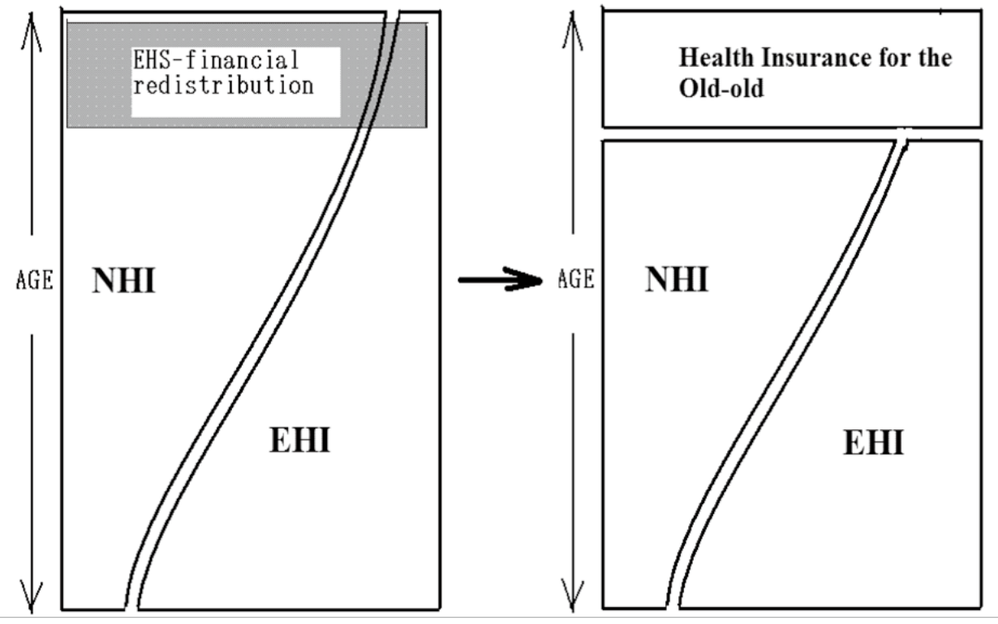
- means-tested Livelihood Protection---100% from tax (government: municipality=3:1)
- NHI and HCSO---approximately 50% (HCSO also receives 40% of benefit payout from all insurers)
- JHIA---16.4%
- corporate-based HIS and MAA---no subsidy and exclusively financed from premium revenue

Financial sources

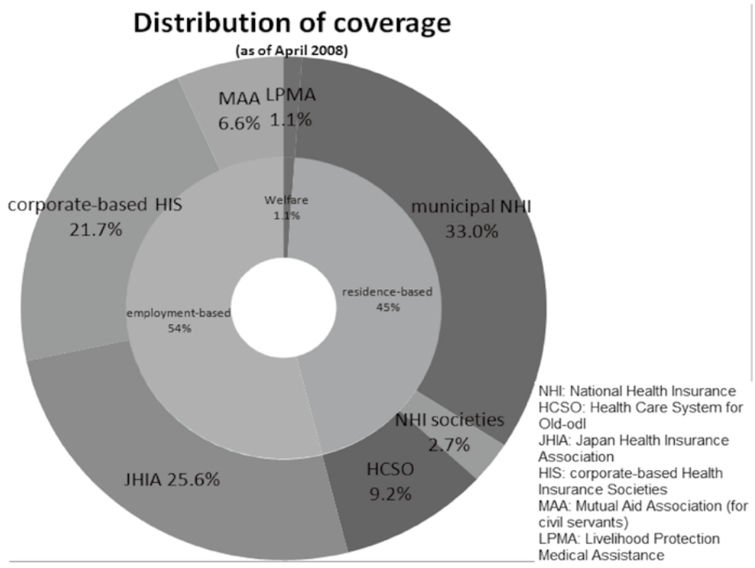


2008 Reform

Establishment of the Health Insurance for the Old-old in 2008



Distribution of coverage



Claims processing and reimbursement

Claims review

- Two kinds of Claims Review & Reimbursement Organizations in each of 47 prefectures
  - Social Insurance Payment Fund (SIPF)
  - Prefectural Federation of NHI (PFNHI)
- Providers submit claims to the CRRO in their prefecture
- Each CRRO has Claims Review Committee
- 10,750 administrative staff, 8094 reviewers (MD, dentists, pharmacists)
- denial rate:0.2% for SIPF, 0.1% for PFNHI

Oversight and regulation against fraud and abuse

- 8 regional branch of MHLW, 123 medical G-men
- 1) individualized guidance for potential inappropriate charges and practices: 3,410 providers
- 2) disciplinary actions in the form of cancellation of contracts (de facto expulsion from medical practices) : 69 providers
- 3) criminal prosecution against severe fraud cases
- 3.67 billion yen returned to insurers

Computerization of health insurance claims

- LTCI claims was electronically submitted since 2000
- Lagged behind but was enhanced by the initiative by Koizumi administration in 2005
- Full computerization was almost achieved by March 2011
- reduction of administrative cost

An example of effective use of claims data by insurers: Kure city, Hiroshima

- 1) drug cost containment through promotion of generic drugs
  - >60% switched to generic July 2008-March 2010
- 2) secondary and tertiary prevention of lifestyle-related diseases
- 3) guidance against “doctor-shopping”
  - 80,550 yen/patient
- 4) detection of multiple/duplicate medication
  - duplicate in 2.7%, adverse interaction 6.4%

Policies for cost-containment

Cost containment under the Koizumi administration

- Koizumi administration (26 April 2001-26 September 2006)
- the Central government reform (January 2001)
  - Merger of MHW and M of Labour→MHLW
- Economic and Fiscal Advisory Council (EFAC)
  - including the group of four civilian members (economists, entrepreneurs)
  - neo-conservative orientation

Tug-of-war over the macro-management

- On 15th February 2005, the group of four proposed "macro management of health care *benefit*" to control the growth of health care cost at the EFAC.
- Their proposal was to contain the health care ***benefit (=total health care cost – patients copayment. patients copayment accounts for approximately 15% of the total health care cost on average)*** by pegging it at a certain % of GDP.
- it was projected that the health care *benefit* would grow from 5.4% of GDP in 2006 to 6.4% in 2015 and 7.7% in 2025. They proposed that the growth of health care cost should be contained at 5.7% in 2015 and 5.8% in 2025 after considering the population ageing.

Cost-containment through health promotion

- On 18th March, MHLW submitted a simulation at another meeting. According to the simulation, the health care cost would be reduced by 1.6 trillion yen through health promotion and 1.7 trillion yen through reduction of length of stay by 2015, 2.8 trillion yen and 4.9 trillion yen by 2025 respectively.
- These simulations translated into the projected health care cost at 6.4% of GDP in 2015 and 7.7% in 2025.

Computerization of claims and the national database

- The new IT Strategy published in January 2006 declared an explicit goal of full computerization of claims within five years (i.e. by March 2011) and, more importantly, proposed a national database.
- It states "Streamline the administrative cost of health insurance through full computerization of claims by no later than early FY2011 and contain the national health cost through prevention and epidemiological use of the claims database.
- The new national database must be instituted by FY2010".

Health Care Cost Containment Plan (HCCCP)

- 1) All 47 prefectures shall develop five-year HCCCPs starting in FY2008 (-FY2012).
- 2) The HCCCP shall include the following policies
  - Health checkups and guidance (HC&G) against metabolic syndrome
  - Reduction of hospital length of stay through conversion of geriatric hospital beds
  - Disease-oriented critical paths for diabetes, strokes, myocardial infarction and cancer
  - Interim and final evaluation (to be conducted in FY2010 and 2013 for the 1st plan 2008-12)
- 3) The MHLW shall collect anonymized data for the purpose of development, implementation and evaluation of HCCCP.

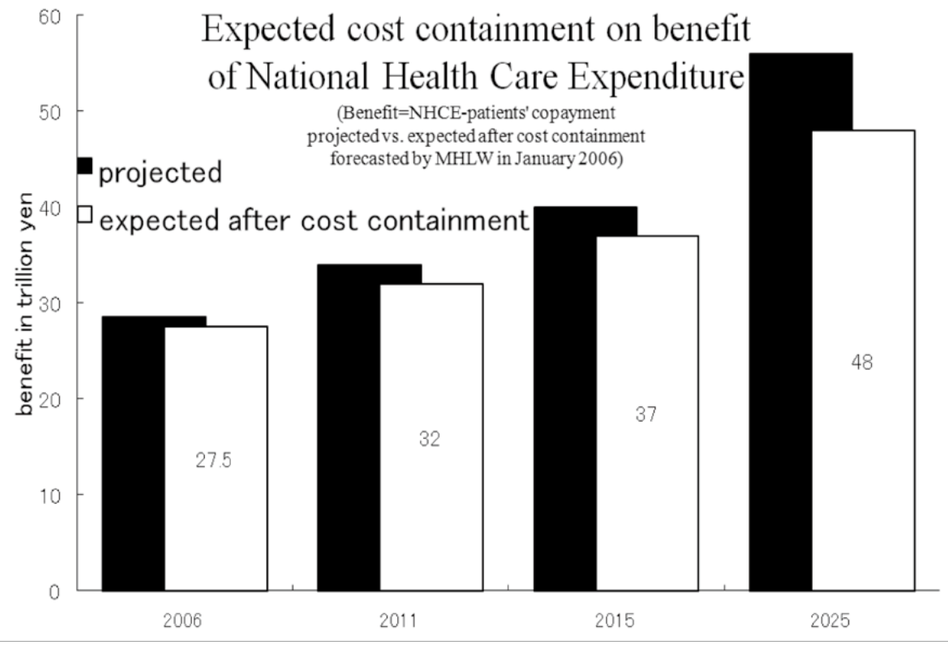
Reduction of hospital length of stay through conversion of geriatric beds

- 380,000 geriatric beds in 2006, of which 250,000 were health insurance beds and 130,000 were LTCI beds.
- Through the five years of HCCCP (FY2008-12), the former would be reduced to 150,000 and the latter would have gone. A total of 230,000 geriatric beds would have to be converted.
- It was targeted that the average LOS in 2012 would be reduced to 29.8 days according the goal set by MHLW (31.3 days in 2009, interim evaluation)

Prefectural HCCCPs and saving from conversion of geriatric beds

- The combined sum of 42 prefectures: 28.6 trillion yen in 2008 was projected to be 32.6 trillion yen in 2012 (the last of five year period) but would be reduced to 31.9 trillion yen as a saving effect of HCCCPs or 0.7 trillion yen (2.2%) saving (author's calculation). The final evaluation for the period of 2008-12 will be conducted in FY2013.
- The interim evaluation by MHLW showed that the number of geriatric hospital beds had been considerably reduced from 352,000 beds in October 2006 to 320,000 in July 2009 contributing the reduction of LOS of the entire hospitals beds from 32.2 days in 2006 to 31.3 days in 2009.

Cost-containment effect of HCCCPs



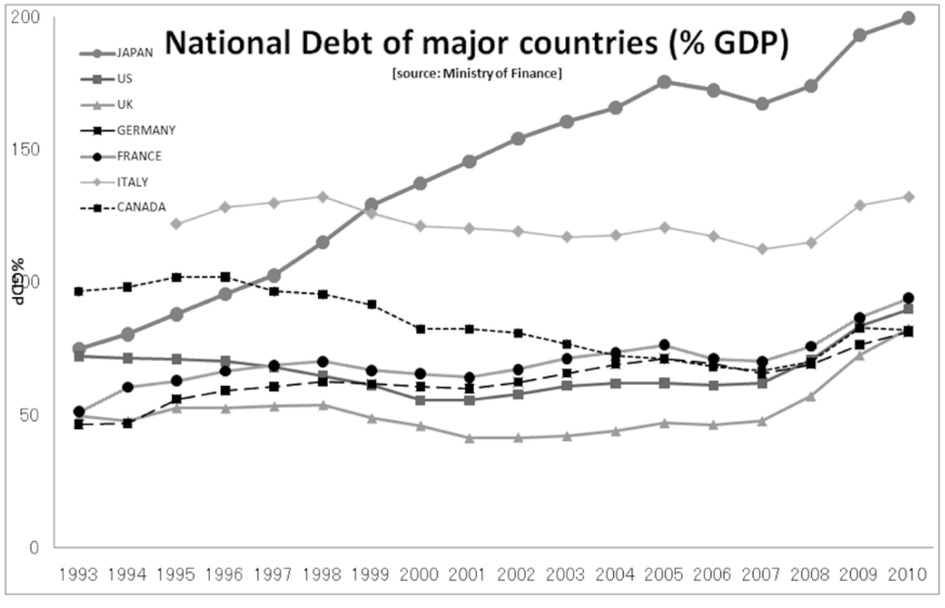
IT initiatives for cost-containment by the Livelihood Protection

- MHLW conducted a sampling survey on LPMA claims to detect duplicate or multiple medication of psychiatric drugs.
- They sampled claims from psychiatric hospitals or clinics identifying 2,555 patients. Of them, 1,797 or 70.3% were judged inappropriate medication.

- 1) double-checking of electronic claims
- 2) detection of duplicate or multiple medication of psychotropic drugs
- 3) enhancement of generic products

What's ahead?

Potential financial catastrophe?



Koizumi's fiscal policy 2006

- neo-conservative ("rising-tide" faction)
- target: achieving positive primary balance by 2011.
- reduction of expenditure before raising tax
- temporary relief of accumulating national debt (new bond issuance was <20 trillion yen in 2007)

The present Democratic Party

- social security is sanctuary
- introduction of children allowance (2 trillion yen)
- 44.3 trillion yen new debt vs. 37 trillion tax revenue
- (FY2010 and 2011...)
- low interest rate (<1% for 10 year bond in 2010) despite downgrading of JGB
- PM Naoto Kan set a fiscal policy to achieve positive primary balance by 2020.

The social security reform plan (2 June 2011)

- increase consumption tax 5%->10% by 2015
- cost-containment of health and LTC cost through IT (exemplify Kure city, disease management similar to LPMA): prevention, effective integrated care, detection of duplicate medication, generic use, etc....
- What will be in 2015? Healthier Japan?....Or Japan under the IMF control!?

Japan's health care financing and cost-containment

- Etsuji Okamoto

(National Institute of Public Health)

I. A brief history

Japan's Health Insurance Act was enacted in 1922 to cover the manual workers of large factories, being much inspired by the Bismarck-model German social insurance system. Unfortunately, its implementation was postponed to 1927 due to the big earthquake devastating Tokyo in 1923. The Health Insurance Act, covered only employed workers of large factories and the non-employed population such as farmers and fishermen were left uncovered. The other insurance system, the National Health Insurance (NHI) Act was enacted in 1938 to expand the coverage to the non-employed population. The new act, however, was not a product of the popular demand. Rather, it was created by a top-down order from the army together with the establishment of Ministry of Health & Welfare (MHW), the National Mobilization Act, both of which were enacted at the same time (NIPH was also established at the same time). The National Mobilization Act was abolished but the two laws; Health Insurance Act and NHI Act serve as two distinct pillars of Japan's health insurance system.

The NHI system failed to achieve universal coverage when it was enacted in 1938 because the NHI program was operated by voluntary societies (NHI societies) and not all municipalities had such voluntary societies. In the post-war era, the NHI Act was further amended to make municipal governments (cities, towns and villages) responsible for operating the NHI programs for their residents. Gradually more and more municipal governments started the NHI programs and in 1961 the universal coverage was eventually

achieved. Many NHI societies disbanded after all municipal governments started the NHI programs but some NHI societies, many of which enroll relatively affluent professionals such as doctors, lawyers and construction workers, remained till today (there are 167 NHI societies enrolling some three million people).

Financing the elderly care has been an Achilles heel of Japan's fragmented health insurance system because the rates of the elderly enrollment vary considerably among insurers. Employees' health insurance has the lowest elderly enrollment while municipal NHI has the highest elderly enrollment (% of the elderly population over 70 years old was 11.4% of the population in 2006 but 22.9% for NHI and 2.1% for corporate-based health insurance societies). How to balance this inequality of elderly enrollment to sustain NHI has always been at the center of health policy debate. A total unification of all insurers is an obvious and ultimate solution, as Korea achieved in 2000, but has not been feasible.

In January 1973, the Elderly Welfare Act was amended to subsidize copayment of health insurance for the elderly >=70 yo. At that time, the "free" care was simply viewed as a symbol of welfare state. Although, post-war Japan has been governed by conservative parties, many local governments were dominated by left-winged parties, which emphasized social welfare. The year 1973 was later called "the first year of welfare state" but the timing was bad. The "oil shock" in October of the year plunged the entire economy into recession while the health care cost for the elderly skyrocketed with no copayment. The increase of the elderly health care cost strained NHI most. A call for some form of financial redistribution mechanism balancing the inequality of elderly enrollment became louder and louder.

Another important reform in 1973 was the introduction of "copayment cap", beyond which the excess copayment would be refunded from insurers upon request. This was good news for chronic disease patients who incur high copayment, namely dialysis, a new technology which became available in late 1960s. Thanks to copayment cap, renal failure patients were able to sustain their lives without fear of financial catastrophes, as had often seen before. Now Japan is known with the highest number of dialysis patients per population (300,000 or over every 427 people).

In 1983, the Elderly Care Act was enacted to create the Elderly Care System (ECS) as a financial redistribution mechanism. The ECS alleviated financial burden of NHI considerably (though not entirely). After the ECS, concerns grew over the quality of the elderly care. Boosted by the ECS, many hospitals were constructed to fill the shortage of nursing homes, which was financed by the Elderly Welfare Act and had always been restricted by budgetary limitations. Since health insurance reimburse on a fee-for-service (FFS) basis, the elderly patients were subject to excessive and medically unnecessary treatment (for example, fed by transfusion even if patients can eat). Also, some of geriatric hospitals did not have rehabilitation services and many elderly disabled patients might have missed the opportunities for recovery. In 1990, as a radical departure from the traditional FFS, the first per-diem reimbursement was introduced to geriatric hospitals paving a way to the present LTCI reimbursement system.

Welfare services and LTCI

As the population grew older, concerns shifted from health care to long-term care or other social services. While economic burden for health care was much alleviated for the elderly, non-medical services such as nursing homes or domestic help were out of coverage of health insurance. In 1988, the Skilled Nursing Facilities (SNF) was created as intermediate facilities between hospitals and nursing homes which were reimbursed from the ECS. The SNFs were required to have enough rehabilitation facilities to ensure recovery of the disabled elderly. At the same time, visiting nursing services were included in the ECS benefit, and later in 199, independent visiting nursing stations were introduced. For the very first time, nurses were allowed to practice on their own though under supervision and prescription of doctors.

In 1990s, interests grew over how LTC should be financed. There was much debate over whether LTC should be financed from tax (Nordic model) or by social insurance (German model). The introduction of LTCI by Germany in 1995 influenced Japan to follow the social insurance model and the LTCI took effect in April 2000. Japan's LTCI is in many respect different system from health insurance and some of geriatric care covered by ECF (SNFs, visiting nursing services and part of geriatric beds) was transferred from health insurance system.

After the new LTCI firmly in place, health policy turned to the elderly care again. In April 2008, as part of the "Health Care Structural Reform", the ECS was transformed to the new Health Care System for the Old-old (HCSO). The crucial difference was the eligibility age: the ECS covered the elderly >=70 while the new HCSO covered those >=75. Another difference was that while the ECS was a financial redistribution mechanism among existing insurers (i.e., the elderly continued to be enrolled to the same insurers with their family members); the HCSO is a totally separate independent insurers. The new HCSO turned out to be very unpopular because the elderly had to pay premiums withheld from their pension (before, premiums were collected from an entire household). The term "old-old" sounded derogative to the elderly. The Democratic Party, in the general election in August 2009, promised the abolishment of the HCSO in their manifest. After the change of administration, a debate going on what the next new system should be. The debate appears to go nowhere, the future of the present HCSO is quite uncertain.

As for welfare services, the Poor Law was enacted in 1929 to help the indigent population after the world recession but the benefit was limited. In the post-war era, the Poor Law was revised to become the Livelihood Protection Act urged by the American occupation army. The Livelihood Protection Act is a means-tested welfare services and financed exclusively by tax. The benefits include medical assistance (LTC assistance was added in 2000 simultaneously with the introduction of the LTCI). The number of beneficiaries of the Livelihood Protection declined in and around 1990 when Japan's economy was in a good shape but increased since then thanks to the long economic slump. Currently approximately two million (1.56%) of the population are beneficiaries, of whom 80% are receiving medical assistance. The medical assistance is gaining importance in terms of the national finance.

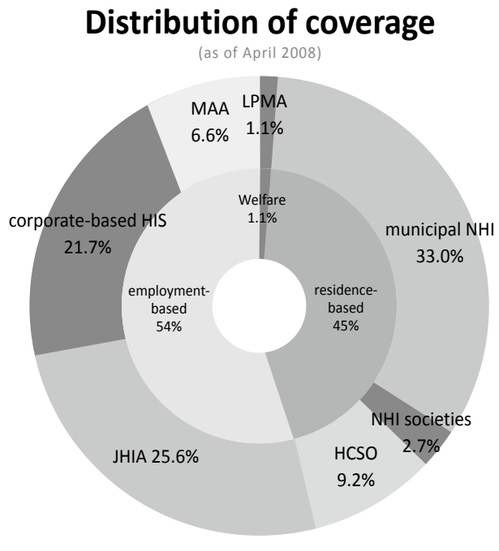
2. Current status

Japan's health insurance is fragmented but universal and compulsory. The distribution of coverage by categories of insurers of the population (128 million) is shown below. Municipal NHI is operated by 1,788 cities; towns and villages, corporate-based Health Insurance Societies consist of 1,497 societies and Mutual Aid Associations (MAA) consist of 77 societies in March 2009.

For employed workers, their employers will enroll them automatically upon employment and collect premiums by withholding from their pay checks. The premium rate for employees of small-medium corporations insured by Japan Health Insurance Association (JHIA, transferred from the Social Insurance Agency in 2008 as part of the reform) is currently 9.5% (for beneficiaries >=40 yo, 1.5% premium for LTCI will be added. Up to maximum annual income of 20 million yen). In addition to health insurance, the premium for pension will also be applied (16%. Up to the maximum of 10 million yen). The combined rate of health, LTC and pension will be 27% to be shared equally between employers and employees, i.e., the workers will receive paycheck deducted by 13.5%. Tax (national and local) will also be deducted. Roughly speaking, workers will receive paychecks at least 20% less than pro-forma basis.

For those who are not employed (self-employed, elderly retirees, unemployed, farmers and fishermen, etc.) will be AUTOMATICALLY (without any procedures) enrolled to municipal NHI where he or she resides. Enrollment is compulsory and if he or she fails to take procedures for enrollment, premiums may be levied retrospectively for up to two years (some foreign residents are exempt from the compulsory enrollment, namely the U.S., France, the Netherland and Belgium citizens who reside in Japan for less than five years pursuant to the mutual treaties. Japan also has treaties with Korea and Germany but they apply only to pension). Part-time workers whose working hours are less than 3/4 (<30 hours/week) of full time workers are currently exempt from employees' health insurance but the exemption is planned to be reduced to half (<20 hours/week) to expand the coverage of employees' health insurance.

Premium schedule of municipal NHI is complicated and vary widely among cities, towns and villages. The premium is levied on household based on the combined annual income and the number of household members. In case of Tokyo 23 wards, annual premium in FY2011 will be 8% of annual income plus 40000 yen/member with a cap of 650,000 yen/year/household.



Health insurance should be financed primarily from premium contributions. However, NHI and JHIA cannot finance themselves by premium contribution alone and is sustained by ample subsidies from the government. JHIA receives 16.4%, NHI and HCSO receive on average half and LPMA receives 100% of their health care benefit as subsidies from the government. Such subsidies to health insurance and livelihood protection amounted to 9 trillion yen or approximately 10% of the total governmental budget of 92 trillion yen in FY2010.

Viewed from the national health care cost, subsidies from the government constitute 1/4 of the national health care cost (36 trillion yen in 2010). When subsidies from both the central and local governments combined, it accounts for 1/3 of the national health care cost (premium contribution accounts for half and the rest (approximately 16%) are patients' copayment).

3. Claims processing and reimbursement

Providers (hospitals, clinics and pharmacies) collect copayments (10-30%) from patients every time the patients visit them (or upon discharge for hospitalization). Providers submit claims for every calendar month by 10th of next month to claims review & reimbursement organizations (CRROs) in the prefecture. CRROs have the "Claims Review Committee" authorized to review claims and deny (or increase as the case may be) part of the claims. After claims are reviewed CRROs will reimburse the rest of the claims (70-90%) to providers by around 20th of the second month after the claiming month. CRROs collect "deposits" from insurers by around 10th of every month, i.e., CRROs keep the deposit in their bank account for 10 days. Given the sheer amount of money, such a short term deposit will bring in handsome interest revenue to CRROs even under the low interest rate.

There are two kinds of CRROs: the Social Insurance Payment Fund (SIPF) and the Prefectural Federation of NHI. The SIPF is a national public corporation with prefectural branches in all 47 prefectures. It was established in 1948 pursuant to the SIPF Act. Before the establishment of SIPF, the health insurance was unpopular among doctors and with good reasons: 1) the price was regulated intentionally lower than private patients, 2) the doctors bore administrative burden of mailing out many claims to multiple insurers and, above all, 3) the reimbursement tend to be late and sometimes defaulted.

A solution to 2) and 3) was to establish a fund which collects deposits from insurers to facilitate timely reimbursement and also serve as a "clearing house" of claims processing. With SIPF, doctors have only to submit all the claims to a single SIPF branch in the prefecture and the claimed fee is guaranteed to be reimbursed by the specified time.

○ Claims review

Also, the SIPF was endowed with another important function: claims review. By law, the "Claims

Review Committee" is established in each prefectural branch and authorized to review all claims and deny part of the claims. The number of reviewers is in the multiple of three, representing three parties: provider association such as medical and dental associations, insurers and public interest. Officially, no qualification is required for reviewers but practically all are doctors, dentists and a small number of pharmacists.

Although the three party equal representations may appear reasonable, the selection of reviewers is not much based on their merits but more influenced by provider associations. Therefore, one might assume that claims review is a form of "peer review" and function as a tool for self-governance of medical and dental associations.

The claims review is a form of corporatism between the often-conflicting providers and insurers. The transaction fee (approximately 110 yen per claim) is paid wholly by insurers and economically reviewers appointed by provider associations will work in the interest of insurers (they are expected to deny the claims rather than increasing them).

SIPF handles all claims EXCEPT those for NHI. Claims for NHI are handled by another CRRO: the Prefectural Federation of NHI (PFNHI) established in each of 47 prefectures pursuant to the NHI Act. The PHNHIs essentially function in a similar manner to SIPF: they maintain deposit and reimbursement and also have the "Claims Review Committee" with the same authority with SIPF.

Currently, SIPF have 5,250 full time staff and PHNHIs have a total of 5,500 full time staff, a total of 10,750 full time staff are engaged in claims processing and review. In addition to these administrative staff, SIPF have Claims Review Committees with a total 4,479 reviewers (3,719 doctors, 760 dentists and 56 pharmacists) and PFNHIs a total of 3,615 reviewers (2,969, 542 and 104 respectively), many of whom are part-time but some are full-time employees. Both CRROs are public corporations but their staff as well as claims reviewers are NOT civil servants, i.e., they are immune to legal restrictions (such as anti-bribery, corruption rules) on civil servants. Claims reviewers carry criminal penalty against violation of confidentiality but such legal responsibility was not imposed on administrative staff until the revision of the SIPF Act in 2008.

SIPF handles 583 million medical and dental claims and 247 million pharmacy claims (a total of 830 million claims in FY 2008) in the amount of 12.6 trillion yen. Through claims review, approximately 0.2% of claims were denied payment or approximately 23.2 billion yen. In November 2009, shortly after the overwhelming victory of the Democratic Party in the general election, the new Democratic administration appraised the cost-effectiveness of many existing policies and the claims review by SPIF was targeted. The appraisers questioned if this amount of denial is cost-effective given the transaction cost incurred, 86.8 billion yen (denial rate of PFNHIs was even lower: 0.1%).

Argument against the cost-effectiveness analysis would be that "Claims review is to assure the appropriateness of the claimed charges and its effectiveness should not be evaluated by the cost-denial rate alone". Two standards by which the appropriateness is reviewed are: 1) the practicing rules of health insurance and 2) the fee schedule dictated by the Minister. The important aspect of the claims review is that it is NOT intended to evaluate the quality of care nor is it intended to improve it. This is a crucial difference from Korean HIRA, which is endowed with quality assessment of providers by law.

○ Oversight and regulation against fraud and abuse

Monetary matters involve fraud and abuse (F&A). Fraud and abuse in health insurance practices will lead to disciplinary actions in minor cases (abuse) and to criminal prosecution in malicious cases (fraud). Almost all providers (approximately 170,000 hospitals, clinics and pharmacies) have contractual agreement with the MHLW and hence under the oversight and regulation by the MHLW. MHLW has eight regional branches authorized for oversight and regulation for health insurance.

Oversight and regulation include 1) individualized guidance for potential inappropriate charges and practices, 2) disciplinary actions in the form of cancellation of contracts (de facto expulsion from medical practices) and 3) criminal prosecution against severe fraud cases. In FY2008, a total of 3,410 providers received individualized guidance. In such cases, providers may be acquitted by voluntarily returning inappropriate charges. A total of 3.67 billion yen was voluntarily returned to insurers by the providers. If the same inappropriate charges are repeated despite individual guidance or the cases are found to be fraudulent, disciplinary actions will be taken. In FY2008, a total of 69 providers were disciplined, in many cases leading to cancellation of contracts.

F&A may be detected through claims review or may be exposed by complaints from patients or whistle blowing from insiders. Insurers are encouraged to send statements of processed claims to patients (the data included in the statements are limited to the number of visits, the name of the providers and the total amount of reimbursement and do not include medical information such as diagnoses or name of drugs). Obvious frauds such as inflating the number of visits may be detected by complaints from patients receiving such statements.

To perform this task, a total of 123 medical (73) and dental (50) doctors are employed at the MHLW regional branches. However, 32 out of 73 medical, and 3 out of 50 dental positions are vacant according to the report by MHLW. Those medical and dental officers are called "Medical G-men" and are similar in status with other medical officers working for MHLW and public health centers. The high rate of vacancy may reflect the unpopularity of the task among doctors and dentists.

There is no quantitative analysis how much cost containment effects these oversight and regulation have on the national health care expenditures. It may have some effects because providers whose the average charges per claim are ranked within top 4% of each specialty will be subject to individualized guidance by G-men.

○ Computerization of health insurance claims

Japan lagged behind in terms of computerization of health insurance claims. Only 10% of medical and approximately half of pharmacy claims were submitted electronically in April 2005, when Korea had already achieved nearly 100% computerization. The then Koizumi administration, much inspired by Korean success of computerization of health insurance claims and their use of the data for cost-containment, declared a full computerization of health insurance claims within five years in its IT strategy published in January 2006. The goal was achieved in April 2011 and the use of computerized claim is hoped to provide an effective tools for cost containment.

The immediate cost-containment effects of computerization are on the administrative cost. When claims were in paper form, all claims were manually reviewed by claims reviewers and administrative staff who support them. The combined number of administrative staff of SPIF and PFNHIs of 10,750 and claims reviewers of 7,976 is quite large when one compares it with 1,730 administrative staff and 630 reviewers of Korean HIRA at the end of 2008 even after the population size taken into consideration. Still, the number of staff in charge of claims processing of PFNHIs has declined considerably from 3,651 in 2004 to 3,026 in 2010 reflecting the on-screen reviewing system. SIPF also reduced the handling charges on a claim from the high of 119 yen in 2004 to 110 yen in 2009.

○ Use of electronic claims data by insurers

Claims reviewed and process by SIPF will be sent to individual insurers. Then insurers will be able to analyze the data on their own. Unfortunately not many insurers seem to be effectively using the data possibly because of lack of analytical skills to handle large and complicated dataset as health insurance claims. Still, some pioneering insurers effectively use the electronic claims data for not only cost-containment but also for health promotion or disease management.

One of the examples is the Kure city in Hiroshima prefecture. The Kure city, with the help from an IT company, used the claims data for the following purposes: 1) drug cost containment through promotion of generic drugs, 2) secondary and tertiary prevention of lifestyle-related diseases, 3) guidance against "doctor-shopping" and 4) detection of multiple/duplicate medication. As for 1), the city analyzed pharmaceutical claims to detect patients receiving brand-products and inform them of the potential saving by switching to generic products. Consequently, over 60% of those who received the notice switched to generic product thereby saving the balance for both patients and the city. As for 3), the city listed up patients who visit multiple providers for the same diagnoses or visit doctors so many times and provided face-to-face interviews. Consequently, a total of 23 patients were interviewed resulting in a total of 432,229 yen in one month (the maximum reduction per person was 89,220 yen). Also, a total of 80 patients were interviewed for excessive doctor visits resulting in the reduction of 80,550 yen/patient.

As for 4), data mining of pharmaceutical claims revealed duplicate medication in 2.7% and adverse drug interaction in 6.4% and contraindication in 0.3%.

4. Policies for cost-containment

○ Cost containment under the Koizumi administration

The Koizumi administration (26 April 2001-26 September 2006) is remembered as the 3rd longest administration in the post-war Japan (5 years and 5 months) with strong leadership and popular support (the >80% support rate after its inauguration is unsurpassed). It also left important footsteps in the field of social security. It is also noteworthy that Japan's administrative system underwent a radical reform shortly before Koizumi took office. In January 2001, the government structure was reformed to enable Koizumi to exert his strong leadership.

As part of the reform, some ministries merged. The Ministry of Health & Welfare merged with the Ministry of Labour to make the present Ministry of Health, Labour & Welfare (MHLW). The central government reform did not stop there. To support the cabinet, the Economic and Fiscal Advisory Council (EFAC) was set up. EFAC is chaired by the prime minister but the members included four civilians who express their opinions from a free standing. The civilian members consist of executives of major corporations as well as university professors of economics. The EFAC under Koizumi administration was dominated by Neo-conservative economists who emphasize market economy and deregulation. The group of four occasionally collided with medical association by proposing radical reforms such as deregulation to allow for-profit corporations to manage hospitals.

○ Tug-of-war over the macro-management

On 15th February 2005, the group of four proposed "macro management of health care benefit" to control the growth of health care cost at the EFAC. Their proposal was to contain the health care benefit (=total health care cost – patients copayment. patients copayment accounts for approximately 15% of the total health care cost on average) by pegging it at a certain % of GDP. At that time, it was projected that the health care benefit would grow from 5.4% of GDP in 2006 to 6.4% in 2015 and 7.7% in 2025. They proposed that the growth of health care cost should be contained at 5.7% in 2015 and 5.8% in 2025 after considering the population ageing.

To this, both MHLW and Japan Medical Association opposed claiming that "health care cost is not something to be limited by economic growth". For MHLW, the proposal from the "Koizumi economists" was a déjà-vu because MHLW itself once proposed a similar plan back in 2002 but had to be withdrawn due to strong opposition from medical community. To counter the strong voice of EFAC backed by the cabinet, MHLW had to present an alternative. The then vice-minister of MHLW was a great fun of fitness

and prevention and a strong believer in the long-term cost-containment effects of health promotion. On 19th February, at a public speech, the vice-minister emphasized the potential of cost containment through health promotion while criticizing the macro-management by the EFAC.

On 18th March, MHLW submitted a simulation at another meeting. According to the simulation, the health care cost would be reduced by 1.6 trillion yen through health promotion and 1.7 trillion yen through reduction of length of stay by 2015, 2.8 trillion yen and 4.9 trillion yen by 2025 respectively. These simulations translated into the projected health care cost at 6.4% of GDP in 2015 and 7.7% in 2025. This simulation fell short of the proposal of macro-management but did suggest the potential of cost-containment through health promotion. Eventually, the staunch Koizumi economists backed down without pursuing their cause further.

After the dismissal of the macro-management proposal, Japan's health care reform began to center around the cost-containment through primary prevention of "lifestyle-related disease". Elsewhere, on 8th April, the assembly of the association of internal medicine was held in Osaka, which adopted the concept and definition of "metabolic syndrome" including the much publicized criteria of the waist size: 85 cm for men and 90 cm for women. Although the adoption of metabolic syndrome had no official relationship with the policy debate, MHLW jumped over this popular, new and authoritative idea and introduced "metabolic syndrome" as a key concept of the subsequent reforms.

○ Computerization of claims and the national database

Shortly after the group of four proposed the macro-management, the IT Strategic Headquarter (ITSHQ) of the cabinet published an interim evaluation of IT development. At the same time of the central government reform in 2001, the IT Promotion Act was enacted with an ambitious plan to make the country "the top-level IT country" and the ITSHQ was established to oversee all branches of the government. The originally set goal in health care field was: 1) >50% of hospitals claims are electronically submitted by 2004 and >70% by 2006, 2) >60% of hospitals with >=400 beds will have electronic health record (EHR) by 2006. The interim evaluation was encouraging in some field but disappointing in others. Particularly disappointing was in health care field. Computerization of claims was far from the targeted goals and lagged behind neighboring countries. Korean success in computerization of claims as well as development and effective use of the national database also provided motives.

The new IT Strategy published in January 2006 declared an explicit goal of full computerization of claims within five years (i.e. by March 2011) and, more importantly, proposed a national database. It states "Streamline the administrative cost of health insurance through full computerization of claims by no later than early FY2011 and contain the national health cost through prevention and epidemiological use of the claims database. The new national database must be instituted by FY2010". The timeline was set.

This decisive policy decision was also boosted by the overwhelming victory of the Koizumi administration in the general election in September 2005. An official of the ITSHQ later confessed to a press interview that he had felt a "move" when PM Koizumi stated that "computerization of claims must be realized" at the ITSHQ meeting on 25th October. Actually most of the important policy decisions were made in a short time around the end of 2005. This fact amply evidences the importance of strong leadership and timeliness in any policy decisions.

○ Health Care Cost Containment Plan (HCCCP)

Development of a national database (NDB), cost-containment through prevention metabolic syndrome, and reduction of hospital length of stay....these agenda must be instituted as a form of law. They were instituted as a form of revision of the Elderly Care Act to a new name: the Elderly Health Care Security Act. The new law includes provisions on Health Care Cost Containment Plan (HCCCP) as follows.

1) All 47 prefectures shall develop five-year HCCCPs starting in FY2008 (-FY2012).

2) The HCCCP shall include the following policies

- Health checkups and guidance (HC&G) against metabolic syndrome
- Reduction of hospital length of stay through conversion of geriatric hospital beds
- Disease-oriented critical paths for diabetes, strokes, myocardial infarction and cancer
- Interim and final evaluation (to be conducted in FY2010 and 2013 for the 1st plan 2008-12)

3) The MHLW shall collect anonymized data for the purpose of development, implementation and evaluation of HCCCP.

The last 3) constitutes the legal basis for the NDB. Essentially, NDB was created for the purpose of "development, implementation and evaluation of HCCCP". It is noteworthy that "research use" or "improvement of quality of care" is not explicitly stated as the purpose of NDB. Research use of NDB is based on the discretion of the MHLW leaving room for future revision of the law.

○ Reduction of hospital length of stay through conversion of geriatric hospital beds

Before discussing about HCCCP, one must understand a peculiar situation about geriatric hospitals beds. Japan has a total of 1.6 million hospital beds as of 1 October 2008 (there are also 146,568 beds in clinics with <20 beds in addition to hospitals) which are classified into three categories: general acute care beds (909,437 beds), psychiatric beds (349,321 beds) and geriatric beds (339,358 beds).

When the LTCI was introduced in April 2000, a peculiar arrangement was made about geriatric beds: hospital administrators chose to "separate" the geriatric wards into on reimbursed from health insurance and another from the LTCI. Consequently some geriatric wards remain exclusively health insurance

wards, some converted into exclusively LTCI wards many chose to be a “mix” of the two (such wards came to be called “care mix” wards). There is an institutional difference between the health insurance beds and the LTCI beds. The health insurance beds, as with as other forms of beds, can admit patients of any age and of any diagnoses at the order of doctors. The LTCI beds, on the other hand, can admit the elderly over 65 and was assessed as in need of care by outside assessors.

The average LOS of 33.8 days in 2008, which is broken down into 18.8 days for general acute care beds, 312.9 days for psychiatric beds and 176.6 days for health insurance geriatric beds and 292.3 days for LTCI geriatric beds. These LOS are much longer than the international standard suggesting inefficiency. Also, some research suggested that the case mix between two types of geriatric beds did not differ significantly despite a slight difference of LOS.

Geriatric beds were thus singled out as a target in HCCCP: abolishing the LTCI beds by March 2012 (the end of the 1st HCCCP) and reduction of the health insurance beds by then. Such abolishing and reduction will be achieved by “conversion” into less-costly nursing homes, group homes, care houses or home care. There were approximately 380,000 geriatric beds in 2006, of which 250,000 were health insurance beds and 130,000 were LTCI beds. Through the five years of HCCCP (FY2008-12), the former would be reduced to 150,000 and the latter would have gone. A total of 230,000 geriatric beds would have to be converted. It was targeted that the average LOS in 2012 would be reduced to 29.8 days according the goal set by MHLW

Targeting geriatric beds alone may be contradictory when one sees that the by far the longest LOS is in psychiatric beds. Actually, a committee reported back in 2004 that as many as 70,000 patients in 350,000 psychiatric beds are stable enough to be discharged and called for “normalization” of psychiatric care. Unfortunately the recommendation in 2004 has not been realized so far and reduction of LOS had to be attempted by conversion of geriatric beds alone.

○ Prefectural HCCCPs and saving from conversion of geriatric beds

By April 2008, all prefectures except one (Niigata prefecture) developed HCCCPs. Of 46 HCCCPs, 42 included the projection of future health care cost as well as potential savings by HCCCPs (notably, Tokyo, the largest prefecture, did not made future projection because they did not plan reduction of geriatric beds). The potential saving was estimated by the reduction of LOS due to conversion of geriatric hospital beds and did not include the saving from HC&G. It was based on the MHLW direction that prefectures did not have to consider the cost saving effects of HC&G because it would take long before the HC&G would take effect.

The combined sum of 42 prefectures: 28.6 trillion yen in 2008 was projected to be 32.6 trillion yen in 2012 (the last of five year period) but would be reduced to 31.9 trillion yen as a saving effect of HCCCPs or 0.7 trillion yen (2.2%) saving (author’s calculation). The final evaluation for the period of 2008-12 will be conducted in FY2013. The interim evaluation by MHLW showed that the number of geriatric hospital beds had been considerably reduced from 352,000 beds in October 2006 to 320,000 in July 2009 contributing the reduction of LOS of the entire hospitals beds from 32.2 days in 2006 to 31.3 days in 2009.

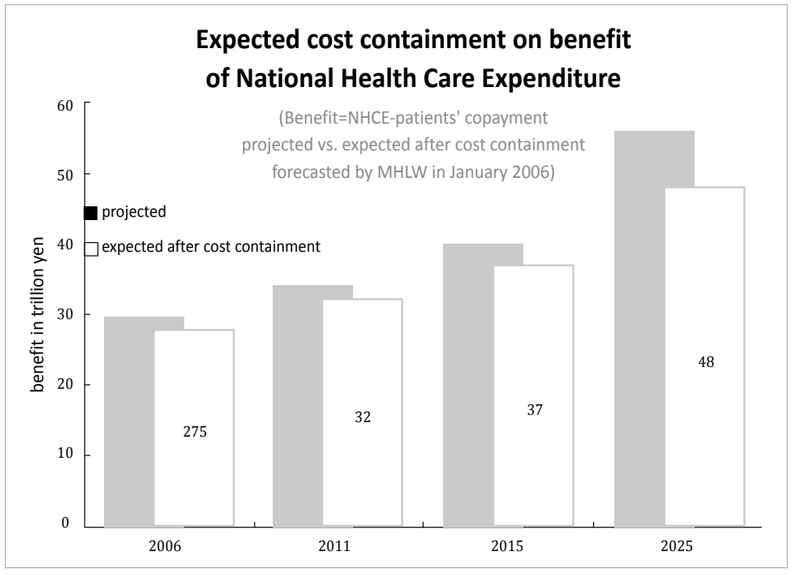
The fate of geriatric beds was twisted by the change of administration in 2009. The Democratic Party declared that “geriatric beds need not be reduced” in their manifest in the general election in August 2009. Following this policy change, MHLW had to put a “hold” on HCCCPs. The abolishment of LTCI beds will remain unchanged but the deadline will be postponed to 2018 from the current 2012. Whether the goal of average LOS of 29.8 days will be achieved by 2012 now appears uncertain.

○ Cost-containment effect of HCCCPs

Are we achieving the goal? To evaluate the cost-containment effects of HCCCP, one must first project the future health care cost without interventions. Because we cannot conduct controlled trials as researchers do for evaluation of drugs, the accuracy and reliability of the future projection will largely determine the results.

The initial simulation MHLW submitted on 18th March 2005 quoted its projection from the projection made by MHLW in May 2004: national health care cost (31.4 trillion yen in FY2004) will be 49 trillion yen in 2015, 69 trillion yen in 2025. It simulated that HC&G would save 1.6 trillion yen and reduction of hospital length of stay would save 1.7 trillion yen or a combined saving of 3.3 trillion yen in 2015 resulting in the total health care cost of 45.7 trillion yen in that year.

Later, MHLW altered the projection in October 2005: 46.5 trillion yen in 2015 and 65 trillion yen in 2025 with a combined saving of 2.3 trillion yen in 2015 resulting in the total health care cost of 44.2 trillion yen. This projection preempted the MHLW May 2006 future projection and remains valid till today. The revision of the future projection in only two years reflected the current economic situation. One is strongly cautioned that the future projections by government tend to err on the optimistic side. The projection made in October 2000 projected the National Income in 2010 as 490 trillion yen. Two subsequent projections in 2002 and 2004 put it as 414 trillion yen and the 2006 projection put the NI in 2011 at 433 trillion yen. As it turned out: the NI in FY2010 was 345.5 trillion yen (the economic outlook decided by the Cabinet on 24th January 2011). The overly optimistic future projection will exaggerate the cost-containment effects of any interventions. A problem concerning the revision of future projection is that it had no explanation why the expected cost-containment of HCCCP had also been reduced from 3.3 trillion to 2.3 trillion yen.



Where does the latest situation stands? The latest estimate put the health care cost in FY2010 at 37 trillion yen (the data is available only up to December 2010 and the author estimated the annual cost up to March 2011 by applying the same growth rate in other months). It appears that Japan's health care cost is growing slower than the originally projected and, even if population ageing will advance further, one can be comfortably certain that the health care cost in 2015 is not likely to exceed the originally projected 46.5 trillion yen.

This finding is remarkable when one considers the rapid population ageing as well as a sharp increase of LPMA recipients with ample evidence of fraud and abuse. The cost-containment effect of LOS was projected at only 0.7 trillion yen in 2012, a minor contribution particularly after the conversion of geriatric beds was halted in the middle of the five year plan period. Can one claim that HC&G is taking effect? Not necessarily.

The MHLW itself acknowledges that HC&G will not bring any savings during the first HCCCP period (2008-12). A systematic review by the author analyzing the results of controlled studies conducted on 31 municipalities during 2002-6 failed to demonstrate any certain cost-containment effects at least during one year after interventions. Rather, one should assume that the future projections were exaggerated. If projected based on age-sex specific population alone, the health care cost in 2015 will be 48 trillion yen and 2025 will be 50 trillion yen, far smaller than previous official projections. The original projection was exaggerated due to the overly optimistic economic growth (consumer prices, inflation, interest rate) while in fact Japan's economy has undergone a serious deflation for last few years.

5. IT initiatives for cost-containment by the Livelihood Protection

The nation-wide attempt of cost containment has just been started for the Livelihood Protection Medical Assistance (LPMA) for the indigent population. Due to the prolonged economic slump, the population receiving the means-tested Livelihood Protection has reached two million (1.5% of the population) recently, of whom 80% also receiving LPMA. The Livelihood Protection is financed exclusively from tax (shared by the central government and local governments by 3:1) and the total disbursement in FY2011 is budgeted at 3.4 trillion yen, of which LPMA accounts for about half. Unlike health insurance which usually requires 30% copayment, LPMA does not require any copayment and patients can receive medical care for free.

The LPMA has long been regarded as "sanctuary". In April 2008, the MHLW issued a notice requiring LPMA patients to be dispensed generic products whenever available for cost-containment. A strong public outcry followed forcing the then minister Masuzoe to revoke the notice shortly. Almost at the same time, the MHLW issued another notice restricting the transportation benefit for LPMA patients after a gang member in Hokkaido had received a sum of 2 million yen for taxi fare to visit clinics hundreds of miles away. Again, minister Masuzoe was forced to revoke it in response to protests.

The only government effort was to encourage municipal governments to double-check the LPMA claims by "contracting out" to the commercial third party claims reviewers. Theoretically, LPMA claims, as well as health insurance claims, are reviewed by the "Claims Review Committee" of the SIPF. Still, many F&A go unchecked. To fill the need, there are many commercial third party claims reviewers (some of them are publicly owned corporations) which contract with insurers for double checking. If they find unchecked F&A, then the insurers can appeal to the SIPF for denials. MHLW encourages municipal governments to double check through subsidy (this is a peculiar situation: the MHLW itself officially acknowledges that the claims review by SIPF is flawed). In FY2007, a total of 1.83 billion yen subsidy was disbursed to 729 municipal governments (out of 1804 municipal governments) resulting in the saving of 11.1 billion yen or six times the cost.

Such sanctity was altered late 2008, when the Lehman shock plunged many people into poverty. The number of the recipients of the Livelihood Protection skyrocketed straining the national and local finances. In April 2010, another scandal was cracked down in Osaka, where >5% of the 2.5 million residents on the Livelihood Protection. Many LPMA patients got prescribed psychotropic drugs from multiple clinics and pharmacies and sold them over the net. The peddlers were arrested for violation of the Drug Control Act.

The MHLW conducted a sampling survey on LPMA claims to detect duplicate or multiple medication of psychiatric drugs. They sampled claims from psychiatric hospitals or clinics identifying 2,555 patients. Of them, 1,797 or 70.3% were judged inappropriate medication. Based on this evidence, the MHLW called for utilizing electronic claims data for detection of such drug abuse.

Osaka city quickly followed suit: they requested SPIF to provide LPMA claims data for detection of abuse,

the very first of such move among municipal governments. The city identified 34 hospitals and clinics whose patients are exclusively (!) LPMA patients in addition to many clinics whose >90% of their patients are LPMA recipients. Then the city conducted interviews and on-site inspections on 127 patients and 16 providers. It was found that many patients were living at residential facilities and affiliated doctors visit them as regular house calls. According to the calculation by the city, the typical charge of office visits of diabetes patients four times a month would be 11,060 yen but it would be 50,000 yen if doctors make the same number of house calls. For health insurance patients, 30% of the charge would be levied from patients but no such copayment is charged on LPMA patients. A patient diagnosed as respiratory failure had rented a home oxygen therapy unit from a clinic which charged the city 65,000 yen/month. When a city official visited the patient, the patient was in a stable condition and the unit had not been used for months. The report stated that patients on health insurance would have returned the unit to avoid 30% copayment.

In FY2011, the MHLW sets an explicit policy to utilize electronic claims for cost containment of LPMA with the following agenda: 1) double-checking of electronic claims, 2) detection of duplicate or multiple medication of psychotropic drugs, 3) enhancement of generic products. The last 3) on generic use is a notable policy change from the revoked directive just a few years ago.

6. What's ahead?

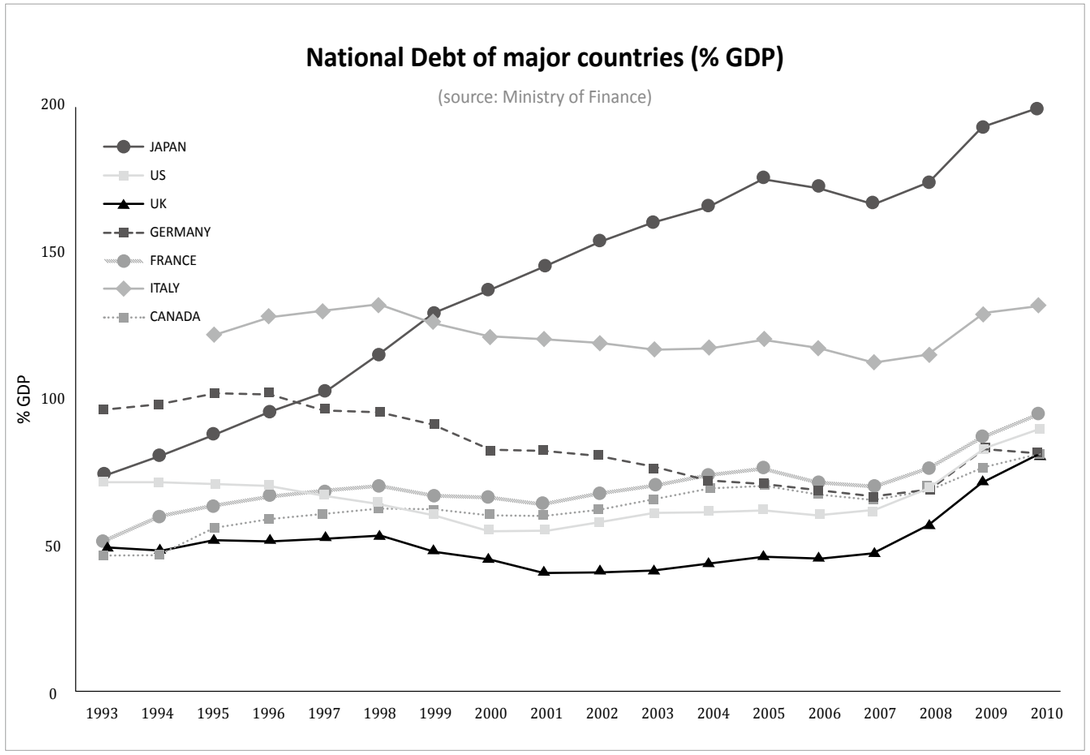
Japan's health care cost has been in good control despite its rapid population ageing. At least, health care cost is not a financial menace to Japanese people yet. However, the stagnant economic growth and resulting tardy growth of income is making the financial burden of health care cost heavier and heavier (Japan's GDP has not grown much for last 20 years and has been passed by China in 2010). Not because of the growth of numerator but the shrinking denominator, the % of health care cost in National Income has already passed 10%.

Then, what is the major concern about Japan's health care cost in the near future? It is not likely that the health care cost increases out of control. What is more worried is the potential financial catastrophe. Japan's national finance is deteriorating due to the accumulating debt (government bonds). Already it is reaching to 200% of GDP, by far the highest in the world.

Why is this a problem for health care cost? As shown before, 1/4 of Japan's health care cost is financed from the government subsidies (when local governments combined it will be 1/3). If the government falls in default, as much as 1/4 or 1/3 of the health care cost will not be paid to providers. This heavy reliance on government subsidy makes Japan's health care vulnerable to the governmental financial conditions.

Of the government's revenue of 92.3 trillion in FY2010, only 37.4 trillion yen was levied as tax and 44.3 trillion yen was raised by selling bonds. Paradoxically, the interest rate on 10 year bonds remains around 1% (it went below 1% in 2010). With this ridiculously low interest rate, the government is sustaining by paying only (!) 10 trillion yen in interest (plus another 10 trillion yen for redemption). Borrowing 44.3 trillion yen while paying back 20 trillion yen: sounds good? What will happen if interest rate goes up to 3% or higher? It is alarming when one recalls that Japan's interest rate was once 7-8%.

The Koizumi administration, with his neo-conservative economists and the overwhelming support in the previous general election, adopted a radical fiscal reform in 2006 to achieve positive primary balance by FY2011. Thanks to controlling the social security budget including the largest price "cut" in the fee schedule in 2006, Japan's financial conditions recovered temporarily as shown as a "dent" in the following graph of accumulating national debt.



Such neo-conservative policy was unpopular, and the Democratic Party won the overwhelming victory in the general election in August 2009 by promising the revocation of such stringent fiscal policy. As soon as the Democratic government took office, "fiscal soundness" was put aside and the new social security policies were adopted, most notably the children allowances (13,000 yen/month for children under 15yo totaling two trillion yen). As much as 44.3 trillion JGB was issued to supplement the pitiful 37 trillion tax revenue in FY2010, the trend which continued in FY2011 as well. The administration was forced to promise at the G20 meeting held in Canada in June 2010 to decrease the deficit in primary balance by half by 2015 and achieve balance by 2020 (the target year agreed at the meeting was 2013 and 2016

respectively but Japan was treated as exception given the sheer size of governmental debt). However, credit rating companies responded by downgrading Japanese Government Bond (JGB).

Belatedly, the present administration adopted a reform plan on 2nd June, calling for raising the consumption tax from current 5% to 10% by 2015, which will generate additional 10 trillion yen tax revenue. To mitigate the rise of consumption tax, the plan included some cost-containment strategies, some of which are continuation of HCCCP and others are new initiatives. The reduction of LOS is estimated to reduce the government subsidy (1/4 of health care cost) by 0.43 trillion yen in 2015 (it is remarkable that the targeted beds include psychiatric beds).

A new initiative was disease management which is expected to save 0.12 trillion yen in 2015 through effective use of ICT by insurers. The IT initiatives by Kure city or in the LPMA are exemplified in the reform plan. The reform plan encourages insurers to guide patients for "optimal" use of health care services making best use of the computerized claims data, something unheard when insurers were not supposed to intervene into patients behaviors. Also it encourages active use of the National Claims Database for regional integration of health care. Other initiatives include enhancement of generic use, prevention of disability to reduce the LTCI cost.

The reform plan was a remarkable about-face when one considers the original stance of the ruling party (there is much debate inside the ruling party itself). The plan set a schedule that the law must be revised by the end of this FY2011. However, given the present unstable political situation (the PM already expressed his resignation) as well as discordant majority between the Congress and the Senate. Unless this ambitious reform sees the light of day, one must expect a day when Japan is placed under the IMF control.

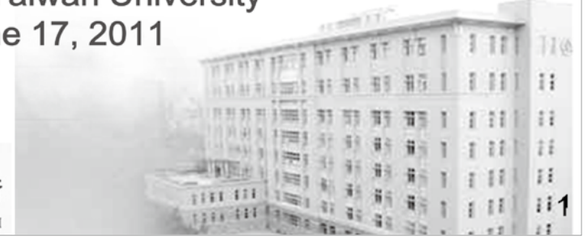
Health Care Financing and Cost-Containment in Taiwan

- Ming-Chin Yang

Health Care Financing and Cost-Containment in Taiwan

Ming-Chin Yang, Dr.PH
Inst. of Health Policy and Management
National Taiwan University
June 17, 2011

臺灣大學 健康政策與管理研究所
INSTITUTE OF HEALTH POLICY AND MANAGEMENT ,NTU



1

Taiwan

General Information (2010)

- Area: 36,191 KM^2
- Population: 23 Million
- Per Capita GDP US$19,155
- Crude birth rate 8.3/1000
- Crude death rate 6.22/1000
- Life expectancy Female 82.5
  Male 75.9

2

Introduction of Taiwan's National Health Insurance

- Taiwan implemented the National Health Insurance Scheme (NHI) in March 1995
- It is a compulsory social insurance system
- The insured shall enroll in the NHI using one of the following six categories

3

Category 1

- Civil servants or full-time and regularly paid personnel;
- Employees of enterprises or institutions;
- Employees hired by particular employers;
- Employers or self-employed owners;
- Independently practicing professionals and technicians

4

Category 2

- Members of an occupational union who have no particular employers, or who are self-employed;
- Seamen serving on foreign vessels, who are members of the National Seamen's Union or the Master Mariners' Association

5

Category 3

- Members of the Farmers Association or the Irrigation Association, or workers aged over fifteen who are actually engaged in agricultural activities;
- Class A members of the Fishers Association who are either self-employed or have no particular employers, or workers aged over fifteen who are actually engaged in fishery activities

6

Category 4

- Military servicemen, military school students, military servicemen's dependents who lost their support, and military decedent's families
- Men at the age for enlisting in the military, who are currently in military-substitute service

7

Category 5

- Members of a household of low-income families as defined by Social Support Law

8

Category 6

- Veterans, household representatives of survivors of veterans;
- Representatives or heads of household other than the insured or their dependents prescribed in categories 1 to 5 and the preceding item of this category

9

Financing the NHI

- The revenue comes from premium contribution.
- Currently the premium rate is 5.17% of the salary or reported income.
- The enrollees have to pay 30% - 60% of that premium
- The remaining portion will be paid by enrollees' employers or the government.

10

Dependents' Premium

- Not employed dependents must enroll the NHI with the insured (spouses, parents or children)
- For each dependent, the insured people need to pay one share of premium
- The maximum share of dependent premium is three

11

Premium Calculations

- NHI premiums for individuals in categories 1, 2, and 3 are calculated based on the monthly incomes
- The premiums of individuals in categories 4, 5, and 6 are based on the average premium paid

12

Benefit package

- NHI provides medical care for injuries, illness, and delivery
- It provides emergency care, outpatient care, inpatient hospitalization, home health care, and medications
- It used to provide preventive care, such as prenatal care, well baby care, Pap smear, and basic physical check-ups (now paid by the Bureau of Health Promotion)

13

IC card

- Each enrolled person will receive a piece of IC card
- One must present this card when seeking medical care from contracted institutions.

14

Co-payment for Outpatient services

Institution Class	Basic Copayments (NT$) Note: 1USD = 29NTD				
Type of Institution	Western Medicine		Em. Care	Dental Care	Chinese Medicine
	With referral	Without referral			
Medical Centers	210	360	450	50	50
Regional Hospitals	140	240	300	50	50
District Hospitals	50	80	150	50	50
Clinics	50	50	150	50	50

Copayment Rates for Inpatient Care

Type of Ward	Copayment Rates			
	5%	10%	20%	30%
Acute	-	30 days or less	31-60 days	61 days or more
Chronic	30 days or less	31-90 days	91-180 days	181 days or more

Financial Status

- At the beginning few years, there were some surplus.
- However, as the growth rates of expenditure continued to exceed that of revenue, the financial status of the NHI turn to deficit in 2005.

Principles of Financial Stability

- premium revenues need to be able to cover medical expenses.
- Short-term discrepancies are to be covered by the reserve fund
- long-term financial balance is to be achieved by setting reasonable levels of premium rates based on actuarial valuation.

Accrual Basis

- The insurance revenues in 2009 increased NT$716 million from the previous year and the average annual increase of insurance revenues was 5.4% from the implementation of the NHI scheme.
- The insurance cost increased by NT$19 billion from the previous year and the average annual increase of insurance costs was 7.6% from the implementation of the NHI scheme.

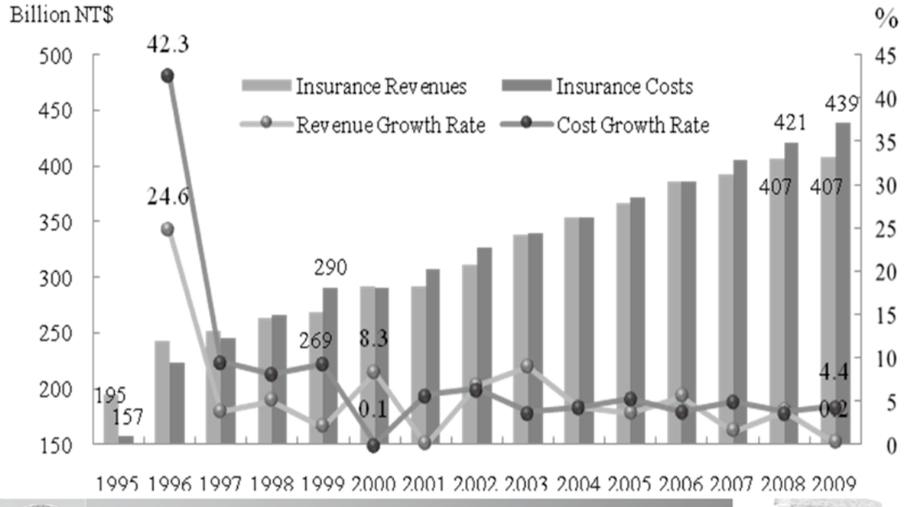
19

Deficit of the NHI

- The deficit was NT$32 billion in 2009, which was made up using the reserve fund according to regulations
- Accumulated deficit was NT$58 billion, which should be made up using the reserve fund

20

Financial Status of NHI – Accrual basis



21

Recent Reforms

- Major reform of cost-containment: the global budget payment system (GBPS)
- Phased-in
  - Dental outpatient, 1998
  - Chinese medicine outpatient, 2000
  - Western medicine clinics, 2001
  - Hospital sector, 2002

22

Effects of GBPS

- After the GBPS was fully implemented in July 2002, the annual growth rate of expenditure has been controlled at 5.0% - 3.7%

GBPS organizatioin

- The Medical Expenditure Negotiation Committee (MENC) was established to negotiate and allocate medical payment
- 27 members consist of one-third each of
  - Medical care providers
  - Premium payers and specialists or scholars
  - Relevant government agencies

Allocating the resources

- The ambulatory care and hospitalization expenditures may be allocated by 6 NHI regions.
- The global budget contains four sectors, namely the ambulatory care provided by physicians, Chinese medicine doctors and dentists, and services provided by hospitals.

Filing the claims

- Providers shall declare to the BNHI the points of the medical services rendered, based on the Fee Schedule and Drug List

Calculating Point Value

- BNHI shall calculate the value of each point based on the budget allocated and the total points of medical service retrospectively.
- The Insurer shall pay each contracted medical care institution according to the reviewed points

Point value

- The point value is a floating value.
- This is because the numerator, predetermined budget, is fixed when the denominator varies month by month.
- This creates the incentives for medical institutions in the same sector to collaborate to control the increase of service volume.

Floating Point Value

$$\text{Point Value} = \frac{\text{Allocated Budget}}{\Sigma \text{ claimed points}}$$

Revenue Reform

- 4.25% in 1995
- 4.55% in 2002
- 5.17% in 2010
- The basis of income used to calculate the premium was also enlarged over the years.
- The financial status could be balance for four to five years.

Controlling Utilization

- co-payment for
  - outpatient medications
  - physical therapies
- Raising the amount of co-payment of large hospitals outpatient care.
- However, the amount of utilization did not seem to reduce overtime

31

Inequity in Premium Collection

- DOH strived very hard to get support from the Legislature to amend the NHI Act in January 2011
- Call it the second generation NHI Act, 2G Act

32

Supplementary Premium

- Categories 1 to 4 people need to pay a supplementary premium
- 2% of income other then reported salary
  - annual bonus exceed 4 times of monthly salary
  - professional practice income
  - stock dividend
  - Interests
  - rentals

33

Challenge of Supplementary Premium

- There is a minimum and maximum threshold for collecting the supplementary premium.
- People may find ways to avoid paying this supplementary premium.
- The revenue from regular premium will not be enough.

34

Cost Containment Performance

- GBPS
  - Most powerful
  - may delay or limit the introducing of new technology
- Co-payment
  - Least powerful
  - At first, outpatient visits reduced some
  - But six months later, the amount returned to the original level

35

Incentives for Hospitals

- The GBPS provides financial incentives to encourage health care providers to exercise self-regulation and to reduce the proportion of cases that can be treated primarily in the clinics

36

Study Objective

- We conducted a study to examine whether there was any change in the proportion of primary care patients before and after the Hospital Global Budget (HGB)

37

Outpatient Classification

- Based on the Clinical Classification Software (CCS) developed by Agency for Healthcare Research and Quality (AHRQ),
- Diseases treated in outpatient were classified into A, B, or C type

38

Definition of Three Types of Diseases

- Type A
  - diseases should be treated at primary care facilities
- Type C
  - diseases should be treated at hospitals of district teaching or higher level
- type B
  - diseases could be treated at any level of health care institutes.

39

Conclusions

- Although the proportion of Type A visits decreased after the HGB, monthly expenditure for Type A disease increased instead.
- Hospitals did not reduce the proportion of type A cases significantly after the HGB.

40

Profile of financial resources

- The revenue of NHI primarily comes from premium.
- Total expenditure was NTD 365.28 Billion in 2009
- 76% of the premium was contributed by the insured and group insurance applicants (basically the employers)
- The government paid the remaining 24%.

41

Financial burden

- According to the table of salary scale the highest amount is NT$182,000/month
- This means that anyone who earns more than this amount can still use this upper limit to calculate his/her premium
- Therefore, the burden of NHI premium will be lower for people with high salary

42

Different roles of the public and the private

- Because of out-of-pocket payment, there is a market for private commercial insurance.
- Most commonly seen benefits of private insurance are daily allowance
  - For example, admitted insured people can receive NT$2,000 per day of hospitalization
- This may reduce the cost awareness of those people enrolled in private insurance.

Sustainability of the reformed system

- The 2G NHI Act requires that the NHI Committee should review the premium rate one month after the global budget has been negotiated
- If the current premium rate is too low to meet the demand for global budget for the next year, the rate will be raised.

Reducing benefits?

- However, if the rate has reached the authorized ceiling (6%) and still cannot meet the demand, the Committee should re-negotiate the global budget.
- This implies the possibility of reducing content of benefit package.

Health Technology Assessment

- Another strategy in the 2G Act is to require health technology assessment (HTA) before new items are included in the benefit list or payment rate being set.

Challenges of HTA

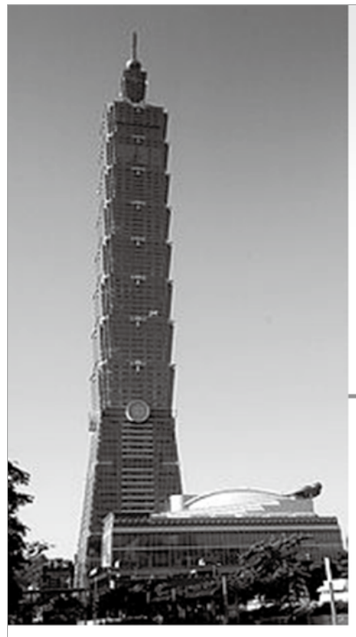
- To what extend should manufactures provide the report
- Do we have enough people and capacity to conduct or to review the HTA.
- Manufactures are now very concern about the details of HTA
- Currently the detail of implementation is still under discussion

47

Conclusions

- Keeping the revenue and expenditure balanced is vital
- It relies on the collaboration of ministries to allocate budget for recruiting personnel and installing information systems
- However, as fiscal condition of the government gets tighter, it tests the wisdom of the ruling party

48



Thanks for your attention

Health Care Financing and Cost-Containment in Taiwan

- Ming-chin Yang

(Institute of Health Policy and Management
National Taiwan University)

○ Abstract

Taiwan implemented the National Health Insurance Scheme (NHI) in March 1995. About 99% of the eligible citizens in Taiwan were enrolled in this mandatory health insurance system. The revenue comes primarily from premium contribution. Currently the premium rate is 5.17% of the salary or reported income. Basically the enrollees have to pay 30% - 60% of that premium. The remaining portion will be paid by enrollees' employers or the government.

At the beginning few years, there were some surplus. However, as the growth rates of expenditure continued to exceed that of revenue, the financial status of the NHI turn to deficit in 2005. The annual growth rates of healthcare expenditure were about 7-10% during the first few years while the growth rates of revenue was 0 to 8.8%.

The major reform of cost-containment was the implementation of the global budget payment system (GBPS). After the GBPS was fully implemented in July 2002, the annual growth rate of expenditure has been controlled at 3.7%-5.01%.

The GBPS was phased-in over four years. In 1998, dental outpatient care was the first sector to implement the GBPS, followed by Chinese medicine outpatient care in 2000, western medicine clinics in 2001, and finally hospital sector in 2002.

On the other hand, revenue side also had some reform. The most profound one was increasing the premium rate from 4.25% to 4.55% in 2005. Later in 2010, the rate was raised to 5.17%. The basis of income used to calculate the premium was also broaden over the years.

The Department of Health (DOH) and the Bureau of NHI also initiated a series of measures to control utilization. They included introducing co-payment for outpatient medications, for physical therapies, and raising the amount of co-payment of large hospitals outpatient care. However, the amount of utilization did not seem to reduce overtime.

In terms of the performance of those reform strategies, the most powerful one is the GBPS. However, it may delay or limit the introducing of new technology. The least powerful one was co-payment. The amount of outpatient visits did reduce to some extent when the co-payment amount was increased. But in six months, the outpatient visits returned to the original level.

In order to solve the inequity situation in premium collection, the Legislature amended the NHI Act in January 2011 (we call it the second generation NHI Act, 2G Act). In this 2G Act, the most challenging one is to broaden the base of income when calculating premium. Currently system may underestimate the real income. Therefore, in the 2G Act, the insured people in categories 1 to 4 (being hired or self-employed) need to pay a supplementary premium in addition to regular monthly premium. Supplementary premiums are 2% of those types of income other then reported salary or earnings. It is feared that people may find ways to avoid paying this supplementary premium. If this situation happens, then the revenue from regular premium will not be enough.

Another strategy in the 2G Act is to require health technology assessment (HTA) before new items are included in the benefit list or payment rate being set. Currently the detail of implementation is still under discussion.

In conclusion, Taiwan's NHI is facing financial problems as well. Therefore, one of the most important issues of reforming the system is to keep the revenue and expenditure balanced. In order to have those reform strategies successful, it relies heavily on the collaboration of various ministries. However, as the fiscal condition of the government gets tighter and tighter, this task also tests the wisdom of the ruling party.

1. Introduction of Taiwan's National Health Insurance

Taiwan implemented the National Health Insurance Scheme (NHI) in March 1995. It is a compulsory social insurance system. Before the implementation of NHI, there existed Labor Insurance, Civil Servant Insurance, Welfare Insurance and Farmers Insurance. All of these insurance provide medical benefit and cash benefit. But they covered only 55% of population and many of those who were not covered were

children and the aged. Therefore the government started to plan the NHI in 1988. At first, the target date was set at the year 2000. However, as political pressure built up, the government moved the date forward to 1995.

Because there were already several types of social insurance providing medical care, the NHI program isolate out the part of medical care from each social insurance and integrated them into one system. When those who already enrolled in other social insurance were mandated to enroll in the NHI, the 45% population who were not covered were also enrolled in the NHI as well. Currently about 99% of the eligible citizens in Taiwan were enrolled in NHI.

The insured shall enroll in the NHI using one of the following six categories:

Table 1.1 Categories of NHI insured people

Categories	Sub-categories
Category 1	(1) Civil servants or full-time and regularly paid personnel in governmental agencies and public／private schools; (2) Employees of publicly or privately owned enterprises or institutions; (3) Employees other than the insured prescribed in the preceding two subparagraphs but are otherwise employed by particular employers; (4) Employers or self-employed owners of business; (5) Independently practicing professionals and technicians.
Category 2	(1) Members of an occupational union who have no particular employers, or who are self-employed; (2) Seamen serving on foreign vessels, who are members of the National Seamen's Union or the Master Mariners' Association.
Category 3	(1) Members of the Farmers Association or the Irrigation Association, or workers aged over fifteen who are actually engaged in agricultural activities; (2) Class A members of the Fishers Association who are either self-employed or have no particular employers, or workers aged over fifteen who are actually engaged in fishery activities.
Category 4	(1) Military servicemen whose compulsory service terms are over two months or who are summoned to serve in military for more than two months, military school students who receive grants from the government, military servicemen's dependents who lost their support recognized by the Ministry of Defense, and military decedent's families who are receiving pensions due to the death of their decedents. (2) Men at the age for enlisting in the military, who are currently in military-substitute service.
Category 5	Members of a household of low-income families as defined by Social Support Law.
Category 6	(1) Veterans, household representatives of survivors of veterans; (2) Representatives or heads of household other than the insured or their dependents prescribed in subparagraphs 1 to 5 and the preceding item of this subparagraph.

In terms of financing the NHI, the revenue comes from premium contribution. Currently the premium rate is 5.17% of the salary or reported income. Basically the enrollees have to pay 30% - 60% of that premium. The remaining portion will be paid by enrollees' employers or the government. Those dependents who were not employed need to enroll the NHI with their spouses, parents or children. For each dependent, the insured people need to pay one share of premium. However, to prevent causing too heavy of a burden to those families having a large number of dependents, the maximum share of dependent premium is three.

To be more specific, the NHI premiums for individuals in categories 1, 2, and 3 are calculated based on the monthly incomes they report to the Bureau. The premiums of individuals in categories 4, 5, and 6 are based on the average premium paid by all those enrolled in the National Health Insurance system.

The formulas used to calculate premiums are as follows:

Table 1.2 Premium calculation formula

Insured Category	Contributor	Formula
Income Earners	The Insured	Income Basis x Premium Rate x Contribution Ratio x (1 + Number of Dependents)
	Insurance Registration Organization or Government	Income Basis x Premium Rate x Contribution Ratio x (1 + Average Number of Dependents)
Non-income Earning Individuals	The Insured	Average Premium x Contribution Ratio x (1 + Number of Dependents)
	Government	Average Premium x Contribution Ratio x (1+Actual Number of Dependents)

Notes:

1. Income Basis: Amount of income on which premiums are levied based on a payroll bracket table
2. Insurance Premium Rate: 5.17% effective from April 1,2010
3. Contribution Ratio: Based on ratios set by National Health Insurance Act
4. Number of Dependents: Maximum of three even if the actual number of dependents is higher
5. Average Number of Dependents: 0.7 effective from jan.1,2007
6. Since October 2009, the average monthly premium for individuals in categories 4 and 5 has been NT$1,376, which is entirely subsidized by the government. For individuals in category 6, the average premium has been NT$1,249, with 60% paid by the individual (NT$749) and 40% by the government effective from April 1, 2010.

Table 1.3 NHI Premium Contribution Ratios

Classification of the Insured			Contribution Ratio (%)		
			Insured	Registration Organization	Government
Category 1	Civil servants, volunteer servicemen, public office holders	Insured and dependents	30	70	0
	Private school teachers	Insured and dependents	30	35	35
	Employees of publicly or privately owned enterprises or institutions	Insured and dependents	30	60	10
	Employers Self-employed Independent professionals and technical specialists	Insured and dependents	100	0	0
Category 2	Occupation union members Foreign crew members	Insured and dependents	60	0	40
Category 3	Members of farmers', fishermen's and irrigation associations	Insured and dependents	30	0	70
Category 4	Military conscripts, alternative servicemen, military school students on scholarships, widows of deceased military personnel on pensions	Insured	0	0	100
Category 5	Low-income households	Household members	0	0	100
Category 6	Veterans and their dependents	Insured	0	0	100
		Dependents	30	0	70
	Other individuals	Insured and dependents	60	0	40

In terms of benefit package, the NHI provides medical care for injuries, illness, and delivery. It not only provides emergency care, outpatient care, inpatient hospitalization, but also home health care. The NHI also provides prescription medications. It used to provide preventive care, such as prenatal care, well baby care, Pap smear for cervical cancer, and basic physical check-ups. After the SARS outbreak in 2003, the Department of Health decided to simplify the responsibility of NHI to provide medical care. Thus, the budget of preventive care is now being prepared by the Bureau of Health Promotion.

Each enrolled person will receive a piece of IC card (figure 1). One must present this card when seeking medical care from contracted institutions.

In order to reduce abuse of medical care, outpatients must pay an outpatient copayment. If a patient is hospitalized, then he or she will have to pay an inpatient copayment when discharged.

Table 1.4 Amount of Co-payment for Outpatient services (NT$)

Institution Class	Basic Copayments				
Type of Institution	Western Medicine Outpatient Care		Emergency Care	Dental Care	Traditional Chinese Medicine
	With referral	Without referral			
Medical Centers	210	360	450	50	50
Regional Hospitals	140	240	300	50	50
District Hospitals	50	80	150	50	50
Clinics	50	50	150	50	50

Table 1.5 Copayment Rates for Inpatient Care

Type of Ward	Copayment Rates			
	5%	10%	20%	30%
Acute	-	30 days or less	31-60 days	61 days or more
Chronic	30 days or less	31-90 days	91-180 days	181 days or more

2. Financial Status

At the beginning few years, there were some surplus. However, as the growth rates of expenditure continued to exceed that of revenue, the financial status of the NHI turn to deficit in 2005. The annual growth rates of healthcare expenditure were about 7-10% during the first few years while the growth rates of revenue was 0 to 8.8%.

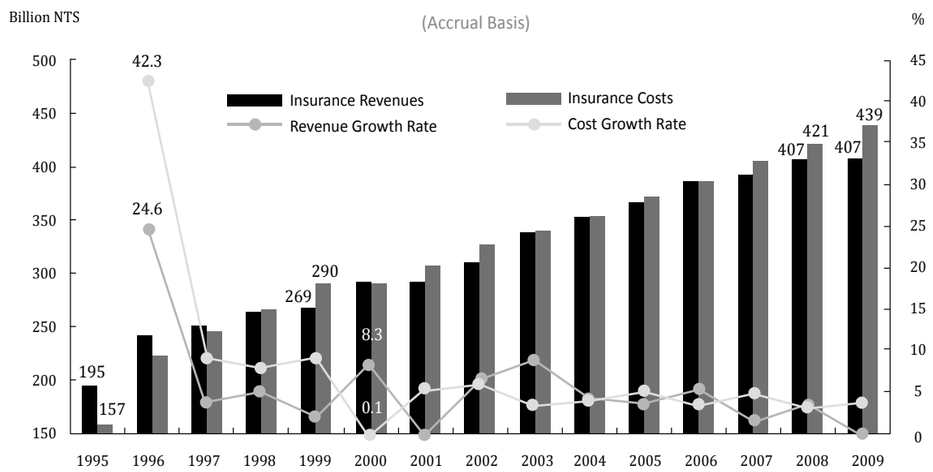
The average annual increase of insurance revenues was 5.4% from the implementation of the NHI scheme; the average annual increase of insurance costs was 7.6%; the financial gap had been widening.

The NHI scheme operates under the principle of balanced revenues and expenditures. In other words, premium revenues need to be able to cover medical expenses. Short-term discrepancies are to be covered by the reserve fund and long-term financial balance is to be achieved by setting reasonable levels of premium rates based on actuarial valuation.

Premium rate was slightly adjusted from 4.25% to 4.55% in 2002; the rate had not been adjusted since then. Although premium revenues had increased a little due to the increase in salaries, the increase of premium revenues was far more than that of medical expenses. The widening financial gap had become a problem that both government and the public must face.

On the accrual basis, the insurance revenues in 2009 increased NT$716 million from the previous year and the average annual increase of insurance revenues was 5.4% from the implementation of the NHI scheme. The insurance cost increased by NT$19 billion from the previous year and the average annual increase of insurance costs was 7.6% from the implementation of the NHI scheme. The deficit was NT$32 billion, which was made up using the reserve fund according to regulations; the accumulated deficit was -NT$58 billion, which should be made up using the reserve fund.

Figure 2.1 Financial Status of BNHI



3. Recent Reforms

1) Overview of reforms that have taken place recently in health care

The major reform of cost-containment was the implementation of the global budget payment system (GBPS). The GBPS was phased-in over four years. In 1998, dental outpatient care was the first sector to implement the GBPS. Followed by Chinese medicine outpatient care in 2000, western medicine clinics in 2001, and finally hospital sector in 2002.

After the GBPS was fully implemented in July 2002, the annual growth rate of expenditure has been controlled at 5.0% - 3.7%.

The Medical Expenditure Negotiation Committee (MENC) was established to negotiate and allocate medical payment. The MENC has 27 members consist of one-third each of the following personnel: 1). Representatives from medical care institutions; 2). Representatives from premium payers and specialists or scholars in the relevant fields; and 3). Representatives from relevant government agencies.

Each year, around April, the DOH needs to propose the lower and upper bounds of the total amount of medical expenditure for next year to the Executive Yuan for approval. After receiving approval, the MENC will negotiate and reach the agreement of the global budget for next year in September. The agreement will then be reported to the DOH for approval. The DOH shall make decision at its own discretion in case the MENC did not reach an agreement in time. Starting January of next year, the BNHI will operate the business on the approved budget.

Of course, this budget is just a cap of expenditure. The BNHI still needs to make every effort to enroll people and collect premium.

The ambulatory care and hospitalization expenditures may be allocated by 6 NHI regions. The global budget contains four sectors, namely the ambulatory care provided by physicians, Chinese medicine doctors and dentists, and services provided by hospitals.

The contracted medical care institutions shall declare to the Insurer the points of the medical services rendered and expense of drugs, based on the Fee Schedule for Medical Services and the Reference List for Drugs. The Insurer shall calculate the value of each point based on the budget allocated and the total points of medical service retrospectively. The Insurer shall pay each contracted medical care institution according to the reviewed points.

One thing worth emphasize is that the point value is a floating value. This is because the numerator, predetermined budget, is fixed when the denominator varies month by month. This creates the incentives for medical institutions in the same sector to collaborate to control the increase of service volume.

On the other hand, revenue side also had some reform. The most important one was increasing the premium rate from 4.25% to 4.55% in 2005. Later in 2010, the rate was raised to 5.17%. The basis of income used to calculate the premium was also enlarged over the years. By doing so, the financial status could be balance for four to five years.

The DOH and the BNHI also initiated a series of measures to control utilization. They included introducing co-payment for outpatient medications, for physical therapies, and raising the amount of co-payment of large hospitals outpatient care. However, the amount of utilization did not seem to reduce overtime.

In order to solve the inequity situation in premium collection, the DOH strived very hard to get support

from the Legislature to amend the NHI Act in January 2011 (we call it the second generation NHI Act, 2G Act).

In this 2G Act there are several reforms related to financial status. The most challenging one is to broaden the base of income when calculating premium. Currently we use only the reported salary or income to calculate premium. But this may underestimate the real income. It is possible that a person earn more from performance bonus than his/ her regular salary. Therefore, in the 2G Act, the insured people in categories 1 to 4 need to pay a supplementary premium in addition to regular monthly premium. Supplementary premiums are 2% of those types of income other then reported salary or earnings. Those types of income include annual bonus exceed 4 times of monthly salary, professional practice income, stock dividend, interests, and rentals.

There is a minimum and maximum threshold for collecting the supplementary premium. It is feared that people may find ways to avoid paying this supplementary premium. If this situation happens, then the revenue from regular premium will not be enough.

2) cost-containment performance

In terms of the performance of those reform strategies, the most powerful one is the GBPS. However, it may delay or limit the introducing of new technology. The lease powerful one was co-payment. The amount of outpatient visits did reduce to some extent when the co-payment amount was increased. But in six months, the outpatient visits returned to the original level.

To contain escalating medical care costs, HI implemented the Hospital Global Budget (HGB) in 2002. One of the purposes of this system: to provide financial incentives to Encourage health care providers to exercise self-regulation and to reduce the proportion of cases that can be treated primarily in the clinics.

We conducted a study to examine whether there was any change in the proportion of primary care patients before and after the HGB. It was a longitudinal data analysis. Data source came from health insurance claims data provided by the National Health Research Institute (NHRI). Dependent variable was proportion of outpatient visits that should be treated in primary care facilities.

Outpatient classification was based on the Clinical Classification Software (CCS) developed by Agency for Healthcare Research and Quality (AHRQ), diseases treated in outpatient were classified into A, B, or C type. Among them, type A diseases refer to those diseases should be treated at primary care facilities, i.e. clinics or on-teaching local hospitals. Type C diseases refer to those diseases should be treated at hospitals of district teaching or higher level. The remaining type B disease refer to diseases could be treated at any level of health care institutes.

There were three steps when conducting the study.

Step 1: classifying each disease into one of the ABC categories.

Step 2: using monthly claims data of each facility as the unit of analysis.

Step 3: applying generalized estimation equation (GEE) model to test the hypotheses.

Table 3.2.1 shows the changes of number of visits, by types ABC diseases and health care institutions. We found that in Hospitals sector, the proportion for Type A disease decreased while Types B and C increased. On the other hand, in clinic sector, the proportion for Type A disease decreased while Types B and C increased.

Table 3.2.2 shows GEE results of monthly outpatient expenditures before and after HGB. After controlling for confounding factors, the overall outpatient visits of hospitals or clinics decreased slightly after the implementation of either primary care global budget payment system (PCGBPS) or HGBPS. As for the expenditure claimed, the change was -4.96% (Z=-14.90, p<.001) after implementing the PCGBPS, but it was not significant (Z=0.39, p>.05) after HGBPS. However, we didn't observe more type A diseases shifted from hospitals to clinics as expected after the HGBPS in this study.

Our conclusion was that hospitals did not reduce the proportion of type A cases significantly after the HGBPS. Future study should consider adopting more sensitive indicators or specific disease categories to examine whether patients shifted between clinics and hospitals after implementing the HGBPS. Although the proportion of Type A visits decreased after the HGB, monthly expenditure for Type A disease increased instead. Future study should consider adopting more sensitive indicators or specific disease categories to examine whether patients shifted between clinics and hospitals after implementing the HGB.

Table 3.2.1 The proportion of outpatient visits, by types of disease and health care institutions, 2001 - 2005

Years	Hospital			Clinics		
	Type A	Type B	Type C	Type A	Type B	Type C
Proportion of visits						
2001	48.97	29.44	21.59	91.08	6.89	2.03
2002	48.33	29.26	22.41	90.63	7.2	2.17
2003	47.13	29.26	23.61	89.86	7.72	2.42
2004	46.48	29.57	23.95	89.14	8.32	2.54
2005	43.81	30.09	26.1	88.26	8.91	2.82
Change rate						
2001-2002	-0.64	-0.18	0.82	-0.45	0.31	0.14
2002-2003	-1.20	0.00	1.20	-0.77	0.52	0.25
2003-2004	-0.65	0.31	0.34	-0.72	0.60	0.12
2004-2005	-2.67	0.52	2.15	-0.88	0.59	0.28

Table 3.2.2 GEE results of monthly outpatient expenditures before and after HGB

Models Variables	Type A diseases		Type B diseases		Type C diseases	
	β	Change	β	Change	β	Change
Clinics	-1.57***		-3.80***		-4.86***	
Hospitals						
GB-hospital	0.10***	10.18%	-0.11***	-10.08%	-0.09***	-8.49%
GB-hospital* clinic	-0.06***	-5.83%	0.09***	9.82%	0.08***	7.82%
GB-hospital* hospital						

Notes:

1. Independent variable is the log transformed (ln) value of the monthly outpatient visits by facilities
2. Other control variables such as time trend, month, Chinese New Year, BNHI branch, institution ownership, outpatient co-payments, and SARS outbreak period (from May to June 2003) were not shown in the table.
3. The formula of Change is (eβ-1)×100%, which means the percentage of difference.
4. ***p<.001

4. Profile of the financing of health care

1) Profile of financial resources

The revenue of NHI primarily comes from premium. The insured people, their employers/ group insurance applicants, and the government all have to share some percentage of the premium. In 2009, out of the a total of 365.28 Billion NT dollars, about 76% of the premium was contributed by the insured and group insurance applicants (basically the employers). The Central and local government paid the remaining 24%.

2) Financial burden

According to the table of salary scale the highest amount is NT$182,000/month. This means that anyone who earns more than this amount can still use this upper limit to calculate his/her premium. Therefore, the burden of NHI premium will be lower for people with high salary.

5. Different roles of the public and the private

The NHI system is a mandatory social health insurance providing comprehensive services. However, the insured people still need to pay out-of-pocket money for copayments or not covered items, there is a market for private commercial insurance. Most commonly seen benefits of private insurance are daily allowance. For example, if a insured people were admitted, he or she can receive NT$2,000 or NT$3,000 per day of hospitalization. This may reduce the cost awareness of those people who enrolled in private insurance.

6. Sustainability of the reformed system

The 2G NHI Act, requires that the NHI Committee should review the premium rate one month after the global budget has been negotiated. If the current premium rate is too low to meet the demand for global budget for the next year, the rate will be raised. However, if the rate has reached the authorized ceiling (6%) and still cannot meet the demand, then the Committee should re-negotiate the global budget. This implies the possibility of reducing content of benefit package.

Another strategy in the 2G Act is to require health technology assessment (HTA) before new items are included in the benefit list or payment rate being set. The challenges are 1) to what extend should manufactures provide the report, and 2) do we have enough people and capacity to conduct or to review the HTA. Of course, manufactures are now very concern about the details of HTA. Currently the detail of implementation is still under discussion.

7. Conclusions

Similar to other countries implementing NHI, Taiwan's NHI is facing financial problems as well. Therefore, one of the most important issues of reforming the system is to keep the revenue and expenditure balanced. This involves not just economic status but also political support. In order to have those reform strategies successful, it relies heavily on the collaboration of various ministries (eg. Department of Health, Ministry of Treasury, Ministry of Economic Affairs, Commission of Labor Affairs, etc.) to design implementation detail and allocate budget for recruiting personnel and installing information systems. However, as the fiscal condition of the government gets tighter and tighter, this task also tests the wisdom of the ruling party.

건강보험재정과 비용절감방안에 대한 국제 세미나 6th

Bringing Stability to the Finances of Health Insurance in Korea: Necessary Policy Steps

- Young-Seok Shin

International Seminar on Health Care Financing and Cost-containment

Financial Projection of National Health Insurance(NHI) in Korea And Policy Measures for Sustainable NHI

June 17, 2011

Korea Institute for Health and Social Affairs
Young Seok Shin

KIHASA 한국보건사회연구원 Korea Institute for Health and Social Affairs

Contents

KIHASA 한국보건사회연구원

Ⅰ. Prospects for Environmental Changes

1. Prospects for Environmental Changes

- Ageing & Low Fertility Society

Increase of older population → Chronic disease Patients & Health care spending ↑ → Caregiving & Financial Burden

  - In 2009, older beneficiaries (9.9% of total) spent 30.53% of total expenditure
  - Exp. per older beneficiary (2,494,000KWR) is three times higher than exp. per average one (811,000KRW)

- New demands in health care : Rapid increases in chronic diseases (e.g. diabetes, hypertension) caused by population ageing and westernized eating habits

1

1. Prospects for Environmental Changes

Rise in Income

- GNI per capita in 2001 was $10,631, but increased to $20,759 in 2010
- Demands in health care is also increased in accordance to a rise in income level (e.g. new health care services, quality of health care)

Increase in Health Spending

- Avg. growth rate, % of national health care exp. in GDP, Korea = 4.7%
  [NOTE] OECD average = 2.0% (2000~2006)
- NHI benefit expenditure's annual growth rate is more than 11%
- Should consider financial sustainability

Burden from increased social exp.

- Projected % of social and health exp. In total exp., 2050 = 48% (higher than OECD average, KIPF)
- % of NHI exp. In total social exp. is projected to 75% in 2050 (if current trend persists)

2

Ⅱ. Discussion Framework for NHI Finance

1. Conditions for Balanced Finance

- Balance = Revenue – Expenditure
  - Revenue = Contributions+ Gov' Subsidy (including surcharge on tobacco)
    - Revenue of contributions = G(contribution rate, the range of income to impose contribution)

      [note] Gov' subsidy (including health promotion fund) is an exogenous variable
  - Expenditure = F(insurance fee ; # of beneficiaries, coverage, technology, medical resources, income, etc)
- Optimal financial status: Revenue = Expenditure
  - Constraints : Affordability

3

2. Variables Relevant to Exp.

Expenditure Variables

- **Medical Fee : being controlled**
  - but, b/c of limitations of delivery system, expensive services provided by tertiary hospitals are over-demanded
- **Beneficiaries**
  - % of older(65+) beneficiaries: 14% (2018) → 20% (2026) → 38.2 (2050)
- **Coverage**
  - coverage rate 2010 is 65%, but continuous needs of coverage expansion
- **Medical Technology, Resources**
- **Income :** will make individuals have more interests in health care
- **No mechanism to control service use**

4

3. Variables relevant to Revenue

Revenue Variables

- **Contribution Rate**
  - dependent on politics and social environment
  - will be increased in accordance to increasing exp.
- **The range of income applicable to impose contribution**
  - Currently, about 45% of total income is exempt from contribution
  - Free ride on NHI benefit as dependants

5

4. Affordability

- According to KIPF(Korea Institute of Public Finance)...
- " in 2009, NHI budget accounts for 2.27% of GDP

  ⇨ % of NHI budget should be controlled below 5% of GDP for sustainable national finance."
- "Annual growth rate of NHI budget should be controlled below 3.66% in 2050 for sustainable NHI finance"
- "Annual growth rate of NHI budget should be controlled below 4.54%, even though % of NHI budget in GDP in 2050 is allowed to be at 7%"

6

Ⅲ. Analysis of Current Financial Status

1. Financial Indicators

- In 2001, benefit amount was 13,000 billion won, but in 2010, the amount was 34,000 billion won (increased 2.55 times or 10.98% per year)

〈Table 1〉 Financial Status (unit : 100 million won)

		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Annual Growth Rate
Revenue	Total	116,423	138,903	168,231	185,722	203,325	223,876	252,697	289,079	311,817	335265	0.1247
	Contributions	90,173	108,764	133,993	150,892	166,377	185,514	215,979	248,300	263,717	281489	0.1348
	Gov. subsidies	26,250	25,747	27,792	28,567	27,695	28,698	27,042	30,540	37,838	39123	0.0453
	Surcharge on tobacco	-	4,392	6,446	6,263	9,253	9,664	9,676	10,239	10,262	10630	0.1168
Expenditure	Total	140,511	146,510	157,437	170,043	191,537	224,623	255,544	275,412	311,849	348989	0.1063
	Benefits	132,447	138,993	149,522	161,311	182,622	214,893	245,614	264,948	301,461	338133	0.1097
	Administrative cost	8,064	7,517	7,915	8,732	8,915	9,730	9,930	10,464	10388	10167	0.0260
Balance		△24,088	△7,607	△10,794	△15,679	△11,788	△747	△2,847	△13,667	△32	△13724	
Cumulative Balance		△18,109	△25,716	△14,922	△957	△2,945	△11,798	△8,951	△22,618	△22,586	△8862	

Note 1) Values based on cash flow, 2) Value in 2010 is estimated, Source: NHIC

2. Analysis of treatment exp.('02~' 09)

- Visit Days per capita increased by about 3.86% per year
- Treatment cost per visit day increased by 3.86% per year

〈Table 2〉 Levels of contribution by Factors increasing exp.

	Growth Rate	Level of Contribution
# of beneficiaries	0.59%	5.38
Visit days per capita	3.86 %	35.32
Treatment cost per visit day	6.48 %	59.30
Total exp. Growth rate	10.94(11.10)% 1)	100.00

Note. Annual growth rate of treatment amount is 11.1%, different from the sum of growth rates of each factors, 10.94% (0.59 + 3.86 + 6.48). The difference is caused by errors in data brought down to a same unit.

2. Analysis of treatment exp.('02~' 09)

- GDP% of National Total Health Exp. (THE), NHI treatment exp. and benefit exp. increase, and the growth rate of health exp. is higher than that of GDP

〈Table 3〉 Health care spending and GDP (unit : billion won, %)

	2002	2003	2004	2005	2006	2007	2008	2009
GDP (A)	720,539	767,113	826,892	865,240	908,743	975,013	1,023,937	1,063,059
Treatment (B)	18,832	20,742	22,506	24,862	28,410	32,389	34,869	39,339
Benefit (C)	13,899	14,952	16,131	18,262	21,489	24,561	26,499	30,146
B/A	2.61	2.70	2.72	2.87	3.13	3.32	3.41	3.70
C/A	1.93	1.95	1.95	2.11	2.36	2.52	2.59	2.84
C/B	73.81	72.09	71.67	73.45	75.64	75.83	76.00	76.63
THE (D)	36,534	40,653	44,071	49,227	54,783	61,888	66,700	-
B/D	51.55	51.02	51.07	50.50	51.86	52.33	52.28	-
D/A	5.07	5.30	5.33	5.69	6.03	6.35	6.51	-
C/D	38.04	36.78	36.60	37.10	39.23	39.69	39.73	-

2. Analysis of treatment exp.('02~' 09)

〈Table 4〉 Annual growth rate of GDP, treatment exp. & related var. (%)

	~2001	~2002	~2003	~2004	~2005	~2006	~2007	~2008	~2009	Avg.
GDP	7.99	10.61	6.46	7.79	4.64	5.03	7.29	5.02	3.82	6.52
Price level	4.10	2.80	3.50	3.60	2.80	2.20	2.50	4.70	2.80	3.22
Treatment exp.	38.25	5.54	10.14	8.50	10.47	14.27	14.01	7.66	12.82	13.52
Treatment exp. (except pharmaceutical exp.)	12.98	4.31	10.57	6.84	9.37	14.22	15.32	7.78	13.09	10.50
Level of Medical fee	7.08	-2.56	2.97	2.65	2.99	3.50	2.30	1.94	2.22	3.13
Benefit exp.	42.11	4.76	7.74	9.21	13.09	17.37	13.77	8.53	12.71	14.36
Contribution	22.51	23.39	25.74	13.38	8.66	11.12	15.51	14.93	4.78	15.56

Note. 1) Level of medical fee is recalculated in consideration of implementation date.
2) Price level means a growth rate of Consumer's Price Index (CPI)

10

2. Analysis of treatment exp.('02~' 09)

- Levels of contribution by factors : # of beneficiaries 5.38%, visit days per capita 35.52%, treatment cost per visit day 59.3%

〈Table 2〉 Levels of contribution by Factors increasing exp. , 2002-2009(%)

	Total		Inpatient		Outpatient		Pharmaceutical	
	Growth rate	Contribution rate	Growth rate	Contribution rate	Growth rate	Contribution rate	Growth rate	Contribution rate
# of beneficiaries	0.59	5.38	0.59	3.93	0.59	6.96	0.59	5.18
Visit days per capita	3.86	35.32	10.50	69.95	3.25	38.33	1.94	17.05
Treatment amount per capita	6.48	59.3	3.92	26.12	4.64	54.72	8.85	77.77
Treatment amount	10.94		15.01		8.48		11.38	

11

IV. Issues Relevant to NHI Finance

1. Concentration of outpatients in secondary and tertiary hospitals

〈Table 2〉 Exp. for outpatients by types of health care institutes (unit: million won, %)

	2005	2006	2007	2008	2009	Annual growth rate
Tertiary Hospital	1,201,625 (10.80)	1,436,858 (11.60)	1,684,175 (12.48)	1,844,169 (12.91)	2,288,408 (14.22)	17.47 (7.12)
General Hospital	1,271,584 (11.43)	1,480,410 (11.95)	1,666,329 (12.35)	1,882,323 (13.17)	2,075,072 (12.89)	13.02 (3.06)
Hospital	648,771 (5.83)	737,947 (5.96)	878,326 (6.51)	929,578 (6.51)	1,122,216 (6.97)	14.68 (4.58)
Clinic	5,919,406 (53.20)	6,486,972 (52.36)	6,894,908 (51.09)	7,137,975 (49.95)	7,790,382 (48.41)	7.11 (-2.33)
Total	11,126,704 (100.00)	12,389,783 (100.00)	13,496,086 (100.00)	14,288,951 (100.00)	16,092,582 (100.00)	9.66

Note. Except pharmacy and oriental health clinic(hospital)

12

1. Concentration of outpatients in secondary and tertiary hospitals

Customers

- Patients' choices of hospital w/o any regulations may cause unnecessary use of medical resources and a rise in health care costs

Providers

- Favorable system for general or tertiary hospitals
  (e.g.) Different Resource-based Relative Values by types of hospital
  - Apply differential added rates on laboratory and other fees by types of hospital
  - Tertiary hospitals get more payment(up to 50%) thru selective medical treatments

No Effective Mechanism for Health Care Delivery

- No effective mechanism and regulations for patient referral system : has been on a statutory footing but no mechanism to follow

2. Excessive exp. of drugs

- Pharmaceutical expenditures('10) : 12,800 billion won, 29.4% in total treatment expenditure
  - Pharmaceutical expenditures increased by 13.7% per year: ('01) 23.5% → ('10) 29.4% (% in total expenditure)
    - Driving factors (2005-2009) : increased dose (prescription days) 14.3%, the level of price -1.7%
    - % of pharmaceutical expenditure in total health expenditure : OECD average 14.3% (Korea 22.5%)

〈Table 7〉 Price level of first 50 components in registered generic drugs

	Korea	A7 Average	France	Germany	Italy	Switzerland	USA
Based on exchange rate	100	115	133	104	112	139	227
Based on PPP	100	70	73	58	64	67	172

2. Excessive exp. of drugs

- Drug Price policy : No strong reasons for differential price levels
  - Not reasonable to differentiate prices of drugs w/ same components
    - Higher price level of original drugs than generic, even after expiration of the patents
    - Differentiate price levels of generic simply by their orders of entry
  - Price level of generic (68% of original drug) in Korea is higher than other countries

※ Price level of generic drug in selected countries : France (50%), Austria(52%), Italy(55%), Netherland(60%), Spain(70%), Japan(70%)

3. Health care resources

〈Table 8〉 Health care institutes, personnel & appliances

	Health Care Institute		Personnel (per 1,000 people)			Appliance (per 1 million people)	
	# of acute care beds (per 1,000 people)	# of long-term Care beds (per 1,000 65yrs+people)	# of physicians (including oriental physicians)	# of pharmacists	# of nurses	# of CT Scanners	# of MRIs
Korea	6.8	9.5	1.8	0.66	2.1	34.7	16.5
OECD	4.1	6.6	2.9	0.7	7.1	17.9	9
compare	1.6 times more	1.4 times more	less than OECD		Shortage	2 times more	1.8 times more

4. Financial system

1) Financial resources for NHI revenue

Income (wage income, financial income, income from rent, transfer income, etc.)
Properties
Cars
Demographics of beneficiaries (set, age)

Including health promotion fund (surcharge on tobacco)

Contributions (83.3%) **Gov't subsidy (16.6%)**

- Foreign examples of gov't subsidy : Taiwan (25.5% of total revenue), France (47% of total revenue), Japan(35.3%)
- % of Gov't subsidy (NHI + Medical Aid) = 23.29%

17

4. Financial system

2) Contribution imposing system

- Problems of "one insurer-two imposing system"
  - One for self-employed and the other for wage income earners
  - Against Equity…
    - Differences of imposing components btwn two systems
    - Differences of qualifying conditions to be beneficiaries
    - Differences of criteria to assess income
  - Regressive imposing system
    - Regressive for the self-employed
  - Complexity
  - Income sources not applicable to impose contribution : more than 40% of total income sources

18

4. Financial system

3) Gov't subsidy

- 20% of total contribution is legislated as the amount of gov't subsidy (including health promotion fund)

  → But, actual amount is less than 20% because the level of subsidy is decided before the next year's contribution amount(estimated) is set

〈Table 9〉 Shortage of Legal Amount of Gov't Subsidy (unit: 100 million)

	2003	2004	2005	2006	2007	2008	2009	2010
Legal Amount (A)	29,748	30,808	28,645	31,612	29,754	34,214	36,309	39,407
Actual Amount(B)	27,792	28,567	27,695	28,698	27,042	30,023	37,834	39,120
Shortage(C)	△1,956	△2,241	△950	△2,914	△2,712	△4,191	215	△287
C/A (%)	△6.5	△7.2	△3.3	△9.2	△9.1	△12.2	0.59	△0.73

Source: NHIC

19

5. Payment system

- Current payment system : Fee-For-Service (paid by unit service)

  Fee for service (medical fee)
  = relative value of a unit service x conversion factor (unit price per each score)

- Under FFS system, difficult to control medical costs because of 1) providers' behavior to maximize their revenue; and 2) information asymmetry

  [Providers' Revenue = Price x Quantity]

  - Providers tend to increase quantity to maximize revenue under the circumstance that price(medical fee) is uncontrollable
  - Because of medical information asymmetry, providers have power to decide service quantity (service frequency and intension)

20

Ⅴ. Financial Projection

Financial Projection

Source	Growth Rate	Decomposing Growth (%)			
		Total	Age effect	Income effect 1)	Residual effect
OECD(2006): base on Public health expenditure	OECD average, 1981-2002	3.6	0.3	2.3	1.0
	OECD average, 1970-2002	4.3	0.4	2.5	1.5
	Korea, 1982-2002	10.1	1.4	6.1	2.4
NHI benefit	Korea, 2000-2009	12.65	1.83	5.83	4.99

Source: OECD, 2006; Korean NIH yearbook, each year; GDP data from Korean Bank
Note: 1) income elasticity = 1

Financial Projection

- GDP % of expenditure on in-kind benefits from 2009 to 2050 is projected to increase by 2.71% (Scenario6, most positive) to 18.81% (Scenario1, most negative)

Year	Estimated GDP	Scenario1	Scenario2	Scenario3	Scenario4	Scenario5	Scenario6
2015	1,368,023	57,955	56,753	55,630	56,346	55,144	54,021
2020	1,682,088	93,192	87,407	82,252	89,580	83,795	78,640
2025	1,940,554	138,321	121,433	107,496	132,422	115,534	101,597
2030	2,238,734	202,218	162,128	132,376	193,604	153,514	123,762
2035	2,418,890	273,716	195,000	147,791	263,644	184,928	137,718
2040	2,613,542	368,050	226,013	162,430	356,278	214,241	150,658
2045	2,737,353	478,508	244,955	170,200	465,210	231,657	156,903
2050	2,867,030	623,418	257,120	176,309	608,911	242,613	161,802

Financial Projection

Year	Scenario1	Scenario2	Scenario3	Scenario4	Scenario5	Scenario6
2015	4.24%	4.15%	4.07%	4.12%	4.03%	3.95%
2020	5.54%	5.20%	4.89%	5.33%	4.98%	4.68%
2025	7.13%	6.26%	5.54%	6.82%	5.95%	5.24%
2030	9.03%	7.24%	5.91%	8.65%	6.86%	5.53%
2035	11.32%	8.06%	6.11%	10.90%	7.65%	5.69%
2040	14.08%	8.65%	6.21%	13.63%	8.20%	5.76%
2045	17.48%	8.95%	6.22%	16.99%	8.46%	5.73%
2050	21.74%	8.97%	6.15%	21.24%	8.46%	5.64%

Note: based on 2009 GDP% of NHI expenditure (when administrative expenditure, excluding benefit expenditure, is 2.93% of GDP in 2009)

Financial Projection

〈Table 12〉 Required Contribution Rate based on Projection Results (%)

Year	Scenario1	Scenario2	Scenario3	Scenario4	Scenario5	Scenario6
2015	7.44	7.28	7.14	7.23	7.08	6.93
2020	9.73	9.12	8.58	9.35	8.75	8.21
2025	12.51	10.99	9.72	11.98	10.45	9.19
2030	15.86	12.71	10.38	15.18	12.04	9.70
2035	19.86	14.15	10.73	19.13	13.42	9.99
2040	24.72	15.18	10.91	23.93	14.39	10.12
2045	30.69	15.71	10.92	29.83	14.86	10.06
2050	38.17	15.74	10.80	37.28	14.86	9.91

Financial Projection

- Data sources and Assumptions
  - Data Sources

DATA	SOURCE	DESCRIPTION
Population	KIHASA, 2011	# of beneficiaries were projected under the assumptions that the percentage of beneficiaries in total population is consistent over the projection period .
Life expectancy, # of death	Statistics Korea, Population Projections, 2006	
Expenditure on NHI, 2009	NHIC, NHI Stat Yearbook, 2009	Benefits in kind by each age group (94% of total benefits)were obtained separately from the other benefits (cash benefit& admin. Finance), which are not age-specific.
GDP	Park, Ryu & Cho, KIPF, 2006	Potential GDP growth rate (~2050)

Financial Projection

- Data sources and Assumptions
  - Methodology : Based on projection methodology used in OECD(2006) 『Projecting OECD Health and Long-term care Expenditures』[1], in consideration of characteristics of Korean NHI
    - Decomposing growth in health spending into (1) age effect, (2) income effect, (3) residual effect in the last 10 years
    - Average amounts of benefit in kind by age group were used to project expenditure increased by demographic drivers; Healthy ageing is also considered in selected scenarios
    - After controlling for demographic and income effects, a residual expenditure can be driven

Financial Projection

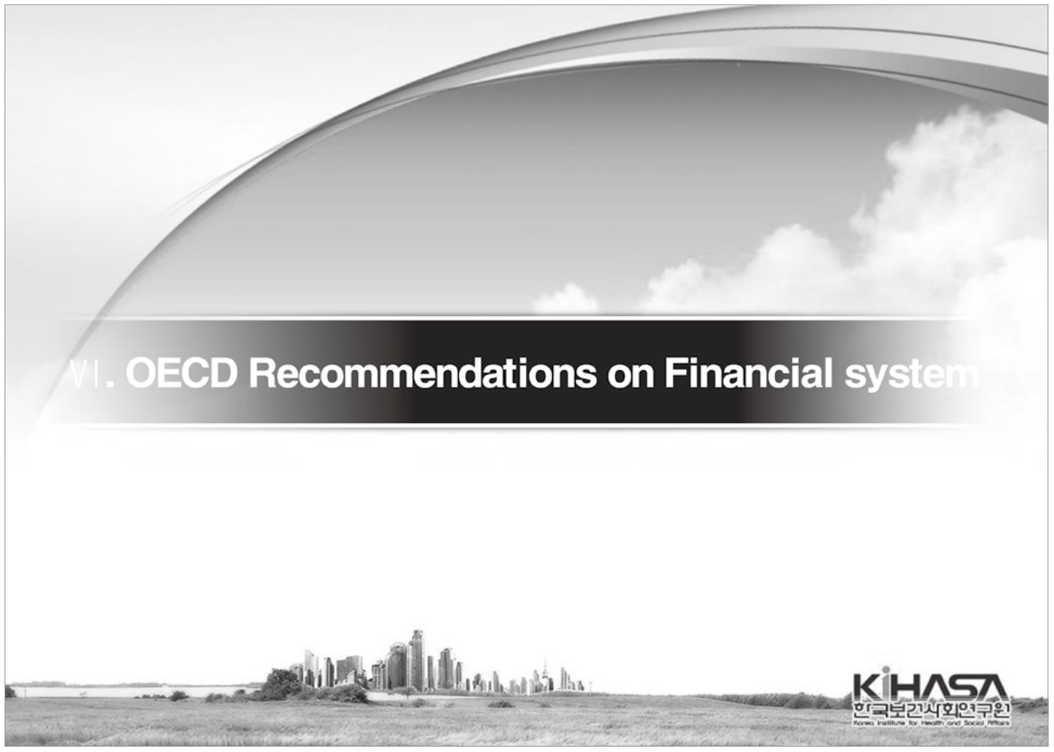
- Projection Assumptions underlying 6 scenarios

Scenarios	Demographic effect	Income elasticity	Expenditure residual
1	No healthy aging adjustment	ε =1	The expenditure residual grows at 4.99% per year over the projection period (in line with past trends)
2			Residual growth converges to 0% by 2050
3			Residual growth converges to 0% by 2030
4	Healthy aging : longevity gains are translated into equivalent additional years in good health		The expenditure residual grows at 4.99% per year over the projection period (in line with past trends)
5			Residual growth converges to 0% by 2050
6			Residual growth converges to 0% by 2030

Financial Projection

- Even under assumptions that % of gov't subsidy (including surcharge on tobacco) in total revenue is kept at 20%, required contribution rate in 2020 is estimated as higher than 9%
  - 2.9 times more contribution amount than 2009
  - Currently, 8% is legislated as a contribution ceiling
- Therefore, financial sustainability of NHI is questionable under the current finance system → Need to extend financial resources

27



OECD Recommendation

- It is necessary to have financial resources enough to meet rapidly increasing health care expenditure
- More revenue from contribution and taxation is needed to meet increasing expenditure
  - Continuous dependency on social insurance may be a barrier against economic growth and employment.
  - As an "economic-friendly" approach, a form of taxation should be introduced to bear expenses fairly among total population and income groups
  - According to OECD(2008), indirect taxes (e.g. VAT) are more favorable than direct taxes (e.g. social insurance contribution, income tax)

28

1. Reform on Delivery System

1) Short-term strategies

Customers

• Control of outpatients' use of tertiary or general hospitals :

Increase copayment of outpatients 'services in general, tertiary hospitals

Motivate primary care utilization

• Differentiate copayment rate of outpatients' drug costs by types of institutes

Providers

• Equalize relative value in Different types of hospitals

• Abolition of fee for selective medical treatments (outpatient services)

•Control of # of outpatients in tertiary hospitals (8-9 patients per an hour/doctor)

29

1. Reform on Delivery System

2) Long-term strategies

emphasis on primary care	Specialized- or base-hospital	Specialized for intensive care
• Primary care as a gatekeeper to manage chronic diseases • Introduction of designated doctor system (esp. for patients w/ frequent service use)	•Competitive hospitals to be disease- specific specialized hospitals • Competitive regional hospitals to be regional base-hospitals •In the long-term, induce 1st&3rd delivery system (w/o 2nd level)	• Large general hospitals to be reorganized into specialized hospitals for intensive care

Long-term strategies

30

2. Appropriate &efficient use of medical resources

- Introduction of monitoring system for appropriate supply and demand of medical resources
  - Make a long-term policy roadmap and monitoring system for health care personnel, institutes and appliances
- Reasonable distribution by region
  - In consideration of different levels of physical health, mental health, public health, disabled people and older population by region, make policy and evaluation system for medical resource distribution
  - Regionalization of essential public health care services (e.g. primary care, emergency care, maternal and child health care services) : in order to meet the each region's service needs

31

2. Appropriate &efficient use of medical resources

- Policy suggestions for expensive medical equipments
  - Only medical equipments, proved as technologically and clinically effective, should be covered by NHI
    - w/ control of utilization : frequency of use (# of cases) interworks w/ medical fee (e.g. Italy) → Prevent inefficient uses
  - Approve only 50% of regular medical fee when epuipments are over the depreciation period
  - In the long-term, pre-payment system (e.g. global budgeting, capitation, DRG) should be used rather than post-payment system (e.g. FFS)
    → Induce providers to reduce unnecessary use of expensive medical equipments

32

2. Appropriate &efficient use of medical resources

- Control of over-supply and inefficient use
  - Group purchase & use of expensive medical equipments
  - Examination result of patients to be available to the referred institutes
  - Should be covered by insurance only for equipments which are evaluated as effective

33

3. Extending NHI Finance

- Recommendation on the amount of gov't subsidy
  : Subsidize for 50% of NHI benefit expenditure of older beneficiaries (65yrs +)
  - If implemented, the amount of gov't subsidy in 2020 is estimated at 19,080 billion won (21.83% of total 87,410 billion won) as the benefit amount of older beneficiaries (65yrs+) is estimated at 38,160 billion won (43.66% of total)

34

3. Extending NHI Finance

- Improvement of the Dependant Status Approval Standards
  - Exclude siblings from the category of dependants
    (In accordance to dependant status of National Basic Livelihood Security Act)
    - Siblings who are excluded should be transferred to self-employment insurance, but those who are eligible for Medical Aid should be transferred to Medical Aid
  - Exclude dependants w/ a certain amount of property : Dependants with considerable amount of property should be seen as having some economic ability, so they should pay insurance premium based on the principles of social insurance.

35

3. Extending NHI Finance

- Levy of insurance premium on earnings omitted from contribution imposing system
  (e.g. pension income, financial income, rent income, transfer income)
  - Imposing contribution on pension income :
    Exclude those who earns more than the minimum cost of living through pension income from the category of dependants and transfer to occupational insurance

36

4. Improvement of Contribution Imposing System

- Short-term : Improvement of current system
  - Simplify the complex contribution imposing system, esp. for the self-employed
  - Reduce repressiveness of contribution imposing system of the Insurance for the self-employed
  - Introduction of base premium : to raise the responsibility of beneficiaries
  - Abolition of the base line of 5 million won in the self-employed insurance : Apply same standards to all
  - Transfer certain kinds of self-employees (e.g. registered as the self-employees, but actually employees) to occupational insurance
- Long-term : introduce base premium and a income-based unified form of contribution imposing system

37

5. Payment system

- Place responsibility on providers through payment system (DRG, Global budget, P4P, etc)
  - Outpatient : Decide the amount of total budget through capitation and family/individuals' doctor system
  - Inpatient : Introduce a new mechanism(decide medical fee in accordance to the # of cases), in addition to overall DRG
    - Differentiate medical fees between acute care and chronic disease care
    - Increase budget in accordance to a rise in GDP, aging, coverage extension, CPI
    - Association of providers who have knowledge and clinical experiences leads to make specific budget distribution plans (including review and assessment of benefit expenditure)

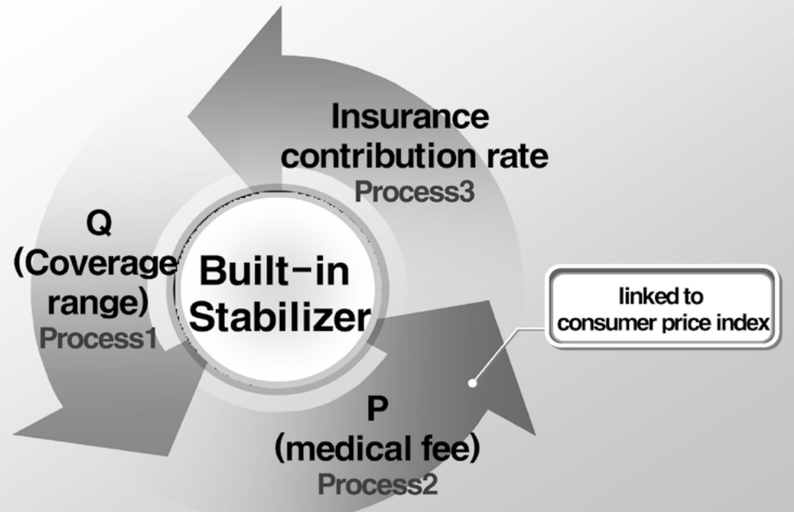
38

5. Payment system

- Considerations to reform payment system
  - Need clear information about hospital administration, finance, cost structure, and accounting standards
  - Functional differentiation of health care institutes and role sharing between specialists and general doctors
  - Continuous extension of NHI coverage (to prevent substitution of covered treatment category to uncovered treatment category)
  - Introduce monitoring system to keep quality of health care services
  - Opening of medical information
    : Provide integrated service system via access to information of medical institutes and IC card
  - Adjust medical fee acceptable enough to providers

39

6. Introduction of Built-in Stabilizer



40

6. Introduction of Built-in Stabilizer

- Mechanism under which, the level of insurance contribution rate is automatically decided according to the scale of coverage and level of medical fee by linking 1) the levels of coverage, 2) medical fee and 3) contribution rate
  - For the mechanism to be possible, medical fee (P) should be decided later in connection with the quantity of medical service (Q), rather than being decided in advance as at present. The total amount of insurance benefits (REV=P×Q) is determined in advance.
  - The quantity of medical service(Q) is set reflecting the degree of aging, increase in income and expansion of coverage.
  - Prospective level of fee (P) is linked to consumer price index

40

Session II

Discussion

윤석준 (고려대학교 보건대학원 교수)
박민수 (보건복지부 보험정책과장)
김진수 (한국보건사회연구원 연구위원)

Session III

Panel Discussion:

Sustainability of Health Care as a Social Insurance Program

Session III

Discussion

Monika Steffen / Franz Knieps /
Etsuji Okamoto / Ming-Chin Yang /
신영석 / 이상일 / 최병호 / 정형선 / 윤석준 / 박민수 / 김진수