Social Protection in Action: Building social protection floors for all

Country Brief: The Republic of Korea

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Extending Social Health Protection in the Republic of Korea: Accelerating progress towards Universal Health Coverage

1. Introduction

The Republic of Korea is a high-income country with a population of approximately 51.71 million. The country has achieved excellent health outcomes, exceeding OECD averages. For example, in 2017, life expectancy reached an average of 82.7 compared to the OECD average of 80.7, and the infant mortality rate was 2.8 deaths per 1,000 births in 2017, exceeding the OECD average of 3.8. These achievements have been facilitated by a strong social health protection system, developed on the principles of universality, social inclusion and non-discrimination, in line with the ILO's ten social protection principles. Notably, the country achieved Universal Health Coverage (UHC) in 1989, just 12 years after mandatory National Health Insurance (NHI) was introduced in 1977. However, financial protection remains a concern, with high out-of-pocket (OOP) expenditures a burden for households. In order to guarantee the right to full and affordable health care, especially for the underprivileged, the Government of the Republic of Korea has defined the goal of expanding the coverage ratio of the NHI scheme to 70 per cent of medical expenses by 2023. Known as Moon Jae In-Care or "Moon Care", the reform is defined by the Comprehensive National Health Insurance Plan (2019–2023).

2. Context

Since 1977, following the amendment of the Health Insurance Law, the Republic of Korea has experienced rapid changes to the social health protection landscape, with legal reforms marking the beginning of compulsory health insurance for the population (Do, Oh and Lee 2014). NHI was established through the Compulsory Health Insurance Act, and initially consisted of a contributory plan for employees in businesses with 500 or more workers, including their dependents (Na and Kwon 2015; National Health Insurance Service 2019). The Medical Aid Programme (MAP), a government funded assistance programme targeted at the poor, was established shortly after, in 1979, through the Medical Protection Act (Kim 2017). In the same year, the NHI system enrolled civil servants and private schools. Over the years, NHI membership was progressively expanded to the entire population, with the self-employed from rural areas added to the system in 1988. Finally, in

1989 the self-employed from urban areas were included in the system. Since the early 2000s, the system has functioned as a single-payer scheme with the National Health Insurance Service (NHIS) as the main insurer (Kwon, Lee and Kim 2015; Sohn and Jung 2016).

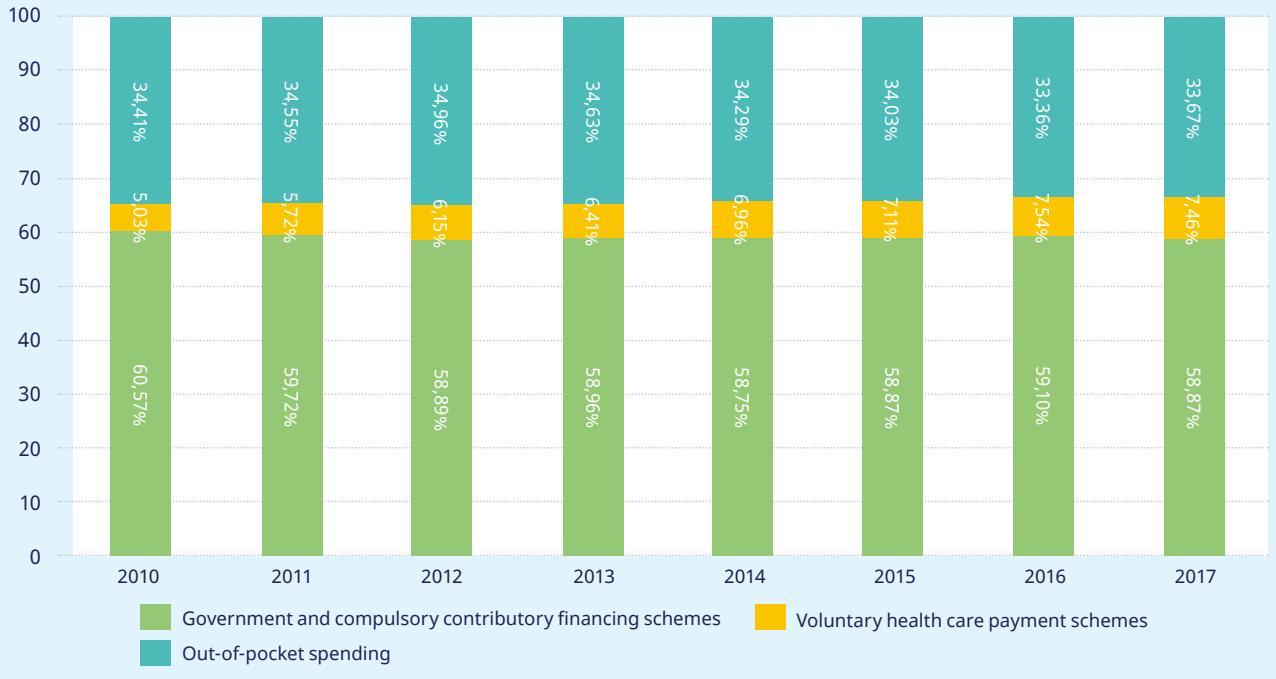
In 2008, to respond to the challenges of a rapidly aging population, the Long-Term Care Insurance (LTCI) scheme was launched, creating a new source for provision and utilization of medical and social care for the elderly in the Republic of Korea (Cheng et al. 2018). The scheme is one of five social security schemes introduced by the Government.[1] The purpose of LTCI is to simplify and improve access to nursing and home care services for the elderly population (Shin 2014). Through the implementation of these three complementary and coordinated schemes (NHI, MAP and LTCI), comprehensive health protection coverage is now provided to the entire population.

3. Design of the social health protection system

- Financing

Republic of Korea's total health expenditures are currently equivalent to 8.1 per cent of GDP. In 2017, per capita spending on health was US$2,283, and in the same year, current health expenditure was 7.60 per cent of GDP (WHO n.d.). The government-financed and compulsory contributory health care schemes (NHI, MAP and LTCI) account for 58.9 per cent of health expenditure, OOP expenditures account for 33.7 per cent and voluntary health care payment schemes account for 7.5 per cent (WHO n.d.). While MAP only covers 3 per cent of the population, its accounts for 16.9 per cent of total NHI expenditure (Yoo et al. 2016). As demonstrated by figure 1 below, this distribution

Figure 1. Current health expenditure by financing scheme



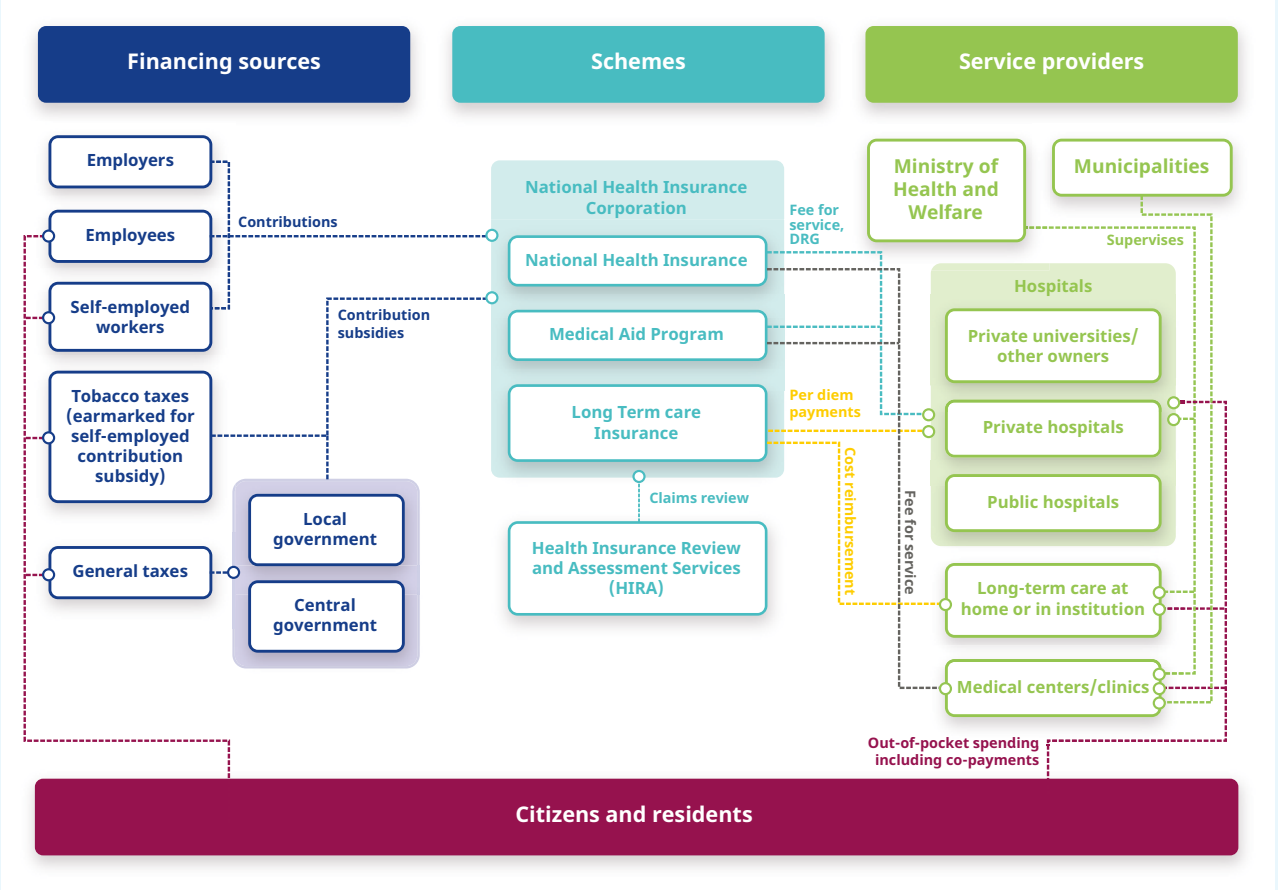
Source: Adapted from WHO Global Health Expenditure Database.

[1] Republic of Korea has implemented four social insurance schemes: National Pension, National Health Insurance, Employment Insurance and the National Basic Livelihood Security System. Long Term Care is considered the fifth scheme (Lee 2015).

of financing sources has remained stable since 2010.

Figure 2 summarises the health financing flows of the social health protection system in the Republic of Korea.

Figure 2. Overview of main financial flows of the social health protection system in the Republic of Korea



Source: Authors.

NHI is the single insurer and purchaser of health care services, and is financed by contributions, government subsidies and tobacco tax (Lee and Lee 2019). In 2019, 86.3 per cent of NHI funding was sourced from social insurance contributions, 11.4 per cent from government subsidies and 2.3 per cent from other sources (Republic of Korea Ministry of Health and Welfare 2019, 648–49). In the same year, the monthly contribution rate was 6.5 per cent – an increase from 5.1 per cent in 2008 (Shim and Hur 2019). Contributions are shared equally between the employee and the employer and contributions of self-employed members are calculated based on their total wealth (income and value of their property) using a scoring system (Kwon, Lee and Kim 2015; Lee et al. 2019; Shim and Hur 2019). There is a monthly income ceiling of 78.1 million Korean won (KRW) (approximately US$63,741) for NHI (Social Security Administration 2016).

Besides contributions, the NHI also depends on government subsidies for the self-employed (Lee et al. 2019). Through the enactment of the Special Act for the Financial Stability of National Health Insurance, established in 2002, government subsidies increased from 28 per cent to 50 per cent of total revenues. Increased government subsidies were financed from increased tobacco

taxes in 2002 (Na and Kwon 2015). [2] In 2019, tobacco tax represented 3.1 per cent of total government subsidies.

There are several full and partial exemptions to contributions. A 50 per cent reduction of contributions applies to the insured working in remote islands or areas, the insured working overseas without any dependents in the country, and beneficiaries working abroad with dependents living in the country. Reduction of the contribution rate applies to the insured aged 65 or older and beneficiaries registered as living with a disability, the self-employed, the insured living in farming or fishing villages, single-parent families, single women over 55 and orphans. Reduction rates range between 10 to 30 per cent. Exemptions from contributions are applied to Koreans working abroad without any dependents in the country, persons serving a jail sentence and persons in the military (National Health Insurance Service 2019).

The MAP is jointly funded by the central government (80 per cent) and local governments (20 per cent) (Lee and Lee 2019) and the contribution payment is made by the Government on behalf of the insured (Type 1 and Type 2 plans).

The financing model of the LTCI scheme is similar to that of the NHI (Shin 2014). The LTCI is funded by long-term care social insurance contributions paid by active workers and employers, in addition to government subsidies (Park 2015). The Government funds about 20 per cent of the annual budget for the scheme. The contribution rate is calculated as a share of the NHI contribution and is paid together with contributions to the NHI. In 2019, LTCI comprised 8.5 per cent of NHI contributions.

- Governance

The NHI scheme is placed under the overall leadership of the Ministry of Health and Welfare (MOHW). The MOHW has delegated the administration of the NHI to two entities: the National Health Insurance Service (NHIS) and the Health Insurance Review and Assessment Service (HIRA). The NHIS is accountable to the MOHW and is responsible for managing beneficiaries, collecting contributions and paying health care providers. It carries out the following functions: (i) administration of insurance benefits; (ii) preventive programmes; (iii) payment of insurance benefit costs; (iv) fund management and; (v) collection of contributions for all social security programmes. [3] The HIRA on the other hand is responsible for health care evaluation, claims review and handling issues related to purchasing, such as benefits coverage and payment system design (Kwon, Lee and Kim 2015; Na and Kwon 2015).

The Board of Directors of the NHIS, as mandated by the National Health Insurance Act, is comprised of the President, executive directors, representatives of labour unions, employer associations, civic groups, consumer groups, agriculture groups, senior citizens' associations and government officials representing the MOHW, the Ministry of Strategy and Finance and the Ministry of Personnel Management (National Health Insurance Service 2019). Public participation in decision-making on social health insurance is enabled through a platform called the Citizen Council for Health Insurance, which was launched in 2010 to increase patients' inputs to priority setting and issues such as the extension of the NHI benefit package (Kwon, Lee and Kim 2015).

The LTCI scheme, which was introduced based on article 1 of the Act on Long Term Care Insurance for Senior Citizens, is also managed and regulated by the NHIS (National Health Insurance Service 2019). The Long-Term Care Committee is placed under the oversight of the Minister of Health and Welfare. The Committee is comprised of 16 to 22 members, with the Chairperson appointed by the Minister of Health and Welfare. Other members include representatives of employees' and employers' associations, non-governmental organizations, long-term institutions and representatives of the academic community. The Committee makes decisions regarding long-term care benefits and contributions, manages and assesses contributions and deals with all essential matters concerning the functioning of the scheme.

[2] In 2012, the government also introduced financial support for Employment Insurance and National Pension contribution for firms with fewer than 10 workers. In 2018, government subsidies to insurance contribution amounted to US$774 million (Shim and Hur 2019).

[3] Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

- Legal Coverage and eligibility

Any member of the population living in the country has a right to NHI coverage. Affiliation is mandatory, with no possibility to opt out (Kwon, Lee and Kim 2015). The republic of Korea's single-payer insurance system presupposes every citizen to be enrolled in the NHI or the MAP, depending on their income levels and criteria set by the Government (see below). Koreans residing overseas have a right to be insured based on article 19 of the National Health Insurance Act (National Health Insurance Service 2019). According to the National Health Insurance Law, foreigners residing in the Republic of Korea for six months or longer are required to contribute to the NHIS, and non-working foreign residents can contribute on a voluntary basis. [4]

Enrolment in the NHI scheme can be undertaken on an individual or a household basis. The social health insurance system encourages family-based membership if the income of dependents is below a certain level. Dependents include spouses, children and other members of the family or household of the insured member paying the contribution. Enrolment of the employed and the self-employed is completed through online submission of the appropriate form to the NHIS (Kwon, Lee and Kim 2015; National Health Insurance Service 2019). It is the employer's responsibility to enrol employees with the NHI.

Persons with low incomes are entitled to enrol in the MAP, and membership criteria is set and revised annually by the MOHW. Beneficiaries of the National Basic Livelihood Security System (NBLSS) and households making less than 40 per cent of the median income in the Republic of Korea qualify for medical aid (Moon and Moon 2020). Eligible persons need to submit their application in order to become a beneficiary. The MAP is divided into Type 1 and Type 2 medical aid. Type 1 medical beneficiaries make up 57 per cent of all members and include: households with without the ability to work; patients with rare and incurable diseases; shelter residents receiving benefits from the NBLSS; homeless patients without family or any support; disaster victims; family members of those who have been injured or who have died while helping others; adoptive children below 18; men and women of national merit; Living Human Treasures; and refugees from North Korea. Type 2 beneficiaries account for 43 per cent of all scheme members (Moon and Moon 2020) and include all other individuals and households who do not fall under any of the Type 1 categories, but receive NBLSS benefits (The Republic of Korea Ministry of Health and Welfare 2019).

Affiliation to the LTCI scheme is mandatory for individuals aged 65 or over and those below 65 with debilitating conditions (Kang, Park and Lee 2012). Those who are younger than 65 and suffering from illnesses such as dementia might also be affiliated (Park 2015). Eligibility for LTCI is determined by a trained NHIS assessor. One of the main criteria for inclusion is the inability of the senior citizen to live on his or her own for longer than six months. An assessment of the person's physical and mental status is made irrespective of their financial status or family support, and eligibility is revaluated once a year (Park 2015). Not all elderly people with care-related needs are covered by the scheme. As such, central and local governments have introduced several smaller programmes for older people with a mild disability or living on their own (Jun Choi 2015). Enrolment is possible for an individual but not for a household. However, family members supporting the beneficiary receive financial support from the NHIS (National Health Insurance Service 2019).

- Benefits

The NHI and the MAP have the same benefit package. This unique benefit package consists of benefits in cash and benefits in kind. Benefits received in kind include diagnosis, tests, treatments, medical supplies, treatments, surgeries, preventive care, rehabilitation, hospitalization, nursing, transportation and health check-ups, including blood tests (Kim 2019). Cancer check-ups are also included, with the patient bearing 10 per cent of the screening cost and the NHIS bearing 90 per cent of the cost. Benefits in cash include reimbursement if the medical cost exceeds the co-payment ceiling, reimbursement of medical devices for people with disabilities, and delivery expenses. NHIS reimburses the full amount (National Health Insurance Service 2019) in cases where the beneficiary or his/her dependent receive treatment for disease, injury or childbirth from other institutions providing similar services to

[4] Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

hospitals— for example, clinics that are permitted to offer in-patient services, as defined under the decree of the MOHW, or the home, in cases of emergency home births.

The benefit package is based on a positive list, with some exclusions. The HIRA determines services to be reimbursed by the NHIS. It is estimated that about 21 per cent of services within the health system are not covered by NHI, including medical imaging, dermatology services, and medical consultation and education for the prevention of chronic diseases (Kwon, Lee and Kim 2015; Do 2013) Cosmetic treatment intervention and dermatology services are not included in the benefits package, with the exception of reconstructive surgery for face burns, which is covered by the NHI (National Health Insurance Service 2019). Screening and preventive check-ups for certain diseases like colon, breast and liver cancer are available only to the members of a certain age, between 40 to 50 years of age and over (National Health Insurance Service 2019). Moreover, limitations in the benefit package include a benefit ceiling of 90 days of utilization per year.

Treatments for which effectiveness has not been proven by the National Evidence-based Health care Collaborating Agency (NECA) are also not covered (Mauna Kea Technologies 2018). NECA contributes to policy and decision-making related to the benefit package by generating evidence on the clinical effectiveness and cost-effectiveness of health services, technologies and health products (Kwon, Lee and Kim 2015). Members of the NHI can purchase additional private health insurance on a voluntary basis to cover benefits not covered by the NHI (Lee and Lee 2019).

LTCI provides a unique benefit package, defined positively, and includes home care services, including bathing, day and night care, nursing elderly family members and providing assistance with household services institutional care and, in exceptional cases, cash benefits (Lee 2015). A family member who supports beneficiaries can receive supportive cash benefits from the NHIS. LTCI also provides financial support to purchase necessary equipment that provides assistance in daily and physical activities for those who have difficulties carrying out their daily routines due to physical or cognitive decline (National Health Insurance Service 2020). Cash benefits are also provided on a case-by-case basis to older persons living in remote areas with no access to in-kind benefits (Jun Choi 2015).

- Provision of benefits and services

The NHI purchases health care services from public and private service providers. Benefits provided by the NHI are equally available to all citizens, since they can use all the treatments in any public or private hospital covered by the NHI scheme. All private facilities have the obligation to participate in the NHI (Kwon, Lee and Kim 2015). The NHI is the central purchaser of health care services. For both the NHI and the MAP, the MOHW is responsible for direct payment to health care providers, which is done in the same way for all members, regardless of whether they are enrolled in the NHI or the MAP.

Depending on the services provided, reimbursement of providers is undertaken by the NHIS through fee-for-service and Diagnosis-Related Groups (DRGs). Public and private hospitals and clinics are mainly reimbursed through fee-for-service payment (Kwon, Lee and Kim 2015). DRGs were introduced in 2013 to pay for inpatient services for seven diseases (Lee 2015; Na and Kwon 2015). Payments are thoroughly examined by the HIRA, which evaluates and decides whether or not reimbursement is appropriate (Lee et al. 2019).

For the LTCI scheme, a purchaser-provider split is implemented. Each institution files a claim for reimbursement of costs incurred from the provision of benefits under the LTCI programme, and the claim is filed with the NHIS. When the NHIS receives a claim for reimbursement of costs of either home care or institutional care, it reviews the claim and proceeds with payment to the provider. The beneficiary's co-payment is deducted from the expenses. [5] Hospitals participating in the LTCI programme are paid based on per diem payments, differentiated by 17 disease categories (Kwon, Lee and Kim 2015).

The NHI implements a co-payment system in order to prevent over-utilization (see Table 2). In cases where costs of health services are split between the NHI and the patient, the patient may bear his or her part of the cost through several forms of payment, including deductibles, co-insurance, a ceiling system, co-payment and indemnity (Sohn and Jung 2016).

[5] Government of the Republic of Korea, National Health Insurance Law of 2011, available at: https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=53994&type=new&key=

Table 1. Co-payments across different levels of care

Type of care	Type of facility	Co-payment
Inpatient	All hospitals	20% of total treatment cost (registered cancer patients 5% and registered rare/incurable disease patients 10%)
Outpatient	Tertiary hospital	60% of total treatment cost and other expenses
	General hospital	50% (Dong district) and 45% (Eup and Myeon districts) of total expenses
	Hospital	40% (Dong District) and 35% (Eup and Myeon Districts) of total expenses
	Clinic	30% of total care benefit expenses
	Pharmacy	30% of total care benefit expenses

Source: Adapted from National Health Insurance Service (2019).

Beneficiaries of the MAP have been required to make co-payments since 2007 (Yoo et al. 2016) with a gradual co-payment schedule based on the level of care and beneficiary classification (type 1 or 2) (Moon and Moon 2020). However, the Healthy Life Maintenance Aid Programme and Co-payment Exemptions Programme were introduced by the Government to better meet the medical needs of beneficiaries. Through the Healthy Life Maintenance Aid Programme, the Government provides US$6.00 per month to each type 1 beneficiary via a virtual health savings account. This money can be used for co-payments of outpatient services. If more than US$2.00 remains, it can be converted into cash once a year. This policy does not apply for inpatient services, which are provided at no cost to beneficiaries. The Co-payment Exemptions Programme is targeted towards type 1 category beneficiaries, such as pregnant women, homeless persons, persons under 18 years of age, patients with organ transplants and patients with rare incurable diseases (Yoo et al. 2016).

Beneficiaries of the LTCI scheme are required to co-pay 15 per cent of the costs of in-home services and 20 per cent of institutional services (Park 2015). The poorest group is entirely exempt from co-payments, while the second poorest is exempt from paying 50 per cent of the co-payment (Won 2013).

4. Results

- Coverage

In December 2019, there were 52.8 million people covered (100 per cent of the population), of which 97.2 per cent were covered by the NHI and 2.8 per cent were covered by the MAP (HIRA and NHIS 2020, 54;82). The fact that the Republic of Korea attained full population coverage within 12 years of the launch of the NHI scheme is a noteworthy success story, particularly considering that in 1977, when the NHI was first implemented, only 8.8 per cent of the total population was covered.

- Adequacy of benefits/financial protection

The rate of OOP payments in the Republic of Korea is considered high for an OECD country (Na and Kwon 2015; WHO n.d.). Evidence suggests that OOP payments are partly driven by private providers inducing demand for new treatments and technologies which are not proven to be cost-effective and therefore not fully covered by NHIS (Kwon, Lee and Kim 2015). The proportion of the population spending more than 25 per cent of household consumption or income on health expenditures was 3.8 per cent in 2015. Some studies have found that poor households

have lower rates of catastrophic expenditure than those that are better off. This may seem like an equitable outcome, but in reality, it is simply the result of poor individuals forgoing the use of health services to avoid having to make high OOP payments (World Bank n.d.; Lee 2015)

- Responsiveness to population needs

    o Availability and Accessibility

The Republic of Korea's health system is characterized by well-trained medical staff and advanced medical equipment. In 2017, there were 2.3 doctors, 6.9 nurses/midwives, and 12.8 hospital beds per 1,000 people. Although the Republic of Korea's health system is one of the most developed in the world, not all Koreans have the same access. Disparities in access to health services and facilities exist between urban and rural populations due to uneven geographical distribution of health workers and facilities (Cho 2013). For instance, in 2016, the average number of beds per 1,000 people was 6.1, with the highest number of beds in Jeonju region (9.9 beds) and the lowest in Seongnam region (3.4 beds) (The Republic of Korea Ministry of Health and Welfare et al. 2017). A survey conducted in 2018 found that 26 per cent of respondents perceived that access to treatment was a major issue of the health system (Ipsos 2018).

    o Quality and acceptability

With life expectancy in the Republic of Korea having increased tremendously over the years, rising from 55.4 in 1960 to 83.2 in 2019 (World Bank n.d.), there is evidence to indicate the positive effect of NHI on health outcomes. Notably, the wide availability of cancer screening programmes financed by the NHI scheme potentially contributed to lower cancer mortality and improved survival rates (Kwon, Lee and Kim 2015). Specifically, the survival rate increased from 41.2 per cent for cancer patients diagnosed between 1993–1995, to 70.7 per cent for cancer patients diagnosed from 2011–2015 (Jung et al. 2018).

When it comes to patient satisfaction with services, a 2011 MOHW survey found that 63.9 per cent of respondents were "satisfied" with the health system's performance (Kwon, Lee and Kim 2015). Another study found that Koreans are generally satisfied with access to health care services, and that satisfaction was higher in the capital than in smaller cities (Park et al. 2016). One study measuring satisfaction with the NHI found that 28.3 per cent of the general public expressed satisfaction with the NHI system and 21.4 per cent expressed dissatisfaction, with the public expressing greater overall satisfaction than physicians (Kim, Park and Hahm 2012). In 2017, approximately 40,000 individuals in the Republic of Korea visited 204 clinics and reported that they were highly satisfied with the service provision and the rapport they had built with doctors (Kang et al. 2019).

The efficient coordination of long-term care remains an important undertaking in the Republic of Korea (Jeon and Kwon 2017; Won 2013), with several studies undertaken in recent years to assess the quality of long-term care provision. A survey conducted by the MOHW in 2014 found that 89.1 per cent of beneficiaries' families were satisfied with the long-term care programme, and 90.5 per cent stated that it reduced their family's financial burden (Jun Choi 2015).

Since 2017, the Korea Institute for Health Care Accreditation has been using 129 criteria to evaluate health care facilities across the country and accredit those that meet the required standards (Shin 2017). The Korean health system has been ranked among the world's best in terms of quality, survival rates, new technology and other quality indicators (OECD 2015). This results in part from the Committee for New Health Technology Assessment, which has the mandate to contribute to quality improvement, and evaluate the safety and effectiveness of medical procedures and diagnostics. The HIRA is also responsible for quality assurance through claim reviews, assessment of appropriateness of health care, technical support to benefit packages, and the design of the provider payment system (National Health Insurance Service 2019).

▶ 5. Way forward

Through successive reforms to consolidate a system with multiple payers into a single system, the health insurance system in the Republic of Korea is has matured quickly in a relatively short period of time. Today, the country's health system is one of the most developed in the world, characterized by universal coverage, impressive health outcomes and state of the art medical services. However, challenges remain, especially in relation to the extension of financial protection,

with OOP expenditures remaining high and placing a burden on low-income families. In addition, falling birth rates and a steep rise in the elderly population require specific types of care, which poses a challenge to the long-term financing of the country's health insurance system. The proportion of the population aged 65 and over is projected to increase from 15.7 per cent in 2020 to 24.1 per cent by 2030.

In order to tackle these challenges and achieve more comprehensive health insurance coverage to increase financial protection offered by NHI, the Government launched the "Moon Jae-in Care" policy (Lee et al. 2019). The main objective of this policy is to increase financial protection by reducing non-reimbursable services, setting maximum deductibles and expanding emergency financial assistance. The comprehensive National Health Insurance Plan (2019—2023), which is designed to deliver Moon Jae-in Care, has five main components: (1) reducing medical costs by strengthening health insurance coverage; (2) constructing a comprehensive health care system that incorporates the community level; (3) strengthening primary health care and operating supportive health insurance fees; (4) providing reasonable and appropriate medical cost compensation; and (5) maintaining cumulative reserves to promote sustainable health insurance and address challenges arising from an aging population. The implementation of this plan will be at the heart of sustaining achievements to date in the context of rapid demographic shifts and epidemiological changes to public health.

▶ 6. Main lessons learned

- The Republic of Korea's achievement of UHC through NHI was reached rapidly in comparison to other high-income countries. Main success factors include the embedding of rights into law, compulsory coverage, progressive expansion of membership and benefits, and the provision of subsidies for those unable to afford contributions.
- The attractiveness of benefits, including high quality of care, played a major role in achieving UHC. The benefit package was progressively expanded through various policies, including: moving from a positive to a negatively defined benefit package; reducing non-reimbursable services; setting a ceiling on OOP payments; the inclusion of health promotion and disease prevention through various health check-ups; covering Long-term care; and a gradual decrease of co-payments, particularly for chronic diseases.
- Health promotion and disease prevention are well integrated into NHI, contributing to better health outcomes overall for the population. High priority is placed on disease prevention, as exemplified by a damages lawsuit filed by the NHI against major tobacco firms. Although the NHI was not successful in this case, efforts are maintained to publicize the harmful effects of smoking and raise awareness about the issue.
- The NHI scheme is an example of the progressive realization of an integrated system, with the consolidation of various payers into a single scheme. Efficiency in administration has also been enhanced over the years, in part due to the unified collection of major social insurance fees (National Health Insurance, National Pension, Unemployment Insurance and Workers' Compensation).

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Contact information

International Labour Organization
Social Protection Department
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

ILO Regional Office for Asia and the Pacific
United Nations Building
Rajdamnern Nok Avenue
Bangkok 10200
Thailand

T: +41 22 799 7239
E: socpro@ilo.org
W: www.ilo.org/asia
www.social-protection.org

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