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Social Expenditure 2008: Analysis and Policy Issues

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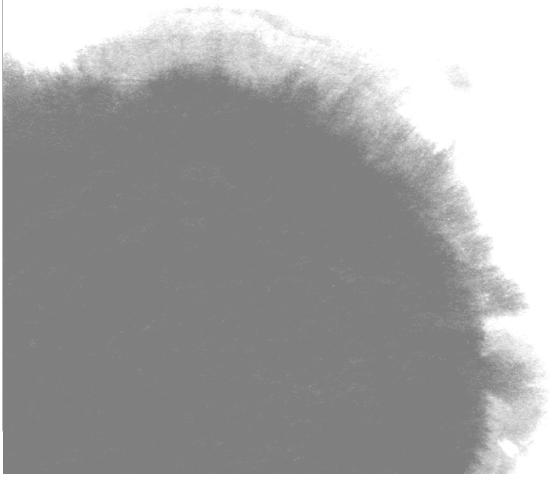


Chapter 1 Introduction

The social sector's budget of Korea has been rapidly increasing for the past several years, outpacing all other sectors'. Though this remarkable growth may be attributable in part to the extraordinary circumstantial changes such as the financial crisis and the policy shifts of the democratic regimes towards social sector, the major causes of fast growth of social sector budget had been due to the aging population, the need to expand social safety net and the rapid expansion social insurance such as pension and health insurance. This trend of rapid increase in social sector budget is expected to continue for some time. In this regard, it is high time to have serious discussions and in-depth studies on an appropriate level of social sector outlays and the need to enhance the effectiveness of social expenditures. This study, therefore, deals with key policy issues in social sector financing, and major controversial issues related to financial operations of health insurance. This paper is composed of two sector son social sector financing in general and four sectors on the policy issues related to financing operations of health insurance.

Chapter 2 is aimed at undertaking a look into the operational structure and contentious issues related to welfare budget financing

with a view to explore policy measures and directions to raise impact of ever increasing welfare expenditures. The major challenges that hamper efficient utilization of welfare financing include the predominance of mandatory spending that poses serious constraint for flexible operation of welfare financing and also distorts rational resource allocation, automatic increase of entitlement spending which is restricted to the entitled legal beneficiaries, uncontrolled increase in medical service costs and ever increasing direct government financing for some patients with chronic diseases. Chapter 2 also highlighted rapidly increased welfare spending for infants care as a consequence of the government's policy to address low birth rates, inefficient utilization of budget and the shortage of financial resources due to the divergence of welfare budget and available resources on the part of local governments.

Chapter 3 recommended various policy measures designed to enhance the efficiency of various voucher programs which have become very popular in undertaking welfare financing in recent years. Since the e-voucher systems have been introduced for many budgeted social service programs and the utilization of voucher system is expected to be applied to broader social services, the scope of voucher system utilization as well as the number and amount of financing involving such voucher system will be greatly increased. While the previously introduced voucher system has been dependent upon service providers, the current system is distinctly different from the previous system in terms of service delivery system in that it is driven by private users and based on market mechanism.

The introduction of voucher system is expected to strengthen consumer power to choose by empowering consumers and to provide

other benefits to consumers in access to service by enabling consumers to select the right service provider. Despite of the benefits mentioned above, the introduction of a voucher system may result in some negative effects such as additional administration costs, additional regulations, excessive and distorted competition to attract more consumers and consequent inefficiency. In order to maximize the benefits of the voucher system and to offset various negative effects, the Paper recommended the clearly defined objective of voucher system, full understanding of consumer characteristics and market environment surrounding the program, appropriately designed program scope to ensure maximum benefit, a detailed implementation plan, flexible operation, promotion of competition among service providers, clearly defined division of works between central and local governments and the need to have effective link with similar voucher programs so as to develop a consolidated management system.

Chapter 4 reviewed various policy measures for ensuring a stable financing operation of health insurance, current financial position of health insurance and financial stabilization programs undertaken by some advanced countries and their experiences and lessons, and explored some policy options to attain stable financing position of health insurance. Health insurance accounts incurred large losses in the early 2000s but it has started running surpluses in its financing from 2004. After some sluggish financial performances during the years 2004-2007, the health insurance accounts recorded a large amount of surplus in 2008 with the accumulated surplus amounting to Won 2,700 billion at the end of that year. Despite the large deficits recorded in the early 2000s, the financial position of health insurance improved very substantially and started to make surplus in

short time, due largely to the strong financial stabilization program undertaken as well as the impact of increased insurance premium which was bigger than anticipated, deferment of benefit expansion, increased share of beneficiaries and the decreased utilization of medical facilities in the wake of the economic downturn.

As a policy alternative for ensuring a stable financial position of health insurance, this chapter presents a strategy under which insurance would be determined by a well-devised formula to safeguard stable financial revenues of health insurance and other features to guarantee political neutrality of premium determination of health insurance. The Paper also recommends that the concept of burden sharing by those who have caused diseases should be explicitly introduced in the strategy paper and a specific deficit strategy must be formulated as well. As the policy measures to improve financial expenditure disbursement management, this chapter recommends the reform in payment compensation system, granting of purchasing function to insured persons and clear delineation of relationship between private insurers and public health insurance. The paper also recommends the introduction of the whistle blower compensation system to prevent leakage of resources, issuance of electronic health insurance cards, and adoption of uniform review procedure for medical treatment cost claims. Moreover, the Paper suggests that financial expenditures can be effectively managed and controlled by encouraging in-house treatment instead of hospital treatment, continued implementation of drug cost reducing program and improvement in medical service fee structure. As measures to improve the inefficient medical service delivery system, it has suggested to introduce the health insurance fee contract and the total

amount contract systems. The paper stressed that it is urgent necessary to convert the inefficient service delivery system to a normal service delivery system by undertaking the recommended policy measures.

Chapter 5 attempts to present a blueprint of an advanced and sustainable future health insurance system for Korea and presents a policy direction for the health insurance in an aging Korea by drawing a road map for the health insurance policy under a new framework. As the health insurance of Korea is about to embark on a step to modernize its health insurance system, an urgent reform of health insurance is strongly called for to enhance the equity and efficiency of the system, to stabilize financial position and to reduce household health expenditure risk. For this purpose, this chapter undertook an overall review of financial status of health insurance by analyzing cost burden of health insurance premium by occupation groups. This chapter also analyzed the health insurance payments by its elements in order to find out the causes of rapidly rising cost of medical consulting fees, especially high fees charged to elderly.

The major problems faced by the Korean health insurance are many in number increasing premium burden on the part of insured and unequal premium burden sharing among different occupational groups, inequity existing in premium determination process, increasing dependence on national budget, increasing costs of drugs, inefficient management of health insurance administration, grave concern on the sustainability of health insurance in the face of aging population and declining fertility, unimaginative government regulation and supervision and limited scope for consumer choice, just to cite a few. The policy reform measures recommended by the Paper in the

financing aspect of the health insurance are as follows: First, it is recommended that the resources for health insurance be expanded substantially and the method of mobilizing financing resources should be diversified; secondly, the National Health Insurance Corporation (NHIC) must be fundamentally restructured through the decentralization of its functions and strengthened accountability of its management so as to redefine NHIC's relationship with its clients and to raise management efficiency; thirdly, there should be radical reforms in the resource flow and service delivery process from service providers to insurers.

Chapter 6 is a basic study for a financial stability of health insurance and undertakes a medium term (2009-2030) financial projection for health insurance. Financial stability is currently threatened by many serious risks: since sufficient budget support from the government could not be obtained, health insurance must be largely dependent on insurance premium revenue. While insurance premium revenues could not be significantly increased due to the declining ratio of economically active population, the drastically increased medical expenditures arising from treatment of rapidly aging population has become a major stumbling block for the financial stability of health insurance. As a consequence of the world wide economic down turn that had adversely affected labor market, the share of workplace employees has been declining. As the premium paid by workplace employees has been the major source of health insurance, the declining share of workplace employees would adversely affect the financial stability of health insurance. Under these circumstances, it is essential for the stability of financial position of health insurance to diversify sources of revenues as the

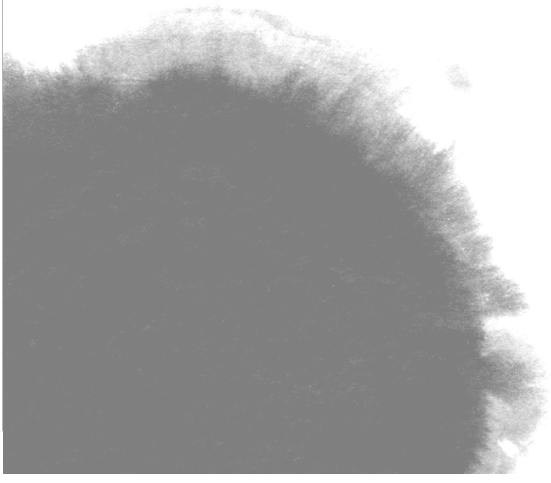
possibility of additional revenues through raising insurance premium rate in the near future seems to be very slim. In this Chapter, per capita monthly medical costs were estimated for medium and longer term periods by using the time series data on average monthly medical expenditure data of NHIC. Based on the outcome of this projection, insurance benefits were estimated and total financial outlays have been estimated by reflecting the shares of detailed expenditures. Moreover, total revenue requirements were estimated and sectoral financial projections were made on the assumption that total outlays would be fully financed under the framework of total revenues.

Chapter 7 is a review of the current financial position and the major problems of the medical benefit services designed to provide services for low income families and came up with some policy tasks for the medical benefits so as to make it a truly worthwhile medical security system for the poor. Main source of this medical service for the poor is the line item of the budget of the Ministry of Health, Welfare and Family (MHWF) listed under the heading of "current subsidy for medical benefit" of the Basic Livelihood Guaranty Scheme in the social sector. Since the bulk of this item of medical treatment cost would be borne by the public sector, it is necessary that an appropriate organization to administer and monitor this item should be in place if a stable financing position for this program is to be maintained. Even though the financial position of the medical benefit appears to be somewhat stabilized mainly thanks to the recent changes in policy and consequent supplementary budget, there is potential risks in this medical benefit financing in the future if there were substantial changes in the numbers of beneficiaries and

government policy. In this chapter, we have reviewed which system could provide more efficient services to the poor with the same amount of fund, the medical benefit system or health insurance. The conclusion was that more poor people can be benefited under the medical benefit service system than under the health insurance though there is no guaranty that the quality of service provided by the medical benefit would be as efficient as the service by health insurance. As the ultimate answer to the question of sustainability of the medical benefit service, this chapter highlighted the need to improve the quality of services to beneficiaries and the need to fill the gaps where qualified poor could not benefit from these services due to the characteristics of beneficiaries and institutional factors.

02

Operational Structure of Health and Welfare Budget and Controversial Issues



Chapter 2 Operational Structure of Health and Welfare Budget and Controversial Issues

1. Structure of Health and Welfare Financing

The health and welfare financing (to be referred as welfare financing) may be defined as the process of mobilizing financial resources required for protecting people from social risks such as poverty, diseases, disabilities and loss of income and for meeting welfare demand of society as a whole throughout lifetime from birth to elderly period and expenditure plans to achieve such objectives. The welfare financing has been the fastest growing sector in Korea in the 2000s, surpassing other budget sectors. In 2008, the welfare financing, comprising both social welfare and health sector budgets, amounted to Won 68 trillion (Note: Based on the classification criteria on "digital budget account system" of the government) which accounted for 26% of total budget. The welfare financing in 2008 was 5.2 times of that in 1998. (Note: Since the "digital budget accounting system" was not available before 2004, the figure for 1998 (Won 13 trillion) was estimated from the final budget report by adding headings under "health", "social security" and "welfare". Source: Ministry of Planning and Finance: Consolidated Government Accounts, various years) Such a rapid increase in welfare financing

can be attributed to the 1997 financial crisis during which budget expenditures for public support programs and social security system expansion were greatly increased as the importance of social safety net investment was given top priority. Considering that total budget had increased only by 2.3 times during the period of 1998-2008, the increase of welfare budget (5.2 times) was remarkably high. (Note: This analysis is based on the budget expenditures of the central government only. Figures for 1998 were based on consolidated budget accounts and the figures for 2008 were drawn from the total expenditures. Sources: Ministry of Planning: "National Budget", various issues)

If we review the sector allocation of government expenditures for major projects, the welfare sector topped the list with an expenditure of Won 21,428.5 billion (34.7%), followed by the housing sector (Won 14,714.5 billion or 23.8%), the labor (Won 10,493.6 billion or 17.0%), the national basic livelihood guaranty (Won 6,857.7 or 11.1%), patriots and veterans affairs (Won 3,129.1 billion or 5.1%), the elderly and youth (Won 2,231.8 billion or 3.6%), child care, family and women's development (Won 1,624.2 billion or 2.6%) and assistance for poor groups (Won 906.3 billion or 1.5%), respectively. Among the health sector projects, support for health insurance topped the list with Won 4,553.8 billion (76.6%), followed by health and medical service (Won 1,209.8 billion or 20.4%) and food and drug safety (Won 178.5 billion or 3.0%), respectively.

〈Table 2-1〉 Structure and Magnitude of 2008 Welfare Financing

(Unit: Won 100 million)

Areas		Ministries in charge	Accounts	2008
National Basic Social Security	68,577	Ministry for Health, Welfare and Family Affairs,	Budget: general account and 4 special accounts	158,874
Support for the Socially Vulnerable	9,063			
Elderly and adolescents	22,318			
Social welfare in general	3,200			
Health care*	12,098			
Support for the National Health Insurance*	45,538			
Childcare, farmily, women	16,242	Ministry of Gender Equality	National Health Promotion Fund, Youth Promotion Fund, Emergency Health Care Fund, Women's Development Fund, Lottery Fund	18,162
Food and drug safety*	1,785	Korea Food and Drug Administration	Budget: general account	1,785
Public pension	214,285	Ministry for Health, Welfare and Family Affairs	National Pension Fund	68,694
		Ministry of Public Administration and Security, Ministry of Education, Science and Technology, Ministry of National Defense	Civil Servants' Pension Fund, Private School Teachers' Pension Fund, Military Personnel's Pension Fund	145,591
Labor	104,936	Ministry of Labor	Budget: general account and three special accounts	9,082
			Employment Insurance Fund, Industrial Accident Insurance Fund, Worker's Welfare Promotion Fund, Wage Claim Guarantee	95,854

			Fund, Disabled Persons' Employment Promotion Fund	
Patriots and veterans affairs	31,291	Ministry of Patriots and Veterans Affairs	Budget: general accounts and two special accounts	30,046
			Veterans Welfare Fund and Patriots Project Fund	1,245
Housing	147,145	Ministry of Land, Transport, and Maritime Affairs	Budget: general account	1,905
			National Housing Fund	145,239
<Total>				
2 sectors (Social welfare and health) 12 areas		9 Ministries	Sectors: Social welfare	617,056
			Sectors: Health	59,421
			Account: Budget: general budget and 4 special accounts	201,693
			Account: 17 funds	474,785
			Total	676,477

Note: 1 - 3 sectors with * mark are health sector while remaining 9 represents social welfare.
2 - Sector accounts not presented in the National Finance Operation Plan are derived from the Government Budget and Fund Operational Plan.
Sources: 1. Korean Government: National Finance Operational Plan for 2008-2012, 2008.
2. Ministry of Planning and Finance: 2008 National Budget Outline, 2008

When carrying out international comparison of welfare financing statistics, it is essential that the country concerned have financial statistics compiled in accordance with the international standards, and countries involved in comparison should have comparable environment in terms of the level of national income, share of elderly population, the maturity of their public pension and social security and other social environment. The magnitude of financial expenditure can vary slightly depending upon the basis of financial statistics compilation, level of national income, share of elderly population and the maturity ratio of public pension. According to the IMF, the financial expenditure of central government of Korea was estimated at 13.1% in 2005. (Note: Financial expenditure under the IMF criteria are estimated by adding 2 items listed in "social

protection" and "health" under 10 IMF functional classifications. IMF, Government Finance Statistics Yearbook 2007, CD-ROM, June 2008).

This figure of 13.1% was composed of 0.36% for health and 12.68% for social protection. The share of welfare expenditure in total budget of Korea was lowest among the OECD member countries except for the Switzerland (0.2%) where health expenditure of general government stood at 11.4%. The reason why such a low share of welfare expenditure in Korea may be that health insurance expenditure was excluded in health financing in the case of Korea. This is a good example where financial statistics compiled not in accordance with international criteria distort international comparison.

According to the government statistics, the share of welfare expenditures in total budget was shown to be 26.3% in 2008 (see Diagram 1) but this figure goes up to 34% if we include health insurance expenditure in welfare financing. (Note: Of the total health insurance expenditure of Won 27,800 billion, only Won 4,700 billion (composed of Won 4,585 billion for health insurance sector and Won 135.6 billion for health insurance subsidies for rural areas) was included in welfare financing while the remaining Won 23,100 billion was excluded).

The level of welfare expenditure of Korea ranged between 27% - 71% of the OECD average, when the differences in GDP level and maturity of social insurance system were not taken into accounts. According to the OECD Statistics (Note: OECD: Fact Book 2008), the average per capita GDP of the OECD members was estimated at $31,555 in 2006 and Korea's per capita GDP was equivalent to 73% of the OECD average in 2006. The share of elderly in total population in Korea was estimated to be 67% of the OECD average

of 14.4% in 2005. The maturity ratio of national pension, which has strong influence on welfare expenditure, was estimated at 13% in Korea that was equivalent to about 1/5 to 1/3 of the OECD countries.

Consequently, it is difficult to say whether the Korea's welfare expenditure is too large or too small compared to other OECD countries'. The social security system has a short history: the government employees pension was introduced in 1960, the Worker's Accident Insurance was launched in 1964, and the health insurance was introduced in 1977 (its universal coverage was achieved in 1989). The National Pension was introduced in 1988 (its universal coverage was completed in 1999) and the Employment Insurance was initiated in 1995. During this period, the government's priority was placed to institutional development of social security system. The immaturity of Korea's social security system is well reflected by the fact that the first batch of retirees with full national pension right (20 years contribution) started to receive their pension payments only in 2008.

3. Controversial Issues in Operation of Welfare Financing

(1) Distorted Resource Allocation - Predominant Mandatory Spending

The major problem facing welfare spending in Korea is that most of expenditures are mandatory spending for which there is no room for policy intervention. Of the 12 programs under the welfare

financing, 3 programs (the Basic Livelihood Guaranty, Public Pension schemes and support for health insurance) are 100% mandatory spending, support for patriots and veterans (including various allowances) involves 86% mandatory spending, and important programs such as the disability allowance, child care allowance, unemployment benefits and worker's accident insurance benefits are all statutory. Consequently, it is estimated that about 85% of welfare expenditures (except for housing support) are mandatory spending in nature. When we review the budget of the Ministry of Health, Welfare and Family Affairs during 2005-2008, the share of mandatory spending ranged between 93% and 95% as shown in Table 4.

〈Table 2-2〉 Budget of Ministry of Health, Welfare & Women's Affairs

(Unit: Won 100 million, %)

	2005	2006	2007	2008
Obligatory expenditure	88,894 (93.3)	99,843 (94.6)	119,810 (94.7)	146,887 (94.4)
Discretionary expenditure	6,384 (6.7)	5,699 (5.4)	6,705 (5.3)	8,666 (5.6)
Total	95,278 (100.0)	105,542 (100.0)	126,515 (100.0)	155,553 (100.0)

Notes: (1) This is consolidated budget and included child care and youth support for 2005-2007.
(2) Mandatory spending was determined by the budget guidelines.
Sources: Internal data of Ministry of health, Welfare & Family Affairs.

(2) Increase in Entitlement Spending Budget

The bulk of entitlement spending are transfer income expenditures (except for the child care support which is being paid by voucher and the medical benefit in the Basic Livelihood Guaranty which is to be paid in kind) which are paid under the provisions of the law. As such, the eligible beneficiaries and benefit amount are as specified in the laws. Among the welfare budget expenditures of the Ministry of

Health, Welfare and Family Affairs, the benefits for the most needy poor (such as livelihood benefit, housing benefit and medical benefit) from the Basic Livelihood Guaranty System, Basic Old Age pension, disability allowance and child care benefit are the most typical entitlement spending. Moreover, pension payment, unemployment benefit and worker's accident compensation are the typical entitlement spending.

As we review the problems of increased entitlement spending, first, it should be noted that the automatic increase in welfare spending is mainly led by the increase in entitlement spending. Secondly, the increase in entitlement spending is directly linked with the old age program and low fertility program as we have noted in the introduction of the old age pension and expansion of child care. Thirdly, the budget operation of entitlement expenditure may contribute in promoting vertical equity by concentrating assistance to certain high priority poor groups but this can be seen as a constraint in promoting welfare of large number of general public, and a serious setback for the promotion of equity.

(3) Increase in Medical Security Expenditures

Though the national expenditure for medical services in Korea is relatively low compared with other OECD countries (Note: The share of medical expenditure of Korea in current GDP was 6.0% in 2005 which was equivalent to 67% of the OECD average of 9.0%. OECD Health Data, 2007.), the medical expenditure in Korea had been increasing at an annual growth rate of 13.1% from Won 10.4 trillion in 1999 to Won 32.4 trillion in 2008. Of this, the growth of the

direct government financing had been much more pronounced, which grew 4.2 times from Won 2.3 trillion in 1999 to Won 9.7 trillion in 2008, as shown in Table I-6. Since total budget had increased by only 2.1 times during this period (1999-2008), the increase in medical expenditures had been remarkably high in Korea. The financial implication of the rapid increase in medical expenditure is that it will have serious negative impact on resource allocation to other high priority sectors such as social welfare and education. Excessive spending on medical service also hampers flexible policy options of the Ministry of Health, Welfare and Family Affairs in tackling other priority areas such as population aging and declining fertility rates.

(4) Increase in Child Care Budget and Over-spending

Reflecting the government's expanded financial investment for child and infant welfare, the child care budget had increased by an annual rate of 31.4% during 2005-2007, reaching Won 1,417.8 billion in 2008. This rapid increase in child care was attributable to the social consensus that the child care sector should be given top priority in order to address the problem of low fertility. Some of contentious issues arising from execution of child care budget are as follows.

First, there is some concern over the effectiveness of utilization of the budget for child care system under which child care money is not paid directly to users (households) but to the care providers (implicit voucher system). The low level of effectiveness of this implicit voucher method was confirmed in the course of investigating the over spending of budget for 2005-2008. While Won 889.3 billion

was budgeted for child care programs for differential child care and support for child care for families with more than 2 children during the 3 year period under review (2005-2007), actual disbursement from this budget amounted to Won 1,101.0 billion, resulting in an over-spending of 23.8%.

Secondly, as the current child care system provides services through child care facilities, there are many low income families who are excluded from this service because they live far from care facilities without having proper means of transport, even though they are classified as the top priority target group.

Thirdly, the basic subsidy for private child care facilities (to be used to support salary of teachers was introduced in order to raise the quality of services, first for infants in 2006. This subsidy was expanded to cover all children in 2008. Since the introduction of subsidy, the number of private child care facilities increased rapidly, mostly small scale family care centers. This mushrooming of small child care facilities raised some concern that the quality of service might be deteriorated rather than improved as intended by the government.

Fourthly, the expansion of public child care facilities has been very disappointing. Since public facilities are supposed to provide services in low income communities, the slow expansion has affected many priority areas. Since the role of public care facilities is critically important in developing child care service, there is an urgent need to apply differential subsidy treatment for such facilities and to resolve pending matters with local governments so as to facilitate public care facility. An overall review of subsidy policy may be required to resolve this problem.

(5) Welfare Budget Burden of Local Governments and Resources Availability

The financial burden of local governments in carrying out welfare budget has become a hot issue which needs a thorough review from the following two angles: first, the Ministry of Health and Welfare (former Ministry) delegated 67 subsidy programs to local governments but there were unsettled issues regarding the means of such subsidy financing and magnitude of financing burden of local governments. These issues arose because transfer of subsidy administration to local government was undertaken without undertaking an in-depth study on new demand for subsidy but resource requirements for subsidy transfer were made based on the demand when such transfer was actually made.

Secondly, as the ambitious government policy to address aging population and low fertility had been pushed on a nationwide scale, the welfare subsidy spending increased continuously, resulting in a heavy financial burden to local governments. During 2005-2007, welfare subsidy programs expanded by 27.5% annually while the consequent financial burden for welfare subsidy programs increased by 31.5% per annum. (Note: The higher financial burden for local governments was due to low average subsidy administration fees and land acquisition costs incurred by local governments.) The national budget grew by 7.2% annually during the same period.

Thirdly, the financial burden effect of subsidy transfer was differently felt to different local governments depending on the size of local governments concerned. According to a study that analyzed the disbursement pattern of old age pensions (Note: In-Hwa Park, "Disbursement of Old Age Pension by Local Governments and

Analysis of Problems", Financial Expenditure Trend Analysis, #3, National Assembly, Oct. 2008), the financial burden of old age pension payment and local government's self-financing burden were negatively correlated. The financial burden arising from old age pension payment was much more pronounced for larger local governments (urban cities) whose financial positions were much more vulnerable while the share of their own project was lower than the national average. This was because the resource transfer from the central government to local government varies depending on the size of the locality. Moreover, differentiated subsidy schedule in administering the newly introduced Old Age Pension did not fully reflect the huge demand in larger local governments.

3. Policy Direction for Enhancing Financial Impact

(1) Practical Usefulness of National Finance Operational Plan

When reviewing the effectiveness of the national finance operational plan for the past 5 years, the practical usefulness of such operational plan would be questioned because virtually every plan had been subject to various substantial changes. After careful review of the health and welfare sector of the national finance plan, it was noted that its mid-term spending plan had changed substantially every year and resources allocation had also changed significantly due to the changes in classification criteria. There was no explanation from the government about the changes in classification at all. Resource allocation to the welfare sector increased from 18% of total budget in

2005 to 25% in 2006 due largely to the reclassification of the housing sub-sector under the welfare sector. In the case of the basic livelihood guaranty program under social welfare, its spending programs have been varying widely with its growth rates ranging between 8%-15% without due regard to the 5-year moving average rates presented in medium term plan. It is high time to undertake a serious review of the National Finance Operation Plan so as to make it a truly binding and effective medium-term financing plan.

(2) Compilation of Finance Statistics According to the International Standards

There are two problems facing compilation of financial statistics in Korea: first, distortion of resource allocation by classifying housing as social welfare that causes undue increase in welfare at the expense of general economic activity; secondly, exclusion of health insurance from government finance reduces health expenditure and total financial magnitude of government. Consequently, the IMF statistics shows very low health expenditure of 0.4% (2005) for Korea. Due to these misleading statistics, the welfare financing of Korea was reported as 13% of total financing in IMF Financial Statistics. This level of welfare financing was about a quarter of the OECD member countries. However, the government statistics reported that 26% of budget was allocated for welfare spending, which is almost double of the IMF figure. If health insurance is factored in the government financing, then the welfare sector allocation would amount to 34% of total outlays of government. Compared to the OECD countries, this level (34%) of welfare spending would be about 70% of the OECD

average. As a transparent and correct information on financial structure and trend would be essential to ensuring rational allocation of resources in accordance with national priorities, it is urgently needed to compile financial statistics based on internationally agreed standards so as to enable meaningful international comparison.

(3) Improvement in Budget Compilation Method

In order to overcome the problems facing the budget finance of the Ministry of Health, Welfare and Family Affairs, the rigidity of spending arising from predominance of entitlement spending and inefficient resource allocation, it may be worthwhile to consider to differentiate entitlement expenditure and arbitrary spending with caps placed on arbitrary spending. As to the entitlement spending, it should be administered separately in close consultation with the national assembly during legislation stage. By taking these measures, the objectives of the top down budget system, i.e., efficiency and horizontal equity of resource allocation would be enhanced. Since the relative share of monetary transfer vs services in kind, which is an important indicator in measuring the impact of budget allocation, could be provided mainly by budget expenditures. (Note: Reallocation: The Role of Budget Institutions, Paris, OECD, 2005).

(4) Establishment of Baseline for Entitlement Expenditures

In order to effectively address the problem of rapidly increasing entitlement spending, it is necessary to strengthen mid- and long-term

financial control, rather than single year budget compilation. First, for the effective control of entitlement spending, it is necessary to establish medium and long term baseline projection for the required expenditure at the stage of legislation and have an institutional mechanism to monitor and evaluate the soundness of budget appropriation to meet the entitlement spending, including some contingency in case of policy changes. For this purpose, the rule of PAYGO, which was established by the enactment of the Budget Enforcement Act by the U.S. Congress in 1990 as well as the current "scorekeeping" system could provide a good reference point. Secondly, as the increasing entitlement spending would create severe financial burden to local governments, it is necessary to evaluate the financial burden to local governments in advance at the stage of legislation. (Note: The Budget Enforcement Act was enacted by the U.S. Congress in 1990 and was expired in September 2002 because no extension action was recorded in 1998 with the budget surplus. Though legal basis of the PAYGO disappeared with the expiration of the Act, the 100th Congress adopted the rule of PAYGO by revising the Regulation (H.Res.21) and the Senate resolution also adopted the PAYGO in its resolution. (Section 201 of S.Con.Res.21). Consequently, the rule of PAYGO is observed in budget operation but without any binding legal power. In this regard, the U.S. Senate has tabled a draft resolution entitled " Restoring Fiscal Discipline Act of 2007"(S.10). Source: National Assembly, Budget Bureau, Report on Budget Estimates. 2008).

(5) Making the Welfare Delivery System More Efficient

As we have seen in the course of examining the child care case, overspending is the most serious problem in budget administration, which must be urgently resolved by enhancing the accuracy of budget compilation and raising efficiency in budget execution. If budget overspending would be allowed by allocating contingencies, this practice would defeat the very spirit of the principle of top down budgeting in the total voluntary resource allocation system. Since the budget financing for child care has been made in earnest for the past 5 years and as the amount of such budget financing exceeded Won 1,700 billion in 2009, it is high time to improve program monitoring and implementation by undertaking in-depth policy analysis and supervise program beneficiaries more effectively so that the impact of budget operation would be visibly enhanced.

(6) Improved Modality to Support Welfare Finance Resources to Local Governments

The following policy alternatives should be considered to support an appropriate level of financial mobilization for local governments and effectively manage local governments' program implementation as a policy to address the increasing financial burden of local governments in the course of implementing welfare programs. First of all, it is necessary to determine differential subsidy rates for local governments and apply them to various local governments within the framework of the current subsidy support policy from the budget. For this purpose, the differential subsidy scheme should take into account

the number of beneficiaries in local governments for each welfare program and financial position of local governments concerned. In order to do this, it is essential to develop a basic indicator which factors in the number of beneficiaries and financial position of localities as a prerequisite. Similarly, large local governments (large urban cities) should reallocate the subsidies to the needy districts in accordance with the basic indicator of subsidies. (Note: In this reallocation of subsidies, one may refer the joint taxation of property taxes by Seoul Metropolitan Government and districts within Seoul consequent to the partial revisions of the Local Tax Act in 2007.) As a next step, one may consider introducing the financial support by category method in which subsidies to local governments will be determined after a detailed measurement of welfare demand and financial position of local governments, though the scope of welfare programs to be transferred is subject to further discussion. The local government subsidy, which is the main source of welfare budget to be transferred to local governments, will be terminated in 2010 and the committed budget will be merged to the General Subsidy account. This problem and the guaranty of national minimum level will be key issues that need to be seriously discussed and studied in the future.

03

Policy Tasks to Enhance Effectiveness of Voucher Programs

Chapter 3 Policy Tasks to Enhance Effectiveness of Voucher Programs

1. Current Domestic Status and Future prospect of Voucher programs

(1) Social Service Voucher Program

The current welfare programs that adopted a voucher method are the following 7 programs: elderly aids, newborn aids, selective disabled welfare, regional welfare service improvement program, subsidies to medical costs for test tube baby, support for elderly low cost accommodations and the nutritional support for pregnant mothers and babies. In the 2008 budget, some Won 269.2 billion was budgeted for voucher programs for the 7 welfare programs, 43.5% up for the voucher program budget from the preceding year. Of the voucher programs, the largest program in terms of budget amount was the regional welfare service improvement program in which local governments develop service programs and beneficiaries and central government disburses budget funds. In the 2008 budget, the children investment program was converted into the general investment voucher program which was further divided into "children intelligence improvement service" and "children obesity management program".

Moreover, as service support duration was extended from 7 months to 12 months, the voucher program budget increased by 62.7% from the 2007 budget. For the children support voucher programs, the major problem was that there were only two service providers that competition was hampered.

〈Table 3-1〉 Social Service Voucher Project

(Units: million won, %)

Project	Policy target	Target population	Provider	Voucher value	Additional payment	Form	Budget 2008
Elderly Carer Voucher	Old-age protection for elderly individuals who have difficulty performing daily activities	Elderly individuals aged 65 or over from a household with a monthly income less than 150% of the average worker's income	Home-help service providers and self-support guardian institutes	202,500-294,000 won/month (21,000 won for 2 hours, 5,500 won for an additional hour)	Yes	Explicit	27,640
Mother and New-born Care Program	Promotion of childbirth for low-income families -Job creation	Families with a newborn whose income is less than 65% of the average worker's income	Women of low-income families who have received assistant training	567,000 won for 2 weeks (out-of-pocket portion of 46,000 won)	No	Explicit	24,600
Activity Assistance Service for Severely Disabled People	Promotion of the self-sufficiency and social participation of the disabled	People aged between 6 and 65 with a 1st degree disability (15 types in all)	Public, non-profit institutions, self-support guardian institutes	8,000 won per hour (hourly rate)- flat monthly out-of-pocket payment (20,000~40,000 won)	No	Explicit	73,800
Support on Vitro Fertilization	Promotion of fertility rate	Infertile couples with an income of less than 130% of the average worker's	Medical institutions	1.5 million won per person (maximum of twice)	Yes	Implicit	12,100
Support on Institutional Long-term Care for the Elderly	Provision of financial support for elderly individuals using long-term care facilities	Elderly people who are users of long-term care facilities	Long-term care facilities	Professional long-term care facility (350,000 won), other long-term care facilities (170,000 won)	-	Implicit	1,001
Nutrition Program for Pregnant Women, New-born Babies, and Toddlers	Provision of food expenses for pregnant women and newborns and toddlers	Women in pregnancy, post-partum, breastfeeding; children under 6 who are from families with an income of less than 200% of minimum living standard	Community health centers	Group-specific, selective nutrition support	-	Implicit	9,200

Project	Policy target	Target population	Provider	Voucher value	Additional payment	Form	Budget 2008
Community Welfare Service Project	Programs and their target groups are selected by communities and financed by the Ministry for Health, Welfare and Family Affairs	All citizens or the citizens whose income is less than the average worker's	Community organizations	Service-specific, area-specific support	-	Implicit	115,000
Total							263,341

Sources: 1) "Introduction to Elder Care Service 2008" (2007), Ministry for Health, Welfare and Family Affairs
2) "Helper Programs for Mothers and Newborns 2008" (2007), Ministry for Health, Welfare and Family Affairs
3) "Introduction to Assistance for Daily Living for Disabled People 2008" (2007), Ministry for Health, Welfare and Family Affairs
4) "Community Social Service 2008" (2008), Ministry for Health, Welfare, and Family Affairs
5) Social Service Center, Ministry for Health, Welfare, and Family Affairs (http://www.socialservice.or.kr)
6) "Analysis of Budget 2008" (2007), National Assembly Budget Office
7) "An Overview of Budget and Fund Management Plan 2009" (2008), Ministry for Health, Welfare and Family Affairs
8) "2008 Action Plan for Active Welfare: Jobs, Opportunity and Care" (2008), Ministry for Health, Welfare and Family Affairs

(2) Child Care and Education Voucher

There are two child care voucher programs. One is the infant/toddler care cost support program under the Ministry of Gender Equality and another is the child education voucher program under the aegis of the Ministry of Education and Human Resources. The Ministry of Gender Equality allocated Won 807.9 billion from the 2008 budget for implementing the following 4 sub-programs: support for differential child care cost, free care for 5-year olds, free care for children with disability and free childcare for families with more than 2 children, which represented an annual increase of 36% over the budget of 2007. The differential childcare cost support provides care cost for children under 4 and amount of support varied depending on the income of household and the age of children. The childcare cost

support for 5-year old sis being paid uniform amount given the compulsory nature of child education of that age group. Support for families over 2 children incorporates the policy objective of low fertility crisis in addition to child care.

On the other hand, the children education voucher program included following four sub-programs: education cost support for children aged 3-4 years from low income families, education cost support for families with more than 2 children, free education support for children aged 5 years and free education support for children with disability. Under these programs, the direct beneficiaries are care providing institutions (care providers), not the benefiting parents. In this regard, this is an implicit voucher system.

〈Table 3-2〉 Education Voucher Programs

(Units: million won, %)

Program name	Policy target	Target population	Provider	Voucher value	Additional payment	Form	Budget 2008
Differential support for education expenses	- Support for low-income group - Increase fertility rate	Children under 4 from families whose income is less than the average worker's	Public child care and education facilities orgovernment-approved child care and education facilities	Support based on income level (flat rate)	-	Implicit	603,132
Education support for children under 5	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Families with an income less than the average worker's	Public child care and education facilities orgovernment-approved child care and education facilities	167,000 won/month	Yes	Implicit	125,512
Education support for children with disabilities	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Families with children under 12 who have disabilities	Public child care and education facilities orgovernment-approved child care and education facilities	372,000 won/month	Yes	Implicit	31,281

Program name	Policy target	Target population	Provider	Voucher value	Additional payment	Form	Budget 2008
Education support for families with more than two children	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Families with more than 2 children whose income is less than the average worker's (for children under 4)	Public child care and education facilities or government-approved child care and education facilities	84,000~186,000 won	Yes	Implicit	47,926
Total							807,851

Source: "Childcare Programs 2008" (2008), Ministry of Gender Equality

(3) Education Voucher

The education voucher system is intended to provide public fund (tax money) to parents of students to enable their children to select any schools (public or private) of their choice. In case of Korea, the voucher program was introduced for the "after school" education program in order to honor education opportunity and human rights of children from low income families. Currently, there are 5 sub-programs as listed in Table 2-3.

〈Table 3-3〉 Education voucher

(Units: million won, %)

Project name	Policy objective	Target group	Provider	Voucher value	Additional payment	Form	Budget 2008
Education support for children under 5	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Families with an income less than the average worker's	Public child care and education institutions and government-approved private child care and education institutions	- Private: 162,000 won/month - Public: 55,000 won/month	Yes	Implicit	16
Support for education expenses for children aged 3~4 who are from low-income families	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the	Families with an income less than the average worker's	Public child care and education institutions and government-approved private child care and education institutions	- Public 55,000/month - Private: 180,000 won/month for children aged 3; 162,000 won/month for children aged 4	Yes	Implicit	8

Project name	Policy objective	Target group	Provider	Voucher value	Additional payment	Form	Budget 2008
	labor market						
Support for education expenses for families with more than two children	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Families with more than two children whose income is less than the average worker's	Public child care and education institutions and government-approved private child care and education institutions	- Public: 55,000 won/month - Private: 90,000 won/month for children aged 3; 81,000 won/month for children aged	Yes	Implicit	2
Education support for young children with disabilities	- Child education service for low-income families - Level playing field for all children - Increase in women's participation in the labor market	Preschoolers in need of special education attending not special education institutions but public and private kindergartens	Public child care and education institutions and government-approved private child care and education institutions	- Public kindergarten: 90,000 won/month - Private kindergartens: 361,000 won/month			1,204
After school programs	- Realization of education welfare - Curbing expenses on their children's private extracurricular education - Communitization of schools	Children from families in receipt of Basic Social Security benefits (children aged between 6 and 17)	Public and private education institutions	Education programs for outside regular curriculum hours	-	Implicit	821
Total							2,051

Source: "Programs and Unit Projects 2008" (2008), Ministry of Education and Human Resources

(4) Other voucher programs

Other voucher programs include culture voucher, vocational training voucher, housing voucher and patriot voucher. The culture voucher was introduced to provide low income earners with an opportunity to have access to cultural affairs so as to prevent cultural alienation of low income group as well as to assist some artists who are suffering from the lack of clients by providing a large number of voucher audiences so that they can recoup at least part of investment costs to produce cultural products. Culture voucher was first introduced in 2005 and some Won 2 billion was allocated to culture voucher in 2008 budget. The vocational training voucher was introduced by the Ministry of Labor to provide vocational training at the training institutes recognized by the Ministry of Labor to the non-regular workers who are eligible for unemployment allowance by providing

them a card under which they are entitled to pay training fees worth Won 3 million during 5-year period with the annual maximum training cost not exceeding Won 1 million. (Source: National Assembly, Budget Office: "Analysis of the 2008 Budget, III, 2007"). Under the housing voucher introduced in 2005, the government provides housing voucher coupons to lessees in order to meet part of their rental costs as a part of housing stabilization program of the Ministry of Construction and Transport. Those who are eligible for housing voucher are those who are in receipt of Basic Livelihood Guaranty benefits and single-mother families. The service providers are the existing house owners who are renting out their houses and the Korea National Housing Corporation. The voucher amount will be the difference between market leasing amount and actual lease paid by the lessee. The patriot voucher was issued to the wounded war veterans and those suffering from the orange agent infected during the Vietnam War. The service providers are the LPG suppliers and the voucher holders are entitled to pay Won 240 (based on the 2006 gas price) less than market price whenever they buy LPG gas.

2. Feasibility and Limitation of Voucher System

The starting point of the voucher system was, in principle, the need to subsidize in consuming specific goods or services for specific policy target groups in the mind of policy makers. The logic behind paying with voucher, rather than cash, is based on the paternalism that such mode can maximize the benefits from house rental, consultation fees, child care and other care services. If such payment is paid in cash, there is no guaranty that the beneficiary household

would spend the cash for the intended purpose as household selects its consumption in a manner to maximize efficiency in its consumption portfolio. If consumers select voucher instead of cash in the case of food supply and if they select voucher instead of housing supply in kind, the power and rights of consumers will be greatly strengthened and the service delivery system will be changed into a consumer-led system. Moreover, since consumers will be in a position to determine service providers, the benefits from the voucher programs will be further increased, compared to the alternative method of direct service supply by government. By adopting the voucher system, the quality of service will be enhanced and the cost further reduced. Since consumers will be directly participating in voucher programs, the participation ratio would be raised and policy objective of voucher program could be achieved effectively.

On the other hand, certain industry can be reactivated through voucher program as the demand for the industry created through voucher program would lead to bigger market for the industry concerned. Another benefit of voucher system is that some non-profit organizations or religious organizations could be promoted as service providers in public service by the introduction of vouchers, by which some additional resources could be mobilized. The voucher system has been utilized by budget authority to control spending within the limited budget allocation as the voucher could be issued within certain upper limit. In this case, voucher is aimed to save cost within the budget allocation, though there could rise a situation in which demand for certain service increases as consumer would be given wider selection and subsidy for service became much clearer. Generally speaking, when the price of the service provided by

providers is higher than its market price, it is possible to use voucher system to limit costs within the budget and to enforce budget control.

When the government opts to use voucher and discontinues its direct service provision, there are some negative effects of voucher system, despite the merits of voucher system presented so far. First, there could incur additional administrative cost and regulations. It is possible that eligibility review for voucher system would be tightened and additional regulation and cost would be necessary to evaluate the quality of services, and to monitor disbursement progress. Secondly, it is possible that excessive competition based on massive marketing among many competitors may result in a distorted competition only rather than quality improvement for consumers and this may result in a multitude of small scale service providers. Thirdly, there may be other undesirable market distortions such as black marketing of vouchers, inefficiency caused by collusion between service providers and consumers, and even some discrimination of consumers of voucher and causing the sense of shame for consumers by stigma effect. Fourthly, if voucher system would be introduced under a circumstance where there are a sufficient number of providers, it will only create additional demand causing a rise in the price of service in the short run. Fifthly, even though it is generally accepted that voucher system is much more efficient than the direct government-provided service, there is no sufficient evaluation on the efficiency of voucher itself. For example, when the housing voucher was introduced, there was no sufficient study on whether a limited housing voucher would be more efficient than a much broader voucher (covering housing, food and cultural services) in serving consumers. In this respect, it is highly desirable to have a thorough

study during the stage of voucher design to enhance efficiency of vouchers.

3. Policy Measures for Enhancing Effect of Voucher Programs

(1) Setting Clear Policy Objective

The success of the voucher programs is closely related to their objectives. The objectives of the voucher programs are the promotion of consumption, promotion of consumer choice and freedom, inducement of completion among service providers and savings in budget. For example, when the government wants to encourage consumption of certain merit goods or services, food voucher and childcare voucher could be good means to achieve these objectives. In these cases, it is essential to establish the needs for promoting consumption of certain goods or services and the evidence that current demand for these goods or services is definitely not enough before issuing vouchers. On the other hand, voucher could be used to promote consumer rights to choose and to enhance the quality of services rendered. In these cases, it is necessary to undertake a thorough analysis of the market to ensure that environment is right to issue such vouchers.

(2) Thorough Knowledge on Consumer Characteristics, Market and Program Environment

In order to make voucher system more effective than the government's direct intervention or cash payment, it is necessary that government should have thorough understanding and knowledge on consumption characteristics of beneficiaries, market and program environment. In theory, the consumption of certain service of beneficiary is bigger than the level of voucher to be introduced by the government, and cash payment should be much better option than voucher system from the point of consumption promotion because cash payment involves the least loss of efficiency. In this case, voucher system can be justified on the ground of empowering consumers to choose among service providers, rather than on account of consumption promotion. When the supply of certain good or service is inelastic with respect to price in the market, the increase in demand arising from voucher may not increase market consumption but will increase market price. This phenomenon could happen when the supply is fixed in the short run. The good example of this case is the housing in which housing supply is restrictive and inelastic to price changes in the short run and increased demand for housing causes rise in housing price in the short run. In this case, direct supply of housing by the government could be more effective than the voucher system. For some markets where non-profit organizations can provide services much more effectively than private enterprises and when market is dictated by some monopolistic or oligopolistic service providers, the direct supply by public sector is much better than the voucher system. Consequently, policy makers should carefully review

the merit of the voucher system in order to ensure that the voucher system is the best option under the objective of the program and prevailing market environment before launching the voucher system.

(3) Analysis of Effects of Voucher System

Before introducing vouchers, the effect of voucher issue should be thoroughly evaluated so as to maximize its effect. For example, the effect of vouchers could vary depending on the supply and demand of the market. While the introduction of vouchers may not affect the consumption and market price at all, there could be cases in which both consumption and price increase. The effect of vouchers varies depending upon the market environment and the characteristics of consumers and service providers. Form the viewpoint of consumers, the effect of vouchers on demand would vary depending on the price elasticity and income elasticity of beneficiaries and non-beneficiaries. From the suppliers' viewpoint, the effect of vouchers on market price and consumption amount of certain goods and services varies depending on supply elasticity. Since the supply elasticity may be different for the short term and long term, the effect of vouchers on consumption level and price could be different in the short term and long term. Introduction of vouchers should be preceded by thorough understanding on characteristics of service providers and consumers and market environment.

(4) Proper Design of Voucher

Vouchers should be properly designed after the effect of vouchers has been fully analyzed and evaluated. For this purpose, it is

necessary to review some key issues such as the most effective eligibility requirements to achieve the voucher objectives, formula to determine the amount, possibility of cash conversion and marginal rate for encashment. For example, as the eligibility of beneficiary based on characteristics of individuals and households would influence the labor supply, we should pay attention to the economic attraction factors of voucher eligibility in determining target groups.

(5) Advanced Implementation Plan and Flexible Execution of Voucher Programs

As to the implementation and operation of the voucher program, it is required that detailed implementation plans for all players must be prepared in advance and these plans must be operated flexibly. The detailed implementation plans for the 3 key players, the government (central and local governments), consumers and service providers, should be prepared in advance together with operational procedures. It is also required to identify the possible issues through undertaking a pilot program. In case of child care voucher program, for example, a detailed operational manual to address various matters should be prepared. Some of potential issues on this care include whether child care provider could claim one day when a child is absent or left earlier, whether the care provider can claim the difference between market price and voucher price, if there is some, to parents, whether part time voucher should be issued and other detailed procedures and method of payments that would be encountered by service providers.

As to the government, there should be well conceived implementation plans that clearly spell out the division of work between central and local

governments, and which address all the possible issues to be encountered before launching of voucher program, including identification of beneficiaries and post evaluation of voucher program, and the feasibility of issuing multi-purpose vouchers (e.g. housing and food voucher?).

The introduction of uniform operational procedure for voucher programs is not practical and may be against the objectives of voucher programs since this may result in adverse effect on actual implementation of voucher. As the objectives of voucher are to provide consumers with broader power to choose service and to ensure more effective delivery of services, it is necessary to operate voucher flexibly without paying attention to its uniform format or method. It is also important to improve voucher system by incorporating feedbacks through undertaking periodic monitoring and post evaluation of its effect. For example, it may be impossible to manage effectively two different vouchers (e.g. housing and food vouchers) by applying the same criteria and objective.

(6) Encouragement of Competition among Service Providers

It is necessary to promote competition among service providers. For example, when a service provider enjoys monopolistic position in a market in isolated area, it is unlikely that the voucher program can be delivered effectively by this provider. In this case, the government should encourage competition among service providers by improving the system under which consumers in this isolated area should be given incentives to use the services of other providers in the nearby areas. A detailed plan to promote such competition must be prepared

in advance. The objective of promoting competition among service providers may be difficult to be successful if the share of voucher market is too small and negligible. Consequently, it is highly desirable to launch a voucher program with substantial market share so that this objective could be efficiently achieved.

(7) Appropriate Division of Functions between Central and Local Governments

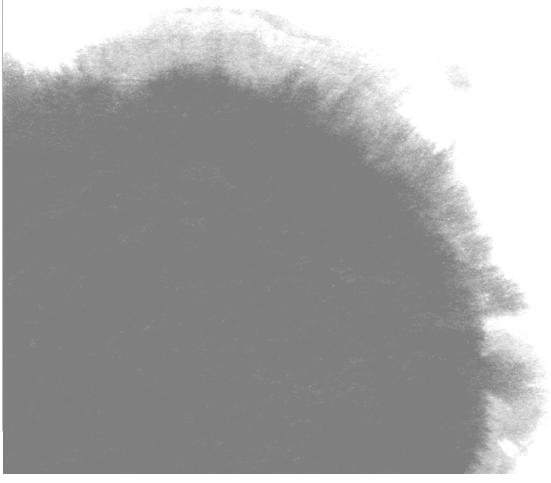
The appropriate division of work between central and local governments is essential. However, it is difficult to apply a uniform principle in determining such division of functions. If we learn from the experience of the United States, the federal government is responsible for deciding the overall magnitude and policy direction in the allocation of the voucher program. Once the voucher policy direction is established, the federal government would allocate funds to local governments to implement the voucher program. Thus, local governments will be responsible for executing the voucher program, including responsibility to determine the scope of beneficiaries, selection of service providers and reimbursement for its services and management of the voucher service quality. One of the most important functions of local governments is contract management. As all service provision and reimbursement for the services will be based on the contract, local government should have well qualified experts to manage contracts professionally and efficiently, unlike other public service provision. It is also necessary to have a mechanism to monitor the progress and evaluate impact of voucher operations as well as sophisticated IT network for computerized system network.

(8) Consolidated Management of Similar Voucher Programs

For some voucher programs which have similar characteristics, it is necessary to have a consolidated management system for their delivery system and eligibility requirements. Though voucher programs are composed of many programs in different fields and under different ministries, we could find some voucher programs that have similar characteristics. If voucher programs are managed individually, it will be very costly to manage because different ministries have different criteria for eligibility and different service delivery arrangement. Since the eligibility for voucher program requires a thorough survey on the income and property of eligible beneficiaries, it will be costly to undertake such a survey for every voucher program. Generally speaking, the voucher program that depends less on complex surveys could be more efficiently managed. In the advanced countries with the well developed voucher system, there are cases of consolidated management of similar voucher programs attempted to minimize the costs of income or asset surveys by undertaking joint surveys and to enhance operational efficiency. The current voucher system we are planning is expected to incur quite high administrative costs in its initiation and monitoring the progress, it is desirable to establish an efficient management system and delivery system.

04

Policy Measures for Stable Operation of Health Insurance Financing



Chapter 4 Policy Measures for Stable Operation of Health Insurance Financing

1. Introduction

The National Health Insurance has run huge deficits during early 2000s, though it started to make surplus in 2004. In 2007, the National Health Insurance ran a huge surplus of Won 2.7 trillion. Despite the financial success of the health insurance, it has been subject to criticism that it has failed to provide sufficient social protection as a social safety net. This criticism is still prevailing and the issue of weak social protection became one of the issues in the ongoing debate on the health insurance. As a matter of fact, the coverage ratio of the health insurance was very low when the universal health insurance was launched in 1989. Since then, the gross expenditure of health insurance benefits has increased substantially, but the coverage ratio remains very low because the expenditure on non-covered items such as new medical technology equipment and high-price drugs has increased much more rapidly than the insurance benefit expenditure.

Since the coverage ratio of the health insurance is closely related to the financial stability of the health insurance, any attempt to raise the coverage ratio is constrained by the financial situation of the health insurance. Even though expanded coverage of the health

insurance is highly desirable, it requires a very substantial resource mobilization that may endanger the very financial stability of the health insurance. Therefore, the key issues and tasks for the health insurance is how the large amount of financial resources could be financed without undue constraints to the stability of the health insurance. Another critical policy issue is the efficient allocation of limited resources through a sound benefit expenditure management system.

2. Current Status of Health Insurance Finance

1. Recent Financial Positions

Policy Measures for Stable Operation of Health Insurance Finance

The total magnitude of health insurance finance increased rapidly from Won 10 trillion when it was first launched to Won 26 trillion in 2008. The rapid expansion of the financial magnitude of the health insurance could be attributed to the huge financial resources required after the separation of prescribing and dispensing, rapid rise in consultation fees and prescription fees, increased frequency of hospital visits, rapidly aging population structure and rapid increase in hospitals. Due to the budget deficits, there were a series of financial stabilization measures (Ministry of Health and Welfare, 2002) and this resulted in surplus of Won75.7 billion in health insurance finance in 2005. Since then, health insurance finance recorded some surpluses consistently and the accumulated surplus was estimated to be Won 2.7 trillion in 2008(Table 3-1).

〈Table 4-1〉 Health Insurance finance

(Unit: hundred million won)

		2004	2005	2006	2007	2008
Revenue	Total	174,667	194,084	210,911	223,878	252,697
	Premiums	140,428	159,254	173,963	185,516	215,979
	National subsidies	27,792	28,567	27,695	28,698	27,042
	Cigarette tax income	6,263	9,253	9,664	9,676	10,753
Expenditure	Total	159,724	173,297	199,800	224,625	255,544
	Insurance benefit payment	148,935	162,645	183,936	214,893	245,614
	Management	6,341	6,930	7,589	8,968	9,734
	Other expenditure	4,448	3,721	8,275	764	196
Accumulative revenue		757	12,249	11,798	8,951	27,168

Note: Figures for the year 2008 are the estimates of the National Health Insurance Corporation.
Source: 1) Health Insurance Statistics Yearbook (2008), National Health Insurance Corporation
2) Financial Projection (2008), National Health Insurance Corporation

2. Premium Revenues and Benefit Expenditures

The stable financial position of the health insurance in recent years could be attributable to the rapid increase in revenues from premiums and decline in benefit payments. During 2002-2003 when the financial position of the health insurance were experiencing a large deficit, the growth rates of revenues recorded high growth rates of 23.4% and 25.7%, respectively, while the revenue growth rates since 2004, when the financial positions of the health insurance had been stabilized, remained steady by recording an annual growth rate of 13.0% during 5 year period of 2004-2008. During the same 5 year period, benefit payments recorded an annual growth rate of 13.6%, implying a potential financial crisis could occur any time. This is why a strong benefit payment control mechanism should be in place for the health insurance. One of the noteworthy facts was that actual

revenues grew much higher than the official premium increase rate because of the salary increases, increase in number of beneficiaries and the improved collection ratio.

3. Government Support

One of the important policies that affect health insurance finance directly and indirectly is the government support which was equivalent to 16.9% of total revenues and 15.4% of total financial expenditures of the health insurance in 2008. Government supports have grown steadily, especially after 2002 when the government decided to transfer Won 1 trillion every year from tobacco revenue account to health insurance finance. Since 2004, the government support remains virtually unchanged and it accounted for less than 20% of premium revenues in 2008.

4. Administration and Management Costs

Since 2000 when the management system of health insurance was consolidated by merging multiple payer system to a single payer system, the administrative and management costs of the health insurance have been very efficiently controlled and their share in total expenditures have remained at 3.8%-4.0% level. At this low level, these costs do not pose a threat to the health insurance finance.

3. Basic Direction of Financial Stabilization Policy

1. Basis of Financial Stabilization Policy

The basis for the policy to maintain stable financial position of the health insurance should be to control the level of benefit payments at a reasonable predicted level while to pursue a stable mobilization of financial resources at the same time. As to the expenditure side, it is desirable to introduce a global budget approach instead of the current practice of allowing different fees for different medical services. As to the financing, it is desirable that all pertinent issues related to the health insurance such as the upward adjustment of premium (method, scope and conditions for raising premium) should be clearly provided in legislation. By adopting the structural approach so far described, all pertinent contents on financial mobilization and benefit expenditures of health insurance must be provided in law after obtaining social consensus on these conditions. In this manner, whenever there would be any need to raise premium, this can be achieved in accordance with the legal provisions in the law so as to prevent any social conflict and social consensus.

2. Priorities of Financial Stabilization Policy

Financial stabilization policies can be broadly broken into benefit expenditure management policy, resource replenishment policy and social environment promotion policy, of which the highest priority should be accorded to the benefit expenditure policy. The second priority policy would be resource replenishment and the last priority

would be given to social consensus promotion. The most urgent issues in benefit expenditure policy are the reform in benefit payment method and the reduction of drug cost. The core of benefit payment method reform would be the introduction of the global budget system which provides the pre-determined upper limit of treatment costs so as to limit medical costs within affordable range. The reduction of drug cost would be an effective control of both price and quantity of drugs to be provided. The key objective of drug cost reduction policy is to make the drug pricing process transparent by encouraging the participation of concerned government officials and related experts while excluding the participation of other stakeholders such as practicing doctors and pharmacists.

Another high priority issues include control of medical facilities and manpower, decreasing medical fees system, prevention of malpractice of excessive charging of fees, empowering of insurers as buyer, introduction of electronic cards for medical fees, expansion of subsidies from national budget, expansion of public hospitals and institutionalization of social consensus.

3. Improvement of Medical Service Delivery System

In the case of Korea, the medical service delivery system is seriously flawed in terms of efficiency and equality as demonstrated by the facts that over 90% of medical services are provided by profit-oriented private medical providers, the resource allocation of medical manpower is not governed by market forces, there are no clear division of work among the primary, secondary and tertiary medical providers with the distorted result that some 70% of medical

services are being provided by hospitals while only 30% of medical services are being provided by many medical clinics. There is an urgent need to reform this delivery system to make primary medical service providers mainly work for out-patients and secondary and tertiary service providers work mainly for inpatients.

4. Policy Instruments for Financial Stabilization

1. Securing Stable Flow of Financial Revenues

(1) Improvement in Method of Premium Determination

The premium should be determined on the basis of formula which should be legally specified. In the process of deciding a premium formula, the capacity to pay of the insured should be fully taken into account in principle. If we take this principle, we can take one example: (Increasing rate of premium) = (wage rate increase of workers) + (policy variable ranging 1-2%) (Note: Bong-min Yang et al., 2003). The reason for taking worker's wage rate as an argument in the formula is based on the logic that premium increase should be made within the worker's capacity to pay.

(2) Explicit Definition of Concept of Disease Causer Burden

It is highly desirable to charge those who cause diseases such as alcohol producers and air polluters, and use those charges as revenues for health insurance. For this purpose, we should explicitly define the concept of "disease causer's burden" charges and introduce new

charges with a justifiable logic and theoretical ground. Once this is done, we should prepare a strategy to obtain social consensus to impose such charges as part of health insurance revenues.

(3) Operational Strategy of Debt Financing

When we use debt financing to expand the coverage of the health insurance, this will bring a net benefit as a whole to the health insurance by decreasing social cost caused by reduced non-benefit payments, though there might be some political burden to carry out such debt financing. Since the strategy to use debt financing is predicated to present benefit expansion, it is a very effective policy since it will enhance the confidence level of general public on health insurance and facilitate to obtain national consensus to increase premium. It is clear that a deficit financing strategy within 10% of total health insurance financing will be very beneficial to extend benefits to all participants without causing undue financial strain to health insurance financing.

〈Table 4-2〉 Financing National Health Insurance

		Policy method	Policy measures
Revenue	Deficit finance	Accumulated deficits	Maintain deficits at certain levels
	Big-Bang	Policy responses on premium and benefit	Increase benefits and reduce premiums at the same time
	Premiums	Burden equity	Unify imposition system
		Automatic adjustment	Introduce premium determination formula
	National subsidies	Ex post setting-up	Ex post setting-up
	Causer liability (Disease liability)	Alcohol excise tax	Impose on alcohol products
		Air pollution excise tax	Impose on fossil fuel (petroleum companies)
Expenditure	Reform of the reimbursement system	Global budget	Implement global budget system in a stepwise manner

		Policy method	Policy measures
	Corporation's buyer function	Contract with long-term care institutions	Foster contracts between private long-term care institutions and the National Health Insurance Corporation
	Alternative treatment	Increase the use of low-cost treatment	Promote home care and hospice treatment
	Reform of the decision-making body	Improvement on expert committees	Increase the proportion of enrollees in the members of expert committees on service, medication, and treatment materials
	Fee for service	Conversion factor	Convert to posted-price system
		Relative value	Prohibit discretionary increase in fee for service
		Relative Value Commission	Increase the number of non-stakeholder members
		Type-based Charge System	Abolish type surcharge
	Fee for medication	Pharmaceutical price contract	Come into a new contract every year taking account of the sales volume
		Change in listed items	Apply the rules of economic estimation
		Improve transparency	Introduce the bar code system for pharmaceuticals; abolish wholesaler middlemanship
		Joint purchase	Allow the Health Insurance Corporation to carry out integrated purchases for national and public medical institutions
		Alternative human resources	Introduce "pharmacy dispenser" system
	Expenditure on materials for treatment	Price contract system	Introduce Internet-based open bidding system
		Economic evaluation	Old and new prices
		Integrated purchase	Allow the Health Insurance Corporation to carry out integrated purchases for national and public medical institutions

2. Effective Management of Financial Expenditures

(1) Reform of Payment and Compensation System

The global budget system should preferably be introduced first to the oriental medicine sector whose share in total medical insurance is the smallest, followed by dental medicine, medical clinics and hospitals. The DRG payment system, which is being introduced as

optional, should be discontinued since it is obviously a failure. Since the introduction of the DRG payment system, the number of treatments and the costs of medical services increased by 2 to 3 times for 5 diseases, except for child delivery and appendectomy, because patients avoided the DRG system and chose to use low cost medical facilities since the DRG was not a compulsory but an optional system.

(2) Introduction of Buyer Function to the Insurer

The NHIC, as a single payer, can effectively control medical costs by discontinuing the automatic designation system of medical organizations and adopting a system in which patients can choose a medical facility they like and enter into a contract with it. The NHIC's function as a buyer can be more actively exercised for the purchase of treatment materials and drugs. As to the procurement of the national and public hospitals, it is desirable to introduce a procurement system under which NHIC procure all the requirements of public sector hospitals on their behalf and distribute to such hospitals. The current system of the medical service fees contract, under which NHIC had signed fees contract with 6 medical and pharmaceutical organizations, should be further sub-divided so much more detailed fees contracts can be made with general hospitals, large specialized hospitals, hospitals and rehabilitation centers. As to the patients of medical clinics, different fees contracts could be made for different specialists depending on the number of patients.

(3) Prevention of Financial Leakages

(ⅰ) Reactivation of Whistle Blower Compensation System

It was widely pointed out that there had been widespread false and baseless medical claims and that punishment for such claims had been too weak. In order to address this problem, it is necessary to impose a strong punishment system under which the violators must be subject to a penalty that will be many times bigger than the expected gains from false claims. Though there is now a whistle blower compensation system, its compensation level and conditions are not attractive enough to motivate "whistle blowers." In this regard, the current system must be substantially improved to provide strong incentives to potential whistle blowers by expanding the scope of whistle blowing, by increasing the penalties up to 30 times of punitive penalties and by raising the compensation amount up to 50% of the punitive penalty.

(ⅱ) Issuance of Electronic Card in lieu of Health Insurance Certificate

It is necessary to change the currently used health insurance certificate to an electronic card in order to enhance management efficiency, prevent the forging of prescription and to firm up the basis of insurance management. Given Korea's internet technology, the issuance of electronic cards encompassing and interconnecting in real time all medical institutions in Korea, NHIC and the Health Insurance Review and Assessment Service (HIRA) can be completed at any time if there is political will to undertake such endeavor.

(ⅲ) Integrated Review of Medical Fees

At present, the reviews of medical costs are undertaken separately

by the health insurance, car insurance and industrial accident insurance. In order to prevent excessive payment and double payments, it is necessary to integrate all reviews on medical fees and it should be exclusively carried out by NHIC only. This integration will ensure quality medical service for the general public and it will be beneficial to service providers in that it reduces administration costs by simplifying administrative procedures.

(ⅳ) Continued Implementation of Drug Cost Reduction Program

Since 2007, the government had been implementing a de-listing policy from NHIC designated drug list for some drugs that are deemed to be not competitive after an economic feasibility study. This de-listing policy should be implemented as planned. It is also necessary to change institutional arrangement in order to carry out a drug price review more transparently and to eliminate the role of vested interest groups in drug pricing determination process.

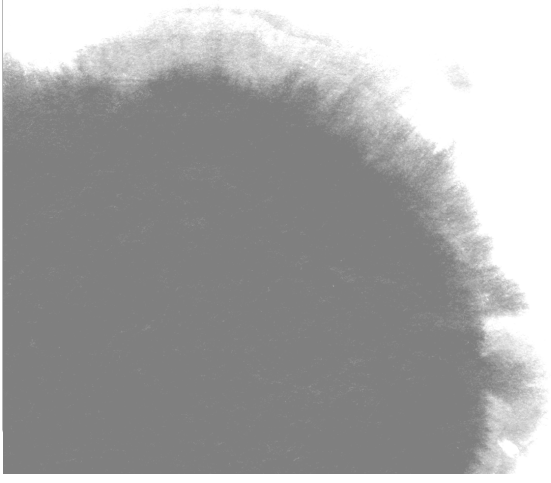
(ⅴ) Improvement of Medical Service Fee Structure

The current differential premium medical fee structure should be applicable only when such differentiated medical services are justified. In the case where such special service is not justified, the premium fee should not be applicable but a reduced fee should be applied. For example, if primary medical facility provides primary service, then the primary medical fee schedule should be applied. When tertiary medical facility provides primary medical service, then the fee applicable to this case would be a discounted fee, not a premium fee so as to discourage them to provide primary medical services.

KIHASA

05

Blueprint and Road Map for Modernizing Korea's Sustainable Health Insurance System



Chapter 5 Blueprint and Road Map for Modernizing Korea's Sustainable Health Insurance System

1. Introduction

The status of the Korean health insurance in 2007, when it celebrated its 30 years operation, can be summarized as follows: The health insurance in Korea was initiated with the 3 characteristics of low premium, low coverage ratio and low medical cost. After 30 years of operation, the average coverage ratio of the health insurance was estimated to be 64.3% in 2007 with annual deficits of Won 284.7 billion and the average premium contribution rate of workplace participants was 4.77% compared with the OECD average of around 10%. The government subsidy for the health insurance amounted to Won 3,671.8 billion and KHIC's current management cost amounted to Won 973.4 billion in 2007.

The health insurance system in Korea calls for a new paradigm shift to meet the rising need in today's rapidly changing socioeconomic environment. The country has greatly changed from the way it was in 1977, when the health insurance was first introduced.

In this regard, the purpose of this Paper is to present a new direction of the health insurance policy in Korea with a new health insurance framework that can address the aging population of Korea.

Since a serious reform in the health insurance in Korea is needed in order to improve it and make it more sustainable, the health insurance reform would encompass the enhancement of its equity and efficiency, financial stabilization, reduced risk in household medical costs and provision of satisfactory coverage.

2. Analysis of the Current Status of the Health Insurance in Korea

Since the integration of the health insurance of Korea was completed in 2000, the financial status of the health insurance was unstable in its early years when the gross revenues, including government subsidies, were less than gross spending. The financial deficits of the health insurance reached their peak in 2001, when the aftermath of the 1997 financial crisis was still strong. Thanks to the government's financial stabilization policy initiated in 2002, the financial deficits of the health insurance started to reduce in 2002. Consequently, the health insurance recorded the largest surplus in its history in 2004.

However, as the government started to implement a generous improvement in coverage expansion program in 2005 in accordance with its Health Insurance Coverage Enhancement road map, the financial status of the health insurance started to deteriorate in 2006 with the resulting deficit of Won 74.7 billion, which was further widened to a deficit of Won 284.7 billion in 2007. As the financial deficits of the health insurance continued during 2005 and 2006, the Health Insurance Reserve Fund of Won 1 trillion was reduced to Won 895.1 billion in 2007 as a result of deficits drawdown in the Fund.

The administration cost of the health insurance had been rising since 2003 from the lowest administration cost of 2002, though the pace of growth was somewhat modest until 2006. In 2007, administration cost of the health insurance rose faster.

The total cost of medical services, including the cost of drugs, had increased rapidly by almost 2.5 times during 2000-2007 from Won 13 trillion in 2000 to Won 32 trillion in 2007, posting an annual growth rate of 14%. The cost of medical consultation and treatment also rose rapidly (by 2.7 times) during this period from Won 8.8 trillion in 2000 to Won 24 trillion in 2007, registering an annual growth rate of 15.4%. Since the integration of medical and pharmaceutical services were carried out on July 1, 2000, the upward adjustments of medical service cost were carried out 5 times during 2007. During 2003 and 2004, however, the medical service fees grew by 2% annually which was less than the changes in consumer price index (CPI). During 2005-2007, the cost of medical services rose faster than the changes in CPI. In the case of hospitalization cost, it grew by an annual rate of 4.4% during 2000-2006, but it grew rapidly by 10.2% in 2007. In the case of out-patient services, the medical service cost grew modestly by 1.5% per annum during 2000-2006, but the cost of medical services for outpatients declined in 2007 by 15.6% over the preceding year.

The number of patient visit to medical service providers increased steadily over the 7-year period of 2000-2007 by 6.9% per annum for hospitalized patients and by 6.1% per annum for out-patients, respectively. In 2007, the number of out-patient visits increased rapidly by 28.2% over that of 2006.

The substantial increase in medical service cost and premium can

be explained partly by the increase in medical service fees and increasing patient visits, but also partly by the rapid increase in medical service spending for the elderly population. The share of the elderly population in total medical expenditure increased considerably from 17.4% to 28.2% in 2007 while the elderly population accounted for only 9.17% of the total population in 2007.

The medical services for the elderly population accounted for substantial portion of total medical service expenditures in 2007: the elderly population accounted for 36.4% of total hospitalized medical service costs, 38.6% of total hospital visits and 35.4% of total consultation-days, respectively. These figures were much higher compared to those of 2005. The elderly patients suffering from chronic diseases had been causing substantial pressure for limited hospital beds.

The main cause of substantial increase in medical service expenditure in recent years has been the continued expansion of insurance coverage undertaken by the government since 2005 as part of its policy to enhance coverage in the health insurance. Another important factor that contributed to rapid increase in medical service cost was the various benefits (including exemptions and food benefits) applicable for the elderly over 65 years that encouraged frequent visits and hospitalization of elderly patients.

The fast increase in medical expenditures can be partly attributable to the structural changes in disease types, i.e., the increasing share of chronic diseases as well as the increasing share of out-patients.

The frequent increases in medical service fees (medical service fees were adjusted upwards during one year time period around 2000) led to the financial crisis of KHIC in 2001. The recent increase in medical service fees is expected to affect the unit hospitalization cost substantially.

Lastly, the steady increase in medical service supply (number of medical service providers, hospital beds and medical practitioners) contributed to the increase in medical benefit expenditures of the health insurance.

3. Problems of the Health Insurance System in Korea

The major problems faced by the health insurance in Korea are summarized as follows:

1. Increasing Premium Burden and Inequitable Burden Sharing between Workplace and Regional Members

The premium contribution burden by workplace participants and regional (area) participants became a serious issue. When the health insurance was first launched, there was reasonable balance between these two groups but the annual growth of one group was 2.5 times higher than that of other group, thereby creating a serious inequity in premium burden.

2. Inequitable Premium Determination Procedures

So far as the dual system of premium determination procedures for workplace participants and area participants would be maintained, there exists structural inequity embedded in the system in which workplace participants tend to unfairly assume too heavy premium burden. Since the wage rate of workplace participants, which is the

basis for premium adjustment, tends to rise higher than the rise in property value of the area, which is the basis for premium determination of area participants, there is built-in inequity in premium burden sharing between workplace participants and regional members. There is also an inherent inequity problem within the premium determination process itself.

3. Continued Increase in Budget Support

The budget support for the health insurance is expected to increase for some time with the expansion of insurance coverage, though there is some serious concern how far and how much budget support should be maintained for the health insurance.

4. Increase in Drug Costs

The cost of drugs amounted to Won 7,329 billion in 2005 which was equivalent to 29.1% of total medical service costs. Since then, the cost of drugs had been increasing rapidly by 15% per annum while the total cost of medical services rose modestly by 8 % per annum. This rapid increase in drug cost is attributable to the substantial increase in drug consumption to address the increased demand for elderly and severe patients (increased prescription days and higher drug cost per day), increased share of high priced and newly marketed drugs and the lack of effective post monitoring system for drug consumption. When the government introduced a new policy to maintain reasonable drug cost measures in 2007, the total cost for drugs rose somewhat modestly by 10.7%.

5. Inefficient Management and Operation System of the Health Insurance

At the end of 2007, some 47.8 million participants were managed by a single public corporation, the Korea Health Insurance Corporation (KHIC). The inefficiency arising from this monopolistic nature of KHIC is considered as one of the main problems of the health insurance in Korea. Given the fact that so many participants are scattered all over the country, it is very difficult to manage them by a single corporation efficiently and it is even harder to prevent excessive faulty medical claims caused by moral hazard of some participants. As premium adjustment is carried out on a national scale, it is facing formidable political opposition in raising premium. Moreover, since the main function of KHIC is to send out invoices and collect premium, there is no incentive to pay closer attention to sound financial management. This is further aggravated by the political appointment of top management of KHIC (Chairman) who is usually a seasoned politician but not a financial manager. Moreover, personnel management of KHIC for important positions like branch managers and head of operating departments were done on the basis of other consideration than the capacity to manage financing. This lack of incentive for sound financial management of KHIC is pointed out as another important problem facing KHIC.

6. Concern on Sustainability of the Health Insurance Caused by Aging Population and Low Fertility

It is projected that Korea would be an aged population society by 2018 and that medical service cost for elderly population may account

for more than 40% by then. If the low fertility trend is assumed to be continued, there is a grave concern on the sustainability of supporting increasing elderly population by declining members of the health insurance system and whether the current KHIC structure based on premium revenues can be sustained under such an environment.

7. Uniform Government Regulation and Restriction of Consumer Choice

Since government intervention on the health insurance has been uniform regulation, it is quite doubtful whether such regulation could manage such a complex market like health insurance and medical service with enhanced efficiency.

Since KHIC is offering a uniform benefit package to all members who are forced to accept such benefits without choice, this may lower the interest of the general public on the health insurance.

Since the current health insurance and medical service systems are legally organized around the service providers and insurance corporation as the key players without proper attention to consumers aspiration that has caused inefficiency in the system, this overall framework should be restructured into a new system in which consumers (not providers) will take center stage and consumer choice would be respected.

4. Blueprint for an Advanced Health Insurance System for Korea

As the Korean society is expected to be an aging society by 2018, the health insurance system in Korea should go through a paradigm

change so as to be reborn as a sustainable health insurance system to better serve the changed clients. Based on the experiences of advanced countries, the Paper presents the major content of reforms which are broken down into various stages of reforms such as reforms at the stage of readjustment of the health insurance system, financial mobilization stage, the stage to enhance management efficiency of the insurer, the reforms required in the course of delivering resources from insurers to medical service providers and reforms needed at the stage of medical service provision.

1. Reforms at the Stage of Health Insurance Readjustment

It is necessary to diversify the financial mobilization of the health insurance which is currently depending on premium payment based on income as a means to stabilize financial position of the health insurance. Considering that many advanced western countries are pursuing an option of adopting a health insurance tax in lieu of premium revenues, and referring the Dekker Reform Plan of the Netherlands, I would like to propose the following reform in the financial resource mobilization method in the health insurance. I propose that about 50-70% of health insurance financing requirement should be met by the new Health Security Tax, which would be introduced and based on consumption. The remaining requirement of 30-50% of health financing should be met by the fixed amount premium to be collected by KHIC. Efficiency and equity of health insurance financing could be enhanced by adopting the proposed reforms. So far as the present dual premium system for workplace participants and area participants remain unchanged, there will be

endless discussions of equity issues in premium payments and the only solution to this problem would be the introduction of the proposed consumption-based tax. Since the accurate assessment of household income, the root cause of all the problem of inequality, could not be undertaken in the near future, consumption-based tax should be the best alternative available to end the complaints of workplace participants.

The advantage of the proposed tax would be the stable revenues for the health insurance since it is based on stable consumption, enhanced equity and the savings in administration cost associated with undertaking income assessment and collection of premium from the self-employed area participants.

The remaining 30%-50% of financial requirements of the health insurance may be mobilized by the fixed per-capita premium which would be broken into 3-5 groups (stages) and to be collected by KHIC in order to achieve social solidarity, to enhance efficiency in collection and to prevent moral hazards on the part of insured participants. As we may find in the case of the Netherlands, if the consumers (insured participants) could be given a right to choose their insurers beyond their regional boundaries, the independent branch offices of KHIC may be able to compete among themselves to attract consumers by offering an attractive fixed premium.

It is also desirable to find additional sources of health insurance finance. One possible policy option is to increase the current health surcharge on tobacco. Another possible source is the imposition of similar health surcharges to alcohol products and fossil oil and to transfer additional resources from the surcharges to the health insurance.

2. Reform to Raise Efficiency of KHIC in Managing and Operating Insured Participants

In order to enhance efficiency of KHIC management and operation which are characterized as controlled entirely by head office and to redefine the functions of KHIC, the Paper would like to propose the following proposal:

First of all, it is recommended to delegate the authority and functions of the head office, including personnel and financing responsibilities, to local departments (since there are 227 branches, it is better to group several branches – say 2-3 branches into a local department) so as to enable local departments to carry out their business more responsively, as is being done in some advanced countries. The purpose of this proposal is to link collection of premium with payment of medical benefits so as to inject some sense of competition. The financial resources mobilized by local departments (premium revenues) and those collected by the head office (consumption tax) will be put into a fund managed by HQ while local departments would be rewarded by providing economic incentives and promotions if performed well. For the poorly performing local departments, some penalty could be imposed. Operating deficits of local departments could be offset by inter-departmental adjustment.

This proposed mode of operation could be efficiently functioned only if local departments are given full independent authority in premium collection, fund management, personnel management and post management of insurance payments.

3. Reforms at the Stage of Resource Delivery from Insurer to Medical Service Providers

It is generally accepted that the current system of fee-for-service payment method is not cost-effective. In this regard, it is worthwhile to change the payment method in order to raise efficiency at the stage of resource delivery from the insurer to medical service providers.

As an alternative, this Paper recommends to introduce on a gradual basis the Global Budget System for medical fees which has been proven to be effective by some advanced western countries including Germany so that a stable financial position of the health insurance could be maintained in the long run and the resource transfer procedure from the insurer to service providers could become more efficiently.

When the annual gross medical service contract would be signed between the insurer and the service providers association on an annual basis, like the case in Germany, the service provider association is responsible to distribute medical service fees among the service providers after thorough review of the claims from medical institutions. By adopting this method, excessive and faulty claims from some service providers could be prevented by cross checking by other service providers and the medical service cost could be ultimately reduced.

4. Reforms at the Stage of Medical Service Provision

In order to effectively address the rapidly aging population and increasing share of chronic disease patients, it is urgently necessary to organize the medical service providers association so that this providers association could be in a position to compete vis-à-vis with

the insurer in the health insurance market.

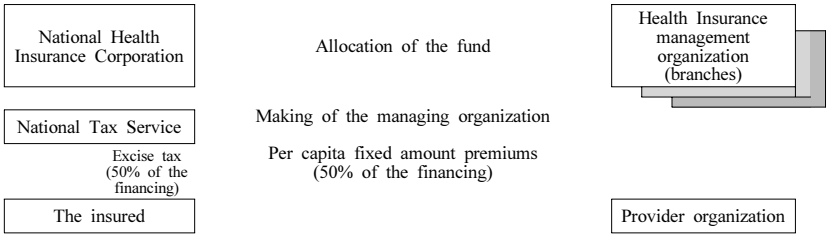
This recommended model is based on the Netherland model, in which the insurer and the service provider undertake managed competition through global contract and the Managed Care model such as HMO in the U.S. in which service providers compete with the branch of the insurer.

The service providers association means an integrated care organization that encompasses medical treatment, rehabilitation, long term care and hospice by integrating various medical organizations horizontally and vertically. This association is a service-oriented linkage system that could be organized by pharmacists, medical clinics, hospitals, large medical centers as well as by long term care providers. It is also possible to organize to comprise both oriental medicine and western medicine. The nature of these associations, whether it is a gate keeper or case manager, will be determined voluntarily by participating organizations.

5. Concluding Remark

The reforms so far described in the above section may be summarized in the following diagram.

Competition Model of the Health Insurance System



In this model, all the players (health insurance participants, medical service providers, and local insurance company departments) are competing: local branches of the insurance company are competing to attract as many participants as possible, while medical service providers are competing with local branches of the insurance company on the favorable payment terms. Every year, local branches of the insurance company have to decide contract terms with a service providers group on the basis of negotiated contract terms and the terms of contracts of other branches of the insurance company. Each participant of the health insurance will have freedom to choose service providers based on his/her own experience with service providers and also taking into account of an objective evaluation report prepared by the insurance company. The role of the head office of the health insurance is to manage 50% of financial resources of the company and to maintain social solidarity on a national scale. It also encourages and ensures that evaluation of medical service providers could be objectively done. The role of government is to provide supervision and oversight to ensure that fair competition rules be maintained among branches of the health insurance company and among service providers groups so that there would not be collusion between the group and service providers.

5. Conclusion

It is high time to consider serious reform of the health insurance system to make it an advanced and sustainable health insurance system since long time of one generation had lapsed after its inauguration.

For this purpose, it is desirable to pursue two objectives of

financial stabilization and palpable improvement of insurance coverage. It is time to mobilize every knowledge and wisdom to achieve the two seemingly contradictory objectives of equity and efficiency of health insurance reform.

06

Mid and Long Term Financial Projections of Health Insurance System(2009-2030)

Chapter 6 Mid and Long Term Financial Projections of the Health Insurance System(2009-2030)

The purpose of this Paper is to provide a financial projection of the health insurance up to the year 2030. Even though there had been various financial projections, most of them were severely limited in terms of the period covered (mostly short term covering 5 year period) or in terms of their purposes, resulting in quite different projections depending on the researchers.

The major difference between this Paper and other previous studies is that the medical cost estimate under this Paper was based on "total" medical service cost while most previous studies had taken medical cost as "medical cost reimbursed by an insurance company". In recent years, time series data on benefit payment data by insurance companies had shown a very unstable trend since the benefit coverage policy had been changed substantially and various items were either added or deleted. Consequently, if the recent volatility of benefit payment will be reflected in the estimation of long and mid term financial projections, the result of such estimation might be distorted. In this regard, the paper had taken the total medical cost which had shown stable time series trend in order to obtain efficient and statistically significant results.

The estimation model used in this Paper was the ARMA model. First, the monthly average per-capita medical cost and its trend were

analyzed by utilizing this model, and the average long term per-capita medical costs were forecast up to year 2030 based on the analysis of the past time series. Next, the ratio of population covered by health insurance to total population was extrapolated by applying the past ratio to the total population projected by the National Statistics Office (NSO). The total annual medical service cost was estimated by multiplying the annual average per-capita medical cost by the number of population to be covered by the health insurance. Once the total cost of medical service was estimated, the base line of the health insurance to be paid by KHIC was estimated by multiplying the average insurance coverage ratio (ratio covered by KHIC) of past 3 years to the total medical service cost. After the estimation of benefit base line, the base line of the total financial expenditure was estimated by assuming that relative magnitudes of benefit payment, administration costs and other expenditures of the past 3 years would be maintained.

Considering that the revenues of the health insurance were determined after the magnitude of financial expenditures were known so that proper level of revenue would be set to meet the required expenditures by raising insurance premium and adjustment in medical fees, detailed sector revenues had been estimated on the assumption of balance in revenue and expenditure. The composition shares of premium , budget support, tobacco charge and other income in total revenue were assumed to be maintained in the future revenue structure.

We have estimated the average medical cost by utilizing the analysis model, the results of which were quite satisfactory; the regression coefficients of all argument variables were found to be statistically significant, the correlation ratio (or sigma coefficient or R

square) adjusted by the degree of freedom was high at 90%, and the Durbin-Watson statistic was estimated at 1.04 showing stability of the model. Moreover, the results of the ARMA estimates were found to be stable as the values of both AR and MA stayed within the unit radical. In order to test serial correlation of the residuals from regression analysis, the Breusch-Godfrey statistic was estimated which showed that there was no autocorrelation and its test also confirmed the white noise nature in testing the normal distribution of residuals by showing F(2,77) values of 0.538 (p=0.586), 1.304 (=0.521). Based on these results of estimation, average per-capita medical costs were calculated up to year 2030. Likewise, the total annual medical service cost was calculated by multiplying the average annual medical cost by the number of population to be covered by the health insurance.

〈Table 6-1〉 Estimated Results of Average Per-capita Medical Cost Analysis Model

Explanatory variable	Estimated regression coefficient	t estimate	Relevancy[2)]
JAN	-96,095.740	-4.506	***
FEB	-98,433.440	-4.599	***
MAR	-96,734.760	-4.499	***
APR	-98,006.620	-4.559	***
MAY	-94,497.840	-4.400	***
JUN	-96,998.050	-4.526	***
JUL	-97,277.890	-4.536	***
AUG	-97,508.830	-4.539	***
SEP	-99,258.860	-4.639	***
OCT	-96,196.840	-4.511	***
NOV	-95,062.990	-4.481	***
DEC	-93,966.950	-4.425	***
CPI	1,425.526	6.805	***
AR(1)	0.936	16.067	***
MA(1)	-0.760	-6.333	***

Notes: 1) =0.91, =0.90, AIC = 19.12, SC = 19.53, D.W. = 1.94
2) ***, **, * denote statistical significant at 1 percent, 5 percent and 10 percent levels, respectively.

〈Table 6-2〉 Per capita average healthcare cost: projections

(Unit: won)

Year/ month	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1	61,829	66,319	70,812	75,305	79,799	84,293	88,788	93,282	97,776	102,270	106,765
2	60,123	64,613	69,106	73,599	78,093	82,587	87,082	91,576	96,070	100,564	105,059
3	62,921	67,411	71,904	76,397	80,891	85,386	89,880	94,374	98,869	103,363	107,857
4	61,994	66,484	70,977	75,471	79,965	84,459	88,953	93,447	97,942	102,436	106,930
5	65,708	70,199	74,692	79,185	83,679	88,173	92,668	97,162	101,656	106,151	110,645
6	63,237	67,728	72,221	76,714	81,208	85,703	90,197	94,691	99,186	103,680	108,174
7	63,397	67,888	72,381	76,875	81,369	85,863	90,358	94,852	99,346	103,840	108,335
8	63,709	68,200	72,693	77,187	81,681	86,175	90,670	95,164	99,658	104,153	108,647
9	62,460	66,951	71,445	75,938	80,433	84,927	89,421	93,915	98,410	102,904	107,398
10	65,391	69,883	74,376	78,870	83,364	87,858	92,352	96,847	101,341	105,835	110,330
11	66,105	70,597	75,090	79,584	84,078	88,573	93,067	97,561	102,056	106,550	111,044
12	67,643	72,136	76,629	81,123	85,617	90,111	94,606	99,100	103,594	108,089	112,583
Year/ month	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
1	111,259	115,753	120,248	124,742	129,236	133,731	138,225	142,719	147,214	151,708	156,202
2	109,553	114,047	118,542	123,036	127,530	132,025	136,519	141,013	145,508	150,002	154,496
3	112,351	116,846	121,340	125,834	130,329	134,823	139,317	143,812	148,306	152,800	157,295
4	111,425	115,919	120,413	124,908	129,402	133,896	138,391	142,885	147,379	151,874	156,368
5	115,139	119,634	124,128	128,622	133,117	137,611	142,105	146,600	151,094	155,588	160,083
6	112,669	117,163	121,657	126,152	130,646	135,140	139,635	144,129	148,623	153,118	157,612
7	112,829	117,323	121,818	126,312	130,806	135,301	139,795	144,289	148,784	153,278	157,772
8	113,141	117,636	122,130	126,624	131,119	135,613	140,107	144,602	149,096	153,590	158,085
9	111,893	116,387	120,881	125,376	129,870	134,364	138,859	143,353	147,847	152,342	156,836
10	114,824	119,318	123,813	128,307	132,801	137,296	141,790	146,284	150,779	155,273	159,767
11	115,539	120,033	124,527	129,022	133,516	138,010	142,505	146,999	151,493	155,988	160,482
12	117,077	121,572	126,066	130,560	135,055	139,549	144,043	148,538	153,032	157,526	162,021

During the 32 months period of January 2006 – August 2008, the average insurance coverage ratio (KHIC- paid cost / total cost) of KHIC was 73.7%. Assuming that this ratio to be maintained in the future, the health insurance benefit payment base line was estimated by multiplying 73.7% to total cost of medical service. In the case of the scenario 1, the base line was estimated by multiplying 75% to the total cost in the first year. It is also assumed that the insurance coverage ratio of 75% would be increased by 0.5% every year in the future. In the case of the scenario 2, the insurance coverage ratio was assumed to increase by 1% per annum. In order to understand the increase in the estimated value of insurance coverage ratio, the

corresponding amount of benefit payment was set aside for the analysis of this increased portion (CR 1%).

In general, financial revenue of the health insurance would be determined by the level of insurance premium that is, in turn, decided by the short term (1year) financial projection of KHIC. The level of budget subsidies and tobacco surcharge would be determined accordingly. Insurance premium for workplace participants would be determined by the level of their monthly salaries while that of area participants would be determined by the points (property ownership points as well as points of other economic activities). Since the current system of premium determination method had been subject to various criticism and complaints, it is expected that this method would be likely to change substantially. Accordingly, under the current environment in which there are constant changes and shifts of status from workplace to area participants and vice versa, it is very difficult to forecast the amount of premium revenue with some confidence level. Sometimes, this kind of forecast exercise becomes meaningless. Under this circumstance, we assumed that total revenue should be equal to total expenditure (balanced financing hypothesis) and the share composition of total revenue remains unchanged among premium revenue, budget subsidies and tobacco surcharge. Once total expenditure level would be determined, the magnitude and composition of revenues would be calculated by applying the historical composition of total revenues.

Long and medium term per-capita monthly medical costs were projected by using the time series model of per-capita medical cost which was applicable to the population covered by the health insurance. Based on the outcome of the projection, the amount of

insurance benefit payments were estimated as well as the total medium and long term financial expenditures broken down into details. Subsequently, total financial revenues required to meet the projected financial expenditures had been estimated together with detailed revenues under various headings on the assumption that total revenues and expenditures would be the same.

Presently, the financial management of the health insurance in Korea is facing a serious challenge and crisis arising from various factors. While the budget support remains insufficient, financial position of the health insurance should be dependent mainly on revenues from premium that could not be substantially increased due to the declining share of economically active population. Furthermore, increasing medical care cost for the elderly population is the grave barrier for the sound financial position of the health insurance. The global economic downturn has aggravated the financial status of the health insurance. It has narrowed the labor market for workplace workers who are the main source of premium revenue of the health insurance. As a further increase in premium rate would be very difficult under this circumstance, every effort should be done to diversify the revenue sources so as to achieve a stable revenue basis for the health insurance.

〈Table 6-3〉 National Health Insurance: Annual health care expenditure and benefit

(Unit: hundred million won)

Year	Per capita annual health care expenditure	Total population taken into account	Annual health care expenditure	Benefit level (CR) by scenario			
				Threshold $\overline{CR_t}$=75%	Scenario1 CR_{t-1}+Δ0.5%	Scenario 2 CR_{t-1}+Δ1%	Benefit of 1% of CR
2008	716,522	48,219,967	345,507	259,130	259,130	259,130	3,455
2009	764,515	48,447,183	370,386	277,790	279,642	281,493	3,704
2010	818,410	48,662,899	398,262	298,696	302,679	306,662	3,983
2011	872,325	48,865,561	426,267	319,700	326,094	332,488	4,263
2012	926,250	49,048,709	454,314	340,735	349,821	358,908	4,543
2013	980,178	49,162,816	481,883	361,412	373,460	385,507	4,819
2014	1,034,109	49,227,451	509,065	381,799	397,071	412,343	5,091
2015	1,088,040	49,277,094	536,155	402,116	420,881	439,647	5,362
2016	1,141,972	49,311,793	563,127	422,345	444,870	467,395	5,631
2017	1,195,904	49,332,392	589,968	442,476	469,024	495,573	5,900
2018	1,249,836	49,340,350	616,673	462,505	493,339	524,172	6,167
2019	1,303,768	49,337,991	643,253	482,440	517,818	553,197	6,433
2020	1,357,699	49,325,689	669,695	502,271	542,453	582,634	6,697
2021	1,411,631	49,299,993	695,934	521,951	567,186	612,422	6,959
2022	1,465,563	49,263,040	721,981	541,486	592,024	642,563	7,220
2023	1,519,495	49,219,121	747,882	560,912	617,003	673,094	7,479
2024	1,573,427	49,167,733	773,619	580,214	642,103	703,993	7,736
2025	1,627,359	49,107,949	799,163	599,372	667,301	735,230	7,992
2026	1,681,291	49,038,710	824,484	618,363	692,566	766,770	8,245
2027	1,735,223	48,958,603	849,541	637,156	717,862	798,569	8,495
2028	1,789,155	48,865,746	874,284	655,713	743,141	830,570	8,743
2029	1,843,087	48,758,260	898,657	673,993	768,352	862,711	8,987
2030	1,897,019	48,634,571	922,607	691,955	793,442	894,929	9,226

Note: Average benefit rate of 75% (reimbursement/total health cost) for a period of 32 months, between January 2006 and August 2008 was factored in.

〈Table 6-4〉 Mid- and long-term financial projections by sector

(Unit: Hundred million won)

	Health Insurance threshold benefit	Administration expenditure	Other expenditure	Total expenditure
% of expenditure[1)]	95.70%	4.10%	0.20%	100.00%
2008	259,130	11,102	542	270,773
2009	277,790	11,901	581	290,271
2010	298,696	12,797	624	312,118
2011	319,700	13,697	668	334,065
2012	340,735	14,598	712	356,045
2013	361,412	15,484	755	377,652
2014	381,799	16,357	798	398,954
2015	402,116	17,228	840	420,184
2016	422,345	18,094	883	441,322
2017	442,476	18,957	925	462,357
2018	462,505	19,815	967	483,286
2019	482,440	20,669	1,008	504,117
2020	502,271	21,518	1,050	524,839
2021	521,951	22,362	1,091	545,403

	Health Insurance threshold benefit	Administration expenditure	Other expenditure	Total expenditure
2022	541,486	23,198	1,132	565,816
2023	560,912	24,031	1,172	586,115
2024	580,214	24,858	1,213	606,284
2025	599,372	25,678	1,253	626,303
2026	618,363	26,492	1,292	646,147
2027	637,156	27,297	1,332	665,785
2028	655,713	28,092	1,370	685,176
2029	673,993	28,875	1,409	704,277
2030	691,955	29,645	1,446	723,046

Note: Average expenditures on individual sectorsare factors in (for the three years of 2005, 2006, and 2007).

〈Table 6-5〉 Mid- and long-term revenue projections by sector

(Unit: Hundred million won)

	Total revenue	Premium revenue	National subsidy	Tobacco excise	Other revenue
%	100.0%	85%	10%	4%	1%
2008	270,773	230,157	27,077	10,831	2,708
2009	290,271	246,731	29,027	11,611	2,903
2010	312,118	265,300	31,212	12,485	3,121
2011	334,065	283,955	33,406	13,363	3,341
2012	356,045	302,638	35,605	14,242	3,560
2013	377,652	321,004	37,765	15,106	3,777
2014	398,954	339,111	39,895	15,958	3,990
2015	420,184	357,156	42,018	16,807	4,202
2016	441,322	375,124	44,132	17,653	4,413
2017	462,357	393,004	46,236	18,494	4,624
2018	483,286	410,793	48,329	19,331	4,833
2019	504,117	428,499	50,412	20,165	5,041
2020	524,839	446,113	52,484	20,994	5,248
2021	545,403	463,593	54,540	21,816	5,454
2022	565,816	480,944	56,582	22,633	5,658
2023	586,115	498,197	58,611	23,445	5,861
2024	606,284	515,342	60,628	24,251	6,063
2025	626,303	532,358	62,630	25,052	6,263
2026	646,147	549,225	64,615	25,846	6,461
2027	665,785	565,917	66,578	26,631	6,658
2028	685,176	582,399	68,518	27,407	6,852
2029	704,277	598,635	70,428	28,171	7,043
2030	723,046	614,589	72,305	28,922	7,230

07

Financing of Medical Grants and Policy Issues

Chapter 7 Financing of Medical Grants and Policy Issues

1. Introduction

While the medical grant has an advantage over the health insurance in that the burden of medical cost in medical grant is so much smaller than that of the health insurance for the same medical service that many low income people can benefit from the medical grants, its major drawback is that financing of medical grants depends completely on the budgets of central and local government, causing serious budget burden to them. Another weakness of medical grants is that it is administered by local governments which do not have strong and experienced management expertise like the health insurance (KHIC).

The focus of the government policy on medical grants is placed on financial stability of the medical grant system. The Paper intends to review the characteristics and current status of the medical grant system with special attention to the financial aspect and would like to propose some policy direction to the medical grant system in order to make it a truly functioning medical security system for the low income group.

2. Financial Status of the Medical Grant System

The budget for medical grants for 2008 amounted to Won 3,516.1 billion which was equivalent to 30.2% of the total budget (Won 11,648.9 billion) of the Ministry of Health, Welfare and Family Affairs (MHWFA) and 51.3% of the budget earmarked for the Basic Livelihood Guaranty Program (Won 6,850.5 billion), respectively.

Current Financial Status of Medical Grants and Policy Issues

From the very beginning, the resources for medical grants came from the Medical Grant funds established at the central government and provincial/city governments. However, since the rules for sharing burden by local governments were revised in 2000, the smaller local governments at the level of basic local governments are now sharing some burden for financing medical grants.

〈Table 7-1〉 Cost Sharing for Medical Grant Fund between Central Government and Local Governments

		Seoul		Metropolitan cities		Provinces		
		Cities	Municipalities	Cities	Municipalities	Do	Si	Gun
1979	Local	50%	Not applicable	20%	Not applicable	20%	Not applicable	Not applicable
	National	50%		80%		80%		
	Total	100%		100%		100%		
After 2001	Local	50%	Not applicable	20%	Not applicable	14~16%	6%	4%
	National	50%		80%		80%		
	Total	100%		100%		100%		

Source: Won Seoup Yoo, 「Medical Aid: Its Achievements and Mid- and Long-term Improvement Plans」, 『Proceedings to the Medical Aid Thirtieth Year Anniversary Forum』, Ministry of Health and Welfare, Health Insurance Review Agency, Korea Health Resources Development Institute, 2007.

Since the subsidies for health insurance are classified under the budget heading of "health sector" under the Ministry of Health, Welfare and Family Affairs while medical grants are classified under the "social welfare sector" in the same Ministry, if a certain person is qualified for medical grant, it decreases the health budget while increases the social welfare at the same time. Consequently, a large increase in medical grant tends to increase social welfare budget as well as the basic livelihood guaranty program budget substantially.

Since the fees for medical services accounted for the largest share in medical grant spending in 2007, the management of medical cost at an appropriate level is one of the most important factors in financial stability of medical grant. As to the trend in medical service cost and characteristics in composition of medical service cost, the number of beneficiaries of medical grants were 1,852,714 persons at the end of 2007, which was equivalent to 3.9% of population covered by the health insurance (47,819,674 persons). The per-capita medical service cost for medical grant was, however, 3.37 times higher at Won 2,279,809 than that of the health insurance (Won677, 319) in 2007. However, when the medical service costs for the medical grants and health insurance would be compared for those who actually utilized the services, the unit cost for medical grant was 2.95 times higher than that of the health insurance.

〈Table 7-2〉 Comparison of Medical Service Fees between Medical Grant and Health Insurance (2007)

	Medical Aid(A)	Health Insurance(B)	A/B
Expenditure(in thousands)	4,223,834,242	32,389,193,040	0.130
Number of the population taken into account	1,852,714	47,819,674	0.039
Number of the population in receipt of health care service	1,943,182	43,938,501	0.044
Health care spending per capita (in won)	2,279,809	677,319	3.37
Health care spending per capita in receipt of service (in won)	2,173,669	737,148	2.95

Source: "Health Aid Statistics"(2008), Ministry of Health, Welfare, and Family Affairs, National Health Insurance Corporation, Health Insurance Review Agency

The discrepancy in total medical service costs are due to the fact that there were some beneficiaries who were not counted due to the transfer to the health insurance from medical grant and also because beneficiaries of medical grant tends to use medical services more frequently than the health insurance participants. Consequently, it is better to use per-capita medical service costs for the comparison of medical service costs between medical grant and the health insurance more correctly. The notable characteristics of changes in medical service cost of medical grant is that the pace of change as well as the scope of increase in medical grant were much higher than those of the health insurance. The increase rate of per-capita medical cost under medical grant rose by about 20% annually during 2004-2006, which was two times higher the growth rate of the health insurance, with the exception of 2007 when their growth rates reversed.

〈Table 7-3〉 Growth Rates of Medical Service Costs of Medical Grant and Health Insurance by Year

(unit:%)

Year	Medical Aid(A)		Health Insurance(B)		A/B	
	Health care spending	Per capita health care spending	Health care spending	Per capita health care spending	Per capita health care spending	Per capita health care spending
2003	9.0	11.1	10.1	8.6	0.9	1.3
2004	17.9	14.5	8.5	7.7	2.1	1.9
2005	23.8	8.9	10.5	9.4	2.3	0.9
2006	21.4	11.3	14.3	12.7	1.5	0.9
2007	7.6	4.3	14.0	12.6	0.5	0.3

Source: "Health Aid Statistics", "Health Insurance Statistics Yearbook", Ministry of Health, Welfare and Family Affairs, National Health Insurance Corporation

Since 2003, the medical service cost under medical grant rose much faster than that of the health insurance but the per-capita cost rose at a much slower pace than the health insurance since 2005. In case of 2007, it is noteworthy that the growth rate of the medical service cost as well as the per-capita medical cost under medical grant rose much slowly than those of the health insurance thanks to the introduction of partial payment for some patients under the medical grants (class 1 category) and the initiation of electronic monitoring of service utilization system. The slower increase in the medical cost can be partly attributable to the medical grant cases that the management system introduced in 2003.

The per-capita medical service costs are higher in medical grant than those of the health insurance for all age groups but the pattern of cost increases was quite different as beneficiaries became older.

The per-capita medical service cost in medical grant was 4 times more expensive than the health insurance in case of class 1 medical grant while it was 1.4 times more expensive for class 2 medical

grants. The costs of hospitalization, out-patient treatment and drugs under medical grants were also higher than those of the health insurance.

The differences in magnitudes of medical costs may be attributable primarily to the differences in demographic characteristics and public health characteristics of the medical grant beneficiaries and health insurance participants. Likewise, this difference may be partly attributable to the differences in utilization of medical facilities of beneficiaries and the treatment types offered by medical service providers, though there is no clear evidence to show such relations.

As to the types of diseases mostly affecting the beneficiaries of medical grants, mental diseases (schizophrenia, dementia, behavioral disorder caused by alcohol and depression), kidney failures, cancer (leukemia, lung cancer etc.) and diseases related to bones are the major diseases accounting for high shares of medical service cost in medical grant.

The coverage ratio of medical grant is much higher than that of the health insurance. While the coverage ratio under the health insurance remained low at 74.6% in 2007, the coverage ratio in medical grant was 97.8% (99.5% for the class 1 and 91.3% for the class 2, respectively), resulting in a coverage ratio differential of 23.2 percentage point.

3. Recent Changes in the Medical Grant System

Since July 1, 2007, the class 1 beneficiaries of medical grant, who had been exempted from paying any medical cost, were obliged to pay some part of the medical cost. It was estimated by the Ministry

of Health, Welfare and Family Affairs that some 270,000 class 1 beneficiaries of the medical grant started to pay some of the medical cost.

The healthy living maintenance support allowance was introduced from 1 July 2007 under which all class 1 beneficiaries of the medical grant had been paid a monthly allowance of Won 6,000. Every month, KHIC credits Won 6,000 allowance to hypothetical accounts of all class 1 medical grant beneficiaries and the partial payments obligations arising from medical service payment would be deducted from the hypothetical accounts once a year. If there is any balance in the hypothetical accounts, the Ministry of Health, Welfare and Family Affairs credits to the bank accounts of class 1 medical grant beneficiaries. As to the fund requirements for this healthy living support allowance, total amount of Won 50, 622 million would be needed (Won 6,000 monthly allowance for 703,088 class 1 medical grant beneficiaries). Since Won 33,748 million would be needed for paying partial payment cost for class 1 medical grant beneficiaries even in the absence of the allowance system, the net additional fund requirement arising from the allowance was estimated at Won 16, 874 million.

Another new system introduced in 2007 was the selective clinic system under which the medical grant beneficiaries (both class 1 & class 2) are allowed to select voluntarily their clinic. Under this system, the Medical Grant Review Committee could restrict clinic selection for some beneficiaries. As of December 2007, some 63,186 beneficiaries of the medical grant (55,724 class 1 beneficiaries and 7,462 class 2 beneficiaries) were elected to take this system (3.4% of total medical grant beneficiaries).

The problem of abuse of medical services by beneficiaries and excessive doctor's bill by some service providers had been chronic problems facing the medical grant system which had been widespread even before the rapid rise in medical service costs. In order to address these problems, the maximum cap on medical service dates was introduced on 1 January 2002. Despite the maximum cap on service dates, there are still continuing problems of excessive abuse of drugs and medical services in the medical grant system due mainly to the nature of Korea's medical service industry which is basically dictated by laisser-faire principle and the management problem of the medical grant administration which could not strictly monitor the maximum service dates effectively. Is it possible to take some supplementary actions so as to make maximum service date cap function effectively? The effective monitoring of the maximum service dates became possible with the introduction of the partial cost sharing for medical service fees and selection of clinic by beneficiaries introduced on July 1, 2007 as the "medical grant eligibility management system" initiated to implement these systems provide with detailed information on the dates of medical services in real time. The availability of this information enabled the medical grant administration to monitor the maximum service dates. Since the system does not provide information on drug prescription and uses, there is no systematic safeguard to prevent abuse of drug prescription. Nor is there any systematic safeguard against excessive medical treatment and abuse of drug consumption due to the lack of correct information on repeated medical treatment and repeated prescriptions. Quite a few beneficiaries of the medical grant are still exposed to the danger of abusive medical treatment.

4. Conclusion

The medical grant system, which was introduced in 1977 with the enactment of the Medical Protection Act, is now more than 30 years old. Despite many amendments made during this long period of time to improve this system as a truly functioning medical protection system for the low income group, the medical grant system is operating not so efficiently as expected by the poor group.

First, the size of beneficiaries needs to be expanded. Though the absolute poverty population exceeds 10% of the total population in Korea, the medical grant system covers only 4% of the population. This low coverage could be attributable to the lack of selection standards to select eligible beneficiaries other than the current beneficiaries of the Basic Livelihood Guaranty program who constitute majority of beneficiaries of the medical grant system at present. Furthermore, low coverage may be partly attributable to the lack of willingness on the part of government to provide additional financial resources for the medical grant.

There could be a heated debate on the issue of which system should be given higher priority, the medical grant system or health insurance, to promote medical protection for the poor. The medical grant is considered as the superior system since it provides the same medical benefit as the health insurance with much smaller cost sharing burden to poor beneficiaries since the cost bearing ratio in the medical grant is lower than that of the health insurance by 72-75% margin. Consequently, the medical grant can provide coverage for more beneficiaries with given financial resources than the health insurance, assuming other factors remain unchanged.

However, the possibility of abuse of medical services on the part of beneficiaries arising from low cost burden may be cited as a shortcoming of the medical grant system. As to the preferred selection for medical protection of the poor group, it is impossible to say which system is better than other systems because of lack of data and methodology to support such a decision. In this regard, further studies are needed to make a reasonable decision in the future.

Financial stability of the medical grant system could be improved substantially by the introduction of the maximum cap on medical service dates and the selection of clinic, which would enable to prevent abuse in medical services and drugs through an effective monitoring system, and the gradual transfer of chronic patients suffering from rare and chronic diseases to the health insurance. In October 2008, the Ministry of Health, Welfare and Family Affairs settled all accumulated accounts payable amounting to Won 247.7 billion acquired under the supplementary budget. The Ministry is further planning to transfer some beneficiaries of medical grant who are suffering from chronic diseases and who are less than 18 years in age to the health insurance so that there would not be any further unsettled accounts of medical costs. With the changes and additional funds so far secured, the financial position of the medical grant is now on the stable basis. Since the problems of the rapid increase in medical costs and resulting accumulation of unsettled accounts in the past could be attributable to the failure of the government's policy to expand eligible beneficiaries and to secure necessary budget, it calls for government's timely action to implement policy on coverage expansion and budget commitment.

The current medical grant system provides free medical services for class 1 beneficiaries who are suffering from simple diseases under the clinic selection system. This system may cause abusive use of medical services and may restrict the opportunity to provide better medical services to patients suffering from complex and severe diseases.

Apart from the important issue of the financial stability of the medical grant system, another important issue of the medical grant system is the quality of medical services received by the beneficiaries of the grant. It is highly likely that the beneficiaries are not receiving proper quality medical services due to the low cost paid, restriction in selection of medical service providers, lack of the evaluation system of medical service quality and low economic capability that characterize the beneficiaries of the medical grant. The effective and efficient operation of the medical grant system could be achieved only if it not only provides medical services and grants but also assures proper quality of medical services to its beneficiaries.