Reform of the Medical Aid Program

Country: South Korea
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Health Policy Issues: Benefit Basket, Access

Current Process Stages

1. Abstract

In July 2007, the Government introduced big changes to reduce the rapidly increasing health expenditure of the Medical Aid program, which is public assistance in health care for the poor, covering about 3-4% of population. The reform introduced cost sharing for outpatient care, and a limit on the choice of health providers.

2. Purpose of health policy or idea

In July 2007, the Government introduced big changes in the Medical Aid program to reduce its rapidly increasing health expenditure. The Medical Aid program, as a public assistance in health care for the poor, covers about 3-4% of the population. It is funded by the government (80% from central government and 20% from local government). Type 1 Medicaid beneficiaries (57%) do not pay cost sharing, while type 2 (43%) beneficiaries pay the cost sharing comparable to that paid by the patients of (social) health insurance program.

One of the major changes is the introduction of cost sharing for outpatient care to reduce moral hazard. Another element of the reform is the introduction of a limit on the choice of health care providers. When the number of outpatient visits reaches the ceiling, patients are encouraged to use designated health providers by exempting them from the copayment. They can still choose other (not-designated) health providers, but with copayment. Because there are no gatekeepers in the Korean health care system, the above change based on financial incentives to use network providers can be an interesting policy experiment.

Main objectives

Health cost containment

Type of incentives

financial incentive (cost sharing)

Groups affected

Poor people
3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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4. Political and economic background

Health care cost inflation of the Medical Aid program is the major factor to make government consider the reform. From 2002 to 2006, the health expenditure of the Medical Aid program doubled.

5. Purpose and process analysis

<table>
<thead>
<tr>
<th>Idea</th>
<th>Pilot</th>
<th>Policy Paper</th>
<th>Legislation</th>
<th>Implementation</th>
<th>Evaluation</th>
<th>Change</th>
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Origins of health policy idea

The main idea of the reform is to introduce financial incentives (cost sharing) to reduce health care utilization and contain health expenditure of the Medical Aid program. The Ministry of Health and Welfare and the Ministry of Planning and Budget are strong supporters of the reform because the Medical Aid program is a tax-financed program and government is concerned about its ever-increasing health cost and budgetary burden. Progressive academics and civic groups are opposed to the introduction of a financial incentive for patients on the ground that the cost sharing will be a barrier to health care access of the poor.

Initiators of idea/main actors

- Government
- Civil Society

Approach of idea

The approach of the idea is described as: new:

Stakeholder positions

Opponents to the reform are worried that the introduction of cost sharing will reduce the utilization of medically necessary or essential services by the poor. The Government maintains that access to necessary care is not harmed because the reform also introduced safety net measures, such as ceilings on out-of-pocket payment (OOP) to all Medicaid beneficiaries and the exemption from OOP for pregnant women, persons below 18 years old,
A hotly debated issue is whether the high health expenditure of the Medical Aid program is due to moral hazard of beneficiaries or their worse health status. The number of outpatient visits per person in the Medical Aid program is 2.5 times greater than that for persons in the health insurance program, implying the existence of moral hazard to some extent. However, prevalence of chronic diseases of Medical Aid patients is twice that of health insurance patients, and the proportion of the elderly is 25% in Medical Aid beneficiaries while it is 8% for health insurance program. So, there is little consensus on why health expenditure is so high in the Medical Aid program.

**Actors and positions**

Description of actors and their positions

**Government**
- Ministry of Health and Welfare: very supportive
- Ministry of Planning and Budget: very supportive

**Civil Society**
- Progressive civic groups: very supportive

**Actors and influence**

Description of actors and their influence

**Government**
- Ministry of Health and Welfare: very strong
- Ministry of Planning and Budget: very strong

**Civil Society**
- Progressive civic groups: very strong

**Positions and Influences at a glance**

**Adoption and implementation**

Although progressive civic groups opposed to the policy change, strong will and power of the Ministry of Health and Welfare and the Ministry of Planning and Budget resulted in the implementation of the new policy.

**6. Expected outcome**

The expected effect of the Medical Aid reform (targeting the moral hazard of patients) is still uncertain because high health expenditure can result either from the absence of cost sharing or from the worse health status and greater health care needs of the Medical Aid patients. Since the government also introduced safety net measures to minimize the negative effect on access to care, the policy change is not expected to seriously harm access to medical care for the poor. A more comprehensive reform should include measures to minimize providers’ moral hazard, such as payment system change, because health utilization and expenditure can be influenced more by supply side than by demand side.

**Quality of Health Care Services**
- marginal
- fundamental
7. References

Sources of Information

www.mohw.go.kr (in Korean)


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