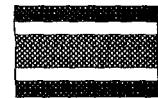




Health Insurance Systems: Korea and Thailand



Background

From November 14-17, 1993, a 10-member delegation from the Philippines visited Korea and Thailand to study the health insurance programs of these countries, derive lessons from their experience, and use these as inputs to the implementation of the Philippine National Health Insurance Act of 1995 which was recently passed into law.

The members of that delegation were Dr. Juan R. Nañagas (leader), Dr. Margarita Galon, Dr. Mariquita Mantala of DOH, Melinda Mercado of PMCC, Lydia Querijero of SSS, Consuelo Manansala of GSIS, Dr. Marilen Danguilan, Atty. Mafeo Vibal of the House Healthcom, Dr. James Jeffers and Emelina Almaro of HFDP, and Oscar Pizazo of USAID.

The experience and lessons learned during that visit are contained in this Technical Brief.

I. The Korean Health Insurance System

Korea's health insurance system, shown in *Chart 1* at right, is built on three principles:

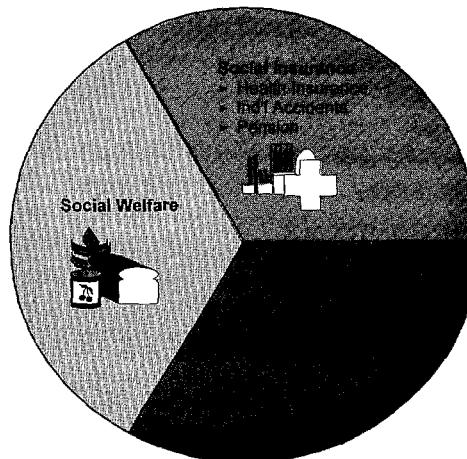
- Compulsory coverage;

- Income-based level of contributions;
- Levels of benefits are independent of premium contributions.

Korea succeeded in achieving universal health insurance coverage in just over a decade, with the passage of the Medical Insurance Law in 1963 when the economy was still tight, and its amendment in 1976 when the economy boomed. The system developed in a phased, voluntary, then compulsory

Chart 1.

Korean Social Security System



The Korean national health insurance system is one of three social programs, the other two being industrial accidents compensation insurance, and pensions. In turn, social insurance is one leg in the tripod of the social security system, the other two being social welfare and public assistance services.



"TECHNICAL BRIEF"

reports on the findings of research studies and their interpretations of implications for health policy. They also highlight information regarding important aspects of health policy based on conferences, research, policy speeches, demonstration and pilot project results, consultations, and public discussions.

"TECHNICAL BRIEF" draws attention to recent factual findings that have significant policy implications. It is meant to disseminate factual information and expressions of opinion bearing on policy and policy related issues to provide important information and to encourage the exchange of ideas, interpretation of facts and expressions of opinion among those interested in development and formulation of health policy in the Philippines.

This publication is issued under the general stewardship of the Health Finance Development Project (HFDP), Office of the Undersecretary, Chief of Staff, Department of Health under a Cooperative Agreement (contract no. 492-0446-C-00-2114-00) with US Agency for International Development. To assure uniform quality and appropriateness of content, the HFDP is assisted by the HFDP Information Communication Committee (InfoComm), and technical editors as appropriate. The views, expressions, and opinions contained in this publication are those of the authors' and are not necessarily endorsed by the USAID or the Department of Health.

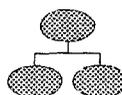
Mary Anne S. Barcelona
Issue Editor

Inquiries may be sent to:
Health Policy Development Staff (HPDS)
Department of Health
San Lazaro Compound
Manila, Philippines
TN: (632) 711-6744
Fax No: (632) 711-6812

Health Finance Development Project (HFDP)
20/F Makati Bldg.
6776 Ayala Avenue, Makati
Philippines
TN: (632) 817-4433
(632) 817-6297
Fax No: (632) 810-1761

manner and progressed with the establishment of insurance societies throughout the labor and employment sectors. It enjoyed the full support of the national leadership and the Ministry of Health and Social Affairs (MHSA).

Organization



The Korean health insurance system is structured along insurance societies which, altogether, comprise the National Federation of Medical Insurance (NFMI) established under the Medical Insurance Law. The NFMI guides the societies, reviews claims, manages a fund for the financial stability of the societies, runs medical and welfare facilities, and accredits medical institutions.

The NFMI reports to the Ministry of Health which issues overall policy guidelines. It is a very potent institution that is capable of enforcing policies over and across the societies. It consists of the groupings shown in Table 1.

Contributions



Contributions vary across societies. For industrial establishments and civil servants, the rate varies from 3 to 8% of standard monthly wages, half contributed by the employee and half by the employer. For private

school employees, the rate also varies from 3 to 8% of the standard monthly wages, half contributed by the employee, 20% by government, and 30% by the school owner. There is no government subsidy. For the self employed in urban and rural areas, total contribution equals fixed amount per household plus income related contribution plus property related contribution. Government contributes 50%.

Benefits & Restrictions



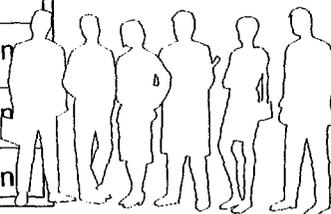
Benefits under the Korean Health Insurance System are in kind and in cash, statutory and voluntary. The Medical Insurance Act prescribes the basic set of statutory benefits.

Statutory in-kind benefits include diagnostics, treatment, in-patient hospitalization, out-patient hospital and clinic visits, drugs with or without prescriptions, dental care, nursing services, transfers, and deliveries. If these services are obtained in non-designated health care institutions, the insured is given statutory in-cash benefits to defray expenses.

Voluntary benefits include funeral expenses, delivery allowance, and compensatory grants when the insured's share of medical expenses exceeds

Table 1. Korean Societies By Groupings

Societies	Membership Coverage	No. of Members
Korea Medical Insurance Corp.	Civil Servants, private school employees+dependents	4.7 million
153 societies	Industrial workers+dependents	16.1 million
137 societies	Rural self-employed+dependents	5.6 million
130 societies	Urban self-employed+dependents	15.4 million
TOTAL COVERED		41.8 million



limits. Although the packages appear liberal, they are saddled by high co-payment rates.

Excluded from the service package are the following:

- * Room charges beyond allowed limits;
- * Direct visits to tertiary care hospitals without referrals from primary care physicians;
- * Maternity benefits after the second child;
- * Cosmetic surgery;
- * Expensive procedures (MRI, CT Scans, etc.)
- * Immunizations;
- * Injuries sustained in criminal acts and intentional accidents.

Provider Payment Systems



The Korean Health Insurance System adopts fee for service as the mode of payment for service providers, with specified co-payments from the insured. The levels of co-payments differ according to type of care, facility, location, and generally follow the following proportions to total costs: in-patient hospitalization (20%); hospital out-patient visits (40-60%); clinic and dental visits (30%); and

pharmacy products (30-60%).

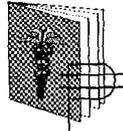
Health Service Provision



Medical care is provided mostly by private hospitals and doctors, and only on a limited scale by government facilities. Institutional providers are categorized into general hospitals, hospitals, and clinics. NMFI is empowered to designate qualified providers who are not allowed by law to refuse such designation.

Relatedly, in 1989, Korea introduced a nationwide patient referral system to ensure that patients see a primary care physician first before going to a specialist or hospital. The system divides the country into 140 First Service Regions, and 8 Second Service Regions. Within his First Service Region, a patient can go to any provider. From his region to another First Service Region, he needs a letter of referral. From any service region to a Second Service Region, he also needs a referral plus permission from his society.

Claims Review & Payment



The generic claims review and payment process is shown on Table 2.

Table 2
Claims Review & Payment Process

Industrial & urban self-employed	NFMI pays all claims filed by all medical care institutions.
Rural self-employed	NFMI pays all claims filed by special or general hospitals; the rural insurance societies pay 1-3 months deposit to NFMI. Non hospital claims are paid directly by societies.
Civil servants/private school employees	KMIC pays directly to medical care institutions.

The Medical Fees Review Committee at NFMI consisting of a central and local committees and 25 professional sub-committees, reviews all submitted claims against the Standard Unit Cost Document published by the health ministry. The reviews are exhaustive and backstopped by a Management Information System (MIS) with information on 25 medical specialties. Review and payments do not exceed 30 days.

Issues & Problems

Problems that continue to face Korea's health insurance system are:

- * **Moral hazard** - in spite of its universal

coverage, the system suffers from high utilization and medical cost inflation.

- * **Weak payment system** - low reimbursable fees force providers to exact high co-payment rates from patients, since RUV systems fail to reflect true economic costs of service provision.
- * **Government subsidy** - high government subsidy is equal to more than five (5) times the health budget and this has alarmed policymakers.
- * **Fragmented societies** - the societies argue over consolidation/non-consolidation.
- * **Weak preventive health programs** - are indicated by high utilization rates
- * **Alternative delivery mechanisms** - day care centers, geriatric facilities, ambulatory surgical units, nursing homes, home care, have been designed to reduce hospitalization.

2. The Thai Health Insurance System

Thailand's Security Act, passed in 1990, is the country's first comprehensive social security program, and comes at the tail end of various legislative measures to initiate such a system made as early as 1954. At present, the Thai health insurance system consists of the following independent programs:

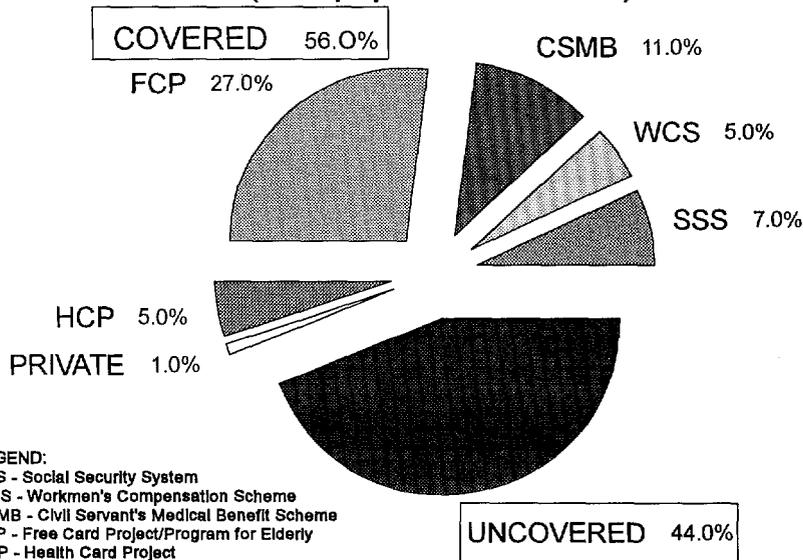
1. Social Security Scheme
2. Workmen's Compensation Scheme
3. Civil Servants' Medical Benefit Scheme
4. Free Card Project and Program for the Elderly
5. Health Card Project
6. Private health insurance

I. Social Security Scheme

Coverage

The scheme provides sickness, maternity, invalidity, and death benefits to workers. Currently,

Chart 2.
THAI HEALTH INSURANCE PROGRAMS
 (% of population covered)



LEGEND:
 SSS - Social Security System
 WCS - Workmen's Compensation Scheme
 CSMB - Civil Servant's Medical Benefit Scheme
 FCP - Free Card Project/Program for Elderly
 HCP - Health Card Project
 PRIVATE - Private Health Insurance

Chart 2 at left shows that Thailand's health insurance system is made up of various separate and independent insurance programs. Their respective coverages are shown.



of employers, employees and government. Each pays 1.6% of wages equivalent to Baht 225 from each of the three contributions.

Benefits

The scheme provides medical care and cash benefits under qualifying conditions. In

it covers only employed workers, excluding their dependents. By 1992, it was estimated to have covered 3.8 million or 7% of the population. The scheme covers enterprises with 20 or more workers, and will soon cover those with 10-19 workers. An enterprise is liable for contribution even if the number of employees fall below limits.

Administration

The scheme is administered by the Social Security Office under the Ministry of Labor and Welfare. The Social Security Fund sustains the program under guidelines set by the Ministry of Finance. The program operates on a capitation scheme.

Contribution

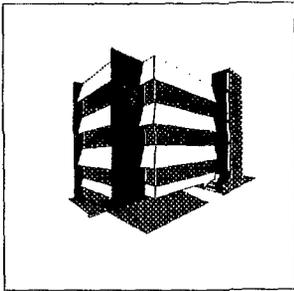
The scheme relies on the tripartite contributions

general, benefits include ambulatory care, inpatient hospitalization at public and private facilities, general practitioner and specialist care, ancillary services, medicines, medical appliances, and ambulance service. Excluded are psychogenic cases, drug addiction, long term care, hemodialysis, cosmetic surgery, experimental procedures, infertility treatments, biopsies for organ transplant, transsexual and reproductive procedures, recovery services, dental care and optical appliances.

Provider Payment System

The scheme adopts a capitation payment system with contracted hospitals to ensure fund security, cost containment, and administrative ease. The scheme pays hospital contractors a fixed capitation fee of B700 to cover subcontracts with lower level hospitals and providers. This amount is based on utilization rates of 2.2 outpatient visits a year and

hospitalization rates of .3 patient days a year. To qualify for capitation payments, hospital contractors are required to serve a minimum of 5,000 insured persons or a maximum of 50,000. Capitation fees are paid monthly, 75% in advance and 25% after three months.



Emergency / Expensive Cases

High cost medical services are paid on a fee for service basis. The insured may use any clinic or hospital and the scheme provides for partial reimbursement.

Maximum reimbursement rates for emergencies are: outpatient, B200 at a time, B400 per year; inpatient, B1,600 at a time, B3,200 per year; and surgery, B10,000 at a time.

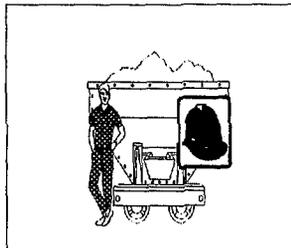
Use of Capitation Fees & Health Service Provision

Hospitals may use capitation fees at their discretion and may budget them according to the following MOPH allocation: 5% administrative fee, 5% nonmedical personnel, and 90% medical costs/personnel for all tertiary level facilities

2. Workmen's Compensation Scheme

Coverage

The scheme covers permanent workers of firms with 20 or more workers except civil servants and employees in



agriculture, fishery, forestry, state enterprises, and private schools.

Administration

The scheme is administered by the Social Security Office, thus, administrative costs are fully subsidized by the government. The fund is maintained separately from the Social Security Fund.

Contributions

Contributions, borne solely by the employer, range from 0.2 to 2.0% of the payroll. It varies according to industrial sector, occupational risk and claims experience. Contributions are assessed on earnings up to B120,000 per year.

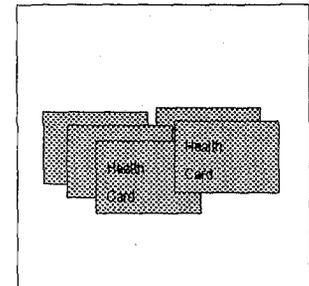
Benefits

Cover treatment expenses of up to B30,000 including all necessary medical, surgical and hospital services. Room and board is limited to B700 per day. The scheme also provides for rehabilitation expenses and acquisition of prosthetics. Other benefits include cash benefits for disabilities, survivor's pensions and death benefits.

3. Health Card Project

This project, set up in 1983 as a joint undertaking of the MOPH and the German Agency for Technical Cooperation (GTZ),

was first established as a pilot experiment of pre-paid health insurance in 18 villages and seven provinces. It was subsequently expanded in phases to cover every province.



Coverage

The program is now operational in 55 provinces with a total of 298,071 cardholders, covering about 5% of the population. The card entitles a maximum of four dependents.

Administration

Whereas the MOPH essentially establishes the general framework and overall guidelines for the operation of the village level funds, it allows local administrators to make decisions within this framework regarding card price, benefits and fund allocations.

Source of Funds

The project operates as a community financing scheme without tax subsidies. Card prices vary over the phases of project implementation, costing from B114 per maternal/child health card to B500

per family card.

Benefits & Restrictions

The project provides ambulatory and inpatient care at public facilities. The benefit package has evolved over the different phases of the project and includes essential health care services with a ceiling per episode of 5 times the card price in case of accident; it also includes plastic surgery, dental prosthesis and eyeglasses. The project restricts chronic diseases, heart conditions, cancer, self-acquired venereal disease, drug abuse and alcoholism.

4. Other schemes

The features of the other schemes are reflected in Table 3 below. These are the Civil Servants Medical Benefit Program, the Free Card and Program for the Elderly, and Private Health Insurance Plans.

Table 3: Other Schemes

<i>Scheme</i>	<i>Coverage</i>	<i>Administration</i>	<i>Fund Source</i>	<i>Benefits</i>	<i>Payment Mode</i>
4. Civil Servants Medical Benefit	Civil servants + dependents	Ministry of Finance	General Taxation	* Inpatient care * Ambulatory care * Preventive & promotive care * Annual exam	Fee for service reimbursement
5. Free Card & Elderly Projects	Low income groups & elderly (aged 60 years up)	Ministry of Public Health	MOPH & Taxation	* Inpatient care * Ambulatory care * Preventive & promotive care	Capitation to public service providers
6. Private health insurance	Rich households	For-profit companies	Premium payment	* Inpatient care * Ambulatory care	Fee for service to private service providers

1

Issues and Problems

Just as in Korea, there are certain problems which continue to be faced by Thailand's health insurance system. Briefly, they may be classified into:

High health expenditures - the high ratio of health expenditures to Gross National Product (GNP) has not exactly translated into better health status for the populations served.

Non-transparency and lack of controls - cause high utilization rates and cost escalations.

Capitation payments - need further refinement as rates were over-estimated.

Income as means test standard - caused leakages in the Free Card Project.

Recommendations

Various lessons can be learned from an observation of the health insurance systems of

Korea and Thailand. They are the following:

1. Any time is a good time as any to start a health insurance program.
2. Health insurance must be undertaken as part of an overall system-wide health care financing reform.
3. Health insurance must be managed with enough reserves for contingencies.
4. Government subsidies have a tendency to grow rapidly and lead to inequity.
5. Indemnity fee for service payment of providers engenders overutilization and cost escalation.
6. Capitation works.
7. Policy reform is as important as systems improvement.
8. Local initiative is not necessarily incompatible with central government authority to set standards.
9. Means testing is necessary for targetting, but income is not necessarily the best measure of a household's ability to pay.

Health Finance Development Project (HFDP)

**20/F Makati Bldg. Bldg.
6776 Ayala Avenue, Makati
Philippines**

TN: (632) 817-4433
(632) 817-6297
Fax No: (632) 810-1761

