Challenges in Financial Allocation and Its Sustainability

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Achieving UHC in Asia

- UHC – everyone can have reasonable access to health care when needed, with lowered financi al barrier
- The most important health system objective in Asian countries
  - Achieved: Thailand, Korea, Japan, Taiwan
- Announced target years for UHC:
  - China, almost done in 2014
  - Philippines by 2016;
  - Indonesia by 2019;
  - Vietnam by 2020;
  - India by 2022
  - Lao PDR by 2030.

source: T Palu, B Yang

UHC

- It is a promising means to achieving ultimate goals of any HCS:
  - Better health outcome (healthy labor, economic growth, Lancet 2014)
  - Financial protection (key to reduced poverty)
  - Reaching the poor: equity (social cohesion/ development/stability)
- However, achieving UHC is never the end of the road
- Real challenge comes after UHC: financial scarcity and system sustainability

UHC

- Scarcity deepens as UHC matures
  - In terms of consumer demand, access to care is replaced by quality care, accompanied by rising income, awareness/expectation of good health, new technologies
  - Societal aging
  - Peoples' reluctance to pay higher contributions (political economy)
- Revenue start to fall short of expenditures
- Question to system's sustainability could be raised

The Case of South Korea

Korean Health Care System: The Current Picture

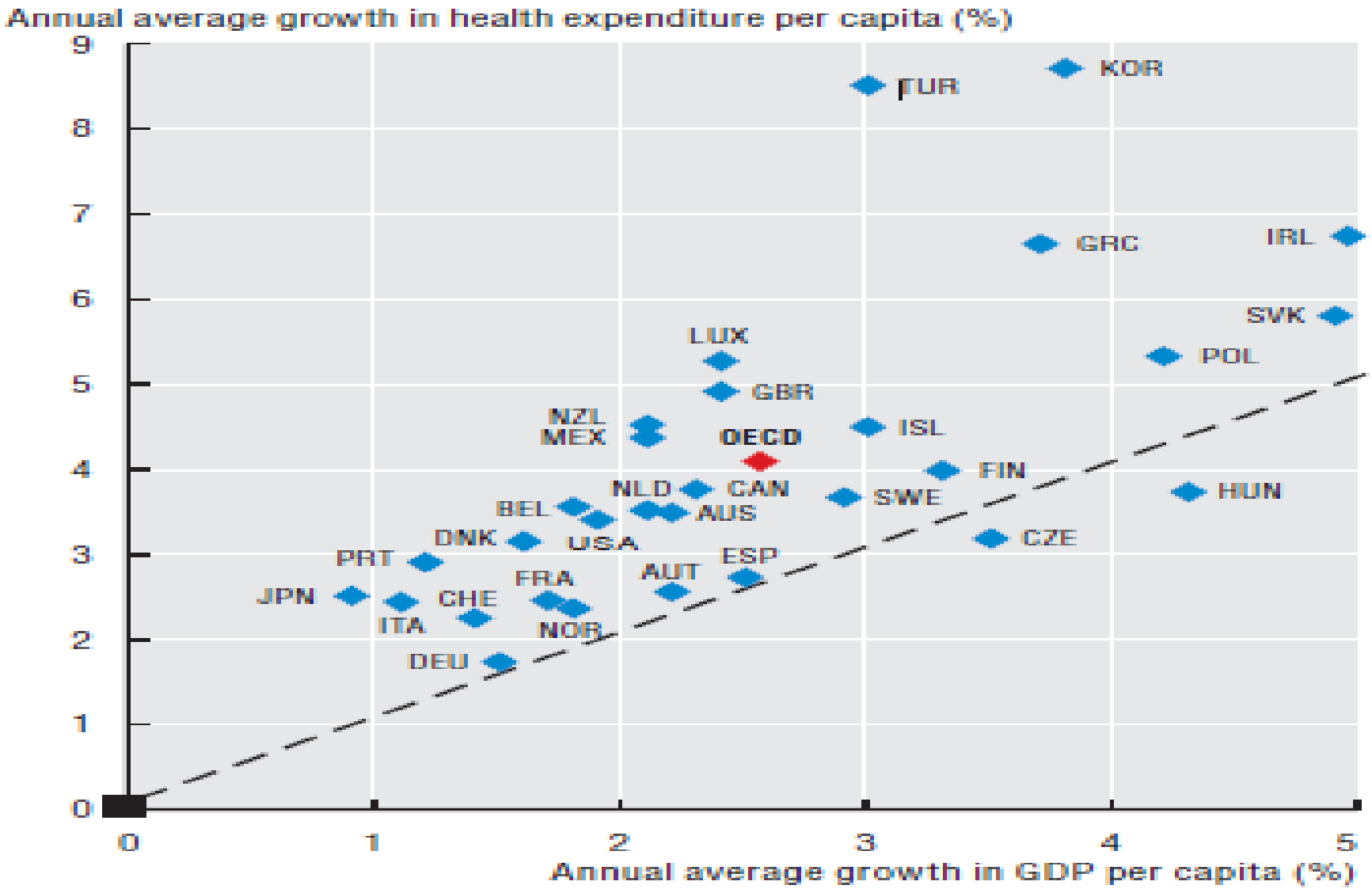
- National health insurance (NHI)
  - SHI covers 97% of population-premium financed
  - Rest 3% by Medicaid –tax financed
  - Under NHI, OOP is about 40%
- Private sector dominant
- Primary method of payment/reimbursement: Fee-for-service
- In terms of health expenditure, a nearly open ended system
  - About 40% non-insurance services combined with FFS

Financing

- Weak government financial support: its proportion keeps declining over the years
  - From about 40% in 1989 to 16.6% in 2012
  - Of total NHI outlays,
    premium contribution: gov't = 83.4% : 16.6% (2012)
- High OOP rate (copayment of insured services + payment of non-insured services and products)
  - Of total HH health expenditures, OOP is 40.2% (2012)
- Health financing total (NHE) - (gov't : contribution : OOP = 10% : 50% : 40%)
- Equity concern with high OOP

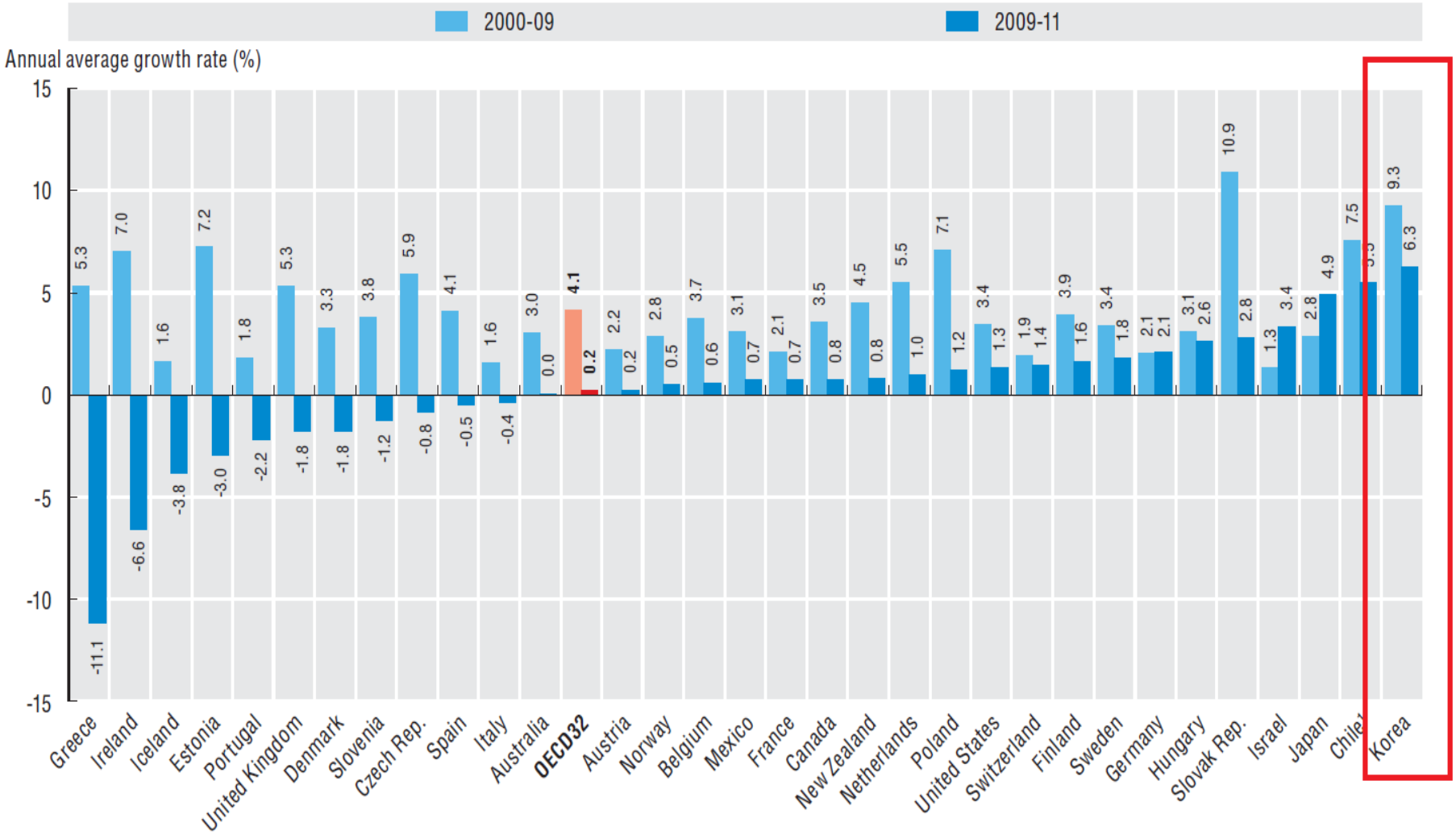
The financial situation has been;

7.1.3 Annual average real growth in per capita health expenditure and GDP, 1997-2007



Source: OECD Health Data, 2009/2010

7.1.2. Annual average growth rate in per capita health expenditure, real terms, 2000 to 2011 (or nearest year)



Source: *Health at a Glance 2013*, p.155

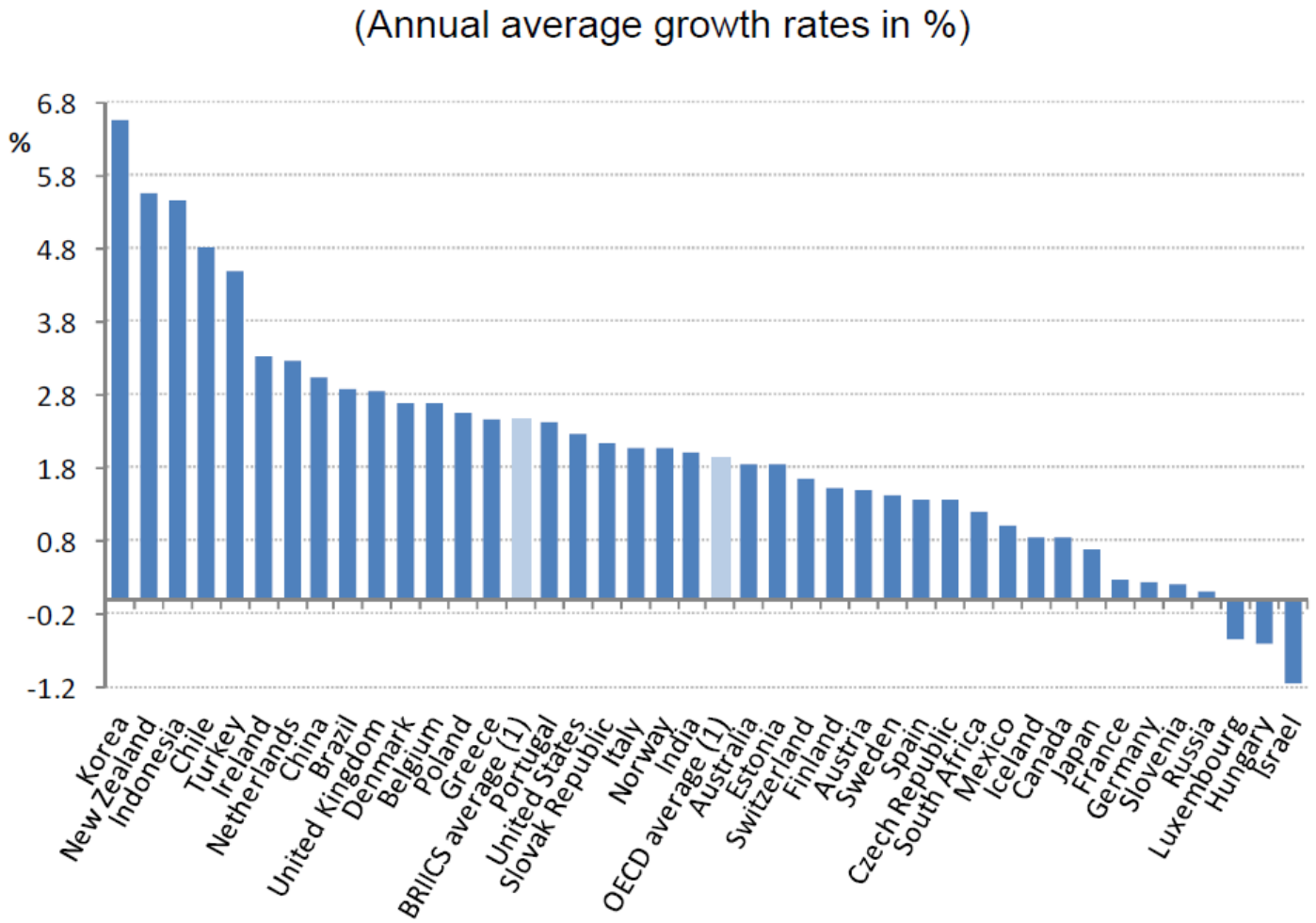
And the future would be?

Decomposing growth in public health spending (1995-2009)

	Real health spending (per capita in 2005 PPPUS$)	Age effect	Income effect (Income elasticity=0.8)	Residual (price, new technology, policy effect)	Memo item: Residual with unitary income elasticity
	(Average annual % change)	(Average annual % contribution to change in spending)			
Denmark	3.7	0.2	0.8	2.7	2.5
France	1.6	0.5	0.9	0.3	0.0
Germany	1.7	0.6	0.8	0.2	0.0
Italy	3.1	0.6	0.4	2.1	2.0
Japan	2.7	1.2	0.8	0.7	0.5
Korea	**11.0**	**1.1**	**3.1**	**6.5**	**5.7**
Sweden	3.2	0.2	1.6	1.4	1.0
UK	4.6	0.2	1.5	2.8	2.5
USA	3.6	0.3	1.1	2.3	2.0
OECD total average	**4.3**	**0.5**	**1.8**	**2.0**	**1.5**
China	11.2	0.6	7.3	3.0	1.3

Source: OECD Economic Policy Papers No:06 *"Public spending on health and long-term care: a new set of projections"(2013)*

Health care residual expenditure growth by country (1995-2009)



Source: OECD Economic Policy Papers No:06 *"Public spending on health and long-term care: a new set of projections"(2013)*

Estimates of public sector (gov't and public insurance) health expenditure (2005-2050)

	Public Health Care Expenditure as a % of GDP(2005)	Pure Ageing Effect	Increase in % Points of GDP 2005-2050	Public Health Care Expenditure as a % of GDP(2050)
Japan	6.0	1.0	1.8	7.8
Korea	2.9	6.1	4.9	7.8
Sweden	5.6	0.5	1.0	6.6
OECD Average	5.6	1.6	1.8	7.4

source: OECD, 2005

Projection scenarios for public health care expenditure: selected countries

		Percentage point increases from base-line (2006-2010) to 2030			
		Contributions of demographic and income effect		Total increase in spending ratio	
	Average 2006-2010	Demographic effect	Income effect	Cost-pressure (residuals)	With cost-containment measures
Denmark	6.3	0.4	-0.2	2.1	1.6
France	7.4	0.3	-0.3	1.9	1.4
Germany	7.3	0.5	-0.3	2.1	1.6
Italy	6.1	0.3	-0.2	2.1	1.6
Japan	6.1	0.6	-0.3	2.3	1.8
Korea	**3.3 (the lowest except Chile)**	**1.1 (the highest among all OECD)**	**-0.5**	**2.6 (highest, OECD)**	**2.1 (highest, OECD)**
Sweden	6.6	0.2	-0.3	1.8	1.3
UK	6.5	0.2	-0.2	1.9	1.4
USA	7.1	0.4	-0.3	2.0	1.5
OECD average	**5.5**	**0.4**	**-0.3**	**2.0**	**1.6**
China	1.9	0.9	-1.1	1.7	1.3

Source: OECD Economic Policy Papers No:06 *"Public spending on health and long-term care: a new set of projections"(2013)*

Financial Projection of NHI Expenditure
(unit: trillion won, %)

Year	NHE	NHE/GDP (%)	Premium Rate (%)
2013	**96**	**7.91**	**6.60**
2014	**103**	**8.07**	**7.07**
2015	**110**	**8.30**	**7.27**
2016	**118**	**8.49**	**7.82**
2017	**127**	**8.84**	**8.26**
2018	**136**	**9.11**	**8.74**
2019	**146**	**9.38**	**9.33**
2020	**156**	**9.60**	**9.74**

Source: Future strategy for Health and Welfare, MOHW and KIHASA, 2010, p.17

Why did it happen?
Will it continue?

Strategies/reforms for managing expenditure and efficiency

- Fee control
  - But no volume control (under FFS)
- Transition from multiple fund system to a single payer system
- Separation of dispensing from prescription
  - To reduce over-prescription & overuse, misuse
- K-DRG (July 2013)
  - For inpatients of 7 DRGs
  - Its impact yet to be assessed (creeping and cost-shifting)
- HTA
  - For NMTs, CE measures incorporated in reimbursement decisions

Challenges: demand side

- Under rapid aging, expanded coverage of LCI (political commitment)
- Greater consumer expectation on better quality of care (however, non-increasing WTP)
- Pressure in favor of NMT (by both patients and providers)
- Political pressure to lower OOP (current rate 40%)

Challenge: supply side, HC system

- Private sector (providers, pharma, device industry) try to circumvent the UHC system
  - Continued adoption and use of new expensive NHI non-covered services and products (NMT)
- Private sector acts as strong interest group
- Private sector challenge public NHI coverage

- FFS
- Referral system non-working
- Tendency toward market driven economy for health care delivery

Sustainability at stake

- Deep concern on sustainability raised

- We seem to know the solutions for long run financial and system sustainability
- But, the real question Korea facing is,
  - is K-gov't ready to cope with the challenges?
  - Is K-govt (politically) able to cope with them?

- How about your own frame?