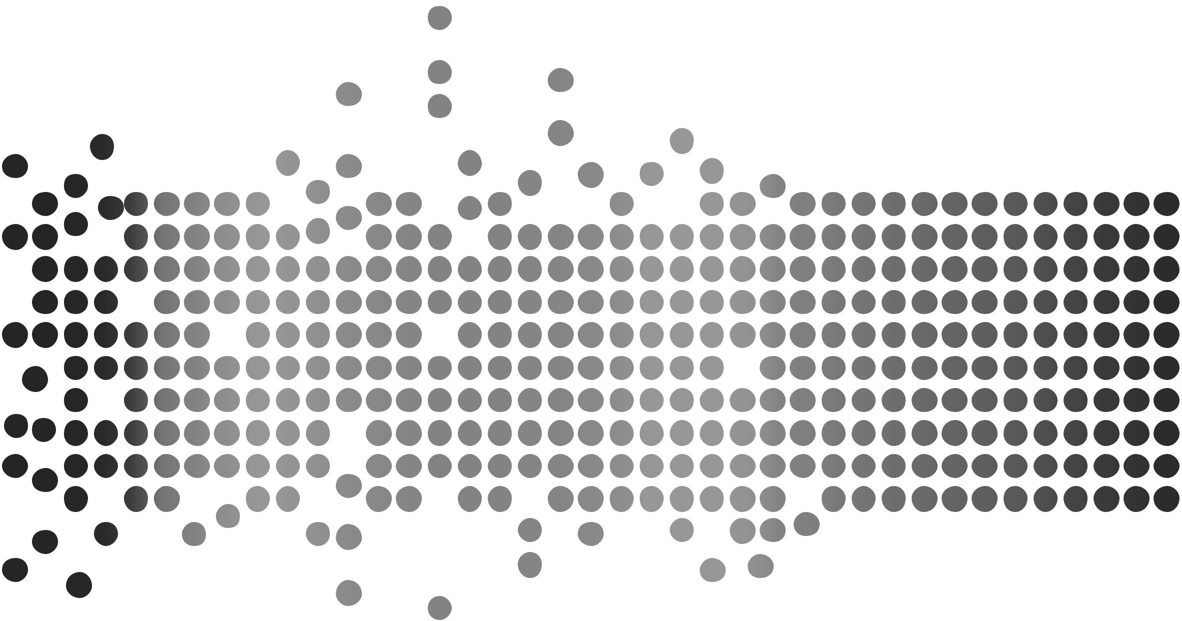
Research Paper 2009-12

A study for improving the efficiency of health security system: the division of roles between public and private health insurance in Korea

Seokpyo HONG



KIHASA Korea Institute for Health and Social Affairs

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A study for improving the efficiency of health security system: the division of roles between public and private health insurance in Korea

Seokpyo HONG, Ph.D in Economics

ⓒ 2009
Korea Institute for Health and Social Affairs

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The Korean National Health Insurance (NHI), Korea's public health insurance, has made a great stride since its introduction in 1977. Despite its remarkable growth in both quantitative and qualitative terms, the coverage and financial structure of NHI have been criticized. Expansion of the role of private health insurance to overcome these weaknesses has become an issue of heated debate in Korean society. The point of the discussion is whether the expansion of private health insurance would result in undermining the foundation of the public health care system rather than complementing it. The key argument of the negative aspect is weakening of equity of medical services.

It is well known that health care is a sector in which the efficiency of market competition is relatively limited. Nevertheless, the need for adopting market competition is continuously argued for in areas where there is no rationale for government intervention. The U.S. government practices the competition principle even in health care and intervenes only in areas where external effect is maximized such as medical services for the underprivileged and R&D. On one hand, such policy has made great strides in medical technology. On the other hand, however, the U.S. faces serious problems such as rising health care expenses and a significant portion of the population left uninsured.

On the contrary, most OECD member states including western European countries have approached heath care from the social security perspective. The traditional approach helped realize universal coverage, but has been criticized for not meeting the needs of the people in responsiveness. To counter this weakness, ways of introduction of competition and appropriate utilization of private insurance have been explored.

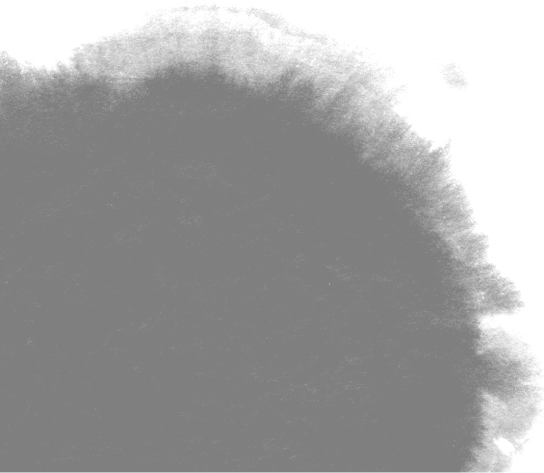
Competition is a fundamental principle. But the problem is whether the principle of competition can effectively function in the health care system. Competition and choice in health care has intrinsic limitations because of asymmetric information with regard to medical goods and services. Therefore, European examples provide implications for Korea since they seek to provide medical services equally and efficiently for the whole population by strengthening the coverage of the public health insurance and containing demand based on the principle of equity.

This study has examined the current status of healthcare system in Germany, France, and the Netherlands. They view health care as public goods, and this approach has been criticized for not rapidly responding to customers' needs though it realized universal coverage. That was why many advanced countries have explored ways to adopt competition and make use of private health insurances. The role of private health insurance differs from one country to another. However, what is in common is that, the private insurance system is a pillar of social security while equity of health care system is maintained through strict regulations on private plans. The expansion of the role of private health insurance needs to be discussed from a number of different perspectives. If the topic is limited to

responsiveness to consumer needs and weakening of equity in health care system with expansion of private health insurance, the European experience provides a lot of lessons to be learned.

01

Introduction



Ⅰ. Introduction

The National Health Insurance of Korea, introduced in 1977, was designed to prevent anyone from being denied medical access or from falling into poverty under the heavy burden of medical expenses. Comparison with other advanced countries reveals that the National Health Insurance of Korea, though introduced rather later, by modeling after various programs of advanced countries, was stabilized in a relatively short period of time and Korea is recognized for the most dramatic improvement in public health achieved during the past three decades among OECD countries.

〈Table Ⅰ-1〉 Time it has taken before universal coverage

Nation	Period of Time
Germany	1854-1995 year(134 year)
Belgium	1851-1969 year(118year)
Israel	1911-1995 year(84year)
Australia	1888-1967 year(79 year)
Luxembourg	1901-1973 year(72 year)
Japan	1922-1958 year(36 year)
Korea	1977-1989 year(12 year)

Note: The figures in parenthesis represent the number of years it has taken from the introduction of the Medical Insurance Act to the achievement of universal coverage.
Source: International Social Security Review, 2005.

Korea has significantly elevated the public's access to healthcare at an affordable price. The implementation of the health insurance has advanced the public health remarkably as Conference Board in Canada(Feb.2006) ranked Korea fifth for the performance of its health care system among OECD countries. Many factors including an improved living standard, a better sanitation, and a higher educational level have contributed to the elevated level of public health. However, the introduction of national health insurance system has also played a significant role.

The health insurance system in Korea has accomplished a new leap forward with the successful integration of its organization. A new decision-making structure based on consensus among subscribers, the insured and health care service providers was established, allowing it to operate more democratically.

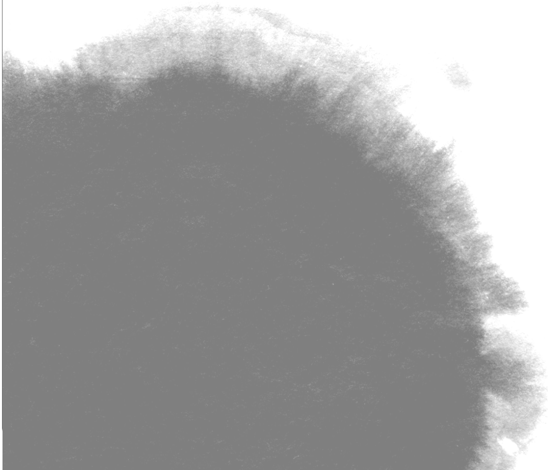
Nonetheless, the public does not seem to regard it positively. Like an overgrown kid, the system has grown in size significantly but falls short of the public's expectation for a reliable social safety net. Since 2005, the covered services have been expanded intensively to include cancers, and some cases of cardiac diseases and cerebrovascular diseases, lessening financial burdens on patients. There are still a great number of serious high-cost diseases that are excluded from the intensive coverage expansion measure. Patients suffering from such diseases are supported with less than half of what they actually pay to be treated. They are forced to personally finance the treatment with a great risk of falling into poverty. In addition, the inequity of insurance

premiums between employees and the self-employed has resulted in discontent on the issue. It is hardly the case that varied desires of the public for medical services are sufficiently and adequately satisfied.

Therefore this study aims to conduct a functional analysis of public and private health insurance which is the parter of national health insurance plan in Korea and provide suggestions on the division of the roles between the two. This study provides the characteristics of the Korean healthcare system: health insurance as a medical security program, national health insurance scheme, promotion of financial stability in national health insurance, status of private health insurance. Also this study examines the characteristics of healthcare system in Germany, France, and the Netherlands, which have successfully promoted private health insurance and at the same time, ensure the equity of medical services. The cases are expected to provide policy implications for Korea where the expansion of the role of private health care insurance is under discussion.

02

Characteristics of the Korean Healthcare System



II. Characteristics of the Korean Healthcare System

What is unique about the Korean healthcare system is that, the national insurance system is maintained along with the private health insurance system. Such trait dates back to the strategy introduced in the early days of the health insurance system. In the 1970s, the government led the health insurance system with centralized procurement of financial resources. In other words, medical services were provided by the private sector while financial resources were supplied in the form of social security, determining one of the important characteristics of the Korean healthcare system. The government led the procurement of financial resources for the healthcare system but the substantial portion was left to individuals, allowing the public portion of the medical costs to remain low, and at the same time, the prices of medical services to be controlled, which in turn expanded the supply of medical services rapidly.

Thanks to such strategy, the Korean public could be covered by the national health insurance in the early stage, but the coverage was not enough as compared to those in other developed countries. In other words, the public's access to medical services was improved greatly in a short period of time but the services not covered by the national health insurance also increased. Low coverage level and

increase in non-covered services led to a high-level of co-payment for patients, which has been seen as one of the biggest culprits for the weak coverage of the national health insurance. In 2006 the public coverage in healthcare accounted for 64.3% of total medical costs including costs for non-covered services, and co-payment level reached 35.7%.

1. Health insurance as a medical security program

Health security plan is part of social security system that helps alleviate the financial burden of medical expenditure. If individuals or the market is responsible for dealing with the issue of medical expenditure, the majority of the people would feel burdened and in particular low-income families would suffer the most. The medical security program is a system where the whole nation takes joint responsibility of medical expenditure. It is to form a social solidarity for social justice.

Medical security program takes a variety of forms subject to the historical and social uniqueness of each nation. However, cross-country comparison helps characterize general medical security plans. They are categorized into national health insurance and national health service subject to their funding method of administrative costs and doctors' fees. National health insurance is a plan where individuals try to deal with various health threats by using an insurance method. It is mainly financed by premiums that individuals pay. Germany, France, Japan, and Taiwan are some examples that operate national health insurance. In some other

countries, the government takes on the responsibility of the public's health, which is called national health service. Under the system, the government collects tax from the public to provide the public with medical security plan. UK, Sweden and Italy are examples of countries that adopt national health service.

Korea has adopted national health insurance for its health insurance system. National health insurance is a plan that takes joint responsibility for and provides security against general social risks such as old age, diseases, disability, death or unemployment. The plan is funded by insurance premiums or tax. Contribution is made based on beneficiaries' financial capability and benefits are provided when beneficiaries' needs arise (or in proportion to their contribution). Health insurance as a part of social insurance is instituted to remedy market failure in the medical economy.

The main characteristic of health insurance plan is that it is a compulsory and short-term insurance. The whole population is required to subscribe to this compulsory insurance by the law. It is a short-term insurance, which means the insured should make a monthly payment to receive benefits whenever they need to seek medical attention. It is public insurance, clearly different from private health insurance in a sense that all the population is equally entitled to benefits and that an insurer is not allowed to choose risks that it provides coverage against. It is also different from a free health benefits plan that the government provides for low-income families since it prepares the insured for future risks by making premium payments against unpredictable future risks.

The institutional framework for health insurance program as medical security was established in the beginning of 1960. The

Medical Insurance Act was enacted in December 1963 to take effect in June 1965 targeting employees of companies with more than 300 employees, farmers, and fishermen on a voluntary basis. However, the implementation was postponed till a better condition for successful establishment was to be created. It was 1977 when the Act was implemented in earnest with the workplace medical insurance program for companies with more than 500 employees. Afterwards, the health insurance system had consistently pursued quantitative expansion till universal coverage was finally provided. In 1979, medical insurance programs for public officials and private school employees were created. In 1988, the population in rural areas was covered by the medical insurance plan. In 1989, the plan was expanded to cover urban population. It took only 12 years to provide universal coverage and the pace was unprecedented.

Health insurance system have supported quantitative and qualitative advancement of medical services, brought down economic barriers to medical services and expanded healthcare access. Universal coverage was a milestone in a sense that ever since, medical service providers have grown in numbers enormously.

During the 1990s, health insurance had dramatically expanded healthcare access of the public as average doctor's appointment per capita was 10.6 days in Korea compared to 7.5 days for OECD average. However, there was a long way to go before the universal medical security for all citizens.

Even though universal coverage was provided in 1989, when the self-employed in urban areas were brought under medical insurance programs, the medical insurance system based on associations with different funding and benefits and entitlement standards had its own

limitations in terms of risk diversification, social solidarity, and administrative efficiency. The way health insurance was managed and administered based on associations led to ailing associations with poor financial health. These ailing associations were impediment to the whole organization's efforts to expand benefit coverage. In order to overcome institutional limitations of health security system relying on small-size associations and to achieve equity in premium payment and a stronger social solidarity, the integration of health insurance seemed mandatory, not an option.

Korean government under the ruling principle of productive welfare implemented an institutional reform on health insurance based on the first five-year reform plan. The most noteworthy outcome of the first five-year reform plan was the integration of health insurance that used to run as associations. In October 1998, the first phase of integration was conducted targeting 227 medical insurance programs for public officials and private school employees and in July 2000, the second phase of integration was implemented on workplace health insurance associations.

The integration was able to bring social integration forward through expansion of the ranges of risk diversification. Risk diversification now was achieved not on association level but on the national level. The same was true to income redistribution functions, which allowed health insurance system to contribute to social integration. Efficiency in administration and operations was improved as well. The total 147 administrative offices of health insurance or 37% of the total number of administrative offices were eliminated, 58 offices were closed at the first integration phase and the remaining 89 offices were closed at the second phase.

2. National health insurance scheme[1)]

1) Brief history of national health insurance

☐ 1960s

- Dec. 1963 The Medical Insurance Act was legislated

☐ 1970s

- Jul. 1977 Compulsory Medical Insurance program was introduced for companies with more than 500 employees
- Jan. 1979 Medical Insurance program was extended to companies with more than 300 employees, and the public officials and private school employees(Korean Medical Insurance Corporation; KMIC). Medical care institutions came to be compulsory designated as medical service providers of Medical Insurance program.

☐ 1980s

- Jan. 1981 Companies with more than 100 employees was included in the National Health Insurance (NHI) program. The 1st pilot program for self- employed medical insurance started in three rural areas
- Jul. 1982 The 2nd pilot program for self-employed medical insurance was initiated in two other rural areas and urban area. The coverage of employees medical insurance was compulsorily expanded to the workers who were employed at companies with 5 workers or more.
- Jan. 1988 The persons who were self-employed in rural area

1) This section is from www.nhic.or.kr, the website of National Health Insurance Corporation.

came to be covered. The employees from companies with 5 workers or more came be covered compulsorily.

☐ 1990s

– Oct. 1998 All self- employed insurance societies and KMIC were merged into the National Medical Insurance Corporation.

☐ 2000s

– Jul. 2000 All insurers were integrated into a single insurer, National Health Insurance Corporation (NHIC). Independent organization for health care service review and evaluation, Health Insurance Review Agency (HIRA), was established. Contract System for determining medical fee was introduced. The separation of prescribing and dispensing of drugs was implemented.

– Jan. 2000 Special Act for the Financial Stability of National Health Insurance was enacted(enforced on July 1, 2002).

– Jul. 2003 The separated health insurance funds between employee and self-employed insurance program was fully integrated in 29 July 2003.

– Jul. 2004 Co-payment Ceiling System was introduced to alleviate financial burden of households against catastrophic or high-cost diseases.

– Jun. 2005 Road Map for extending benefit coverage was made and publicized.

– Jan. 2006 Foreigners employed in Korea were mandatorily covered with the NHI program by law. Costs of meals for hospitalization were covered by the NHI program.

– Jul. 2008 Introduction of Long term care Insurance.

2) Related laws

☐ Introduction

- There are two Acts that regulate the national health insurance program of the Republic of Korea. One is a National Health Insurance Act which was promulgated on February 8, 1999. The other is a Special Act for Financial Stabilization of National Health Insurance which was promulgated on January 19, 2002 as a law in force only for a limited period of time.

☐ National Health Insurance Act

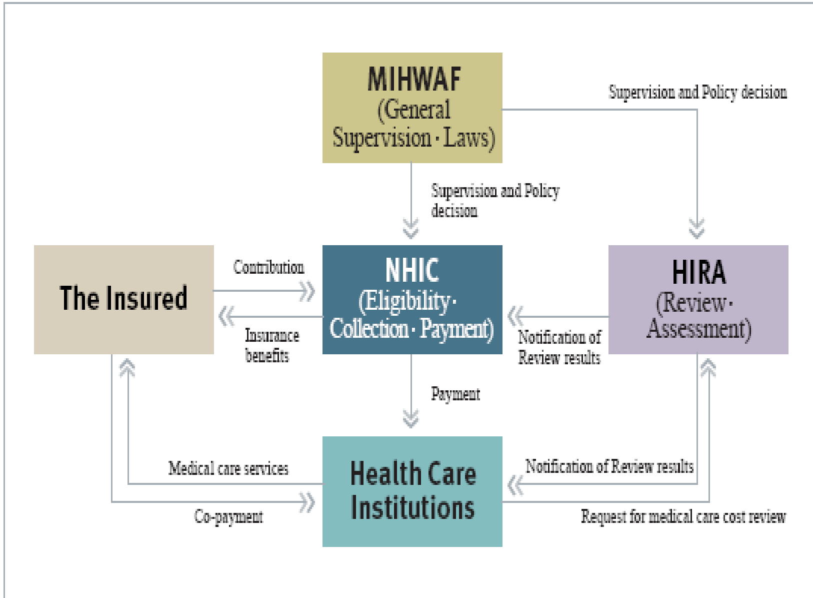
- The main objectives of the National Health Insurance Act are to integrate multiple insurance societies into a single insurer system, to enhance administrative efficiency and equity of financing, and to provide comprehensive health care services including health prevention and promotion for the people.

☐ Special act provides for financial stabilization

- This Act was legislated to address the financial crisis in the NHI which had been getting deteriorated rapidly since 1999, while maintaining a balance between revenue and expenditure for a sustainable health insurance system. Most importantly, the Special Act provided for Government's financial responsibility to secure a certain level of funds through government subsidy. However, the Act expired on Dec. 31, 2006

3) Operation structure of health care system

[Picture II-1] Relations between parties of national health insurance



☐ Ministry for Health, Welfare and Family Affairs (MIHWAF)

- The Ministry for Health, Welfare and Family Affairs (MIHWAF) provides general supervision about the operation of the NHI program through the formulation and implementation of policies.

☐ National Health Insurance Corporation (NHIC)

- The National Health Insurance Corporation (NHIC) is a public insurer for the public health insurance program in Korea. The NHIC is responsible for administering the national health insurance, including management of the enrollment of the insured and their dependents, the collection of contributions, the setting of medical fee

schedules through negotiation with providers, the provision of health insurance benefits, and so on.

☐ Health Insurance Review Agency (HIRA)

- The Health Insurance Review Agency (HIRA) is responsible for reviewing medical fees and evaluating whether health care services are medically necessary and delivered to beneficiaries at an appropriate level and cost.

4) Health care delivery system

☐ Health care delivery system

- Patients can select any practitioner or any medical care institution. When a patient wants to receive the medical care from a secondary hospital (specialized general hospitals), the patient must present a referral slip issued by the doctor who saw the patient first. Exceptions in the referral system are in the case of childbirth, emergency medical care, dental care services, rehabilitation, family medicine services and medical services for a hemophiliac in which case any health care institution can be utilized without any limitation.

☐ Referral arrangement

- First step : all institutions except for specialized general hospitals
- Second step : specialized general hospitals

5) Population coverage

(1) Mandatory coverage

— By covering the total population, the Health Insurance System of Korea constitutes one of major parts of the Korean social insurance system. Enrollment is mandatory for all Koreans residing in Korean territory, except for some Medical Aid beneficiaries.

— The insured persons under National Health Insurance Program are classified into two categories : the employee insured and the self-employed insured.

〈Table II-1〉 Number of covered population, 2007

(unit: person)

Classification		Coverage	(%)
Total		49,672,388	100
Subtotal		47,819,674	96.3(100)
NHIC	Employee Insured	28,424,424	59.2(61.5)
	Self-Employed Insured	18,395,250	37.1(38.5)

(2) Covered population

— In 2006, the total number of persons covered by the NHI reached over 47 million, or about 96.4%of the total population. The remaining 3.6%, 1.7 million, who are indigent or belong to low-income brackets, are covered by the Medical Aid program, a Korean public assistance program.

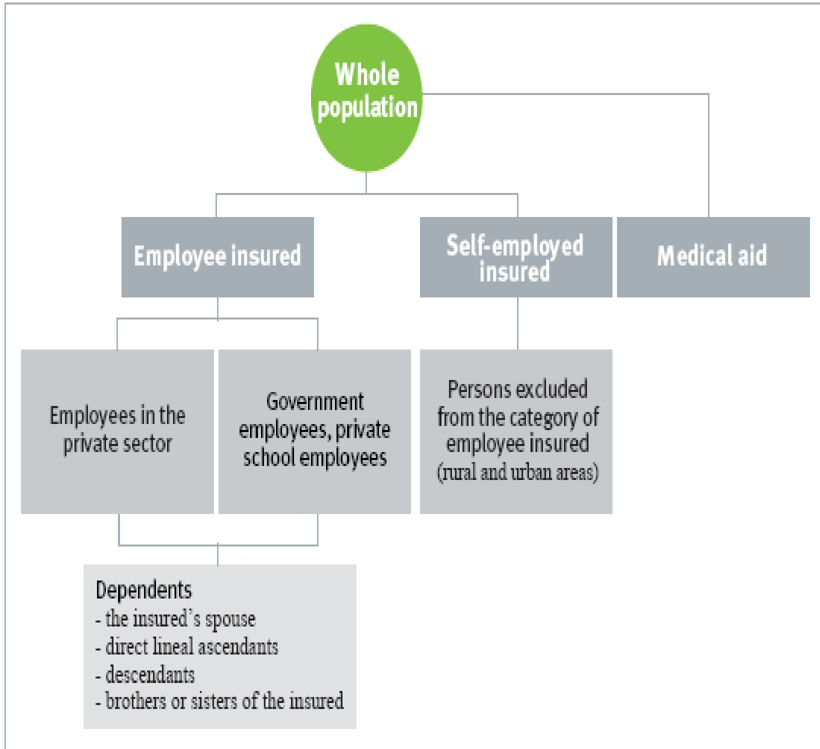
〈Table II-2〉 Number of covered population, 2006

(unit: person)

Classification		Coverage	(%)
Total		49,238,277	100
Subtotal		47,409,600	96.3(100)
NHIC	Employee Insured	28,455,033	57.7(59.9)
	Self-Employed Insured	18,964,567	38.6(40.1)
Medical Aid		1,828,627	3.7

(3) Category of the insured

〔Picture II-2〕 Category of the insured persons



〈Table II-3〉 Number of insured 2006

(unit: person)

Classification	No. of companies	No. of employees	No. of dependents	Dependency ratio
Employee Insured	727,622	10,415,340	18,029,693	1.73
	No. of households	Insured individuals		Insured members per household
Self-employed Insured	8,107,304	18,964,567		1.34

☐ Contribution

- The payment of contributions is the responsibility of employers and all members of households. In the case of any failure of payment, the insurer (NHIC) could carry out coercive collection in accordance with the relevant provisions of the law.

☐ The employee insured

- The contribution of employee insured is based on salary of the insured. And the current contribution rate of the employee insured is 5.08%. The contribution of the employee insured is borne by both the employee and the employer.
- Monthly contribution = average monthly salary × contribution rate(5.08%)

☐ The self-employed insured

- For the self-employed insured, contributions are basically calculated on the basis of income. The contributions are calculated by using a formula in which the insured persons' properties, income, motor vehicles, age, and gender are taken into consideration.

— Monthly contribution = contribution points × value per point(148.9 KRW; Korean Won)

〈Table II-4〉 Contribution rates

Classification	Year	2005	2006	2007	2008
Employee Insured	Contribution Rate	4.31%	4.48%	4.77%	5.08%
Self-employed Insured	Value per Point	126.5 KRW	131.4 KRW	139.9 KRW	148.9 KRW

〈Table II-5〉 Imposition and payment of contribution

<table>
<tr><th></th><th colspan="2">Employee Insured</th><th>Self-employed Insured</th></tr>
<tr><td>Monthly Contribution</td><td colspan="2">Average Monthly Wage × Contribution rate(currently 5.08%)</td><td>Contribution points × value per point(currently 148.9 KRW)</td></tr>
<tr><td rowspan="2">Responsibility of payment</td><td rowspan="2">Corporate Employees
- employee 50%
- employer 50%</td><td>Government employees:
- employee 50%
- government 50%</td><td rowspan="2">Members of household</td></tr>
<tr><td>Private School employees:
- employee 50%
- owner of private school 30%
- government 20%</td></tr>
<tr><td>Collection</td><td colspan="2">Deducted from salary</td><td>Monthly billing, individual payment</td></tr>
<tr><td>Due Date</td><td colspan="3">By the 10th day of following month(every month)</td></tr>
</table>

☐ Reduction of contribution

— For the insured in rural areas

- 50% of contribution can be reduced for the insured in islands or remote rural areas, 22% for the insured in rural areas, 10 ~ 30% for insured who have a low income.

— For the insured who have a family member aged 65 or over

and the disabled

• The maximum reduction rate for contribution is 30%.

(4) Foreigners

☐ What is the national health insurance ?

– To enhance the public health and strengthen social security, the National Health Insurance Corporation (NHIC) is providing health care benefits against illnesses and injuries for the insured persons. The insured persons under the NHI program are classified into two categories: the employed insured (including the public officers) and the self-employed insured (including farmers, fishermen and the self-employed in urban areas)

☐ Condition for enrollment

– The employed insured: Those who have registered as foreigners at the Immigration Office and are the employers or the employees of work places in Korea are covered as the employee insured.

• The coverage for foreigners who work at the work places under the NHI has been compulsory since the first of January in 2006.

• For the following, regarding company employees, they can be excluded from application as of July 31, 2007.

– For foreigners receiving medical benefits under foreign law and insurance.

– For those receiving medical benefits under contract with employer.

※ But for holders of E-9 and H-2 residing certification visas, the benefits are provided unconditionally.

- For the French health insurance company plan subscribers, tentative application is possible (From June 1, 2007)

─ The self-employed insured: Foreigners who have the following status of sojourn and are excluded from the category of the employee insured can be the self-employed insured on the voluntary basis.

- The status of sojourn: F-1~5, D-1~9, E-1~10, H-2, Korean nationals residing foreign countries ＊However, the coverage of those who have the status of stay E-6 and E-10 are effective from the first of January, 2008.

□ Enrollment procedures and documentations required

─ The employed insured: Foreign workers shall make an application for enrollment to the employer of their work places who is by law responsible for submitting the application to the NHIC with relevant documents including a certificate of foreign registration.

─ The self-employed insured: For the self-employed coverage, foreigners shall make an application for enrollment at any nearest NHIC branch office in their residential area with a certificate of foreign registration.

□ Imposition of contributions and payment

─ The employed insured:

- Monthly Contribution = 「Monthly Wage × Contribution Rate」 (50% of which are paid by the employer)
- The obligation of contribution payment is retroactive up to the date the enrollee was employed and the contribution

shall be deducted from the monthly salary.

– The self-employed insured

  • For those who have identified income,

Monthly Contribution = 「Monthly Wage × Contribution Rate」

  ※ If monthly Contribution of household is below the average Contribution, NHI imposes the average Contribution on the household

  • In case of unavailability of income information, the average Contribution for the region based on the end of the previous year should be applied. For residential qualification, holders of religion (D6) with residing certification visas receives a reduction of 30%, holders of overseas education visa (D2) and Korean nationals who usually reside abroad receiving education in Korea are given the reduction of 50%.

  • However, the foreigners who have a residence status of F1~ F2 or F5 shall pay the contribution amount calculated by the same imposition standard of Korean nationals on a monthly basis.

  • The obligation of contribution payment is retroactive to the date the applicant was registered as an alien in Korea and the contributions shall be paid in advance every month.

  ※ For foreigners who is self-employed insured: Contribution bill notice available in English, Japanese and Chinese.

– Contribution for Long-term Care Insurance

  = 「Health Contribution × Long-term Care Insurance

Contribution Rate(4.05%)」

□ Insurance benefits

- The insurance benefits for foreigners are all the same as those for the Korean nationals.
- A patient is required to pay 20% of the total medical charges for inpatient care and 30~50% for outpatient services depending on the level of health care facilities or the total amount of service charges.
- In addition, the NHIC is providing cash benefits including childbirth expenses and is carrying out various customer support programs such as health education, temperance movement, etc. in an effort to improve the health of the population and prevent illness.

〈Table II-6〉 Benefit of health examination

Category	Examination Subject	Examination Period	Examination Contents	Charge of Expense
Infant Health Examination	Infant under 6years old	4, 9, 18, 30 month old, and 5years old. Total 5times	Physical measurement, Examination, Development assortment evaluation	No expense on the examinee
General Health Examination	The employed insured, The self-employed insured, (Household) over 40 years old, Company Supporter	White Collar: Every other year Non-white Collar: Yearly	Primary: 23 items including examination, consultation Secondary: 28 items of 8 diseases	No expense on the examinee
Cancer Examination	Among the subject of general health examination, depending on the	White Collar: Every other year Non-white Collar: Yearly	Stomach cancer, Large Intestine cancer, Liver cancer, Breast cancer, Uterus Cervical cancer etc. step by step examination depending on the types of cancer	*Top 50% of Contribution → 20% charge on the examinee *Bottom 580% of Contribution → No expense on the examinee
Lifetime Transition Period Health Examination	Person at the age of 40, and 66	Once a person reaches the age of 40 and 66	40years old: 23 items 66years old: 26 items	No expense on the examinee

☐ Long-term care insurance services

– From the first of July 2008, medical treatment service including bath, taking care of the body waste of the elderly, laundry, nursing care are to be commenced for the aged and

those who with restricted movement suffering from senile diseases such as Alzheimer's disease, paralysis, Parkinson's disease

— In the case of benefiter (person him or herself) receives long-term care grant from long-term care facility, benefiter shall bear a portion of long-term care grant expenses. The assessment of the expense is as follows:

Stay at home care grant	In patient care grant (Old-age care facility)
15% of the long-term care grant expenses	20% of the long-term care grant expenses

6) Financial resources

The National Health Insurance is financed through the contributions paid by the insured and their employers, and government subsidies. As the National Health Insurance Program has been run as a social insurance program, the contributions from the insured contribute the major source of its revenue of the program.

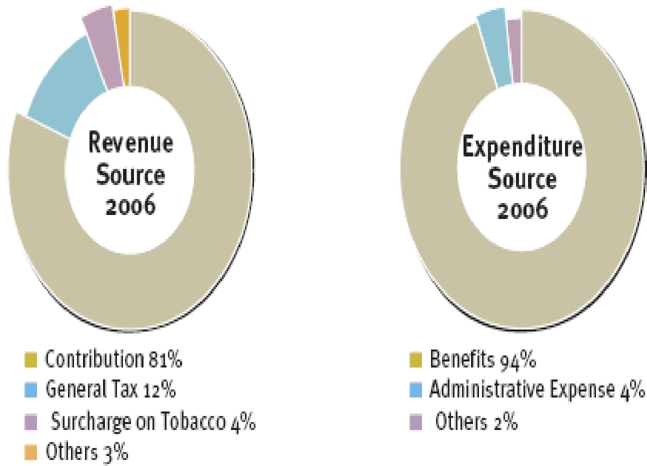
(1) Contribution

☐ The Employee Insured: The contribution of employee insured is based on salary of the insured. And the current contribution rate of the employee insured is 5.08%.

☐ The Self-employed Insured: For the self-employed insured, contributions are basically calculated on the basis of income. The contributions are calculated by using a formula in which the insured persons' properties, income, motor vehicles, age, and

gender are taken into consideration.

[Picture II-3] Annual revenue and expenditure



□ Reduction of contribution amount

- For the insured in rural areas: 50% of contribution can be reduced for the insured in an island or remote rural areas, 22% in rural areas, 10~30% for insured who have a low income.
- For the insured who have a family member aged 65 or over and the disabled

: The maximum reduction rate for contribution is 30%.

(2) Government subsidy

Through government subsidy the government provides 14% of the total annual projected revenue raised through NHI contributions from the insured. The NHIC gets further financial support from the Health

Promotion Fund at 6% of the total annual projected revenue raised through NHI contributions from the insured.

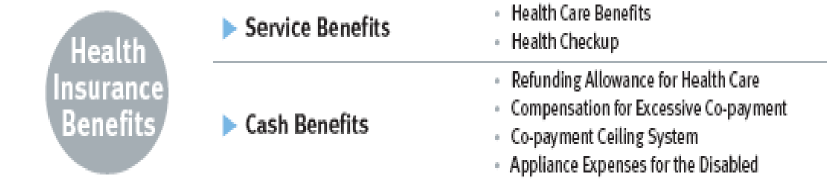
(unit: person)

Classification	2002	2003	2004	2005	2006	2007
General Tax	2,575	2,779	2,857	2,770	2,870	2,704
Surcharge on Tobacco	439	645	626	925	966	968

7) Insurance benefits

(1) Insurance benefits

[Picture II-4] Types of insurance benefits



☐ Service benefits

- Health Care Benefits
  - Provided by health care institutions in case of diseases, injuries, and etc.
  - Including diagnosis, tests, drugs, medical materials, treatments, surgery, preventive care, rehabilitation, hospitalization, nursing, and transportation.
- Health Screening
  - Periodic Health Examination Program
- 2 steps procedure (1st screening test → 2nd confirmative test)

– cost-free

• Cancer Program

– Cost : shared by NHIC(80%) and beneficiary(20%)

– Stomach, colon, breast, and liver cancer screening and pap-test

☐ Cash benefits

– Refunding Allowance for Health Care

• When received treatments in an emergency situation from non NHI provider

• Peritoneal dialysis purchases for chronic renal failure

• Childbirth at a place other than a health care institution

– Compensation for Excessive Co-Payment

• Co-payment exceed 1.2 million KRW within 30 days

• Compensated 50% of the exceeding amount

– Appliance Expenses for the Disabled

• 80% of the expenses for medical appliances e.g. canes, wheelchairs, hearing aids

(2) Uncovered service

☐ Criteria for Non-benefits

– any medical services, drugs, or materials provided or used for diseases which do not cause serious problems in daily life or business

– any medical services, drugs, or materials provided or used for care, which is not for the improvement of physically essential functions

ex) plastic surgery, freckles, and simple snoring

☐ Example of Non-benefits

– the services not considered necessary for activities in daily life such as plastic.

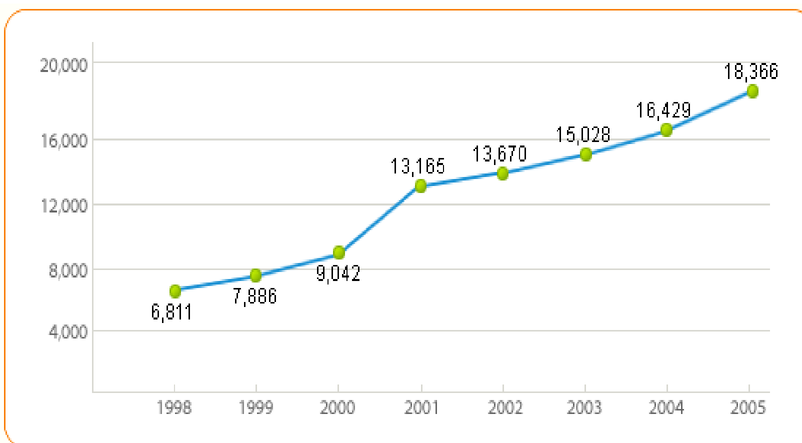
– freckles, and simple snoring

(3) Insurance benefit expenditure

〈Table II-7〉 Expenditure of insurance benefits, 2005

		Number of Cases (thousand)	Amount (billion KW)
Total		807,673	18,366
Service Benefits	Sub-total	807,200	18,224
	Health care benefit	800,080	17,989
	Health Screening	800,080	236
Cash Benefits	Sub-total	473	142
	Refunding Allowance for Health Care	17	17
	Funeral Expenses	197	49
	Compensation for Excessive Co-payment	143	28
	Co-payment Ceiling System	68	26
	Appliance Expenses for the Disabled	49	22

〔Picture II-5〕 Trends of NHI benefits cost



〈Table II-8〉 Expenditure of service benefits by type

(unit : billion KRW, %)

Year	Total	Medical Facility			Pharmacy
		Sub-total	Inpatient Care	Outpatient Care	
1998	6,584	6,422	2,693	3,729	162
1999	7,653(16.9	7,452(16.0	3,059(13.6)	4,393(17.8)	201(23.8)
2000	8,789(14.9)	7,941(6.6)	3,144(2.8)	4,797(9.2)	848(322.3)
2001	12,941(47.2)	9,532(20.0)	3,533(12.4)	5,999(25.0)	3,409(302.1)
2002	13,425(3.7)	9,796(2.8)	3,653(3.4)	6,142(2.4)	3,409(302.1
2003	14,755(9.9)	10,798(10.2	4,354(19.2)	6,444(4.9	3,957(9.0)
2004	16,130(9.3)	11,641(7.2)	4,737(8.8)	6,904(7.1)	4,489(13.5
2005	17,989(11.5)	12,897(10.8)	5,277(11.4)	7,620(10.4	5,091(13.4)

〈Table II-9〉 Expenditure of cash benefits

(unit : billion KRW, %)

Year	Total	2002	2003	2004	2005
Total	case	6,422	2,693	3,729	162
	amount	6,422	3,059(13.6)	4,393(17.8)	201(23.8)
Refunding Allowance Refunding Allowance	case	21,168(9.7)	22,577(6.7)	21,099(-6.5)	16,515(-9)
	amount	24(10.5)	25(7.1)	24(-5.0)	17(-11)
Funeral Expense	case	208,486(3.9)	205,187(-1.6)	200,038(-2.5)	196,790(-1.6)
	amount	52(4.2)	51(-1.6)	50(-2.5)	49(-1.6)
Compensation for Excessive Co-payment	case	169,812(7.8)	125,784(-25.9)	134,689(7.1)	142,779(6.0)
	amount	32(-22.0)	25.7-20.3	27.9(8.8)	27.6(-1.4)
Co-payment Ceiling System	case	-	-	5,708	67,985
	amount	-	-	6.7	26
Appliance Expense for the Disabled	case	24,566(10.9)	27,067(10.2)	32,079(18.5)	48,957(52.6)
	amount	6.7(3.1)	77(6.8)	8.6(20.3)	22(152.0)

8) Co-payment system

Persons who receive health care treatments pay certain portions of the health care costs as co-payments. In order to curtail overuses of health care services, and lessen the concentration of medical services in large urban hospitals, the co-payment for outpatient and in-patient

services have been set differently according to the level and type of medical care institutions.

〈TableⅡ-10〉 Types of co-payments

	Co-payment
Inpatient	10~20% of total treatment cost
Outpatient	
Tertiary care hospital	Per-visit consultation fee + 50% of treatment cost
General hospital	50% of (treatment cost + Per-visit consultation fee
Hospital	40% of (treatment cost + Per-visit consultation fee
Clinic	30% of treatment cost
Pharmacy	30% of total cost

□ Co-payment ceiling system

- When an insured individual pays for co-payments exceeding the co-payment ceiling threshold currently set at 3 million KRW within a period of 6 consecutive months, he or she is exempted from any further co-payments incurred. This is to alleviate the financial burden of households against catastrophic or high-cost diseases helping to prevent them from falling into bankruptcy. This ceiling system is applicable for inpatient, outpatient, and pharmaceutical services.

9) Health promotion

Active health management is required on a preventive basis to ensure the good health of the general public and the diversification of disease structures, a reduction in the birth rate, and society's becoming an aging society, etc. In accordance with these trends, we

are actively pushing ahead with projects promoting health checkups and health promotion in order to discover and treat diseases early and, thus, improve the people's health.

- Current employees : Total 10,334

□ Examinations for specific cancers

- Subjects
  - Those eligible for health checkups in the year concerned
  - Stomach cancer and breast cancer : Those 40 years of age or older
  - Colon cancer : Those 50 years of age or older
  - Cervical cancer : Those 30 years of age or older
  - Liver cancer: Those 40 years of age or older (However, this is also open to younger persons found to be hepatic sufferers during regular health checkups.)
- Costs
  - The NHIC funds 80% of all medical costs, and the examinee contributes 20%. (However, costs for eligible cancer checkups are borne by the national treasury.)

□ Health promotion and disease prevention

- Campaign for a healthy life
  - A campaign for measures of health improvement, such as non-smoking and drinking in moderation campaigns, and the distribution of paperback books on healthy living.
  - The implementation of health classes targeted to middle and high school students.
  - The provision of health information for campaigns in non-smoking, drinking in moderation, and the prevention of high blood pressure and arthritis among adults.

- The provision of customized information and telephone or in-person counseling for persons with abnormalities found during health checkups.

— Health promotion projects in which people participate

- The implementation of targeted and customized exercise classes for personal physical characteristics, such as gymnastics for the elderly, dances and gate balls, all suitable for those 65 years of age or older.
- Everyday health practice through healthy walking programs, the operation of a health camp, and so forth.
- Health risk evaluations (HRA) and the provision of corresponding materials for health improvement.
- Free-of-charge measurement of obesity, blood pressure, and bone density by the installation of body composition analyzers, blood pressure meters, and bone density meters.

☐ Obesity-related projects

— The operation of obeiity treatment programs, such as exercise and dietary treatment, targeted for overweight primary school children over a 2 to 3 month period.

— The installation of health booths at local festivals providing health counseling services and obesity measurements.

3. Promotion of financial stability in national health insurance

1) Progress

Changes in the national health insurance environment such as the

deficit factors of the increasing expenditure, medical insurance unification in 1998 and separation of dispensary from medical practice in 2000 has caused a net loss of 1 trillion and 9 billion KRW in 2000 and 4 trillion and 200 billion KRW in the end of 2001. As such, the financial status of insurance has been aggravated. With support from national health insurance corporation, medical related personnel and the insured, the government has taken measures as to subjugate the financial crisis through minimization of insurance premiums and has announced a general countermeasure plan (31 May 2001). The government has made a statement as to be able to overcome the financial crisis and maintain a sound finance system by May of 2006.

Subsequently, the government has established additional measures such as the additional health insurance financial stability measures (5 October 2001) that includes restriction of insurance coverage days, discontinuance of general medication support and other issues followed by a third additional measure in April of 2002. Furthermore, measures have been consistently supplemented as to establish a "national health insurance financial special law (19 January 2002)" and adopt a stabilized financial system.

2) Principal issues of financial stability measures

General health insurance financial measures mainly attempt to provide an efficient structural plan through management of cost by improvement of pay system, increase in government financial support, increase of insurance premium in annual equation and other actions as to result to net income in 2003 and resolve the accumulated loss

issue by 2006.

As for expenditure management plans, cost management may be practiced through decrease of medical fees, change in additional application time at night, and other measures. In addition, expenditure containment through change in co-payment rates, investigation of false claims and continuous investigation of medication cost as to manage expenditure. Establishment of a partition payment system for long term contribution delinquents, activation of automatic contribution transfer system and other various measures have been executed for increase in revenue together with continuous efforts for finding of dependents with income.

Enactment of "special act for the financial stability of national health insurance" has established a health insurance review committee for reviewing of contributions and medication cost. In addition, legal obligation of a 50% government support for the self employed insurance finances and other necessary measures such as providing of medical personnel and installation of medical equipments have been introduced.

3) Promotion of financial stabilization measures

One of the main concerns in the development of national health insurance systems is financial stabilization in a short period and increase in coverage. Recent studies show that the increasing rate of rapid aging phenomena has led to development of more chronic diseases while expenditure continuously rises 10% each year and double in two years due to development of new technology and change in the medical environment. In order to manage such

expenditure, contributions need to be increased 5% each year for balance, in which it shows the rapid increase of expenditure and the burden on the insured. Widening of coverage or other measures to increase pay in the insurance industry would only induce an increase in the contribution. Therefore, there is a need for the government to consistently promote the various financial measures necessary for financial stabilization of health insurance and establish financial measures in the basic fundamentals.

In 2007, the government has reduced medication costs and established financial stability systems that have been proposed since 2001, in which there is a fixed co-payment rate for small amount out-patient treatments. However, such short term financial measures, improvement of medical systems, contributions and other financial issues must be managed by the entire society as a whole to present financial measures in the long run.

4. Widening the coverage of national health insurance

1) Promotion background

Currently, Korea's "less burden but low benefits" national health insurance system has shown that contribution is one-third or even one-fourth that of the advanced countries. Meanwhile, insurance benefits extent and standards remain to be rather low. However, the recent improvement in standards of living has caused changes in medical treatment and development of new technology in treatment of chronic diseases. Basically, medical expenses have increased, followed

by higher demands of the insured in terms of coverage.

As for patients suffering from severe illness of expensive medical treatment, medical expenses have led to the breakdown of families. Patients and their families may feel that benefits of the insurance are rather limited and it may incur distrust of the health insurance system. As regards to such issues, the Korean government has actively promoted widening of the coverage with foundation in a stabilized financial structure in 2004.

Since July of 2004, the price cap systems for co-payments have been established. However, demands for more systematic measures have been requested and the government has announced a "road map on widening the coverage of the national health insurance" in June of 2005. National Health Insurance Corporation, Health Insurance Review Agency and related expert groups have organized a "Health Insurance Innovation TF" in preparation of measures to widen the coverage. Numerous discussions were focused on support of expensive medical treatments such as cancer and the expansion on the coverage level of the health insurance to achieve a 70% coverage rate.

2) Principal issues of “widening the coverage of national health insurance"

The coverage rate of health insurance was 61.3% in 2004, rather low in comparison with advanced nations. The coverage rate of 49.6% for cancer shows the desperate need for increase in the coverage rate for development of the health insurance system.

The "widening the coverage of the health insurance" focuses on

reduction of medical costs for patients suffering from severe illnesses. This plan attempts to prevent the breakdown of families due to expensive medical costs and intensify its role as a social safety net by increasing the coverage rate of medical costs of patients suffering from chronic diseases. Subsequently, this plan has been designed to increase the health insurance coverage rate to the level of advanced nations and holds the objective of presenting coverage rate over 70% by 2008. There was a need for social agreement by convincing the insured of the inevitable increase in contribution in the process of acquiring financial resources. Related personnel from Ministry for Health, Welfare and Family Affairs, National Health Insurance Corporation, Health Insurance Review Agency and other experts have organized "Health Insurance Innovation TF" for operation. TF has conducted various investigations and prepared specific plans for the innovative widening of insurance coverage.

The coverage widening plan for 2008 focused on expansion of coverage level on serious diseases while 2005 plan focused on reduction of medical costs of serious diseases such as cancer. On the other side, after 2006, the coverage widening plan focused on food costs and ward costs of severe diseases not covered by the health insurance. For execution of the plan, the government designed a financial plan of 1 trillion and 500 billion KRW in 2005, 1 trillion KRW in 2006, 700 billion KRW in 2007, 500 billion KRW in 2008. At the same time, the contribution increase plan was settled to be over 2.38% in 2005, over 3.5% in 2006, over 6% in 2007, over 3.5% in 2008.

Experts have evaluated coverage priorities based on the size, emergency, treatment effectiveness of medical expenses and the

results have shown cancer, cerebrovascular and heart disease patients to be of the highest priority group. Afterwards, a discussion on the specific support method of this patient group was conducted. As for cancer patients, the support of items that were not supported previously and reduction of co-payment from 20% to 10% had been settled.

In addition, a review agency for severe diseases, which plays a significant role in the medical association in relation to acknowledging insurance issues, has been established. Subsequently, patient focused, accommodating and prompt decisions were possible in addition to reduction of medical expenses. Along with health insurance support for the social disadvantaged, contributions to social cohesion has been made possible. Health insurance supports such as reduction of exceptions from separation of dispensary from medical practice, medication support for incurable diseases, support for organ transplant, co-payment exemption for in-patients below age six and other medical costs have been reduced through government support of health insurance.

Meanwhile, PET(Positron Emission Tomography) is mainly used in examination for cancer. Its average cost of 1 million KRW is rather burdensome and it has been covered by health insurance since June of 2006. Food expenses for in-patients hold 20.7% of the total medical costs and it was to be paid by the patients. Although this amount wasn't all that burdensome, the government has decided to reduce costs of the patients by supporting funds for food expenses since June of 2006. Furthermore, the co-payment cap for patients has been reduced to 2 million KRW in July of 2007 for further cost reduction. Therefore, the compensation system for the co-payment which has been less effective had been abolished.

3) Outcomes of widening coverage and promotion plans

National Health Insurance Corporation has conducted investigations on co-payment rates of medication costs by patients. Results have shown to be 49.6% coverage rate for cancer patients in 2004 with an increase of 20.5% to 70.1% in 2006. The rate seemed to be relevantly high for out-patients being 73%. The Korean government looks forward to continuous widening the coverage of the health insurance. Massive financial resources are necessary for expansion of the coverage. Incessant government support and increase in contributions are inevitable. Furthermore, the government plans to carry out a rational support plan side by side. There is a need to reduce benefits level of mild diseases for out-patients and establish a reasonable structure that concentrates on diseases of high expenses.

5. Status of private health insurance

Korea has a large private health insurance market given its general economic scale. Korea has the 7th largest private health insurance market in terms of life insurance premium income. The ratio of private life insurance premium paid in the GDP is the 4th largest in the world. In the absolute amount, private medical insurance market amounts to 8 trillion Korean won in 2005. A research finding reported that 86.6% of the total households in Korea held at least one private health insurance policy.

Despite the fast growth of the market, there have not been adequate researches to assess whether private health insurance have

done its due part from the medical consumers' perspective. In addition, the desirable roles and relations between private health insurance and public health insurance in terms of overall national medical expenses and public health security.

Researches or discussions on private health insurance have been unfolded only theoretically as in the case of introduction versus facilitation or substitution versus supplementation, failing to incorporate the important aspect of public health and neglecting the needs to establish proper roles of public health insurance and private health insurance. There was an attempt by the Ministry of Health and Welfare in 2005 when its taskforce team for National Health Insurance innovation selected private health insurance as agenda, civic groups strongly criticized the selection itself by saying that discussion on private health insurance would lay a foundation for the introduction of alternative private health insurance and virtually break down public health insurance system.

However, such subconscious denial of the presence of private health insurance in the market could not stop the fast and wide spread of private health insurance among the general public. What is more is that the revised Insurance Industry Act 2003 allowed life insurers to carry insurance products that compensate medical expenses not covered by National Health Insurance. Given that the presence of life insurers in the private health insurance market (life insurers account for about 85% of the market), private health insurance has become a formidable force that has direct impact to the consumption of healthcare services or National Health Insurance.

According to a research conducted by the Korean Social Security Association in 2005, disease-induced poverty where a sudden accident

or disease forces middle-class family into poverty, accounting for 21 % of the total poverty. It is mainly attributable to the failure of National Health Insurance as a social safety net due to is inadequate benefit coverage. However, private health insurance's failure in complementing public health insurance is also partially responsible. Despite the fast growth that the market has enjoyed, the healthcare aspect of private health insurance has been overlooked while the financial product aspect has been magnified. This imbalance has led to indifference in examining private health insurance from the perspective of public health improvement or consumer production.

According to an analysis performed by Korea Consumer Protection Board in 2006, out of the total 121 cases of remedies for damages relative to private health insurance, 40.5% of consumers were denied benefit payment on the ground that the disease diagnosed is excluded from diseases covered by terms and conditions. As for the provision of product information to consumers, insufficient information to compare quality and price of other similar products and policy terms using medical jargons that is elusive to the general public has often created product plans unfavorable to consumers.

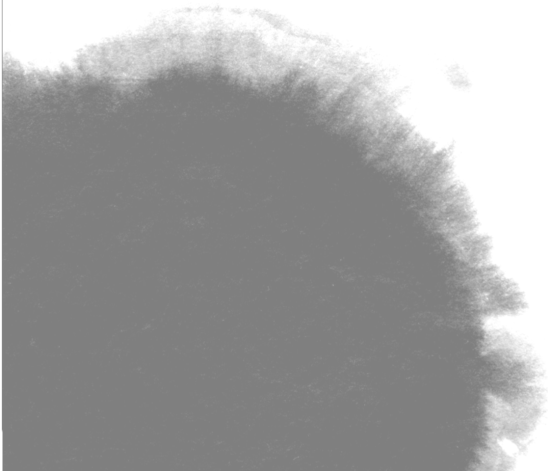
What should be taken more serious among many issues created by private health insurance was that, existing private plans compensate more than what was paid for medical services (through lump sum payment commitment) or compensate fully what patients paid for their medical expense (health insurance products). This type of medical insurance plan has led to an unnecessary increase in overall medical expenses and even in expenditures of National Health Insurance. The serious impact of private health insurance coverage against urinary incontinence was a case in point. For the five years

after private health insurance provided coverage for medical surgery on urinary incontinence, the number of cases operated on urinary incontinence soared by 730%, putting a heavy and unnecessary financial pressure on National Health Insurance.

As private health insurance policies that protected urinary incontinence made benefit payments more than 10 times of co-payment for urinary incontinence operations, the cases of the operations reported to National Health Insurance Corporation for payment grew dramatically.

03

Characteristics of Healthcare System in Selected Countries



III. Characteristics of Healthcare System in Selected Countries

1. Healthcare system in Germany

1) Overview

In Germany, 88% of the population is covered by a basic health insurance plan provided by statute. Of them, 74% are compulsorily insured in the public health care scheme and the remaining 14% voluntarily stay with the public system. Also, 9% of the population has alternative private insurance and 10% of the members of nonprofit sickness funds are insured in complementary private insurance to cover their medical bills not covered by the government. And 2% of the population receive free-of-charge medical services as police officers, military personnel, and social service beneficiaries and less than 0.2% of the population has no health insurance of any kind. In principle, the German Social Law (SGB) mandates that all salaried employees as well as the unemployed, pensioners, farmers, students, artists, and the disabled are obliged to be members of the public health care scheme. However, public officers, self-employed people, and employees earning above the periodically revised income ceiling may join the private system.

The German health care system is unique in that, only high-income employees, self-employed persons, and civil servants may opt for private insurance, and those who left the public scheme for a for-profit insurance carrier are generally not allowed to return to public insurance. Residents who have been insured in the public system for a certain period of time may stay with the system. In other words, persons earning more than a certain level of income have a choice of public funds and also buy a private insurance policy. Because private insurance carriers directly compete with the public system, they offer more than one type of benefits so that their insured have a wider choice of facilities and treatments more rapidly.

Private insurance companies need to provide attractive products in terms of coverage and premium to be chosen by consumers in the market while people are compulsorily insured in social insurance. Employees earning less than the income ceiling[2)] may not choose private insurance. Thus, they have no choice but to be compulsorily insured in one of the sickness funds.

2) Prevention of adverse selection in private health insurances

Through the 1980s, rising health expenditures prompted most countries to introduce more competition into the public health care system. Theoretically, more choice and competition would improve efficiency of a health care scheme and there are various ways of

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2) Ceiling of mandatory public health care program is 75% of the income ceiling of public annuity insurance. As of 2007, the ceiling of annuity insurance was 5,250 euros per month and the ceiling of mandatory health care system was 3,975.5 euros.

competition and choice within a health care system. But the problem is whether they can effectively function in the real world. It is viewed that only a 'managed' or 'regulated' competition by the insurer can be introduced in the German health care system because competition and choice are limited due to particularity of medical services and asymmetric information.

In Germany, members of a sickness fund may switch to another fund and those eligible for private insurance may choose between the public and private system. Change of sickness funds was first allowed in 1997 after the unification of Germany, and it is said that this has contributed to integration of funds centered around those with economy of scale. However, for equity of medical services, restrictions are imposed on choice between private and public insurance.

Members of the private medical plan voluntarily gave up their legal right to terminate sickness insurance, and this is reflected in the insurance contract law. Insurees may not terminate sickness insurance and sick benefit insurance if they fully or partially substitute the statutory system. However, sick benefit insurance that does not allow payment of the employer may be terminated after 3 months of period of notice only for the first 3 years.

Pensioners who were insured in the private system during their working period have to contract private insurance. From January 1, 1994, only pensioners with public insurance for more than 90% of the second half of their working period were allowed to stay with the insurance. This policy aimed to prevent younger population with good risks contract from contracting with private carriers and those with bad risks and low income from entering sickness funds.

3) Restrictions on risk calculation-based premiums

(1) Principle of equivalence (Äquivalent-Prinzip)

Individual agreement based on the principle of equivalence is applied to the private health insurance. The principle of equivalence means that the level of premiums are directly related to scope of coverage. The policyholder has to pay a higher premium to receive a higher percentage of coverage because the premium depends on the individual risks in the private system. The premium is set according to an individual agreement between the insurance company and the individual defining the set of covered services regardless of entrance age, gender, and state of health. According to the principle of equivalence, the same level of premiums are applied to a group of people with the same risk level. Therefore, those with bad risks have to pay higher rates than those with good risks because the former would require higher percentage of coverage.

On the contrary, the public system is based on social solidarity. In the public health insurance program, the premium is set according to earnings rather than risks. Family dependents of the insured without earnings or earning less than a certain threshold can be co-insured in the public system. In addition, the same set of covered services are offered to all income groups.

The principle of equivalence can be found in premium calculation in the following four ways:

First, premiums are dependent on covered benefits. For example, Single-bed hospital rooms require higher premiums than multi-bed ones.

Second, utilization of medical services increase according to age. Thus, premiums in the private plan are dependent on entrance age into the plan, which means the younger you purchase the policy, the lower your rates would be.

Third point to consider is health conditions when the policy is initially taken. In actuarial terms, those with record of disease occurrence is an additional risk that requires higher premiums (additional risk fee) on the basis of the principle of equivalence.

Fourth, premiums differ between men and women. Individual conditions at the time of entrance into the private system are always important. Premium calculation is based on them. Occurrence of a risk event such as exacerbation of health conditions after the entrance does not affect premium calculation. Additional risk fee after the entrance cannot be reflected in the calculation. However, the policyholder decides to expand coverage by purchasing a new set of covered services at a later time, his or her risks will be evaluated once again.

(2) Premium and payment

Because premiums are set for every individual in the private insurance, his or her family dependents cannot be exempt from payment. In the private system, the employer has to pay one half of the premium too, but not more than the average maximum premiums of the sickness funds.

Premiums of private life insurance are estimated based on actuarial formulas. This means, savings are accumulated over time in order to cover individuals' higher medical costs with rising age. Therefore,

policyholders have to pay premiums for their current risks plus additional money for their health costs in old age.

All in all, part of the premiums becomes an aging reserve that entails interest. The savings are used to cover increasing medical expenditures in old age. Throughout the entire insurance term, policyholders pay more than they actually spend on medical services when they are young while paying less than they spend on health care. The difference in amount between premiums and actual medical costs is accumulated as an aging reserve that entails interest. And the reserve is used to make up the difference between premiums and actual costs in old age.

(3) Risk pooling through aging reserve

Medical costs increase according to age. Those in their 80s spend 15 times more than younger members in drugs. That is why private medical plans earmark a certain percentage of premiums to cover higher health costs. In the private system, increase in medical costs with age is already reflected in the initial premium calculation and aging reserve is accumulated over time. This is one of the important measures to partially alleviate the impact of risk-based premium calculation.

Statutory interest rate applied to aging reserve is 3.5% a year. This rate was set based on very conservative assumptions. The per annum interest rate of 3.5% is a relatively easy goal to achieve even in difficult economic times. If the rate is higher than that, the market rate might become lower than the rate in economic downturn, resulting in less than expected savings for the aging reserve.

If the market rate exceeds 3.5%, the difference between the two rates is recorded as excess interest in actuarial terms. Excess interest can be accumulated to offer reduction of the sum insured or reimbursement in old age. More than 90% of excess interest is required to be used for reduction of the sum insured in old age. Significant amount of the interest should be used for reducing or limiting increase in premiums for senior citizens 65 years old or more.

2. Healthcare system in France

1) Overview

Private health insurance in France is a complementary insurance that covers 87% of the population for covering medical services the statutory public insurance does not cover. There are three types of private complementary health insurances: non-profit Mutuelles and caisses de prévoyance, and assurances commerciales privées, a for-profit organization. Mutuelles covers almost 60% of the complementary coverage and the other two a further 15-20%, with the market share of the private insurance system, about 20%.

Unlike other countries in Europe, French private health insurances are not used to jump the public waiting lists or secure extras. Rather, they refund patients medical costs they have to pay under the public health care system or reimburse certain medical care, such as dental and optical treatments, that is refunded only minimally or not at all by the basic health insurance. There is no standard level of coverage for private health insurance in France. Also, there is neither definition

of the set of medical goods and services private insurances have to offer nor list of prohibited or restricted medical items for private plans. Because of the complementary nature of private insurances, they offer a range of health cover to the areas minimally or not covered by the Social Security while they do not play an important role in those covered by the basic health care system.

2) Regulations for ensuring accessibility

The three private organizations have different set of goals and operation rules. Mutuelles is operated under Code de la Mutualité, caisses de prévoyance is controlled by Code de la Sécurité Sociale, and commercial insurance company is governed by Code de l'assurance. These regulations share a lot of similarities. As long as the principle of industrial specialization is respected, complementary insurances are neither required to provide certain benefits nor prohibited from offering any medical items. Likewise, there are no regulations for standard coverage level.

French complementary insurances may not exclude certain medical conditions for employer-sponsored contracts, which means, the principle of solidarity is strongly advocated in France. But they are allowed to exclude certain conditions for individually-purchased contracts. However, even for individual contracts, the insurer has to clearly define contractual conditions and should be able to prove that consumers were informed of the conditions before entrance into the insurance plan. Policyholders may not terminate contract or reduce covered services from 2 years after the purchase of policy. And retirees and those who left the insured group may remain in the

same complementary insurance.

The Code de la Mutualité was revised as the French government was forced to adopt EU rulings. The code was finally revised in 2001 after years of discussions started in 1993. The new Code stipulates that each body should manage "social undertakings" within the organization and contains strict conditions for solvency. It also says premiums can be differentiated based only on income, policy holding after the initial contracting, type of contracted medical fund, location of residence, number, and age of beneficiaries. However, private insurance companies may determine premiums and a set of covered services based on their questions about medical conditions for applicants if they decide not to practice the solidarity principle. Though applicants sometimes are required to fill out a questionnaire about their medical conditions for comprehensive insurance contracts, they aren't for basic contracts.

3) Adverse selection and selective contracting in private health insurance

In France, private insurance supplements public health care system, and is a pillar of national health care. In this context, regulations intended to restrict free competition can be justified in the private insurance system. Though EU rulings are likely to affect those restrictions, they are justified within the scope of public roles of private insurance. In France, regulations and taxation policies for Mutuelles are different from those for private insurance companies. The current picture reminds of the times when Blue Cross/Blue Shield and private insurance companies coexisted in the United

States. At the time, commercial insurance companies improved their competitiveness through risk reduction called cream skimming while Blue Cross/Blue Shield was in danger of being driven out of business due to adverse selection of consumers. As a result, Blue Cross/Blue Shield had to give up community rating. A similar scenario is played out in France.

Private insurance companies made their debut in the complementary health insurance market in the 1980s when it was monopolized by Mutuelles. Solidarity was at the heart of Mutuelles system. Traditionally, Mutuelles set premiums at a flat rate (a percentage of salaried income) and provide the same level of coverage for all members. They did not limit subscription of high-risk consumers through non-price strategies. On the contrary, private players in the complementary insurance market set premiums based on risk, age or medical conditions recorded in questionnaires. They also provided a variety of coverage packages designed to help consumers choose products based on their risk. Not only that. various 'risk selection' strategies were adopted, such as exclusion of certain consumers from certain products.

Emergence of private companies was not a threat to Mutuelles specializing in employer-sponsored contracts for specific groups (i.e. civil servants). Their business was already stabilized, so they could continue to operate business based on solidarity. But it was a serious threat to Mutuelles doing business in individual contracts. The possibility of adverse selection emerged. That is, consumers with good risks might switch to cheaper contracts offered by private insurance plans. The same was true for the employer-sponsored contract market for private enterprises. Years of fierce competition

between Mutuelles and private insurers for private companies led to an increasing number of Mutuelles adopting similar strategies to their private competitors.

For individual contracts, both Mutuelles and private insurers set different premiums according to age. Aged persons often have to pay additional fee or are not allowed to subscribe to certain policies. However, Mutuelles have fewer number of age rates than private insurers. As mentioned earlier, according to Code de la Mutualité, Mutuelles may differentiate premiums based only on age, and other criteria such as gender and health status should not affect premiums. In both Mutuelles and private insurance, there is a list of medical conditions that will become eligible medical expenses after a defined period of time. For examples, most contracts generally do not cover pregnancy-related treatments for 9 - 10 months after sign-up. In addition, Mutuelles provide multiple contracts with different scope of benefits but the choices they provide are not as wide as private insurers.

Though distribution of medical expenses is concentrated in France, that of expenses incurred by complementary insurances is not. Thus, insurance companies have no incentive to deter high-cost individuals from taking insurance. Also, for people with serious or chronic illnesses, the insurance system reimburses them 100% of expenses and waives their co-pay charges. About 7% of the population with diseases like diabetes, cancer and AIDS falls into this category. Such social system helps reduce risks of policyholders with higher medical costs. Another point is that, the regulatory difference between Mutuelles and private insurers is not as large as that between Blue Cross/Blue Shield and commercial insurance companies in the United

States. Because of its complementary nature, private insurance paid by the employer does not consider risk pooling as a major issue. The compulsory employer-sponsored contracts are more expensive than individually-purchased contracts, but the difference is not significant.

3. Healthcare system in the Netherlands

1) New health insurance system

The Netherlands combined mandatory public insurance system (63% of the population) with private medical plans (37% of the population) in 2006. Prior to 2006 (and since the end of World War II), two separate systems of health insurance covered the population.

A key feature of the reform is strengthening of market competition. For-profit insurers are encouraged to compete with each other in terms of premiums, types of packages, and service levels. All legal residents in the Netherlands are obliged to purchase a basic health insurance (complementary packages are optional). People are free to select the type of insurance programs. Consumers also have the right to switch to an alternative insurance or another insurer.[3)]

Market competition help insurers increase their negotiating power with health care providers. Both parties negotiate price, amount, service level, and quality of medical care. The new health care system enabled insurers to contract price, waiting time, and other issues with preferred providers.

Another aspect of the new scheme is premium calculation.

3) According to recent data, at least 18% of the insured changed insurance companies, which is much higher than most experts forecast.

Insurance companies are obliged to set a flat rate for each package they offer. They are not allowed to set premiums according to purchasers' age, gender, and health risks. Children under age 18 are covered for free and those in the low income bracket receive compensation from the government to help them pay their insurance. Employees have to pay premiums, which is 6.5% of their earned income (ceiling: €30,000, contribution rate for self-employed, retiree, and lower income groups is 4.4%).

2) Equity and solidarity in health insurance

Policyholder contract may renew contract with the current insurance or change insurer every year. Under the new system, insurers are authorized to drop out insurees who do not comply with the agreement. Insurance companies can also set their own fixed rates and operate business for profit. Due to these new elements, the new system seems to switch its focus from the public health insurance to private plans. If we take a closer look at the reform, however, the new health care system is based on the principle of equity and solidarity since it protects public interests such as accessibility and utilization of medical care for the whole population.

First of all, from the perspective of equity and solidarity of health insurance, insurers are prohibited from setting premiums based on health risks and have to accept all applicants. This regulation is an important element of collective responsibility. However, prohibition on risk selection is imposed on the basic health insurance, not on complementary insurances. Second feature of the new system is increase in annual premiums. While the average per capita premium

was €239~€455 in 2005, that was €1,050 as of 2006. In order to ensure income solidarity, an extra government allowance is paid to make sure low-income groups can pay for their health care insurance. Third, the new scheme obliges all legal residents to health insurance by integrating the state-run insurance and the private insurance. Given that the sickness fund system of the past covered only 63% of the population, it is safe to say that the new system practices the principle of solidarity much better than the previous one. Fourth, new health care packages cover broader scopes of medical services and the government defines the set of insured packages. Fifth, risk variances between funds due to the different risks presented by individual policyholders are compensated through risk equalization.

3) Management of health insurance

From the management point of view, the new system is somewhat private-oriented because insurances are provided not by public insurers but private ones. This is not a dramatic change because the health funds were executed by private organizations even prior to 2006 in the Netherlands. However, there is a clear difference. While the health funds were non-profit organizations though they could hold a certain level of fund, the new insurers are allowed to seek profit.

Under the new system, insurers have to compete with each other on premium and service level. Insurance companies have a chance to increase their market share through competition but at the same time they may go bankrupt. Market competition is not a new concept in the statutory health insurance but the second phase of change triggered by the loss of regional monopoly and right to set fixed

rates by health funds in the early 1990s.

Fiercer market competition will affect the management of the health insurance. All insurers including non-profit funds will gradually adapt to the new market landscape. Insurance companies will focus more on the market and attract customers from market competition perspective. These changes can be explained as privatization of the management and operation of health insurance.

4. Remarks on healthcare system in selected countries

Basically, European countries contain demand for health insurance by strengthening coverage of the public insurance based on the principle of equity. With this, they seek to provide equal access to health care efficiently. There are strict restrictions imposed on the private health insurance in Europe. In some European nations including U.K., private insurances are disadvantaged in the form of taxes. In Germany, members of private insurances face limitations in selecting medical providers: only 1% of hospitals not contracted with the doctors association as covered facilities and 5% of general practitioners (non-office based physicians) are allowed to treat patients with private insurance. In France, private insurance complements the public health care system as a pillar of social security. Therefore, regulations for limiting free competition of private insurances are justified in France. Though EU rulings affects the regulations, they are justified to the extent that private insurances play public roles. The new health insurance system that came into effect in 2006 reinforced the principle of solidarity practiced by the previous health

insurance system. Key features of the new system are a combination of the two separate systems of health insurance and prohibition of risk selection. Even though the new system is controlled by private law, the system can be described as a public-oriented insurance rather than a private system.

It is well known that health care is a sector in which the efficiency of market competition is relatively limited. Nevertheless, the need for adopting market competition is continuously argued for in areas where there is no rationale for government intervention. The U.S. government practices the competition principle even in health care and intervenes only in areas where external effect is maximized such as medical services for the underprivileged and R&D. On one hand, such policy has made great strides in medical technology. On the other hand, however, the U.S. faces serious problems such as rising health care expenses and a significant portion of the population left uninsured.

On the contrary, most OECD member states including western European countries have approached heath care from the social security perspective. The traditional approach helped realize universal coverage, but has been criticized for not meeting the needs of the people in responsiveness. To counter this weakness, ways of introduction of competition and appropriate utilization of private insurance have been explored.

Competition is a fundamental principle. But the problem is whether the principle of competition can effectively function in the health care system. Competition and choice in health care has intrinsic limitations because of asymmetric information with regard to medical goods and services. Therefore, European examples provide

implications for Korea since they seek to provide medical services equally and efficiently for the whole population by strengthening the coverage of the public insurance and containing demand based on the principle of equity.

This chapter has examined the current status of the private health insurance in Germany, France, and the Netherlands. They view health care as public goods, and this approach has been criticized for not rapidly responding to customers' needs though it realized universal coverage. That was why many advanced countries have explored ways to adopt competition and make use of private insurances. The role of private health insurance differs from one country to another. However, what is in common is that, the private insurance system is a pillar of social security while equity of health care system is maintained through strict regulations on private plans.

The expansion of the role of private health insurance needs to be discussed from a number of different perspectives. If the topic is limited to responsiveness to consumer needs and weakening of equity in health care system with expansion of private health insurance, the European experience provides a lot of lessons to be learned. In addition, the new health insurance system of the Netherlands, which is the combination of public financing and private operation, offers policy implications in that, it is a typical outcome of political compromise between those arguing for more governmental intervention and those supporting more participation of the private sector in public welfare policies.

5. Healthcare expenditure

Health care systems in OECD countries are characterized by high levels of public expenditure. With the exception of Australia, Greece, Korea, Mexico, Slovak Republic, Switzerland and United States, public expenditure accounted for more than 70% of all expenditure on health care in 2007 in OECD countries, while in Czech Republic, Denmark, Iceland, Ireland, Japan, Luxembourg, Norway, Sweden and United Kingdom, public expenditure accounted for more than 80% of total expenditure on health.

The last twenty years have seen some decline or no significant change in levels of public expenditure as a proportion of total expenditure on health care in OECD countries with exception of Ireland, Japan, Korea, Mexico, Portugal, Switzerland, Turkey and United States. Between 1985 and 2007 the share of public expenditure on health care decreased substantially in Canada (-7.3%), Czech Republic (-7.6%), Finland (-5.1%), Iceland (-5.2%), New Zealand (-10.3%), Poland (-22.8), Slovak Republic (-27.2%), Spain (-11.5%) and Sweden (-9.6%).

〈Table III-1〉 Public and private expenditure as a percentage of total expenditure on health care in OECD countries, 1985-2007

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Australia	public	70.6	66.2	67.1	67.4	67.7	-	-4.1
	private	29.4	33.8	32.9	32.6	32.3	-	9.9
Austria	public	76.1	73.4	76.8	76.1	75.9	76.4	0.4
	private	23.9	26.6	23.2	23.9	24.1	23.6	-1.3
Belgium	public							
	private			24.0				
Canada	public	75.5	74.5	70.4	70.3	69.8	70.0	-7.3
	private	24.5	25.5	29.6	29.7	30.2	30.0	22.4
Czech Republic	public	92.2	97.4	90.3	88.6	88.0	85.2	-7.6
	private	7.8	2.6	9.7	11.4	12.0	14.8	89.7
Denmark	public	85.6	82.7	82.4	83.7	84.1	84.5	-1.3
	private	14.4	17.3	17.6	16.3	15.9	15.5	7.6
Finland	public	78.6	80.9	71.1	73.5	74.6	74.6	-5.1
	private	21.4	19.1	28.9	26.5	25.4	25.4	18.7
France	public	78.5	76.6	79.4	79.3	79.1	79.0	0.6
	private	21.5	23.4	20.6	20.7	20.9	21.0	-2.3
Germany	public	77.4	76.2	79.7	77.0	76.8	76.9	-0.6
	private	22.6	23.8	20.3	23.0	23.2	23.1	2.2
Greece	public	-	53.7	60.0	60.1	62.0	60.3	-1.0
	private	-	46.3	40.0	39.9	38.0	39.7	-1.0

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Hungary	public	-	-	70.7	72.3	72.6	70.6	-20.8
	private	-	-	29.3	27.7	27.4	29.4	169.7
Iceland	public	87.0	86.6	81.1	81.4	82.0	82.5	-5.2
	private	13.0	13.4	18.9	18.6	18.0	17.5	34.6
Ireland	public	75.8	71.7	73.5	77.5	77.5	80.7	6.5
	private	24.3	28.3	26.5	22.5	22.5	19.3	-20.6
Italy	public	-	79.5	72.5	76.2	76.8	76.5	-2.5
	private	-	20.5	27.5	23.8	23.2	23.5	9.3
Japan	public	70.7	77.6	81.3	82.7	81.3	-	15.0
	private	29.3	22.4	18.7	17.3	18.7	-	-36.2
Korea	public	29.4	36.5	44.9	52.1	54.6	54.9	86.7
	private	70.6	63.5	55.1	47.9	45.4	45.1	-36.1
Luxembourg	public	89.2	93.1	89.3	90.2	90.9	-	1.9
	private	10.8	6.9	10.7	9.8	9.1	-	-15.7
Mexico	public	-	40.4	46.6	45.5	44.2	45.2	11.9
	private	-	59.6	53.4	54.5	55.8	54.8	-8.1
Netherlands	public	70.8	67.1	63.1	-	-	-	-11.7
	private	29.2	32.9	36.9	-	-	-	28.4
New Zealand	public	87.0	82.4	78.0	77.9	78.0	-	-10.3
	private	13.0	17.6	22.0	22.1	22.0	-	69.2
Norway	public	85.8	82.8	82.5	83.5	83.8	84.1	-2.0
	private	14.2	17.2	17.5	16.5	16.2	15.9	12.0

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Poland	public	-	91.7	70.0	69.3	69.9	70.8	-22.8
	private	-	8.3	30.0	30.6	30.0	29.1	250.6
Portugal	public	54.6	65.5	72.5	71.8	71.5	-	31.0
	private	45.4	34.5	27.5	28.2	28.5	-	-37.2
Slovak Republic	public	-	-	89.4	74.4	68.3	66.8	-27.2
	private	-	-	10.6	25.6	31.7	33.2	295.2
Spain	public	81.1	78.7	71.6	70.6	71.2	71.8	-11.5
	private	18.9	21.3	28.4	29.4	28.8	28.2	49.2
Sweden	public	90.4	89.9	84.9	81.6	81.6	81.7	-9.6
	private	9.6	10.1	15.1	18.4	18.4	18.3	90.6
Switzerland	public	50.3	52.4	55.4	59.5	59.1	59.3	17.9
	private	49.7	47.6	44.6	40.5	40.9	40.7	-18.1
Turkey	public	50.6	61.0	62.9	71.4	-	-	41.1
	private	49.4	39.0	37.1	28.6	-	-	-42.1
United Kingdom	public	85.8	83.6	79.3	81.9	82.0	81.7	-4.8
	private	14.2	16.4	20.7	18.1	18.0	18.3	28.9
United States	public	39.3	39.2	43.2	44.4	45.2	45.4	15.5
	private	60.7	60.8	56.8	55.6	54.8	54.6	-10.0

Source OECD HEALTH DATA 2009, June 09

Spending on PHI as a proportion of total expenditure on health care is low in OECD countries, accounting for less than 10% of total expenditure in 2007 except Canada (12.8%), France (13.4%) and United States (35.2%) and well under 5% of total expenditure in most of OECD countries. PHI as a proportion of total expenditure on health care rose in OECD countries except Australia, Austria, Ireland and Switzerland between 1985 and 2007.

As a proportion of private expenditure on health care, spending on PHI in 2007 is accounting for less than 10% in Czech Republic, Finland, Greece, Hungary, Italy, Korea, Mexico, Poland, Sweden, United Kingdom and for less than 25% in Austria, Belgium, Denmark, Japan, Luxembourg, New Zealand, Portugal, Spain and Switzerland. Its share is the highest in France (63.9%) among OECD countries except United States, where 85% of the population is covered by complementary PHI to cover the cost of co-payments imposed by the statutory health care system.

The relatively small proportion of private spending on PHI can be attributed to the fact that governments in European countries have tended to rely on other methods of shifting health care costs onto consumers, such as user charges, rather than promoting and subsidizing PHI. Consequently, out-of-pocket payments make up the bulk of private expenditure on health care except Canada, France, Ireland and United States.

〈Table III-2〉 Breakdown of private expenditure as a percentage of total expenditure on health care in OECD countries, 1985-2007

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Australia	PHI	10.5	12.4	7.2	7.4	7.5	-	-28.6
	OOP*	13.8	16.1	19.7	18.5	18.2	-	31.9
	Other**	5.1	5.3	6.0	6.6	6.6	-	29.4
Austria	PHI	9.8	7.5	4.8	4.6	4.6	4.6	-53.1
	OOP	-	-	15.3	15.7	15.9	15.4	1.3
	Other	-	-	3.0	3.5	3.7	3.7	-19.6
Belgium	PHI	-	-	-	4.4	4.5	5.4	22.7
	OOP	-	-	-	18.5	17.9	18.3	-6.6
	Other	-	-	-	0.7	0.6	0.3	-57.1
Canada	PHI	-	8.1	11.5	12.7	12.5	12.8	73.0
	OOP	-	14.4	15.9	14.5	14.9	14.9	0.7
	Other	-	2.9	2.2	2.5	2.8	2.4	-17.2
Czech Republic	PHI	-	-	-	0.2	0.2	0.2	0.0
	OOP	-	2.6	9.7	10.9	11.5	13.2	407.7
	Other	-	-	-	0.3	0.3	1.5	400.0
Denmark	PHI	0.8	1.3	1.6	1.5	1.5	1.6	100.0
	OOP	13.6	16.0	16.0	14.8	14.3	13.8	1.5
	Other	-	-	-	0.1	0.1	0.1	0.0
Finland	PHI	1.8	2.1	2.5	2.2	2.2	2.1	16.7
	OOP	18.3	15.5	22.3	20.1	19.0	18.9	3.3
	Other	1.2	1.4	4.1	4.3	4.2	4.4	266.7

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
France	PHI	5.9	11.0	12.7	13.2	13.3	13.4	127.1
	OOP	14.4	11.4	7.1	6.8	6.8	6.8	-52.8
	Other	-	-	0.8	0.7	0.7	0.7	-12.5
Germany	PHI	6.5	7.2	8.3	9.2	9.2	9.3	43.1
	OOP	11.2	11.1	11.2	13.0	13.3	13.1	17.0
	Other	4.9	5.4	0.4	0.4	0.4	0.4	-91.8
Greece	PHI	-	-	-	-	-	-	-
	OOP	-	-	-	-	-	-	-
	Other	-	-	-	-	-	-	-
Hungary	PHI	-	-	0.2	1.1	1.3	1.1	450.0
	OOP	-	-	26.3	23.8	23.1	24.9	128.4
	Other	-	-	2.8	2.8	2.9	3.3	13.8
Iceland	PHI	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	OOP	13.0	13.4	18.9	17.2	16.6	16.0	23.1
	Other	-	-	-	1.4	1.4	1.4	0.0
Ireland	PHI	-	9.1	7.5	7.6	8.7	8.1	-6.9
	OOP	14.5	15.7	10.9	13.0	11.8	9.9	-31.7
	Other	-	3.5	8.1	1.8	2.0	1.3	-62.9
Italy	PHI	-	0.6	0.9	0.9	0.9	0.9	50.0
	OOP	-	17.1	24.5	20.5	19.9	20.2	12.8
	Other	-	2.8	2.1	2.4	2.3	2.4	-35.1

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Japan	PHI	-	-	0.3	2.5	2.6	-	550.0
	OOP	-	-	16.9	14.3	15.1	-	-1.3
	Other	-	-	1.5	0.6	1.0	-	-16.7
Korea	PHI	1.3	2.0	4.7	3.9	3.9	4.1	215.4
	OOP	64.3	58.2	45.9	39.0	36.8	35.7	-44.5
	Other	5.0	3.3	4.6	5.0	4.8	5.2	4.0
Luxembourg	PHI	-	-	1.1	2.3	1.7	-	21.4
	OOP	9.2	5.5	7.0	6.5	6.5	-	-29.3
	Other	-	-	2.6	1.0	1.0	-	-28.6
Mexico	PHI	-	1.2	2.5	3.3	3.4	3.7	208.3
	OOP	-	58.3	50.9	51.2	52.4	51.1	-12.3
	Other	-	-	-	-	-	-	-
Netherlands	PHI	-	-	15.9	17.7	5.5	5.7	-65.2
	OOP	-	-	9.0	7.1	5.6	5.5	-34.5
	Other	-	-	7.1	6.6	5.0	5.8	-13.4
New Zealand	PHI	1.8	2.8	6.3	4.6	4.7	5.0	177.8
	OOP	10.8	14.5	15.4	16.5	16.4	14.0	29.6
	Other	0.5	0.3	0.4	1.0	0.9	1.0	100.0
Norway	PHI	-	-	-	-	-	-	0.0
	OOP	-	14.6	16.7	15.7	15.4	15.1	3.4
	Other	-	-	0.8	0.8	0.8	0.8	-

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Poland	PHI	-	-	-	0.6	0.6	0.5	-
	OOP	-	8.3	30.0	26.1	25.6	24.3	192.8
	Other	-	-	-	3.9	3.8	4.3	48.3
Portugal	PHI	0.2	0.8	3.1	3.9	4.1	-	1950.0
	OOP	-	-	22.2	22.8	22.9	-	3.2
	Other	-	-	2.2	1.5	1.4	-	1300.0
Slovak Republic	PHI	-	-	-	-	-	-	0.0
	OOP	-	-	10.6	22.6	25.9	26.2	215.7
	Other	-	-	-	3.0	5.7	7.0	-
Spain	PHI	3.7	3.7	3.9	5.9	6.0	5.9	59.5
	OOP	-	-	23.6	22.4	21.5	21.1	12.8
	Other	-	-	0.9	1.2	1.2	1.3	44.4
Sweden	PHI	-	-	-	0.1	0.1	0.2	100.0
	OOP	-	-	-	16.3	16.2	15.9	-
	Other	-	-	-	1.9	2.0	2.2	-
Switzerland	PHI	11.1	11.0	10.6	9.0	9.1	9.2	-17.1
	OOP	37.6	35.7	33.0	30.6	30.8	30.6	-18.6
	Other	1.0	1.0	1.0	0.9	0.9	1.0	0.0
Turkey	PHI	-	-	4.4	-	-	-	340.0
	OOP	-	-	27.6	19.9	-	-	-36.6
	Other	-	-	9.4	8.7	-	-	-11.2

		1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
United Kingdom	PHI	2.5	3.3	1.6	1.2	1.2	1.1	-56.0
	OOP	-	10.6	13.4	11.9	11.4	11.4	7.5
	Other	-	1.8	5.3	4.4	4.2	4.2	133.3
United States	PHI	30.1	33.3	34.3	35.6	35.3	35.2	15.8
	OOP	22.1	19.4	14.5	12.7	12.3	12.2	-44.8
	Other	4.1	8.1	8.0	7.2	7.2	7.2	-11.1

Source OECD HEALTH DATA 2009, June 09

*OOP refers to out-of-pocket expenditure.

**Other refers to expenditure incurred by corporations and Non-profit institutions serving households

〈Table III-3〉 PHI expenditure as a percentage of private expenditure on health care in OECD countries, 1985-2007

	1985	1990	2000	2005	2006	2007	Overall growth(%) 1985-2007
Australia	35.7	36.7	21.9	22.8	23.2	-	-35.0
Austria	41.0	28.2	20.7	19.4	19.2	19.3	-52.9
Belgium							
Canada	-	31.8	38.8	42.5	41.4	42.6	43.9
Czech Republic	-	-	-	2.2	1.8	1.5	-34.8
Denmark	5.4	7.4	9.0	9.0	9.5	10.5	94.4
Finland	8.4	11.2	8.8	8.1	8.5	8.3	-1.2
France	27.5	46.9	61.6	63.6	63.9	63.9	132.4
Germany	28.7	30.4	40.8	39.9	39.5	40.1	39.7
Greece							
Hungary	-	-	0.6	4.1	4.9	3.9	1850.0
Iceland	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Ireland	-	32.2	28.4	33.9	38.8	41.9	33.4
Italy	-	3.0	3.2	3.7	3.9	4.0	33.3
Japan	-	-	1.7	14.3	13.7	-	448.0
Korea	1.8	3.2	8.5	8.2	8.6	9.2	411.1
Luxembourg	-	-	10.0	23.6	18.6	-	38.8
Mexico	-	2.1	4.7	6.1	6.1	6.8	223.8
Netherlands		-	43.0	-	-	-	
New Zealand	13.5	15.9	28.5	20.9	21.2	-	57.0
Norway							
Poland	-	-	-	1.8	1.9	1.9	5.6
Portugal	0.5	2.3	11.1	14.0	14.5	-	2800.0
Slovak Republic							
Spain	19.3	17.4	13.7	19.9	20.9	20.8	7.8
Sweden	-	-	-	0.7	0.7	1.1	120.0
Switzerland	22.3	23.0	23.8	22.2	22.3	22.6	1.3
Turkey		-	11.8	-	-	-	
United Kingdom	17.6	19.9	7.8	6.8	6.5	6.0	-65.9
United States	50.1	54.8	60.3	64.0	64.4	64.5	28.7

Source OECD HEALTH DATA 2009, June 09

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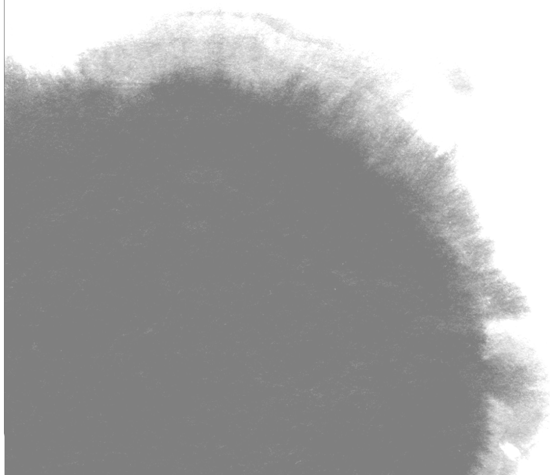
04

Private Health Insurance, the Partner of Health Insurance Plan



Ⅳ. Private Health Insurance, the Partner of Health Insurance Plan

The National Health Insurance of Korea, which had been first introduced in 1977 for workplaces with more than 500 workers, was expanded to include all the Korean public in 1989. For the past 30 years, the development of the national health insurance has greatly increased the medical access for the Korean people, contributed to the growth of the health industry, and improved overall health conditions of the population. Despite such great achievements, with the expectation of exponential increases in healthcare costs due to its aging population, there are growing doubts about sustainable management of the national health insurance. Also, there are increasing criticisms against relatively-higher co-payment than in other developed countries due to insufficient coverage.

To make up for such weaknesses and achieve efficient management of the national health insurance, there has been growing argument for the promotion of private health insurance to improve the efficiency of the overall insurance system by using price mechanism in the areas not covered by the national insurance, and to enhance the effectiveness of the medical coverage by developing both national and private insurance systems together. However, there are many people who are opposing it. They say that the promotion of only the

complementary private health insurance can weaken the public insurance, which in turn delays the expansion of the public coverage for high-cost critical illnesses and leads to increase in the private insurance or co-payment. They go on to argue that the private health insurance will aggravate social inequality, worsen the already-inefficient healthcare structure and undermine the value of social unity, which has been the basis for the health insurance system.[4]

4) The private health insurance can be classified on whether it substitutes for the public health insurance, whether it provides complementary coverage for non-covered areas by the public health insurance, or whether it provides additional coverage to offer wider choices for consumers and faster access to medical services. The substitutive private health insurance is used in countries where the public health insurance exists but the public can reject the public insurance and buy private insurance products (e.g. Germany). The complementary private health insurance provides coverage for areas not fully or sufficiently covered by the public health insurance (e.g. France). The supplementary private health insurance is used in the healthcare systems where almost-free medical coverage is provided but the public have to put up with long waiting time. This type of private insurance is provided to consumers who already have public insurance for wider choices and faster access to medical services (e.g. the UK). (Mossialos, E., Dixon, A., Figueras, J. and Kutzin, J, 2002:128~160)

〈Table IV-1〉 Comparisons between the national health insurance and private health insurance

Item		National health insurance	private health insurance
Operator	Purpose	Basic coverage	Coverage based on individual needs
	Operator	Government/Public organizations	Private insurance companies
	National responsibility	Yes	No
Goal	Short-term	Fiscal balance	Profits
	Long-term	Expansion of social security	Increase of profits
Principle	Rights	Legal rights	Contract-based rights
	Insurance subscription	Mandatory Impossible to select subscribers No risk avoidance	Optional Possible to select subscribers Risk avoidance
	Coverage	Universal	Differential (based on contract)
	Premium calculation	Collective equivalence Proportional to ability Risk-sharing	Individual equivalence Proportional to risk Individual risk

Source: Heung-won Jung, 2002, “Feasibility study on the introduction of the private health insurance,” Alternative Policy Forum.

It is said that the private health insurance may provide wider choices for consumers as compared to the public insurance, and improve the efficiency of insurance management via profit motivation. But because of information asymmetry between insurers and the insured, such strengths may not be realized without proper regulations. In addition, the private health insurance does not have much effect on the underprivileged in terms of medical coverage, and may damage social equality due to possible retrogressive payment of insurance premium based on income level. As shown in Table 1, the

private health insurance leads to burdens by risk factors and limited coverage. For the public health insurance, insurance premium is paid in proportion to income level, but insurance premium is determined by risk factors in the private insurance system. The national health insurance is mandatory for all the public so reciprocal help among different income levels and income redistribution may become secondary goals, but the private insurance is based on the beneficiary pays principle.

In the private health insurance market, one of the biggest problems caused by information asymmetry between insurers and insured is “adverse selection.” Adverse selection means that, when information is distributed asymmetrically, there are growing chances that those with less information do business with undesirable people. This applies to the private health insurance market in that, more unhealthy people tend to buy health insurance than healthy ones. As a result, insurers design different insurance products or screen subscribers based on risks to avoid adverse selection. This means that private medical insurers want to exclude high-risk groups who are likely to use medical services while selecting low-risk groups who don’t use medical services often, resulting in "risk selection” in the private insurance market. Because of risk selection and premium calculations based on risk factors, the elderly, those with chronic illnesses, and others with risk factors, may have to pay higher premiums or not be able to buy private insurance (uninsurable), or insurance premium may be retrogressive based on income level.

Korea's public coverage level in healthcare has expanded continuously but is still limited. The public coverage in healthcare, the share taken by the National Health Insurance Corporation in total

medical costs, stood at 53.6% as of 2005. As a result, total co-payment (co-payment for covered areas plus non-covered areas) is about 46.4%, which is the third-highest among OECD members following Mexico and Greece (OECD, 2005).

The low premium-low coverage structure of the national health insurance may be seen as the product of the earlier health insurance policy, which started with low-premium system to cover more people in a short period of time. In other words, a low-premium system was needed to increase people covered by the national insurance in a short period, which in turn resulted in low coverage.

High co-payment in this low premium-low coverage structure prevents the insurance system from playing its fundamental role of risk diversification properly because of excessive expenses when a disease occurs. In addition to low coverage level, the coverage structure focusing on low cost and minor illnesses is also a problem. As mentioned earlier, the fundamental role of an insurance is the diversification of catastrophic cost risks, so, it is desirable that the insurance system focuses on the coverage for high-cost, critical illnesses. But the coverage structure of the current public health insurance is distorted in that the coverage for critical or costly illnesses is lower than the one for minor illnesses.

The cap on co-payment system, which was recently introduced, helps the insured avoid economic losses for areas covered by the public health insurance when a disease occurs. But this system applies only to legal co-payment and does not consider the medical costs of non-covered patients, having only limited effects.

In the future, more money will be required for the national health insurance because of rapidly-aging population, increasing demand for

advanced and customized medical services due to income increase, and the emergence of high-cost, sophisticated medical services. As a result, it is highly likely that the government will have to provide more financial support for the public health insurance. Therefore, within the current national health insurance system, the complementary role of the private health insurance will become more important than ever before by sharing financial burdens for health insurance and encouraging healthcare consumers to use more efficient medical services.

In June 2009, the Financial Services Commission announced the "private medicalcare insurance improvement plan," which sets the minimum co-payment of gap-coverage insurance, and simplifies and standardizes insurance products. This has finished discussions on the gap-coverage private health insurance following the approval of selling of gap-coverage private health insurance products by life insurers in September 2005, and the introduction of the "role assignment plan for the national and private health insurances" by the Presidential Commission on Healthcare Industry Innovation in 2006. Despite the rapid growth of its market, there has been criticism that the gap-coverage private health insurance has been left unregulated. This improvement plan of the Financial Services Commission can be regarded as a 'minimum' response to such criticism. This plan does not include the gap-coverage product management policy among the discussions by the Presidential Commission on Healthcare Industry Innovation in 2006. For the cap on coverage, which is the core of the gap-coverage product reform, full coverage is permitted for co-payment that exceeds 2 million Korean won, and up to 90% is covered for co-payment below 2 million Korean won. In fact, the

entire co-payment has become the business target for gap-coverage products. The simplification and standardization of insurance products are also very limited as compared to the discussions in 2006.

There have been discussions and attempts to promote the private health insurance, but no concrete policies have been introduced to do it yet. The improvement plan of the Financial Services Commission does not have any plan to directly support the gap-coverage insurance either. However, the Korean healthcare system itself has proper conditions to promote the private health insurance. That's because private burdens on health costs are very high due to the weak coverage of the national health insurance. As of 2007, the average coverage of the public health insurance in total public health costs is 73.1% in other OECD countries while the coverage is 54.9% in Korea. In other words, the public cannot rely entirely on the national health insurance when they face high-cost, critical illnesses and the resulting economic difficulties. That's why more than 60% of the adult population in Korea buys private health insurance products.

Since it is still possible that the promotion of even the complementary private health insurance conflicts the coverage expansion of the national health insurance, there are still ongoing debates over the future direction of the private health insurance and the long-term role of the national health insurance. When the private health insurance complements the structural limitations of the national health insurance within the current healthcare system, the complementary role of the private insurance as well as the entire social efficiency will be maximized.

But if the private health insurance covers the co-payment in the medical service coverage by the national health insurance, the actual

expenses burdened by individuals will be reduced, resulting in decrease in price sensitivity and in turn causing moral hazard. In particular, if moral hazard leads to an increase in the use of medical services and more money is required for the national health insurance because of it, this might be construed as against the principle of equity because those only with the public insurance will have to support those who have bought private health insurance products additionally. But whether such moral hazard actually occurs and whether more money is required for the national health insurance because of moral hazard are triggering many controversies. Many studies quoted domestic and overseas empirical analyses to argue that the private health insurance may cause moral hazard and increase the use of medical services, forcing the national health insurance to require more financial resources. On the other hand, the private medical insurers point out to errors in those empirical analyses arguing that the actual degree of moral hazard and increase in financial resources for the national health insurance are insignificant.

As the private health insurance covers the co-payment in the medical service coverage by the national health insurance, there is a chance that moral hazard occurs and more financial resources are required for the national health insurance. But the private coverage for co-payment will improve the public's access to medical services and the welfare of the beneficiaries. Therefore, the following approaches to the private health insurance may be possible. If the private coverage for co-payment increases the financial resources required for the national health insurance, it might be a good idea to permit the partial coverage for co-payment by the private insurance and impose "special fee" on insurance premium. And the resulting

"special fee" revenues may be used to support the national health insurance. The introduction of a proper level of “special fee” can prevent moral hazard from occurring and increase the financial resources for the national health insurance as well as reduce the resistance of some social levels against the promotion of the private health insurance.

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신간 안내

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보고서 번호	서 명	저자	가격
연구 2009-01	의료서비스 질 및 효율성 증대를 위한 통합적 의료전달 시스템 구축 방안	신호성	7,000
연구 2009-02	고가의료장비의 적정공급과 효율적 활용방안	오영호	8,000
연구 2009-03	신의료기술의 패턴 변화에 따른 의사결정제도의 발전방향: 의약품 허가제도와 약가제도를 중심으로	박실비아	6,000
연구 2009-04	생애의료비 추정을 통한 국민의료비 분석(1)	정영호	미정
연구 2009-05	미 충족 의료수준과 정책방안에 대한 연구	허순임	미정
연구 2009-06	식품안전관리 선진화를 위한 취약점 중점 관리 방안	정기혜	7,000
연구 2009-07	부문간 협력을 통한 비만의 예방관리체계의 구축 방안	김혜련	8,000
연구 2009-08	국가건강검진사업의 성과제고를 위한 수요자 중심의 효율적 관리체계 구축방안	최은진	7,000
연구 2009-09	취약계층에 대한 사회보험 확대적용 방안 - 국민연금을 중심으로 -	윤석명	미정
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연구 2009-14	저소득층 지원제도의 유형 및 특성 연구	여유진	미정
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연구 2009-24	보건복지가족부 웹사이트 통합·연계 및 발전방안 연구	송태민	7,000
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연구 2009-26-1	2009년 국민기초생활보장제도 모니터링 및 평가: 법제정 10년의 제도운영 점검	이태진	10,000
연구 2009-26-2	가난한 사람들의 일과 삶: 심리사회적 접근을 중심으로	이현주	6,000
연구 2009-26-3	근로빈곤층 지원정책 개편방안 연구	노대명	미정
연구 2009-26-4	사회복지지출의 소득재분배 효과분석	남상호	5,000
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보고서 번호	서 명	저자	가격
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연구 2009-31-3	정부의 사회복지재정 DB구축에 관한 연구(3차년도): 중앙재정 세출 예산을 중심으로-	고경환	6,000
연구 2009-31-4	보육지원정책의 효과성 분석	최성은	미정
연구 2009-31-5	자활사업의 평가 및 과제	고경환	미정
연구 2009-32-1	2009년 한국복지패널 기초분석 보고서	손창균	14,000
연구 2009-32-2	2008년 한국복지패널 심층분석 보고서	여유진	6,000
연구 2009-33	2009년 전국 출산력 및 가족보건·복지실태조사	김승권	미정
연구 2009-34-1	다문화가족 증가가 인구의 양적·질적 수준에 미치는 영향	이삼식	5,000
연구 2009-34-2	육아지원 인프라의 양적·질적 수급 적정화 방안	신윤정	미정
연구 2009-34-3	장기요양등급외자 관리를 위한 노인복지관과 보건소의 보건복지 서비스 연계 방안	오영희	미정
연구 2009-34-4	노인자살의 사회경제적 배경 및 정책적 대응방안 모색	이소정	미정
연구 2009-34-5	고령친화용품 소비실태 및 만족도에 관한 연구	김수봉	미정
연구 2009-35	보건복지통계 정보시스템 구축 및 운영	이연희	미정
연구 2009-36	인터넷 건강정보 평가시스템 구축 및 운영	정영철	미정
연구 2008-01	건강수명의 사회계층간 형평성과 정책과제	강은정	6,000
연구 2008-02	여성 흡연과 음주의 요인 및 정책대안	서미경	9,000
연구 2008-03	공공보건조직의 효율성 분석 및 운영 합리화 방안	신호성	7,000
연구 2008-04	건강한 미래세대를 위한 영양 관련 요인 분석과 정책과제: 모유수유 및 아동·청소년 영양문제를 중심으로	김혜련	7,000
연구 2008-05	남북한간 보건의료 교류·협력의 효율적 수행체계 구축방안 연구	이상영	6,000
연구 2008-06	저소득층 생계비 지원정책의 개선방안 연구	강신욱	7,000
연구 2008-07	건강보험 지불제도와 의료공급자의 진료행태: 의료공급자의 유인 수요와의 연관성 파악	허순임	7,000
연구 2008-08	공적연금의 지속 가능성에 관한 연구: 재정적·정치적 지속 가능성 중심으로	윤석명	7,000
연구 2008-09	국민연금 기금운용 성과 평가	원종욱	7,000
연구 2008-10	사회통합을 위한 사회적 배제계층 지원방안 연구: 사회적 배제의 역동성 및 다차원성 분석을 중심으로	김안나	9,000
연구 2008-11	사회재정지출의 효율성과 형평성 분석	최성은	6,000
연구 2008-12	한국복지모형에 대한 연구: 그 보편성과 특수성	노대명	6,000
연구 2008-13	한국인의 행복결정요인과 행복지수에 관한 연구	김승권	10,000
연구 2008-14	다문화시대를 대비한 복지정책방안 연구 -다문화가족을 중심으로 -	김유경	15,000
연구 2008-15	아동·청소년복지 수요 추계 연구 Ⅰ	김미숙	8,000
연구 2008-16	지역복지 활성화를 위한 사회자본형성의 실태와 과제	박세경	6,000
연구 2008-17	노년기 사회경제적 불평등의 다차원적 구조분석	이소정	8,000
연구 2008-18-1	2008년 국민기초생활보장제도 모니터링 및 평가 연구-조건부 수급자를 중심으로	이태진	7,000
연구 2008-18-2	국민기초생활보장제도 모니터링 실효성 제고를 위한 기초연구 - 법, 조직, 정보 인프라를 중심으로	이현주	6,000
연구 2008-18-3	2008 빈곤통계연보	김태완	8,000
연구 2008-18-4	의료급여 사례관리 효과분석 Ⅱ	신영석	6,000

보고서 번호	서 명	저자	가격
연구 2008-18-5	의료급여 선택병의원제도 모니터링에 관한 연구	신현웅	5,000
연구 2008-18-6	서구 근로빈곤문제의 현황과 쟁점	노대명	6,000
연구 2008-19-1	국민연금기금의 의결권행사 기준개선을 위한 해외사례 연구	원종욱	6,000
연구 2008-19-2	한국의 복지 GNP	홍석표	5,000
연구 2008-20-1	저출산·고령사회 기본계획의 추진실태와 효율화 방안 연구	오영희	10,000
연구 2008-20-2	저출산·고령사회관련 주요 현안 및 대응방안 연구	오영희	9,000
연구 2008-20-3	저출산 대응 정책의 효과성 평가에 관한 연구	이삼식	7,000
연구 2008-20-4	저출산·고령사회에 대응한 여성인적자본의 효율적 활용방안	신윤정	6,000
연구 2008-20-5	노인 장기요양보장체계의 현황과 개선방안	선우덕	9,000
연구 2008-20-6	농촌지역 고령자의 생활기능 자립을 위한 보건복지 지원체계 모형 개발	선우덕	5,000
연구 2008-20-7	노후생활안정을 위한 인적 및 물적 자산 활용방안	김수봉	미정
연구 2008-20-8	국제적 관점에서 본 고령화에 대한 정책적 대응현황과 과제	정경희	6,000
연구 2008-21-1	2008년 한국복지패널 기초분석 보고서	김미곤	15,000
연구 2008-21-2	2007년 한국복지패널 심층분석 보고서	여유진	9,000
연구 2008-22-1	한국의료패널 예비조사 결과 보고서	정영호	9,000
연구 2008-22-2	2008년 한국의료패널 조사 진행 보고서	정영호	8,000
연구 2008-23-1-1	사회재정사업의 평가	유근춘	미정
연구 2008-23-1-2	사회재정사업의 평가 -가족복지서비스 전달체계의 운영평가: 상담서비스 네트워크를 중심으로	고경환	6,000
연구 2008-23-2	사회재정평가지침-사례와 분류	유근춘	미정
연구 2008-23-3	조세 및 사회보장 부담이 거시경제에 미치는 영향	남상호	5,000
연구 2008-23-4	의료급여 재정모형과 재정지출 전망	최성은	6,000
연구 2008-23-5	복지제도의 발전방향 모색-가족부문 투자	유근춘	미정
연구 2008-23-6	정부의 복지재정지출 DB 구축 방안에 관한 연구(2차년도)	고경환	5,000
연구 2008-23-7	2008 사회예산 분석과 정책과제	최성은	7,000
연구 2008-24-1	국립소록도병원의 만성병 관리체계에 대한 건강영향평가	강은정	5,000
연구 2008-24-2	드림스타트의 건강영향평가	강은정	7,000
연구 2008-24-3	KTX의 건강영향평가 -의료이용을 중심으로	김진현	6,000
연구 2008-24-4	기후변화에 따른 전염병 감시체계 개선방안	신호성	6,000
연구 2008-25	보건의료자원배분의 효율성 증대를 위한 모니터링시스템 구축 및 운영(1년차)	오영호	5,000
연구 2008-26	인터넷 건강정보 평가시스템 구축 및 운영	송태민	8,000
연구 2008-27-1	능동적 복지의 개념정립과 정책과제	김승권	8,000
연구 2008-27-2	보건복지재정 적정화 및 정책과제	유근춘	미정
연구 2008-27-3	능동적 복지개념에 부합된 국민건강보험제도의 체계개편 방안	신영석	6,000
연구 2008-27-4	능동적 복지와 사회복지서비스 실천방안	김승권	7,000
연구 2008-27-5	능동적 복지 구현을 위한 건강투자 전략	최은진	6,000