Health Care System in Korea

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Foreword

Korea is now experiencing an epidemiological transition. During the last few decades, the incidence of infectious diseases has decreased while the incidence of chronic diseases has been consistently growing. To cope with this epidemiological change, the Korean government has placed more emphasis on health promotion.

The implementation of health insurance for the whole nation by the Korean government has increased the demand for health care and subsequently the need for more health manpower and facilities. The main issue of the health care system in Korea is therefore the improvement of accessibility, equality and availability of health care with lower costs for the majority of the people.

Policy measures for long term development of the health security sector were suggested by the Health Security Reform Commitee(1994). Concrete implementation strategies were provided to enhance health security by the Medical Care Reform Committee(1996). Most recently, a special committee for integration of the health insurance societies was organized, in March 1998, to improve management of the health insurance system.

The purpose of this paper is to report to the OECD on the health care system and health reform movement of the Republic of Korea. The current state and problems in Korea's health status, medical delivery system, health care resources, regional health care resource distribution, and the health insurance system were

discerned and the recent health reform movement was examined. The individual health statuses of Asian countries were also compared.

This publication was prepared by Dr. Eunyoung Choi at the Korea Institute for Health and Social Affairs in collaboration with Dr. Jinsoo Kim and Mr. Woobaik Lee.

The authors would like to thank Dr. Youngseok Shin and Dr. Youngho Oh at KIHASA and Dr. Jeong-kee Hong at MOHW for their valuable advice, and Julie Oh and Nanhee Lee for editing the draft.

The views and opinions expressed in this report are those of the authors alone and do not reflect the views of the Korea Institute for Health and Social Affairs.

December, 1998
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List of Abbreviations

CDPA : Communicable Disease Prevention Act
CMHP : Community Mental Health Program
CT : Computerized Tomograph
FPP : Family Planning Program
GNP : Gross National Product
HCT : Health Care Technopolis
HCTI : Health Care Technology Innovation
HPDP : Health Promotion Demonstration Programs
HRDP : Health Research and Development Programs
IHR : Internal Health Regulation
JCMI : Joint Commission for Medical Insurance
KFDA : Korea Food and Drug Administration
KHCA : Korea Health Control Association
KIHASA : Korea Institute for Health and Social Affairs
KIOM : Korea Institute of Oriental Medicine
KLCA : Korean Leprosy Control Association
KMA : Korean Medical Association
KNTA : Korean National Tuberculosis Association
LE : Life Expectancy
LC : Life Committee
NCC : National Cancer Center
MAD : Medical Aid Program
MCHP : Maternal and Child Health Program

MFRC : Medical Fees Review Committee
MHA : Mental Health Act
MIA : Medical Insurance Act
MIP : Medical Insurance Program
MIRC : Medical Insurance Reappeals Committee
MOE : Ministry of Education.
MOHW : Ministry of Health and Welfare
MSA : Medical Service Act
MSRC : Medical Care Reform Committee
NAC : National AIDS Committee
NAP : National AIDS Prevention Program
NFMI : National Federation of Medical Insurance
NHIC : National Health Insurance Corporation
NHPA : National Health Promotion Act
NHPF : National Health Promotion Fund
NIH : National Institute of Health
NMC : National Medical Center
OECD : Organization for Economic Co-operation and Development
OMB : Oriental Medicine Bureau
OTMC : Organ Transplantation Management Center
PHC : Primary Health Care
PHDs : Public Health Doctors
SCHR : Special Committee for Health Reform
SEMC : Special Emergency Medical Centers
VC : Vaccination Committee

Summary

Ⅰ. Introduction

The purpose of this paper is to report to the OECD on the health care system and health reform movement of the Republic of Korea. The current state and problems in Korea's health status, medical delivery system, health care resources, regional health care resource distribution, and the health insurance system were discerned and the recent health reform movement was examined. The individual health statuses of Asian countries were also compared.

Ⅱ. Health Indices

Due to the development of health and medical science, improved living standards and national nutrition, and the upgrading of the quality of health and medical care, the life expectancy of the Korean people has been greatly prolonged. The life expectancy for males increased from 51.1 years in 1960 to 69.9 years in 1995 and from 53.7 years to 77.4 years for females. The crude birth rate was down to 16.1 per 1000 persons in 1995 and the crude death rate was 5.4 per 1,000 persons, giving a natural increasing rate of 10.7 per 1,000 persons. The infant mortality rate also dropped from 89.2 per 1,000 live births in 1962 to only 9.9 in 1993. In the past, the main causes of

death were acute and communicable diseases, but now these have been replaced by chronic and non-communicable diseases. The leading causes of death in 1996 were diseases of the circulatory system, malignant neoplasms, accidents, chronic liver disease and diabetes mellitus.

Ⅲ. International Comparison

Korea's life expectancy in 1994 was lower than the life expectancies in Hongkong, Japan, and Singapore and the infant mortality rates and age-adjusted mortality rates in Korea are among the highest in major Asian countries. Age-adjusted mortality in Korea was higher than that of Singapore and Japan and has increased since 1992. The level of age-adjusted mortality due to malignant neoplasm in Korea was lower than in Singapore and Japan before 1987 but increased sharply and became higher after 1990. The level of age-adjusted mortality due to ischaemic heart disease in Korea is the lowest in the major Asian countries but has increased rapidly since 1990.

Ⅳ. Public Health

Korea is now experiencing an epidemiological transition. During the last few decades, the incidences of infectious diseases has decreased while the incidences of chronic degenerative diseases has consistently grown. To cope with this epidemiological change, the Korean government enacted the National Health Promotion Act in January 1995 which placed more emphasis on health promotion. This act provided a legal and institutional base for people to raise the responsibility for and value of their own health. The main contents of the Act are as follows:

― *Health Promotion Plans in Central and Local Governments*

— *Nutrition and Dental Health Care Programs*
— *Promotion of Health Education*
— *No Smoking and No Drinking Movement*
— *National Health Promotion Fund*

The prevention of adult diseases is essential because most adult diseases have no symptoms and are not detected until the terminal stage. Currently, the mortality rate from chronic diseases is rapidly increasing and it is anticipated that this tendency will become more pronounced with the aging of the population structure, change in diet, increased smoking population, and decrease in physical activities. Focus has therefore been put on prevention activities, various public education methods, and the 13 chronic disease screening centers of the Korea Health Control Association(KHCA) where screening at a low price is carried out through mobile screening teams.

The hospital cancer registry project has been implemented by the National Medical Center(NMC) since 1980. Cancer patients who are diagnosed in general hospitals are registered and controlled at the NMC. The National Cancer Center(NCC) carries out national cancer control programs which include prevention, screening and treatment.

The Maternal and Child Health(MCH) program is aimed at improving the level of national health through prenatal care for pregnant women as well as health care services for preschool children. The Ministry of Health and Welfare(MOHW) also provides free vaccinations for diseases such as PDT, Polio, MMR and DT, Rubella and Hepatitis B. The Family Planning Policy also aids in improving national health by maintaining the present low fertility trend. It focuses on quality-oriented programs such as sex-education for the youth, prevention of induced abortion and other MCH programs.

A communicable disease control system was established and a notification system and immunization programs were implemented for the management of communicable diseases.

Quarantine stations inspect passenger and provides health information to overseas trvelers and the National Medical Center(NMC) provides orphan drugs.

In December 1985, the first HIV positive persons were identified and the first AIDS case was reported in February 1987. The cumulative number of persons with HIV/AIDS is continuously increasing. Since 1985, MOHW has coordinated a wide range of activities for AIDS prevention and control and the Center for AIDS Control provides technical support for the National AIDS Prevention program(NAP).

To improve the quality of life and human rights of the mentally ill the government enacted the 'Mental Health Act' in December 1995. The fundamental objectives of the 'Mental Health Law' are to shift present mental health policies to a community based management system and to improve human rights of the mentally ill through a variety of support for their return to society.

Ⅴ. Medical Care System

Due to industrialization, urbanization and aging of the population in the past years, the demands, both in quantity and quality, of the people for health and medical care services has increased. There is an uneven distribution of medical care resources in Korea, though. The implementation of health insurance for the whole nation increased the demands for health care and revealed the fact that more health manpower and facilities are needed. The crucial issues of the health care system in Korea are the improvement of accessibility, equality and availability of health care with lower costs for the majority of the people.

Medical services are provided indirectly by medical care institutions established and operated by the national government or by local government and educational institutions or predominantly

by private corporations and private individuals. Medical care institutions are categorized by their scale of operations into general hospitals, hospitals, and clinics.

At the end of 1997, there were approximately 156 physicians(including oriental medical doctors) per 100,000 persons. By the year 2,000 it is estimated that there will be about 200 per 100,000 persons. In 1996, 58.2% of licensed physicians were specialists.

The health system depends mainly upon the private sector. Private clinics and hospitals make up more than 91.0% of all medical facilities, employ 88.8% of physicians, and include 91.0% of total beds. Most private facilities are concentrated in urban areas.

In Korea, 75.6% of the population resides in urban areas, but 95.8% of the physicians and 92.0% of hospital beds are concentrated in the cities. This makes it difficult for the rural population to have access to medical care. The skewed distribution of health resources is the result of laissez-faire policy towards the private medical care sector. The private sector tends to concentrate more in the cities where the demand for medical service is higher

To alleviate the maldistribution of medical facilities between urban and rural areas, the government provides those who establish medical facilities in rural areas with public doctors and financial incentives such as long-term low-interest loans.

The government has also made additional efforts in many areas. The people's convenience in the emergency medical system was improved at every stage from emergency calls, to delivery, and medical care. The government announced preliminary proclamation of the Organ Transplantation Law, which contains the legal definition of cerebral death, prevention of organ sale and extraction of internal organs from the cerebrally dead, and establishment of the Life Committee. A home care demonstration program was launched in 1994 which provides home care in the form of medical and nursing services to patients at home whom

were discharged early from a hospital with consent.

Oriental medicine, which is traditional Korean medicine, differs fundamentally from western medicine in principles and characteristics. Oriental medicine has long contributed to the improved health of Koreans with excellent clinical treatment effects. However, the lack of appropriate systems and organization for the development of oriental medicine in Korea has been a barrier for the standardization and modernization of oriental medicine. Increased research and support should also be focused on the globalization of oriental medicine.

Ⅵ. Health Insurance

The health insurance scheme was introduced in 1977. In 1988, insurance coverage was expanded to workplaces with more than 5 employees and to rural residents.

In 1989, the Korean government implemented a compulsory health insurance program for the entire population. Insurance coverage was gradually expanded from corporate employees to the self-employed and farmers. Pharmacies were also included as part of the medical insurance system.

There are two kinds of health insurance schemes; one is for ordinary employees and the other is for government employees, private school employees and self-employed persons. Ordinary employee insurance covers workers at industrial establishments with five or more employees and their dependents.

All insurers are members of the National Federation of Medical Insurance(NFMI). NFMI, on behalf of its members, designates medical care institutions to provide services to the insured and reviews and pays all claims from medical care institutions. All societies, National Health Insurance Corporation(NHIC) and the NFMI are under the guidance and administrative supervision of the Ministry of Health and Welfare.

Health care benefits include medical consultation, drugs and other therapeutical materials, medical and surgical treatment, hospitalization, operations and other care such as nursing care and transportation.

The financial resources of the insurance system consist of contributions paid by the insured and their employers and government subsidies. The system has social insurance characteristics resulting in contributions being the major source of income. There are two different insurance fund schemes with one covering employees and the other covering the self-employed. In both employees medical insurance and government and private school employees medical insurance, contributions are based on the income of the insured. However, the scope and amount of income and the contribution rate between the two are slightly different.

In the employees medical insurance program, the employee and employer each pay half of the contribution. In the government and private school employees medical insurance program, the government, as employer, pays half for the government employee, while for private school employees the owner pays 30% and the government subsidizes 20%.

The self-employed medical insurance program is financed by contributions from the insured and by government subsidies. The contribution of the insured is determined by income and property.

Ⅶ. Future Issues

Although Korea has established universal health care, problems remain. Consumers have been dissatisfied with the services provided by the health insurance scheme both in terms of quantity and quality because the supply of health services was not sufficient to meet the consumers' increased and diverse demands caused by health insurance expansion.

The initial objective of the government was to make sure

everyone was covered by an insurance scheme. In order to achieve this goal in a short period though, the government had to maintain premiums at a low level. This low premium policy resulted in a high copayment rate.

In response, the Korean government organized the Special Committee for Health Security Reform in January 1994. The goals of the reform are to increase efficiency of the system through restructuring of the health care system, to increase the satisfaction of both consumers and suppliers and to correct the inequity in the different insurance funds.

In 1996, the need for health reform was raised again, mainly by domestic causes. To overcome these problems the government reorganized a special Committee for Health Reform in November 1996. The goal of the committee's reform in 1997 was to increase the quality, access, and comprehensiveness of care and to increase efficiency of the health care delivery system. To improve management of the health insurance system, a special committee for integration of health insurance societies was organized in March 1998.

Ⅰ. General Information

1. History

The history of Korea can be traced back nearly 5,000 years when, according to Korean folk legend, Ko-choson was founded by a semi-deity named Dangun in 2333 B.C..

Korea has been invaded many times since Dankun founded the country, but despite these invasions, it remained independent and self-reliant. Korea was under Japanese rule for 36 years(1910～1945) and then was divided into two parts at the 38th Parallel shortly after being liberated at the end of World War Ⅱ. The Korean War from 1950 to 1953 separated the people and the land along the 155-mile Demilitarized Zone which stretches from the mouth of the Imjin River on the west coast to the Kumgang Mountains on the east coast.

The Korean War(1950～1953) left Korea devastated. During the sixties and seventies Korea succeeded in developing the economy and during the eighties the people's wish for democracy was achieved.

In 1988, Korea hosted the 24th Olympic Games in Seoul, which was the largest and most successful sports festival to date. In 1991, Korea joined the United Nations along with North Korea, and joined the OECD in 1996 marking its advancement into the ranks of developed nations.

Today Korea has reached an advanced stage of democracy with freely elected local councils and separation of the legislative

and executive branches of government. Korea's main political goal for the future is to be peacefully reunited.

2. The Land

Korea stretches southward from the eastern end of Asia and consists of the Korean Peninsula and the more than 3,400 islands adjacent to it. It has a total land area of 221,000㎢. The country has four distinct seasons and a climate that is well suited to a variety of activities. Seventy percent of the land is covered with mountains and in spite of the mountainous terrain, the inhabitants of Korea began to farm early on. Korea is bordered on the north by China and Russia and across the East Sea lies Japan.

3. Population

3.1 Population Size and Growth Rate

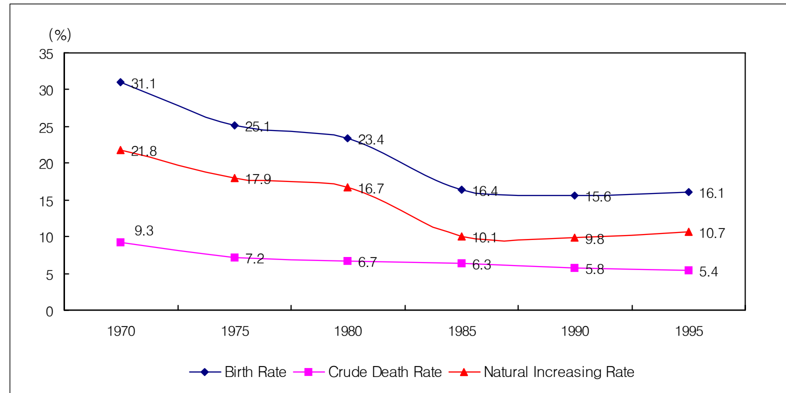
As of 1997, the population of Korea was estimated to be 46 million persons. The population growth rate was 3% in 1960, but economic and social development, together with a successful family planning campaign, gradually reduced the growth rate to 2% in 1970. It has remained under 1% since 1985.

3.2 Birth, Death and Natural Increasing Rate

Since 1970, the birth, crude death and natural increasing rate have been steadily decreasing. The birth rate in 1970 was 31.1 per 1,000 persons but in 1995 was 16.1 per 1,000 persons. The crude death rate in 1970 was 9.3 per 1,000 persons but in 1995 decreased to 5.4 per 1,000 persons. The natural increasing rate was 21.8 per 1,000 persons in 1970 and this rate also decreased to 10.7 per 1,000 persons in 1995(see Figure 1).

Figure 1. Birth, Death and Natural Increasing Rates

(unit: 1,000 persons)

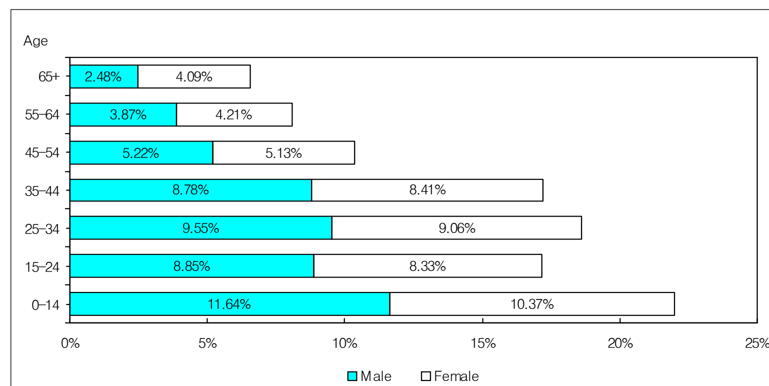


Source: National Statistical Office, *The Future Estimated Population,* 1996.

3.3 Age Structure

The age structure of the population in 1998 shows 22.0% of the population to be ages 0～14, 71.4% to be ages 15～64, and 6.6% to be 65 and over. The age structure of the population in the past, especially in 1960, was pyramid-shaped, a typical structure for less developed countries.

Figure 2. Age Composition of the Population



Source: National Statistical Office, *The Future Estimated Population,* 1996.

However, the pattern has become bell-shaped as a result of low birth rates and low mortality rates. In the near future, it is expected to become post-shaped like those of advanced countries which have a relatively low birth rate.

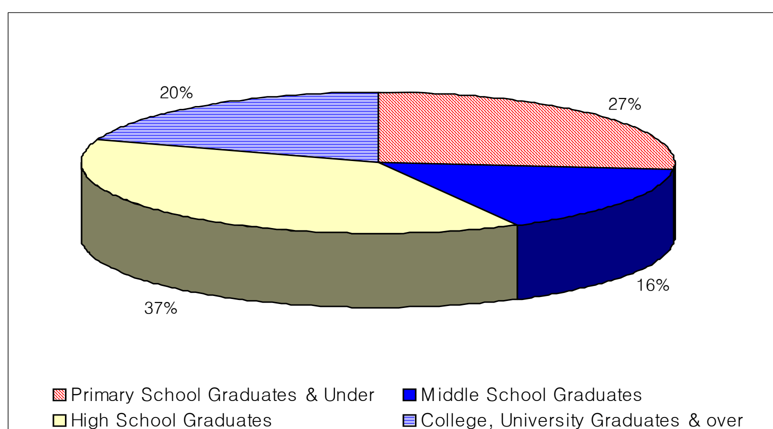
3.4 Marital Status

In 1995, of the 34,210,000 persons aged 15 years or above 30.2% were unmarried, 61.2% married, 7.5% widowed and 1.1% divorced.

3.5 Education

According to the Population-Housing Census, as of November 1, 1995, people with an elementary school education (including those who attended elementary school and dropouts of middle school) accounted for 92.7% of the population with a total of 37.5 million, out of 40.5 million persons aged 6 and over.

Figure 3. Composition of the Population by Educational Attainment (25 Years of Age & Over)



Source: National Statistical Office, *Population & Housing Census,* 1995.

In Korea, the rate of school attendance for preschool children rose to 39.9% in 1997. The total number of elementary schools

has been decreasing since 1980 so that there are now 5,721 elementary schools with a school enrollment ratio of 98.9%. The total number of higher education schools including colleges and universities in 1997 was 950, which was over twice the number for 1990, which demonstrates the high demand for college education in Korea.

Figure 3 shows us the distribution of educational attainment in the population aged 25 or over, 37% of these people have graduated high school.

3.6 Population Distribution and Density

Table 1 shows the regional distribution and population density of Korea population. It shows that 22.9% of the population lives in Seoul and 17.1% lives in Kyonggi Province. The population density of Seoul is highest at 16,864 preson per km^2 and the population density of Kangwon Province is lowest at 87 preson per km^2.

Table 1. Population Distribution and Density

Region	Population (%)	Density (Person per ㎢)
Whole Country	44,551,183 (100.0)	448
Seoul Metropolitan City	10,215,222 (22.9)	16,864
Pusan Metropolitan City	3,809,107 (8.5)	5,084
Taegu Metropolitan City	2,445,007 (5.5)	2,757
Inchon Metropolitan City	2,303,606 (5.2)	2,414
Kwangju Metropolitan City	1,256,931 (2.8)	2,510
Taejon Metropolitan City	1,270,895 (2.9)	2,354
Kyonggi Province	7,638,115 (17.1)	752
Kangwon Province	1,465,835 (3.3)	87
Chungchongbuk Province	1,395,213 (3.1)	188
Chungchongnam Province	1,765,272 (0.4)	211
Chollabuk Province	1,900,719 (4.3)	236
Chollanam Province	2,066,132 (4.6)	174
Kyongsangbuk Province	2,672,530 (6.0)	141
Kyongsangnam Province	3,841,500 (8.6)	332
Cheju Province	505,099 (1.1)	277

Source: National Statistical Office, *Population & Housing Census,* 1995.

4. Economic Activities

4.1 Economic Growth

Less than 50 years ago, Korea was still primarily an agricultural land. After the devastating war from 1950 to 1953, the Korean Peninsula was in ruin, but around 1960 Korea began to rebuild its economy. By 1965, the average annual growth rate of Korea's economy was 8.4 percent. In less than 30 years Korean development came to be referred to as the Miracle on the Han River and the country became industrialized.

Korea made up for its lack of natural resources through exports. In steel production, ship building, the heavy chemical industry, semiconductors, automobiles, and other advanced technology and skills, Korea made swift inroads into world markets. The composition of the business sector is slowly shifting towards service industries. Korea joined the OECD in October of 1996. Recently, at the end of 1997, Korea entered a period of economic crisis and became managed by the International Monetary Fund (IMF).

4.2 National Income

The gross national product(at current prices in 1997) totaled 437 billion US dollars(416.1 trillion won) with a decrease of 9% over the previous year. GNP per capita in 1997 was recorded as 9,511 US dollars.

4.3 Employment Trend

The labor force population, which includes persons aged 15 and over, exceeded 35.7 million persons in 1997 showing an increase of 1.6% over the previous year(35.1 million). The economically active population participating in the labor market was registered at 21.6 million persons with a 1.9% increase over the previous year.

The labor force participation rate in 1997 was 60.5% and the

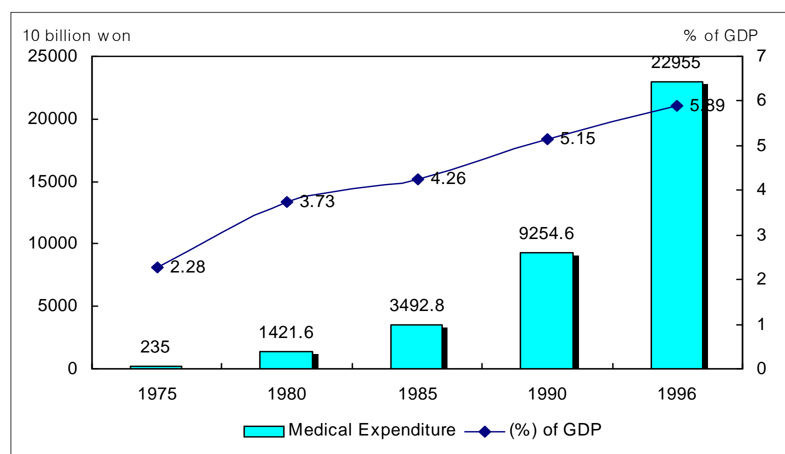
unemployment rate was 2.6%. The unemployment rate in May 1998 was 6.7%.

5. Health Expenditure

The level of spending on health care is decided by the providers and patients. The providers are doctors and hospitals. They are entitled to be paid for each service they decide to provide. If the service is on the fee schedule for reimbursable health care goods and services, they are paid by the insurance fund and patient copayment. Hence, there is no limit on total spending even for insured services. Additionally, patients pay in full for goods and services which are not on the fee schedule.

Estimates of total spending on health care depend precisely on what is included, particularly with regard to out-of-pocket payments. It is estimated that, in 1996, Korea spent 5.89 percent of its gross domestic product on health care. This is marginally less than the average of OECD countries(see Figure 4).

Figure 4. Health Expenditure in GDP

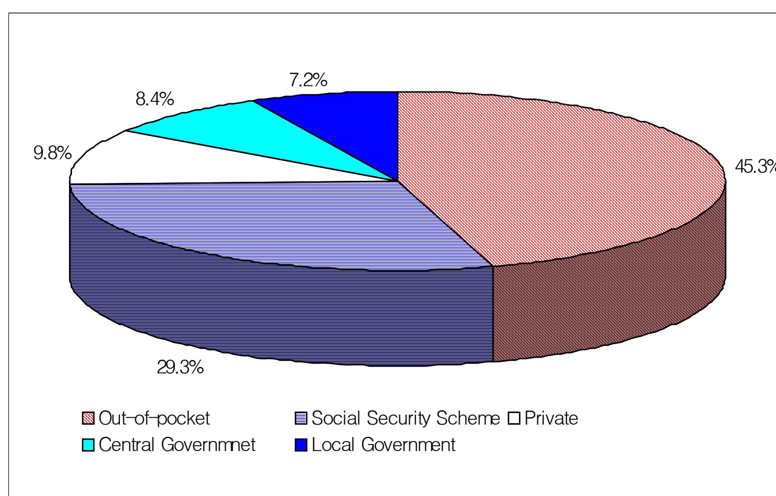


Source: KIHASA, *Estimation of National Health Expenditures and Analysis of the Type of Expenditures,* Forthcoming.

In 1996, total spending on health care was estimated to be 22,955 billion won. Figure 5 shows the composition of health expenditure. Direct payments were estimated to be approximately 45.3%.

Figure 5. Expenditure on Health Care in Korea by Source(1996)

(Total Spending: 22,955 billion won)

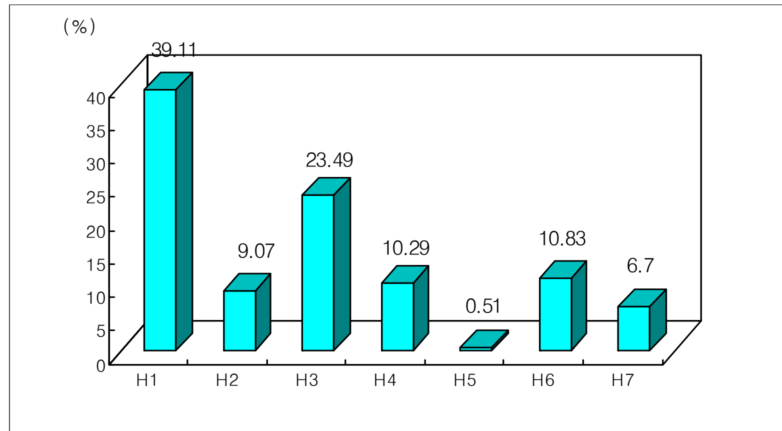


Source: KIHASA, *Estimation of National Health Expenditures and Analysis of the Type of Expenditures,* Forthcoming.

Figure 6 shows health expenditure distribution by type of medical facility; 39.11% of health expenditure was being used in general hospitals and 23.49% was being used in clinics.

Figure 6. Expenditure on Health Care in Korea by Type of Institution(1996)

(16,210 billion won)



Note: H1: General Hospital, H2: Hospital, H3: Clinics, H4: Dental Hospital and Clinics, H5: Public Health Center and Midwifery, H6: Oriental Medical Hospital and Clinics, H7: Pharmacy

Source: KIHASA, *Estimation of National Health Expenditures and Analysis of the Type of Expenditures,* Forthcoming.

6. Medicine

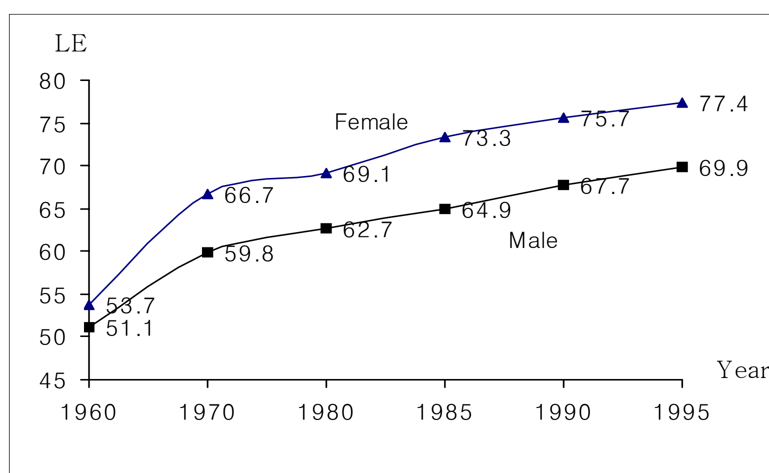
The prices paid for drugs which are dispensed to patients are controlled by the government. The government sets a standard price list for each item of pharmaceuticals. The price that the consumer is actually paying for drugs, which are sold, is less than the standard prices. Parmacists sell drugs at 20~50% less than the standard prices. The government therefore decided to eliminate the standard prices by January, 1999.

Prescribing and dispensing of medicines are not generally separated in Korea. In practice, this means that nearly all drugs are available without prescription. Prescribing and dispensing of medicine will be separated starting July 1999.

7. Health Indices

Due to development in health and medical science, the betterment of living standards, the improvement in national nutrition and the upgrading of the quality of health and medical care, life expectancy of the Korean people has been greatly prolonged, from 51.1 years in 1960 to 69.9 years in 1995 for males, and from 53.7 years to 77.4 years for females in the same period(see Figure 7). The crude birth rate was down to 16.1 per 1000 persons in 1995 and the crude death rate was 5.4 per 1,000 persons, giving a natural increasing rate of 10.7 per 1,000 persons. The infant mortality rate dropped from 89.2 per 1,000 live births in 1962 to only 9.9 in 1993.

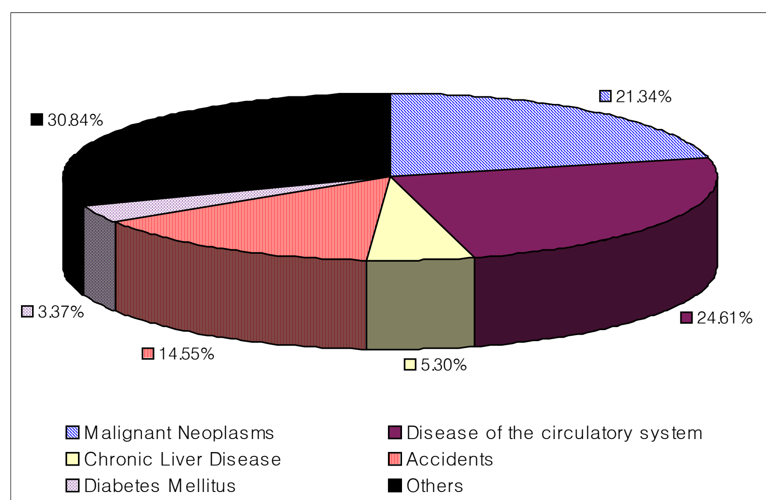
Figure 7. Life Expectancy at Birth



Source: National Statistical Office, *1995 Life Tables for Korea,* 1997.

Figure 8 shows the distribution of causes of death for our country. Disease of the circulatory system is shown to be number one in total causes of death.

Figure 8. Leading Causes of Death(1996)



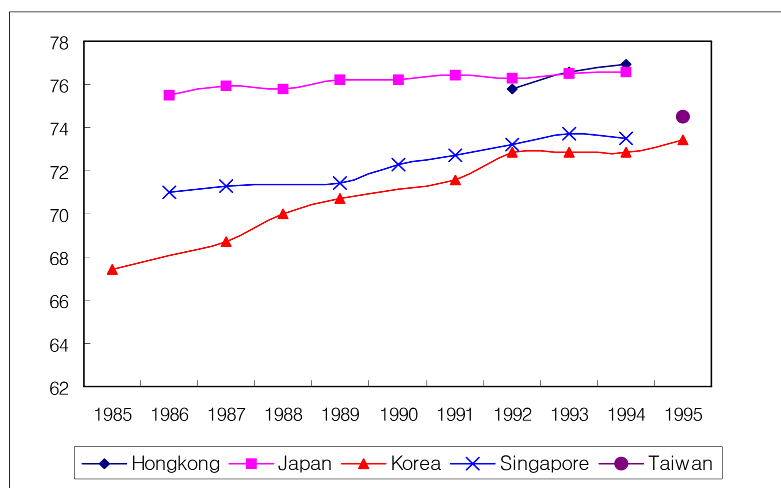
Source: National Statistical Office, *Annual Statistical Report on Causes of Death,* 1997.

8. International Comparison of Health Status

When comparing the life expectancy(LE) of three Asian countries(Japan, Korea, Singapore)in the eighties, life expectancy in Korea was the lowest of the three countries. Life expectancy in Japan has been 75 years or higher since 1986 and the trend of life expectancy has been stable over the past years. Life expectancy in Korea was below 68 years in 1985, but has increased to 71 years with a higher annual increment. The difference of life expectancy between Singapore and Korea has been narrow over the last few years. In 1994, The LE in Korea recorded 72.8 years but is still lower than those of Hongkong, Japan, and Singapore(see Figure 9).

Figure 9. Evolution of the LE at birth in Major Asian Countries

(years)

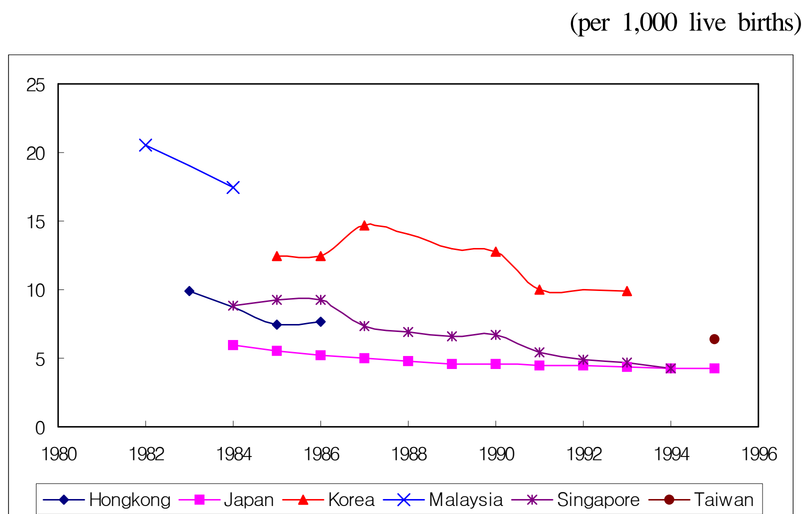


Source: WHO, *World Health Statistics Annual,* Each Year.

Korea still has one of the highest infant mortality rates among the major Asian countries. The level of infant mortality in Korea was above 10 before 1990, but then slightly decreased to 9.9 in 1993. In Japan, infant mortality was above 5 before 1987 and declined at a steady rate to 3.7 in 1997. The level of infant mortality in Singapore was above 5 before 1991, but the infant mortality gap between Singapore and Japan has reduced since then(see Figure 10).

Figure 10. Evolution of Infant Mortality in Major Asian Countries

(per 1,000 live births)



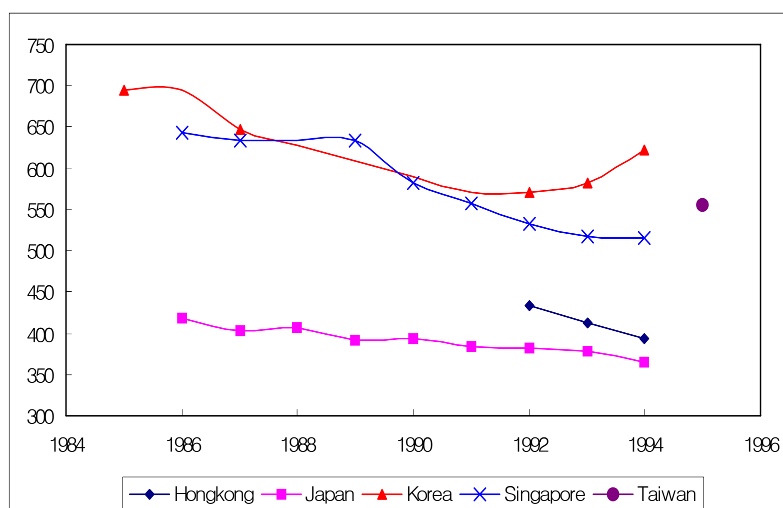
Source: WHO, *World Health Statistics Annual,* Each Year.
KIHASA, *Research on the infant mortality rate and cause,* 1996.
National Statistical Office, *1995 Life Tables for Korea,* 1997.

Currently Korea also has one of the highest age-adjusted mortality rates among the major Asian countries. Age-adjusted mortality in Korea was higher than that of Singapore and Japan and has tendency to increase after 1992. Age-adjusted mortality in Singapore has continuously decreased but is still currently at a higher level than in Japan(see Figure 11).

Figure 11. Evolution of the Age-adjusted Mortality in Major Asian

Countries

(per 100,000 persons)

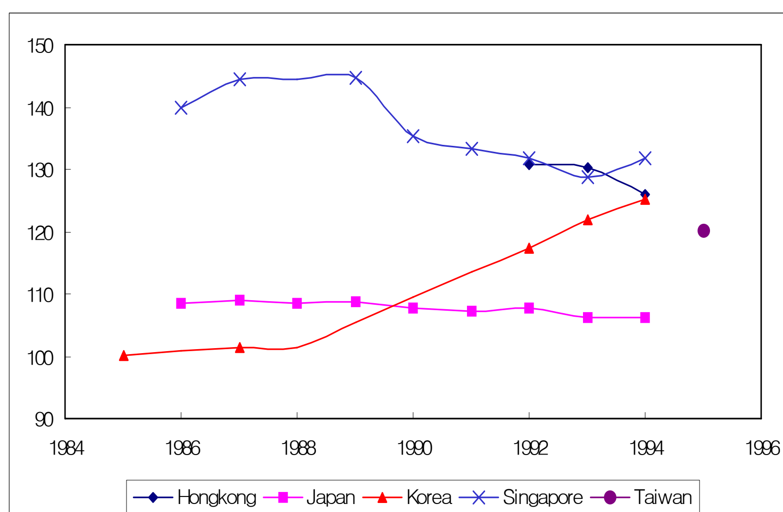


Source: WHO, *World Health Statistics Annual,* Each Year.

The level of age-adjusted mortality due to malignant neoplasm in Korea was lower than in Singapore and Japan but increased sharply after 1990. The level of age-adjusted mortality due to malignant neoplasm in Japan has maintained a slightly decreasing trend and was the lowest of four Asian countries in 1994. During the period from 1986~1989, the level of age-adjusted mortality due to malignant neoplasm in Singapore decreased, but after 1990 was still higher than Korea and Japan(see Figure 12).

Figure 12. Evolution of Age-adjusted Mortality due to Malignant Neoplasm in Major Asian Countries

(per 100,000 persons)

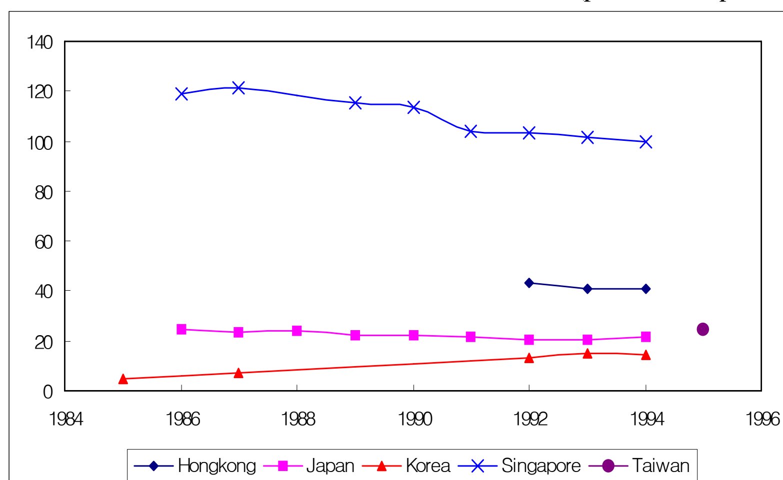


Source: WHO, *World Health Statistics Annual,* Each Year.

The level of age-adjusted mortality due to ischaemic heart disease in Korea is the lowest in major Asian countries but has rapidly increased since 1990. However, the highest level of age-adjusted mortality due to ischaemic heart disease in Singapore decreased continuously but was still almost 6 times higher than that of Korea in 1994. In Japan. the level of age-adjusted mortality due to ischaemic heart disease has maintained a slightly decreasing trend(see Figure 13).

Figure 13. Evolution of the Age-adjusted Mortality due to Ischaemic Heart Disease in Major Asian Countries

(per 100,000 persons)



Source: WHO, *World Health Statistics Annual,* Each Year.

Ⅱ. Health Promotion and Protection

1. Implementation of the National Health Promotion Act

The government enacted the National Health Promotion Act in January 1995 and proclaimed its regulations and rules in September 1995. This act provided a legal and institutional base for people to raise the responsibility for and value of their own health. The main contents of the Act are as follows:

― *Health Promotion Plans in Central and Local Governments*

The government has implemented the health promotion demonstration programs at public health centers since 1995. Currently 16 demonstration health centers are established in 16 cities and provinces. The demonstration health promotion program will be implemented nationwide after appraisal of its' practicability and appropriateness.

― *Nutrition and Dental Health Care Programs*

To promote the nutritional status of the community, the government has implemented nutrition demonstration programs at public health centers from 1994. The oral health care program is aimed at increasing public awareness of oral health and early discovery, prevention, and control of oral diseases. To achieve these objectives, the government has promoted several projects such as water fluoridation, mouth rinsing with fluoridated water,

oral disease examination, pit and fissure sealing and also school and health programs.

— *Promotion of Health Education*

The government, in cooperation with other related organizations such as the Korea Institute for Health and Social Affairs, plans to develop a health textbook and national healthy life guidance book and to construct a national health education database.

— *Smoking and Drinking*

The government is trying to create a social environment for non-smoking, encouraging related authorities to designate public areas as non-smoking zones and prohibiting cigarette and alcoholic sales to the youth. In particular, the government is promoting the movement as a civil movement by providing financial support for relevant non-government organizations.

— *National Health Promotion Fund*

To secure financial resources for promoting the health status of the whole population, the government raises funds from cigarette producers by levying 2 won per cigarette pack and from health insurers by subtracting 5 percent of their preventive health care expenditures. As a result, about 13.7 billion won was raised in 1997 and 16 billion won will be collected by the end of 1998.

2. Prevention of Adult Diseases

The prevention of adult diseases is most important because most adult diseases have no symptoms and are not detected until the terminal stage. Currently, the mortality rates from chronic disease(or noncommunicable diseases) are rapidly increasing and it is anticipated that this tendency will be more pronounced

because of the aging of the population structure, change in diet habit, increase of the smoking population, and decrease in physical activities. The crude mortality rates(per 100,000 population) of major adult diseases in 1996 were; malignant neoplasm 111.9, cerebrovascular 74.7, hypertensive diseases 13.8, chronic liver disease 27.3 and diabetes mellitus 17.4.

Therefore focus is on prevention activities, various public information methods, and the 13 chronic disease screening centers of the Korea Health Control Association(KHCA) where screening at a low price is carried out by utilizing mobile screening teams.

3. Cancer Control Programs

The National Medical Center(NMC) has implemented the hospital cancer registry project since 1980. Cancer patients who were diagnosed in general hospitals are registered and controlled at the NMC, where 72,323 patients were registered in 1996. Data for cancer patients registered at 154 training hospitals were collected and analyzed by the NMC.

The National Cancer Center(NCC) will be built by 1999, and will carry out national cancer control programs including prevention, screening and treatment of cancer.

4. Promotion of Maternal and Child Health

The Maternal and Child Health Program is aimed at improving the level of national health by prenatal care for pregnant women as well as health care services for preschool children. Population coverage of the Maternal and Child program in 1996 included 4,560,596 persons, with 4,213,751 being preschool children and 346,845 being pregnant women.

57,116 pregnant women and 332,011 infants are registered in public health centers for regular medical examinations. Others

visited private clinics or hospitals. Pregnant women receive prenatal services of at least nine kinds, including examination for anemia and of urine and blood pressure. Infants receive nutrition, teeth and sight examinations, inborn errors of metabolism test, and medical examinations. Those who are found to be abnormal receive a follow-up examination and then treatment, if necessary.

The Ministry of Health and Welfare(MOHW) also provides free vaccinations for diseases such as PDT, Polo, MMR and DT, Rubella and Hepatitis B for 4,213,751 infants and babies. As a result, the infant mortality rate was reduced to 9.9 per 1,000 persons in 1993.

5. Family Planning Program

Korea has attained comparative success in controlling its population growth by means of family planning. As a result, the natural increasing rate fell from 3.0% in 1960 to 1.01% in 1995, while the total fertility rate dropped from 6.0 to 1.7% in the same period(see Table 2).

Table 2. Prospects of Population

Classification	1960	1970	1980	1985	1990	1995	2020
Gross Population (1,000 persons)	25,012	32,241	38,124	40,806	42,869	45,093	52,358
Total Fertility	6.0	4.5	2.7	1.7	1.6	1.7	1.8

Source: National Statistical Office, *Social Indicators in Korea,* 1996.

The basic direction of the family planning policy is to maintain the present low fertility trend, and the detailed program prospects are as follows:

- Contraceptive Supply
- Countermeasures for Unbalanced Sex Ratio and Adolescent Sexuality Problems
- International Cooperation in the Family Planning Program

Ⅲ. Control of Communicable Diseases

1. Notifiable Disease and Reporting Procedure

According to reporting procedures, notifiable diseases are categorized into three classes and the cases of notifiable diseases in recent years are shown in the following table(see Table 3 & 4).

Table 3. List of Notifiable Diseases and Reporting Procedure

Class	Name of Diseases	Reporting
1	Cholera, Plague, Epidemic typhus, Typhoid fever, Paratyphoid fever, Diphtheria, Bacillary dysentery, Yellow fever	Notify immediately to a nearby Health Center
2	Polymyositis, Pertussis, Measles, Mumps, Japanese encephalitis, Rabies, Malaria, Murine typus, Scalet fever, Relapsing fever, Amoebic dysentery, Meningococcal meningitis, Hemorrhagic fever with renal syndrome, Tetanus, AIDS, Leptospirosis, Tsutsugamushi disease	〃
3	Tuberculosis, STD[1], Leprosy, Chronic viral hepatitis B	Report once a month

Note: 1) syphilis, gonorrhea, non-gonorrheal urethriti(NGU), chanchroid, lymphogranuloma venereum, granuloma inguinale

Source: Ministry of Health and Welfare, 1998.

Table 4. Annual Cases of Notifiable Diseases

Name of Disease	1993	1994	1995	1996
Cholera	12	36	68	62
Typhoid Fever	307	267	370	475
Paratyphoid Fever	32	8	30	9
Bacillary Dysentery	113	233	23	9
Pertussis	39	39	3	7
Measles	765	7,883	71	65
Mumps	474	1,874	430	254
Japanese Encephalitis	4	3	0	0
Murine Typhus	11	9	14	3
Scarlet Fever	76	152	141	132
Amoebic Dysentery	8	2	3	3
Meningococcal Meningitis	7	5	4	3
Hemorrhagic Fever with Renal Syndrome	109	132	89	118
Leptospirosis[1)]	–	7	13	6
Tsutsugamushi Disease[2)]	–	238	274	263

Note: 1) Data available since 1994
2) Imported cases
Source: Ministry of Health and Welfare, 1998.

In addition to the notification system, a laboratory surveillance system is in operation for diseases such as influenza, Japanese encephalitis, typhoid fever and vibrio infections. If an epidemic outbreak occurs, a special investigation is conducted.

2. Immunization

The Communicable Disease Prevention Act was revised in 1994 to provide compensation at a national-level for side effects caused by vaccines and came into effect in 1995. If a person becomes ill from vaccination, the government reimburses the medical fees and if a person becomes permanently disabled or dies, the government will pay compensation. The experts of the Vaccination Committee in infection, vaccination, epidemiology and law are responsible for inspection and deciding whether

vaccination caused the claimed side effect or not. The recommended vaccination schedule is shown in Table 5.

Table 5. Recommended Schedule of Vaccination(1997)

Vaccine	Initial Immunization	Booster Immunization
BCG	within one month of birth single dose	
DTaP/Td	3 times(2nd, 4th, 6th month) with DTaP	DTaP at 18th month & between 4th and 6th year/Td between 14th and 16th year
OPV	3 times(2nd, 4th, 6th month)	between 4th and 6th year
MMR	single dose at 15th month	booster between 4th and 6th year/Rubella, at first year of girls, high school(15th year) For a limited period of time by the year 2006
HBV	3 times(immediately after birth,1st and 6th month)	
JE	twice at 3rd year once at 3rd year	every other year until 15th year

Source: Ministry of Health and Welfare, 1998.

3. Control of Tropical Diseases and Orphan Drug Services

The number of international travelers has increased markedly in recent years. During overseas travel or after returning home, some people may suffer from an illness that is rare in Korea. In that case, diagnosis and appropriate treatment for patients may be delayed due to lack of experience by the physician or unavailability of the appropriate drug. In order to cope with this problem, measures to counter infectious tropical diseases and to prepare orphan drugs were introduced in 1994.

Major components of these countermeasures are as follows;

— to provide appropriate information for overseas travelers on

how to protect themselves during their stay abroad
- to offer laboratory services to facilitate diagnosis in hospitals
- to supply orphan drugs to help patients and physicians
- to promote research

The National Institute of Health(NIH) is designated as the Center for Tropical Disease, and assumes major roles. The NMC provides essential drugs(orphan drugs) free of charge when requested by a physician. Travelers can also obtain useful information at quarantine stations.

4. Quarantine

Thirteen national quarantine stations are in operation and the major roles are as follows:

- to inspect passengers and crafts for cholera, plague and yellow fever
- issue international certificates of vaccination in accordance with International Health Regulations
- provide health information to overseas travelers.

5. Control of Tuberculosis and Leprosy

The annual risk of tuberculosis infection for a child was lowered from 5.3% in 1995 to 0.5% in 1996. The tuberculosis and leprosy control program with technical assistance from the Korean National Tuberculosis Association(KNTA) and the Korean Leprosy Control Association(KLCA) are two of the most successful public health programs in Korea.

6. Control of AIDS

In December 1985, the first HIV positive persons were identified and the first case of AIDS was reported in February 1987. Although the rate of increase appears to have become moderate, the cumulative number of persons with HIV/AIDS is continuously increasing(see Table 6).

Medical personnel must, upon identification of AIDS patients or death due to AIDS, immediately report this to a public health center.

Since 1985, the MOHW has coordinated a wide range of activities for AIDS prevention and control. The National AIDS Committee(NAC) was organized in March 1987. The Center for AIDS Control established at the NIH in May 1987 provides technical support for the National AIDS Prevention Program(NAP).

□ National AIDS Prevention Program(NAP)

- Laboratory testing
  - Since July 1987, general screening of blood for transfusion and blood products have been conducted to protect blood users.
  - Free and anonymous HIV antibody testing services are available at public health centers.
- Training of professionals
- Research activities
- Education

Table 6. Annual Trend of HIV Infection and AIDS Cases

	HIV Infection			AIDS Cases		
	Male	Female	Total	Male	Female	Total
Total	546	77	623	56	7	63
1986	2	3	5	-	-	-
1987	4	5	9	1	-	1
1988	17	5	22	2	1	3
1989	35	2	37	-	1	1
1990	50	4	54	2	-	2
1991	38	4	42	-	1	1
1992	72	4	76	2	-	2
1993	71	7	78	5	1	6
1994	78	19	108	10	1	11
1995	89	19	108	14	-	14
1996	90	12	102	20	2	22

Source: Ministry of Health and Welfare, 1998.

Ⅳ. Control of Mental Health

1. Enhancement of the Mental Health Act

To improve the quality of life and human rights of the mentally ill, the government enacted the 'Mental Health Act' December, 1995. This law has been in effect since March 1, 1997[1] and it makes legal and institutional provisions for strengthening the mental disease management system. The fundamental objectives of the 'Mental Health Law' are to shift present mental health policies to a community based management system and to improve human rights of the mentally ill through various support for their return to society.

2. Promotion of the Community Mental Health Program

The goal of the community mental health program in public health centers is to improve quality of life and human rights of the mentally ill, which will be achieved by preventing mental illness prolongation and by recovering the severely mentally ill

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1) In 1996, the number of mentally ill patients who utilized mental health services is estimated to be approximately 2.16% of total population. In 1996, about 3.9% of total medical expenditure has been spent on psychiatric disorder. This figure is much smaller than that of other developed countries.

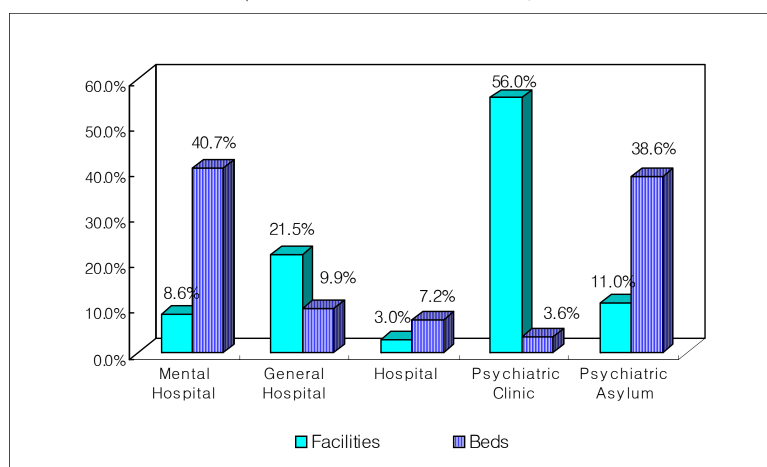
person's social functions. To facilitate the mental health program, the government plans to allocate mental health workers to public health centers by the end of 1998. They will undertake various duties such as early discovery of the mentally ill and admittance to hospitals. For implementation of this program, the 650 educated mental health workers present in 1997 will be increased to 1,750 by the year 2001.

3. Mental Health Care Facilities

There were 574 psychiatric facilities and 78 psychiatric asylums(approved mental health care institutions) in 1997. As shown in figure 14, the number of psychiatric beds in 1997 was 45,194 including those in psychiatric asylums (there were 57 beds per 100,000 persons excluding beds in psychiatric asylums or if including beds in psychiatric asylums, there were 98 beds per 100,000 persons).

Figure 14. Psychiatric Facilities in Korea(December 31, 1997)

(Number of Total Facilities, Number of Total Beds)



Source: Ministry of Health and Welfare, 1998.

Figure 14 shows the distribution of the psychiatric facilities and psychiatric beds; 56.0% of psychiatric facilities are psychiatric clinics and 40.7% of beds are in medical hospital.

However, the number of mental health care facilities does not meet the need. The government plans to transfer existing mental nursing homes to mental hospitals and social rehabilitation facilities by the year 2003. Furthermore, the government will give support of approximately 23 billion won for the construction and operation of private social rehabilitation facilities, which will reach a total of 210 in 2003.

Ⅴ. Medical Care System

1. Overview

Due to industrialization, urbanization and aging of the population in the past years, the demands, both in quantity and quality, of the people for health and medical care services have increased. Health and medical care in Korea is uneven in distribution of medical care resources. The implementation of health insurance for the whole nation increased the demands for health care and revealed the fact that more health manpower and facilities are needed. The crucial issue of the health care system in Korea is the improvement of accessibility, equality and availability of health care with lower costs for the majority of the people.

2. Medical Facilities

Medical services are provided indirectly: medical care institutions established and operated by the national government or local government, by educational institutions and predominantly by private corporations and private individuals. Medical care institutions are categorized by their scale of operations into general hospitals, hospitals, and clinics. This classification is also applied to dental care institutions and oriental medical care institutions.

For health care in rural areas, government-oriented public health centers, health subcenters, and primary health care posts have been established throughout the nation. There are also pharmacies, dental hospitals and clinics, oriental medical hospitals and clinics, and midwifery. Medical personnel include doctors, dentists, pharmacists, oriental medical doctors, midwives, nursing aides, and medical engineers.

The general hospital is a medical institution where doctors or dentists give medical treatment, which is equipped with facilities capable of hospitalizing more than 100 inpatients, and whose specialized departments for medical treatment include at minimum internal, surgical, pediatric, obstetrics, X-ray, anesthetic, pathological, psychiatric and dental sections, with necessary medical specialists at each section.

Hospitals, dental hospitals or oriental medical hospitals are medical facilities where doctors, dentists or oriental medical doctors give medical treatment, and are equipped with more than 30 inpatient beds. However, dental hospitals are not subject to the requirements of facilities for inpatients.

Medical clinics, dental clinics or oriental medical clinics are medical institutions where doctors, dentists or oriental medical doctors give medical treatment and which have facilities for medical examination and treatment.

A midwifery is a medical institution where a midwife assists in child delivery, and conducts guidance on the health and nursing of pregnant women, women in childbirth or with newborn babies, and which is equipped with facilities sufficient in the providing of medical examination and treatment(see Table 7).

At the end of 1996, there were 271 general hospitals, 421 hospitals, 15,242 clinics, 14 dental hospitals, 8,761 dental clinics, 81 oriental medical hospitals, 6,172 oriental clinics and 161 midwiferies in Korea.

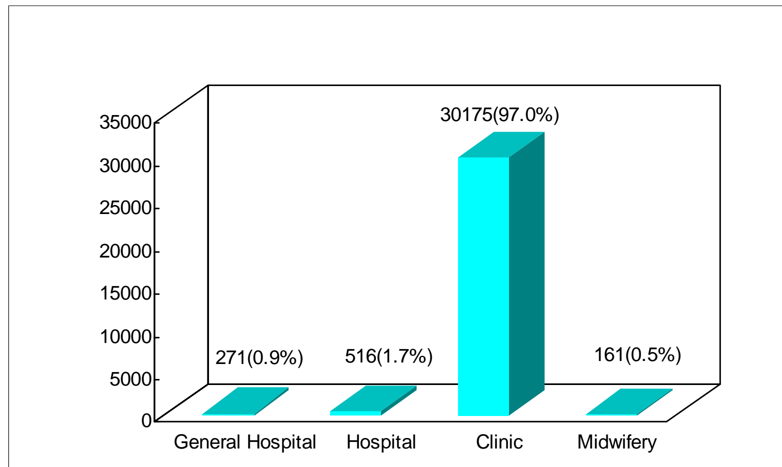
Table 7. Classification of Medical Facilities

	Institution	Patient	Doctor
Primary Health Care Facilities	- Public Health Center - Health Subcenter - PHC Post - Special Clinic	- Outpatient in the Area	- General Practitioner - Medical Specialist at Special Clinic
Secondary Hospitals	- Hospital with 30～99 Beds - Hospital with 100～699 Beds	- Outpatient and Inpatient Referred from PHC Facilities	- Medical Specialist
Tertiary Hospitals	- Hospital with 700 or More Beds - University Hospital with 500 or More Beds	- Outpatient and Inpatient Referred from PHC Facilities and Secondary Hospitals	- Medical Specialist in Each Field
Special Hospitals	- Mental Hospital - Rehabilitation Center - Cancer Hospital & Communicable Disease Hospital, etc	- Special Disease Patient	- Medical Specialist on Specific Diseases

Source: Ministry of Health and Welfare, 1998.

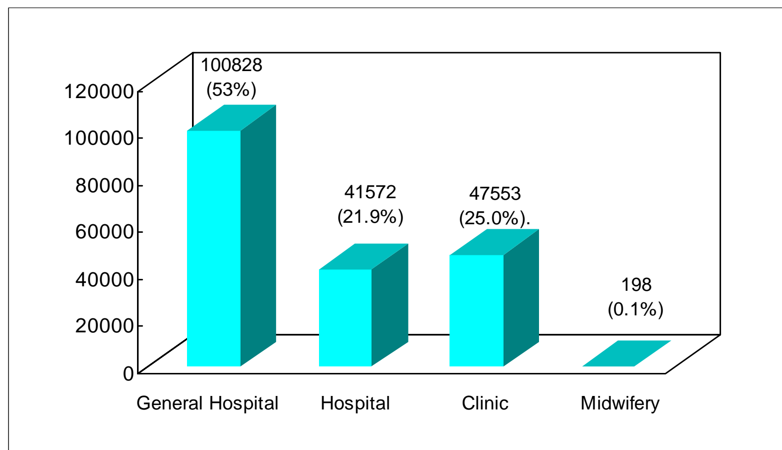
Figure 15 shows the distribution of medical facilities; 97% of medical facilities are clinics. At the end of 1996, in Korea there were 190,151 hospitals beds. Figure 2 shows the distribution of beds; 53% of beds were in general hospitals and 25% of beds were in clinics.

Figure 15. The Distribution of Medical Facilities



Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

Figure 16. The Distribution of Beds



Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

3. Health Manpower

In 1998, there were 41 medical schools, 11 oriental medical schools, 11 dental schools, 112 nursing schools and 20 pharmaceutical schools. There were 3,300 medical students, 760 dental students, 750 oriental medical students, 11,125 nursing students and 1,301 pharmaceutical students in 1998(see Table 8).

At the end of 1996, there were 507,315 licensed medical personnel. Of them, 59,399 were physicians, 9,299 oriental medical doctors, 14,371 dentists, 127,145 nurses, 197,788 nurses aides, 8,447 midwives, 85,517 medical technicians and 5,349 medical records officers. At the end of 1997 one physician served 736 persons, one oriental medical doctor served 4,999 persons, a dentist served 2,992 persons and a pharmacist served 1,004 persons.

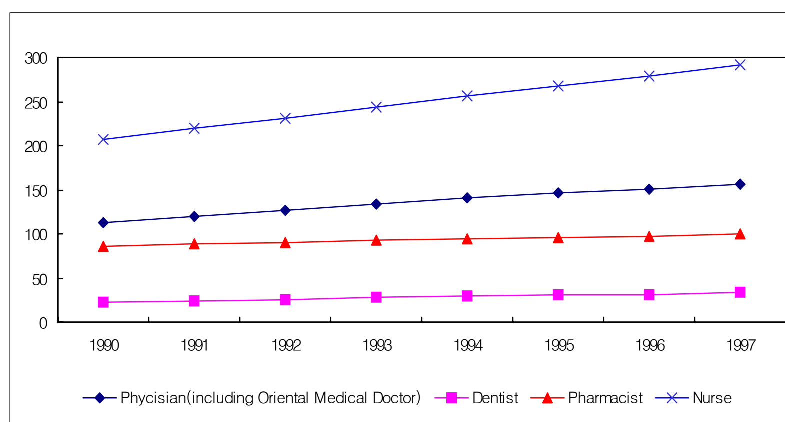
Table 8. The Number of Medical Education Institutes(1998)

Classification	Number of Institutes	Number of Enrolled
Doctor	41	3,300
Dentist	11	760
Oriental Medical Doctor	11	750
Pharmacist	20	1,301
Nurse	112	11,125

Source: Ministry of Education, *Yearbook of Educational Statistics,* 1998.

Figure 17 shows the number of health related persons per 100,000 persons. The number of health related persons has rapidly increased in the last decade, but is still fewer than in developed countries. At the end of 1997, the number of physicians(including oriental medical doctors) per 100,000 persons was about 156. The number of physicians per 100,000 persons by the year 2,000, is estimated to be about 200.

Figure 17. The Number of Health-related Persons Having Registered Licenses Per 100,000 Persons



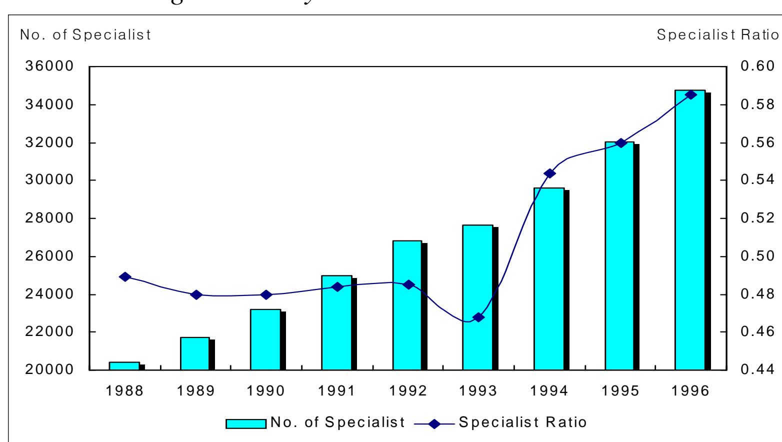
Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

Specialists are those who take a training course in internship and residency at a hospital or medical institution designated by the government after obtaining a doctors license according to the provision of the Medical Service Act, and whom pass the qualifying examination for specialists provided by the Korean Medical Association(see Table 9).

The purpose of the medical specialty system is to encourage physicians to receive intensive and complete training in clinical specialties and to continue to acquire new medical knowledge in order to upgrade the quality of medical care services to improve care for the health of the people. There were 26 specialties and 34,726 specialists in 1996. This represents a 4.1 times increase in the number of specialists compared to that of 1980. Figure 18 shows the number of specialists and proportion of specialists in physicians. The number of specialists has increased and the proportion of specialties in physicians has also increased since 1993. In 1996, 58.2% of licensed physicians were specialists. Table 9 shows the distribution of specialties; 14.2% of specialties was internal medicine, 10.6% of specialties was general surgery,

10.1% of specialties was obstetrics & gynecology, 8.4% of specialties was paediatrics and 8.3% of specialties was family medicine.

Figure 18. The Number of Specialists and Ratio of Specialists to Registered Physicians



Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

Table 9. Qualified Medical Specialists by Specialty(1996)

Specialty	Persons(%)	Specialty	Persons(%)
Internal Medicine	4,917 (14.16)	Anatomical Pathology	466 (1.34)
General Surgery	3,691 (10.63)	Clinical Pathology	429 (1.24)
Orthopedics Surgery	2,339 (6.74)	Tuberculosis	195 (0.56)
Neurosurgery	1,079 (3.11)	Rehabilitation medicine	276 (0.79)
Chestsurgery	580 (1.67)	Preventive medicine	514 (1.48)
Plastic surgery	606 (1.75)	Diagnostic radiology	1,311 (3.78)
Anaesthesia	1,533 (4.41)	Therapeutic rapidiology	547 (1.58)
Obstetrics & Gynecology	3,498 (10.07)	Neurology	746 (2.15)
Paediatrics	2,902 (8.36)	Psychiatry	1,211 (3.49)
Ophthalmology	1,233 (3.55)	Family medicine	2,868 (8.26)
E. N. T	1,605 (4.62)	Occupational medicine	114 (0.33)
Dematology	886 (2.55)	Nuclear medicine	71 (0.20)
Urology	1,058 (3.05)	Emergency medicine	51 (0.15)

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

4. The Regional Distribution of Health Resources

The health system depends mainly upon the private sector. Private clinics and hospitals make up more than 91.0% of all medical facilities in number, employ 88.8% of physicians, and include 91.0% of total beds. Most private facilities are concentrated in urban areas.

In Korea, while about 75.6% of the population reside in urban areas, 95.8% of the physicians and 92.0% of hospital beds are concentrated in the cities. This situation makes it difficult for the rural population to have access to medical care. The skewed distribution of health resources is the result of laissez-faire policy for the private medical care sector. The private sector tends to concentrate more in the cities where the demand for medical services is higher than in rural areas(see Table 10).

Table 10. Regional Distribution of Health Resources(1996)

	Urban Areas(%)	Rural Areas(%)
Population	75.6	24.4
Beds	92.0	8.0
Physicians	95.8	4.2

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

Table 11 shows the regional distribution of physicians. 36.8% of physicians work in Seoul and approximately 11.0% of physicians work in the Kyonggi province. On average, there were 93.9 physicians per 100,000 persons. Table 12 shows the regional distribution of beds. 25.5% of beds were in Seoul and 13.8% of beds were located in the Kyonggi province. On average, there were 440 beds per 100,000 persons.

Table 11. Regional Distribution of Physicians(1995)

Region	Number of Physicians(%)	Number of Physicians per 100,000 persons
Whole Country	41,853 (100.00)	93.94
Seoul Metropolitan City	15,409 (36.82)	150.85
Pusan Metropolitan City	4,142 (9.90)	108.74
Taegu Metropolitan City	2,730 (6.52)	111.66
Inchon Metropolitan City	1,498 (3.58)	65.03
Kwangju Metropolitan City	1,744 (4.17)	138.75
Taejon Metropolitan City	1.505 (3.60)	118.42
Kyonggi Province	4,589 (10.96)	60.08
Kangwon Province	1,195 (2.86)	81.52
Chungchongbuk Province	994 (2.37)	71.25
Chungchongnam Province	1,157 (2.76)	65.54
Chollabuk Province	1,815 (4.34)	95.49
Chollanam Province	1,017 (2.43)	49.22
Kyongsangbuk Province	1,432 (3.42)	53.59
Kyongsangnam Province	2,358 (5.63)	61.38
Cheju Province	268 (0.64)	53.06

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

Table 12. Number of Beds by City and Province(1995)

Region	Number of Beds(%)	Number of Beds per 100,000 persons
Whole Country	196,232 (100.0)	440.46
Seoul Metropolitan City	50,090 (25.53)	490.35
Pusan Metropolitan City	19,022 (9.69)	499.38
Taegu Metropolitan City	9,809 (5.00)	401.18
Inchon Metropolitan City	8,709 (4.44)	378.06
Kwangju Metropolitan City	5,419 (2.76)	431.13
Taejon Metropolitan City	6,523 (3.32)	513.26
Kyonggi Province	27,204 (13.86)	356.16
Kangwon Province	8,552 (4.36)	583.42
Chungchongbuk Province	6,415 (3.27)	459.79
Chungchongnam Province	7,552 (3.85)	427.81
Chollabuk Province	8,967 (4.57)	471.77
Chollanam Province	9,022 (4.60)	436.66
Kyongsangbuk Province	9,058 (4.62)	358.46
Kyongsangnam Province	17,473 (8.90)	454.85
Cheju Province	1,895 (0.97)	375.17

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

5. Health Care Resources in Rural Areas

In preparing for the expansion of the health insurance system, the government has continuously strengthened the supply of medical manpower and facilities in rural areas since 1981. To alleviate the maldistribution of medical facilities between urban and rural areas, the government provides those who establish medical facilities in rural areas or industrial complexes with public doctors and financial incentives such as long-term low-interest loans.

The government expanded primary health facilities(public health centers/Health Subcenters, Primary Health Care Posts) to enhance health services for people in rural and fishery areas. With the expansion of facilities, the government has also provided

advanced medical equipment to those primary health facilities(see Table 13).

Table 13. Distribution of Health Resources(in 1996)

	Health Centers	Health Subcenters	PHC Posts
Number of Facilities	244	1,327	2,034
Number of Health Manpower	891(doctors)	1,859(doctors)	2,034 (Community Health Practitioners)

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

To solve the persistent problem of "Doctorless areas" in rural and fishery areas, the government enacted a special law in 1980 to post "Public Health Doctors(PHDs)", who are selected to work in doctorless areas instead of undertaking military service duty, which is compulsory in Korea. The government established 1,327 health subcenters in rural and fishery areas and posted PHDs at 1,327 health subcenters in 1996.

6. Emergency Medical System

With enhancement of the Emergency Medical Treatment Law in 1994 and its regulations and rules in 1995, the government has actively made efforts to improve the emergency medical system, by increasing people's convenience at every stage from emergency calls to delivery and medical care.

The 119 Rescue Agent takes charge of emergency calls and ambulance services, while the 129 Emergency Information Center carries out first-aid guidance, selection of emergency medical centers, analysis of emergency care procedures, management of emergency information, and education of emergency agents. The government plans to open and operate local emergency medical

centers in 11 areas throughout the country starting 1998. Also, Special Emergency Medical Centers will be established in 1998, where emergency patients can receive special medical care according to their diseases.

7. Organ Transplantation Management System

In 1996, the government legislated a draft of the Organ Transplantation Law. After strict reviews through a public opinion census, public hearings, and the Medical Care Reform Committee, the government announced preliminary proclamation of the Organ Transplantation Law, which contains legal recognition of cerebral death, prevention of organ sale and extraction of internal organs from the cerebrally dead, and establishment of the Life Committee. In addition, the government plans to establish an Organ Transplantation Management Center to collect relevant data and information on Organ Transplantation.

8. Home Care Program

A home care demonstration program was launched in 1994. Home care is medical and nursing services given to patients at home whom were discharged early from a hospital with consent of the patient or legal guardian. Four model hospitals constructed the first demonstration program, from September 1994 to August 1996, and 45 model hospitals constructed the second program from May 1997 to April 1999, which was based on results from the first project.

9. Hospital Service Evaluation Program

To improve the quality of medical care services provided by medical institutions and thus to increase convenience to patients, in 1995 the government introduced the hospital service evaluation program. As a result of this program, 39 tertiary medical institutions in 1995 and 50 general hospitals with more than 400 beds in 1996 have been assessed for their medical services.

10. Medical Management

Medical demand has increased as a result of the growth of national income, the expansion of the medical insurance program and the enforcement of local autonomy. Also, in operation of medical facilities, efficient management has been necessary as a result of the increase of factors such as medical malpractice, medical waste, the treatment of contaminated laundry and the provision of proper meals. Accordingly, the MOHW established the Medical Management Division in 1992 to improve the degree of medical management.

11. Oriental Medicine

Oriental medicine, which is traditional Korean medicine, differs fundamentally from western medicine in principles and characteristics. Oriental medicine has long contributed to the improved health of Koreans with excellent clinical treatment effects. However, the lack of appropriate systems and organization for the development of oriental medicine in Korea has been a barrier for the standardization and modernization of oriental medicine(see Table 14).

Table 14. Status of Oriental Medical Doctors and Medical Institutes (1996)

Number of Oriental Medical Doctors	Number of Institutes of Oriental Medicine		
Total	Total	Oriental Medical Hospitals	Local Oriental Clinics
9,210	6,253	81	6,172

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics,* 1997.

The Oriental Medicine Bureau(OMB) was established as one of the major bureaus of the Ministry of Health and Welfare(MOHW) on November 23, 1996 to fulfill the public demand for the development of oriental medicine nationally and internationally.

The establishment of the Korean Institute of Oriental Medicine(KIOM) was initiated by National Act No. 4758 (on March 24, 1994), followed by opening of the Institute on October 10. 1994 to contribute to the enhancement of public health through the systematic and specialized research of oriental medicine. The facilities and research of KIOM will be further expanded to make it the major oriental medicine research institute of the nation.

— Major research topics of KIOM
- · Investigation and analysis of literature and theories of traditional oriental medicine
- · Clinical trials for the development of oriental medicine and research on standardization and development of oriental medicinal drugs
- · Investigation and analysis of acupuncture
- · Research on policy planning related to oriental medicine
- · Mutual research cooperation with other domestic research institutes
- · Research on the efficiency and stability of oriental medicinal drugs
- · Research for the development of the industry related to oriental medicine

12. Health Care Science and Technology

For the purpose of promoting cooperative research activities among industrial, academic, and research organizations, and to maximize research effectiveness, the government plans to construct the Health Care Technopolis. Construction of the Health Care Technopolis will be completed within ten years(1997～2006). As of 23 September 1997, the government designated and announced the Health Care Technopolis as a national industry complex.

The government established the Health Care Technology Innovation Plan in November 1994. Under this plan, the government implemented Health Research and Development Programs in 1995. The government provides funds for research on the seven major sectors of medical science, pharmaceutical products, biomedical engineering, biotechnology, food, health information, and G7 medical engineering.

In June 1996, the government established a long-term plan for the advancement of health and welfare information to be in effect until the year 2000. The plan contains the following;

- Advancement of community health care information
- Construction of a health care information data base
- Establishment of a public health service information system
- Demonstration programs of the blood distribution information management system
- Organ transplantation information management system
- Out-patient reservation system
- Telemedical care system
- Emergency medical care
- Telemedical dementia care system

Portions of the express information public application service system were completed in 1997. Extension to the whole country will be determined after appraisal in 1998.

Ⅵ. The National Health Insurance Program

1. History of Health Insurance

With the increasing public interest in the social security system, the first Health Insurance System of Korea was promulgated from the Medical Insurance Act of 1963.

To maintain the drive towards accelerating economic growth and improving social security, the first Medical Insurance Act was fully amended in 1976. Under this law, a compulsory health insurance program was introduced which included all large industries with 500 or more workers.

The Medical Insurance Act for Government Employees and Private School Employees was enacted in 1977. This was followed by the establishment of a medical insurance corporation for management of this program, which started making benefits payment in 1979.

In 1979, the Medical Insurance Act was amended again requiring that medium-sized industries with 300 or more workers provide insurance. At the same time, to make the insurance program more effective and less complicated, the Council of Korea Medical Insurance Societies(KMIS, the former name of Federation of Medical Insurance) was established.

In 1981, the Joint Commission for Medical Insurance(JCMI) was formed and expansion was increased to provide insurance

coverage for workplaces with 16 or more persons.

In 1988, Insurance Coverage was expanded to workplaces with more than 5 employees and to rural residents.

In 1989, the government of Korea completed a compulsory health insurance program for the entire population. Insurance plans were gradually expanded from corporate employees to the self-employed and farmers. Pharmacies were also included as part of the medical insurance system.

After many years of debating, the period of medical benefits was extended in 1995 from 210 days to 240 days per year. In addition, there is no longer a maximum duration for those 65 years of age or more, people with disabilities, and persons of national merit.

In January 1996, the duration of medical benefits was extended further from 240 days to 270 days per year and Computerized Tomographs(CT) were included in the list of reimbursable services.

In October 1998, for better operations that improve the convenience and interest of the beneficiaries and to develop the health insurance system, the health insurance management and contribution systems were once more completely amended. Under this new law, the three types of insurance controlling the administration of insurance were reduced to two types. Also, the level of contribution for self-employed individuals was then made to be calculated only on the basis of the insured's income and property value.

2. Structure

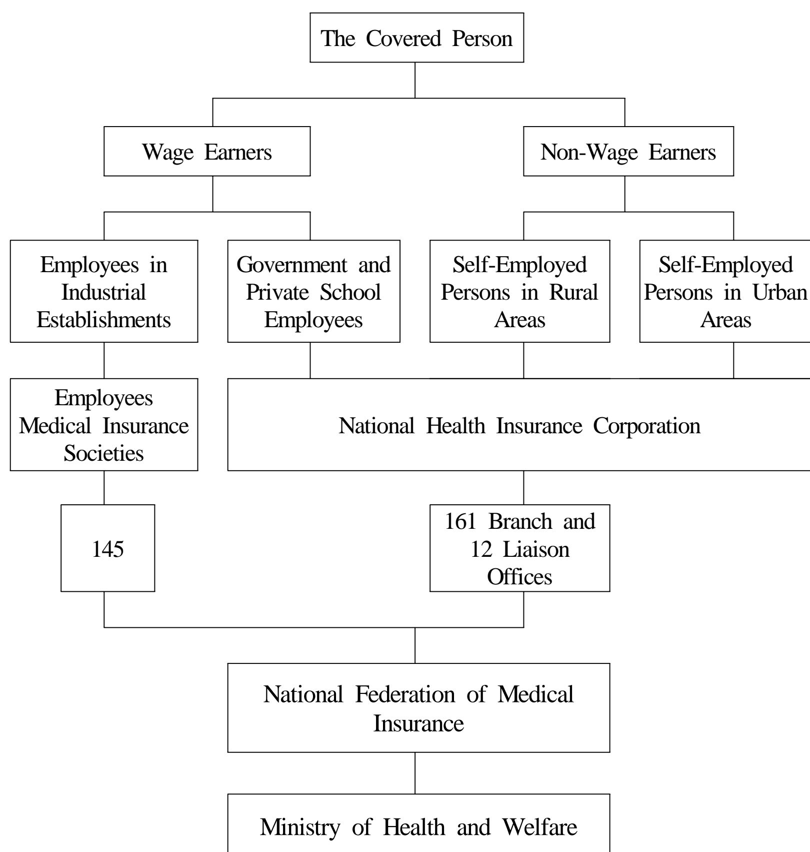
There are two kinds of health insurance schemes; one division is for ordinary employees, the other is for government employees, private school employees and self-employed individuals. Ordinary employee insurance covers workers at industrial establishments with five or more employees and their

dependents. The program for self-employed individuals was introduced in January 1988. At first, the program only covered self-employed individuals from rural areas, but it was expanded in July 1989 to cover all self-employed individuals. The two types of health insurance schemes are as follows;

- The National Health Insurance Corporation(NHIC)
  - · manages the health insurance program for government employees, private school employees, military servicemen and their dependents
  - · manages the health insurance program for rural or urban self-employed individuals
- Health Insurance Societies
  - · manages the insurance programs for employees of industrial or commercial companies.

All insurers are members of the National Federation of Medical Insurance(NFMI). NFMI, on behalf of its members, designates medical care institutions to provide services to the insured, reviews and pays all claims from medical care institutions. All societies and the NFMI are under the guidance and administrative supervision of the Ministry of Health and Welfare(see Figure 19).

Figure 19. Coverage and Organization of National Health Insurance(October, 1998)



Source: National Health Insurance Corporation, 1998.

3. Incentives

Insurance Funds: Insurance funds have only a small influence on spending on health care. The volume of medical services is decided by the providers and patients; the prices for medical services are fixed by the national fee for service schedule. However, the premiums that insurance funds charge depend on

what they have to pay out to their members. Hence, if they want to keep premiums down, they have the following incentives: to resist the inclusion of extra services in the fee schedule; to dispute claims for excessive services; and, where relevant, to ask for an increase in government subsidies.

Providers: Primary care doctors and hospitals are paid mainly on a fee-for-service schedule covering several thousand items. They therefore have an incentive to treat as many as possible; and to give each patient as much treatment as possible. This may expand the volume of services beyond that which is ideal on medical grounds. Furthermore, hospitals have an incentive to expand medical technological facilities for providing services that are outside the fee schedule because there are no price controls on such services.

4. Beneficiaries

The medical security system of the Republic of Korea consists of the Medical Insurance Program and the Medical Aid Program. The Medical Aid Program is a form of public assistance, which provides medical care services for low-income people.

In the self-employed insurance program, there is no concept of a dependent. All self-employed persons and their dependents are considered to be insured. But in the employees insurance program, only the employees, and not their dependents are considered to be insured.

□ Insured Persons

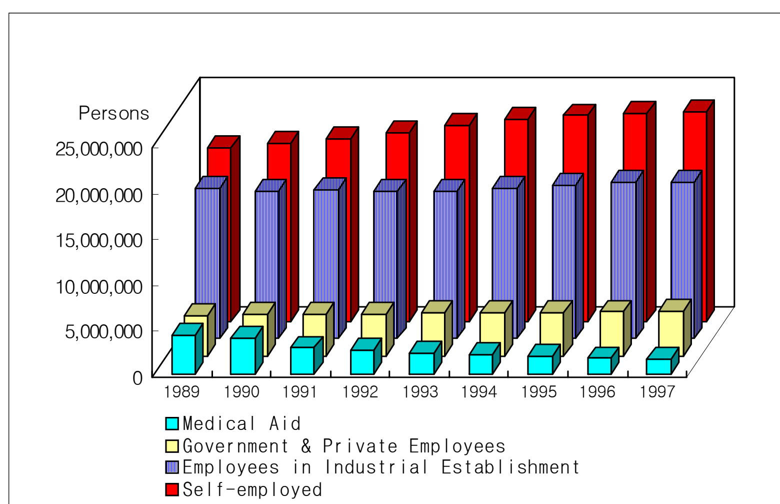
- Public employees of central and local governments
- Employees of private schools and private school foundations
- Military servicemen
- Employees of industrial or commercial companies
- Self employed persons and their dependents

☐ Dependents

- Spouse
- Linear ascendents(including ascendents of spouse)
- Descendents(including descendents of spouse from previous marriage who live together)
- Spouses of descendents
- Brothers and sisters of insured persons
- Those under 20 years of age who due to some unavoidable circumstance are supported by insured persons

Figure 20 Shows beneficiaries by year.

Figure 20. Beneficiaries By Year



Note: 1) Military servicemen and their families are included
2) Government Employees, Private School Employees and Self-Employed are unified under the management of National Health Insurance Corporation.

Source: National Health Insurance Corporation, *Health Insurance Statistical Yearbook*, 1998.

The following table shows the number of persons covered by the medical insurance program(see Table 15).

Table 15. Current Standards in Medical Insurance Coverage (December, 1997)

(Unit: persons)

Classification				Coverage	Percent(%)
Total				46,567,193	100.0
Medical Insurance	Subtotal			44,925,068	96.5
	Employees of Industrial Establishment			17,101,287	36.7
	National Health Insurance Corporation	Government and Private School Employees		4,938,464	10.6
		Self-Employed	Subtotal	22,885,317	49.1
			Rural Areas	3,476,517	7.4
			Urban Areas	19,408,800	41.7
Medical Aid				1,642,125	3.5

Source: National Health Insurance Corporation, *Health Insurance Statistical Yearbook*, 1998.

5. Benefits

5.1 Benefits in Kind

5.1.1 Health Care Benefits

Health care benefits include medical consultation, drugs and other therapeutical materials, medical and surgical treatment, hospitalization, operations and other care such as nursing care and transportation.

5.1.2 Maternity Benefits

Maternity benefits are payable when an insured woman or a dependent of the insured gives birth to a child at a designated health care facility.

5.2 Coverage Exclusions

For the purpose of maintaining finances and appropriate standardization of benefits, the following items are excluded from coverage;

— Special or non-standard treatments not recognized by the medical profession

— Impermissible cases
- · Dermatological problems(e.g. freckles, macula, acne, etc) which cause no problems in everyday life
- · Congenital, genital malformation or urogenital and gynecological disease which cause no problems in everyday life or at work
- · Vaccination(except a serum injection of tetanus, if necessary)
- · Physical examination without any symptoms
- · Treatment of addiction to narcotics
- · Cosmetic surgery
- · Dental prosthesis, orthodontics and scaling for prevention of dental disease

— Other limitations
- · Intentional accidents
- · Expenses compensated by benefits or cash grants from other sources

— Suspension of benefits
- · Short military service
- · Travel abroad

5.3 Benefit limit in days

The number of days covered by health insurance schemes is scheduled to be increases gradually by 30 days each year. By the year 2000, the days of health insurance benefits will reach 365 days. The elderly, whom are 65 years of age and disabled are under health insurance without benefit limit.

5.4 Cash Benefits

Cash benefits are reimbursements for medical care expenses and delivery expenses paid by the insured or their dependents and some fixed amount for funeral expenses. When the copayment exceeds 1000,000 won within 30 days, the insurer pays back 50% of the difference.

Medical expenses and delivery expenses are compensated when the insured or their dependents have, in an emergency or for other unavoidable reasons, been treated in an institution not designated by the National Federation of Medical Insurance.

6. Financial Resources

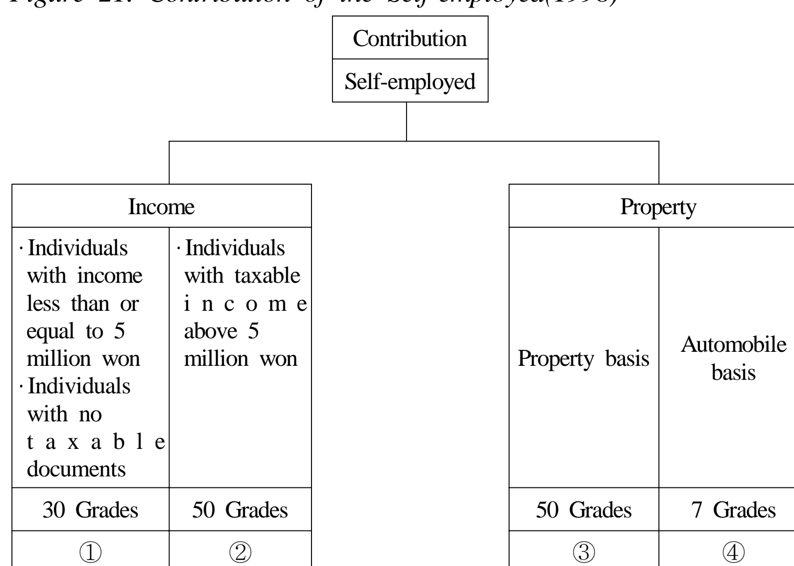
The financial resources of the insurance system are contributions paid by the insured and their employers and government subsidies. As the system has social insurance characteristics, contributions are the major source of income. There are two different insurance fund schemes. Of these, one covers employees, while the other covers the self-employed. In both employees medical insurance and government and private school employees medical insurance, contributions are based on the income of the insured. However, the scope and amount of income and the contribution rate between the two are slightly different.

In the employees medical insurance program, the employee and employer each pay half of the contribution. There is no government subsidy for this. However, in the government and private school employees medical insurance program, the government, as employer, pays half for the government employee, while for private school employees the owner pays 30%, with the government subsidizing 20%.

The self-employed medical insurance program is financed by contributions from the insured and by government subsidies. The contribution of the insured is composed of a contribution

determined by income and property(see Figure 21). The government subsidizes part of the contribution as well as all administrative costs of the program, providing about 30% of the total expenditure of the program.

Figure 21. Contribution of the Self-employed(1998)



Note: 1) In case of individuals with income less than or equal to 5 million won a year or with no taxable documents : ①+③+④

2) In case of individuals with taxable income above 5 million won a year: ②+③+④

Source: National Health Insurance Corporation, *Health Insurance Statistical Yearbook,* 1998.

7. Copayment

The insured or dependents are required to share a part of the medical expenses when receiving medical care services provided by the medical insurance program. In the case of hospitalization, they pay 20% of total costs. For outpatient services, the following Tables 16, 17, 18 and 19 show the amount chargeable.

Table 16. General Hospitals and Hospitals

Classification	Expense per Visit	General Hospital	Hospital
Urban Area		Consultation fee＋(55%×(total cost-consultation fee))	Consultation fee＋(40%×(total cost-consultation fee))
Rural Area	Not exceeding ₩10,000(₩12,000[1])	₩4,500	₩4,000
	Exceeding ₩10,000 (₩12,000[1])	55% of total cost	40% of total cost

Note: 1) in case of dental treatment

Table 17. Clinics and Public Health Centers

Expense per Visit	Clinic	Herb Doctor's Clinic	Public Health Center	Public Health Sub-Center	Primary Care Health Post
Not exceeding ₩10,000	₩3,000 (₩2,200)[1]	₩3,000	₩1,000[2]	₩800[2]	₩800[3]
Exceeding ₩10,000	30% of Total Cost				

Note: 1) when prescription is issued and medical cost does not exceeding 7,000 won
2) when not exceeding three days
3) when getting treatment

Table 18. Dental Clinic

Expense per Visit	Not exceeding ₩9,000[1]	Not exceeding ₩12,000	Exceeding ₩12,000
Cost-Sharing by Patients	₩2,700	₩3,500	30% of Total Cost

Note: 1) when prescription is issued

Table 19. Pharmacy

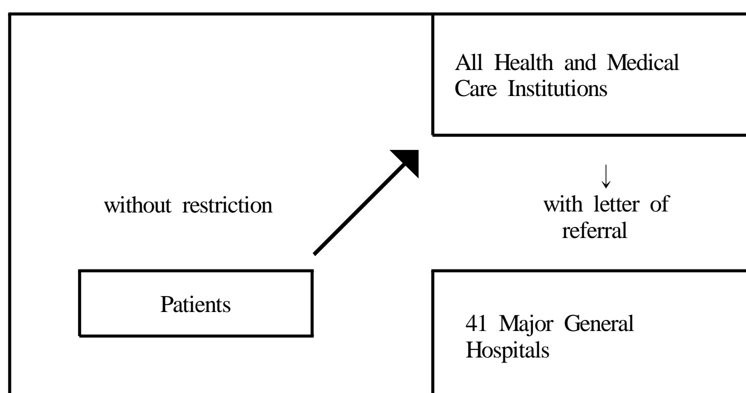
Classification	Total Cost	Cost-Sharing by Patient
without prescription from doctor	₩4,000 or less	₩800[1] or ₩1,500[2]
	more than ₩4,000	40% of total cost
with prescription from doctor	₩ 3,000 or less	₩800
	more than ₩3,000	30% of total cost

Note: 1) for 1 day
2) for 3 days

8. Patient Referral System

With the new referral system, started in October 1998, patients are now allowed to visit all medical facilities, except the 41 large facilities. For referral to one of the 41 major general hospitals, a patient should first go to a clinic or a hospital to obtain a referral slip issued by a doctor who saw the patient. The nationwide referral system also applies to dental and Oriental medical services. There are certain exceptions in the application of the referral system intended to minimize inconvenience. In the special cases of child birth and emergencies, they can visit anywhere without a slip(see Figure 22).

Figure 22. Patient Referral System

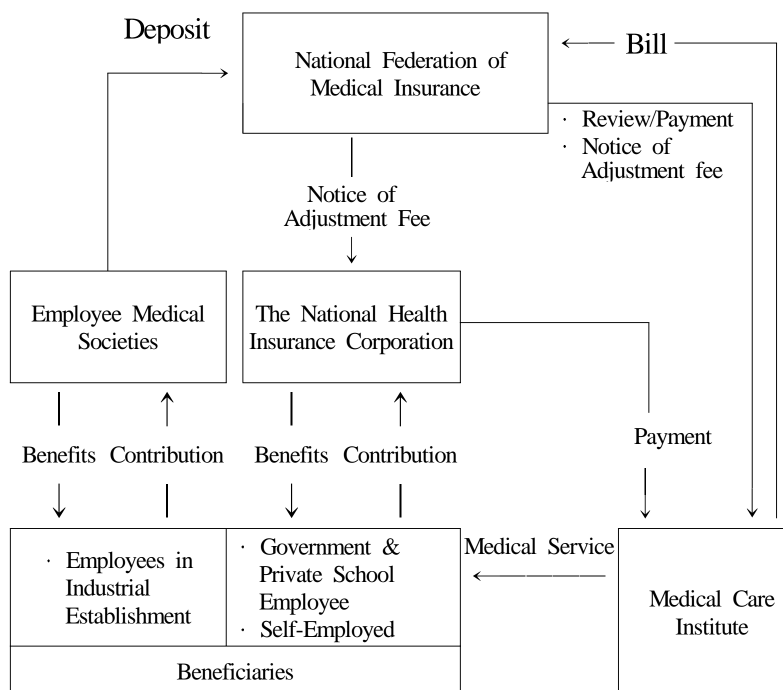


9. The System for Review of Claims and Payment of Medical Fees

The review and payment of medical care services is a type of merit system which pays for the actual services rendered on the basis of an itemized cost of medical services.

Submitted claims are reviewed by the Medical Fees Review Committee at NFMI. It is divided into a central committee and local committees. The former consists of 10 full-time and 500 part-time members who are medical specialists. The latter consists of up to 50 members who are recommended by local professional associations such as doctors, pharmacists and appointed by the president of NFMI. Pharmacists, nurses, medical engineers, and administrative staff are assigned to assist the committee. Apart from the main committee, there are 25 professional sub-committees. These committees review the claims with the fee-schedule and other guidelines determined by the MOHW and the decisions of the committee. The review process is shown in the following chart(see Figure 23).

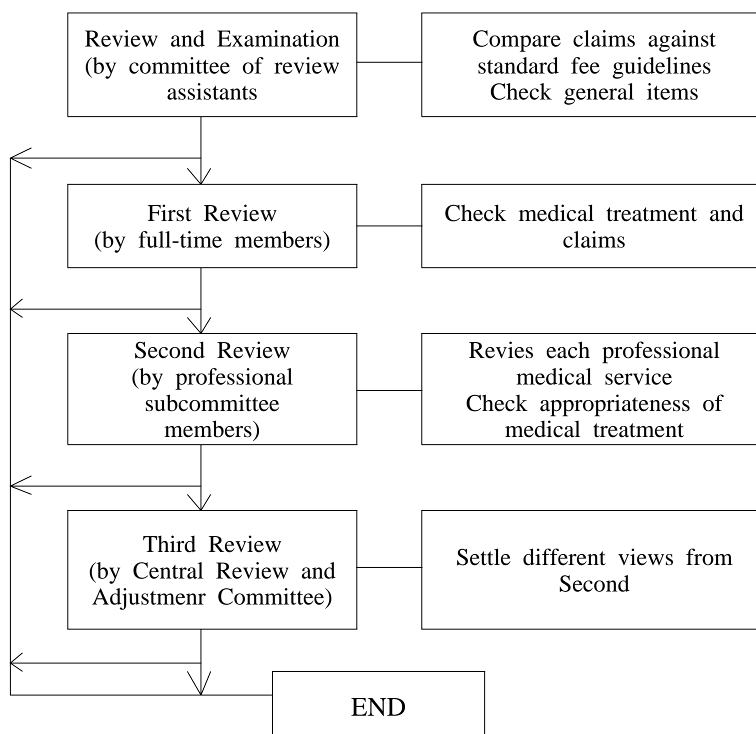
Figure 23. Medical Claims Review and Payment



The method of review is continuously being improved and has been decentralized. Local committees review the claims filed by clinics, while the central committee handles those filed by general hospitals and hospitals.

All claims submitted by hospitals and higher institutions undergo very thorough review, while those submitted by clinics are processed somewhat more expeditiously. Claims are processed through a computerized system. There are national average figures of the 25 sectional costs of the medical care system. If a clinic's claim registers less than the national average, the review process is relatively brief and only the validity of the claim is checked. If the claim is higher than average, it is reviewed in more detail.

Figure 24. The Review Process for Claims for Medical Services



Review and payment of medical fees claims should be completed within 30 days of submission. NFMI pays the claims filed by all medical care institutions for the employees program. Employee insurance societies make deposits to NFMI for this purpose based on the average of the previous three months' payments. Medical fees for government employees, private school employees, self-employed and their dependents are paid by the National Health Insurance Corporation(NHIC)(see Figure 24).

10. Appeals System

If the insured or their dependents are dissatisfied with decisions made by medical insurance societies or the NHIC about qualifications, contributions, benefits, or the like, they can submit appeals to the Medical Insurance Appeals Committee of the NFMI and NHIC. The NHIC committee deals with all appeals submitted by the Government, private school employees and the self-employed. All other appeals are handled by the NFMI committee. If the insured or their dependents are still dissatisfied after this appeals process, they can take their cases to the Medical Insurance Re-Appeals Committee of the MOHW. Beyond that, they can sue in a higher court of law.

The NFMI Appeals Committee consists of the following: three representatives each from the medical and pharmaceutical professions, the insured and the employers, four representatives from the insurer and the committee is chaired by the president of NFMI.

The Re-Appeals Committee consists of the following: three representatives each from the medical and pharmaceutical professions, the insured and the employers, four representatives from the insurer and the committee is chaired by the Vice-Minister of MOHW.

The examination procedure for both begins when the insured files an appeal. A decision is normally reached within 60 days from the date of appeal. These proceedings are handled semi-judicially.

The committee has the authority to have the appellant submit necessary dossiers, verbal statements, or written reports, and to appoint experts to conduct an examination or diagnosis.

Ⅶ. Future Issues

1. Issues

Although Korea has established universal health care, problems remain. Consumers have been dissatisfied with the services provided by the health insurance scheme both in terms of quantity and quality because the supply of health services was not sufficient to meet the consumers' increased and diverse demand caused by health insurance expansion. The initial objective of the government was to make sure everyone was covered by an insurance scheme. In order to achieve this goal in a short period though, the government had to maintain the premium at a low level. This low premium policy then resulted in a high copayment rate.

Suppliers have also been dissatisfied with the controlled medical fees that were inevitably adopted by the low premium policy. The controlled fees have not functioned well in health resource allocation. In reality, many health care institutions have come to provide health services in distorted ways to reduce the financial distress caused by the low fees. For example, large hospitals have developed services which are not covered by the insurance benefit scheme while smaller hospitals which could not develop such services have reduced the quality of services. These behaviors are keenly criticized by consumers. In response, the Korean government organized the Special Committee for Health Security Reform in January 1994. The goals of the reform are to

increase efficiency of the system through restructuring of the health care system, to increase the satisfaction of both consumers and suppliers and to correct the inequity of the different insurance funds. In 1996, the need for health reform was raised again, mainly by domestic incentives. They demonstrated different views with regard to the education system. The need for health care reform was newly raised in order to resolve conflicts among the concerned interest groups and to also make sure the health care delivery system was well fitted to universal health insurance. To overcome these problems the government reorganized a special Committee for Health Reform in November 1996. The goal of the reform designed by the committee in 1997 was to increase quality of care, to ensure better access to care, to insure comprehensive care and to increase efficiency of the health care delivery system. To make better management of health insurance system, a special committee for unification of health insurance societies was organized in March 1998.

2. Proposal for 1997

2.1 Proposal

□ Efficiency of the Health Care Delivery System
- Establishment of the Organ Transplantation Management System
- Improvement of the Emergency Medical System
- Establishing an Effective Medical Dispute Coordination System
- Separation of Prescription and Dispensing
- Efficiency of the Health Adminstration System
  · Reorganized MOHW in 1998

□ Improvement of the Education and Training System for Public Health Manpower
- Efficient Management of the Qualifying Examination for Public Health Manpower

- Quality Control for Foreign Educated Public Health Manpower
- Quality Control and Specialization of Public Health Manpower
- Supply Control of Public Health Manpower

☐ Reinforcement of the National Health Security System
- Reform of the Medical System
  - Introduction of a deductible system for small treatment costs
  - Financial imbalance among Insurance Funds
  - Private Insurance as a supplement to Public Insurance
- Adjustment of the Medical Services Fee
- Efficiency of Insurance Management
- Reinforcement of Medical Aid
  - Appropriation of a sufficient Medical Aid Budget
  - Increased benefits
  - Remedying differences in fees between medical aid and insurance

☐ Reorganization for improving of the health care industry
- Support for medical facilities
- Support for pharmaceutical industries
  - Strengthening support for the development of new medicines
  - Development of pharmaceutical production, price control and distribution structure
- Construction of a Public health care system for elderly people

☐ Development of Oriental Medicine
- Research & Support for the globalization of oriental medicine
- Improved marketing efficiency and quality control of herbs
- Expansion of the insurance benefits for oriental medicine
- Making oriental medicine and pharmaceutical services more scientific.
- Establishment of a cooperation system and mutual exchange between western and oriental medicine.

2.2 Progress

☐ Developing a Client-oriented Health Care System
- Improvement of an Emergency Medical System
- Reinforcement of Health Care Resources in Rural Areas
- Establishment of an Organ Transplantation Management System
- Establishing an Effective Medical Dispute Coordination System
- Practice of a Home Care Program
- Introducing the Hospital Service Evaluation Program

☐ Providing Preventive and Comprehensive Health Care Services
- Enactment of the National Health Promotion Act
- Implementation of National Health Promotion Programs
  - · Operation of Demonstration public health centers for Health Promotion Programs
  - · Promotion of the National Nutrition Improvement Program
  - · Promotion of Oral Health Care
  - · Development of Health Education Materials
  - · Promotion of the No Smoke and No Drink Movement
  - · Raising of the National Health Promotion Fund
- Reinforcement of the Mental Health Management System
  - · Enactment of the Mental Health Law
  - · Promotion of the Community Mental Health Program
  - · Construction of Mental Health Care Facilities

☐ Advancing Health Care Science and Technology
- Construction of the Health Care Technopolis
- Implementation of the Health Research and Development Program
- Advancement of Health Care Information

☐ Safety of Food and Pharmaceutical Products
- Establishment of the Korea Food and Drug Administration
- Strengthening of Food Safety Management System

- Strengthening of Safety Control System of Drugs
- Support for Pharmaceutical Industries
  - · Strengthening Support for the Development of new Medicines
  - · Effecient Pharmaceutical Production and Distribution Structure

3. Proposal for 1998

□ Construction of a small-scale and efficient management system for national health insurance

- Establishing small-scale and highly efficient organization
- Improving quality of services
- Establishing a computerized information system
- Placing of local offices that are optimally sized
- Introducing an evaluation system for the management of health insurance.
- Organizing a new committee for the unification of 4 major insurances(November 1998). The 4 major insurances are national health insurance, national pension scheme, workers compensation and unemployment insurance.
- Establishing active and diverse committees.
  - · Organizing a committee for health insurance review
  - · Organizing a committee for review of claims
  - · Organizing a committee for financial resources
  - · Organizing a review committee for medical care

□ Establishing of equal imposition in the new fee payment system

- Implementing insurance rates with basis on income for equal contributions
- Implementing fee-payment equity between employees and the self-employed

□ Stabilization of financial resources
- Unifying diverse financial resource schemes
- Developing effective devices for the stabilization of financial resources

□ Establishing of review system for effective fee-payment
- Establishing a fair, objective and professional review system for medical service fees
- Developing and utilizing a diverse fee-payment system

□ Adaptation of the policy of role separation between dispensing by pharmacists and prescription by doctors(July 1999).

□ The National Health Insurance Act will be submitted to the National Assembly in 1999. Under this act all employee medical insurance societies will be integrated into the National Health Insurance Corporation(NHIC) to create a unified system. Prevention and rehabilitation will also be included making comprehensive service possible. Finally, an article will be included which allows provision of a sickness allowance.

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