衛生福利部出國報告（出國類別：會議）

參加 2018 年韓國「健保給付之現況與未來」國際研討會

服務機關：行政院衛生福利部中央健康保險署
姓名職稱：戴組長雪詠
派赴國家：韓國
出國期間：**107.11.22-107.11.24**
報告日期：**108.2.15**

摘 要

韓國總統文在寅在 2017 年宣佈推動 moon care，希望將現行韓國健保醫療給付內容擴增到 70%，涵括 CT、超音波及醫院病房費用等，但卻面臨國內醫界反彈甚而走向街頭，輿論質疑韓國健保可能在 2026 年破產，為汲取韓國內部建言及國外經驗，韓國健康保險署邀請我國及英國分享擴大健保給付經驗。

我國健保醫療資訊雲端查詢系統(Medi Cloud System)及健康存摺(My Health Bank)所展現之資訊分享及減少不必要之資源浪費效益，引發韓國官員及媒體矚目，當地英文媒體在報導中指出，台灣健康存摺系統成就遠遠超過韓國，並引述韓國健保署官員指出台灣規劃之雲端查詢機制是韓國想做而尚未能做到的。

韓國健保雖然有 100%人口覆蓋率，但民眾自掏腰包之醫療支出高達 63.4%，且健保不給付之 CT、超音波服務，成為自費市場獲利最多之區塊，亦即韓國學界所稱之氣球效應，故針對外界建議健保新藥可採差額負擔，以加速健保給付之建議，應審慎評估其負面效應。

由英國公眾治理及病人團體參與，比純粹由醫療人員或經理人員進行決策，更具效益且減少行政壓力，因為這些利害關係人在了解資源有效的現實面後，更可以透過討論達到資源重分配的共識，如何透過病人團體之漸進式參與給付決策，例如建立教育訓練及溝通平台，應是可行方向。

目　　錄

壹、目的.....1
貳、行程及會議議程.....2
　　一、行程表.....2
　　二、會議議程.....2
參、會議內容摘要.....4
肆、心得與建議.....7
伍、附件.....9

壹、目的

韓國健康保險署(National Health Insurance Service, NHIS)於 2018 年 11 月 23 日舉辦國際研討會以「健保給付之現況與未來」(The Current Status & Future Directions of NHI Benefit Coverage)為題，邀請了韓國首爾及延世大學兩位教授以韓國健保之未來規劃及長期照護體系如何迎接老年社會挑戰為題發表演講。

在國外講者部分，則邀請我國健保署及英國國民保健署(National Health Service UK)前官員分享台灣及英國經驗。韓國衛生部長及健保署署長亦到場聆聽及致詞。

貳、行程及會議議程

一、行程表

日期	行程
11/22	台北 →韓國首爾
11/23	韓國國際研討會
11/24	韓國首爾 →台北

二、會議議程

Date	Time	Contents	
NOV 22	Arrival		
NOV 23	09:30~10:00	Registration	
	10:00~10:05	Welcome Ceremony	• Opening Speech－Yong-IK Kim, President, National Health Insurance Service
	10:05~10:10		• Welcome Speech－Neung-Hoo Park, Minister,Ministry of Health&Welfare
	10:10~10:15		• Welcome Speech－Myung-Soo Lee, Chairman, Health& Welfare Committee of the National Assembly
	10:15~10:30	Photo Shooting&Break	
	Session 1.Experience & Future Directions on NHI Benefit Coverage of Republic of Korea		
	10:30~11:10	[Session 1]Future directions of NHI benefit coverage of Korea – speaker:Yoon Kim(Professor, Seoul National Univ.)	
	11:10~11:20	Q&A	
	11:20~12:00	[Session 2]Health insurance strategies corresponding with aging populating – speaker:Ju-Hwan Oh(Professor, Seoul National Univ.)	
	12:00~12:10	Q&A	
	12:10~13:30	Lunch	
	Session 2.Experience & Future Directions on NHI Benefit Coverage of Taiwan and England		
	13:30~14:10	[Session 3]Presentation by Taiwan －speaker:Hsueh-Yung Tai(Director, Ministry of Health & Welfare)	
	14:10~14:20	Q&A	
	14:20~15:00	[Session 4] Presentation by England －speaker:Rakesh Marwaha(Former CEO, NHS Erewash CCG)	

NOV 23	15:00~15:10	Q&A
	15:10~1530	Coffee Break
	Session 3.Discussion	
	15:30~16:10	[Panel Discussion] Measures and future directions for enhancing NHI benefit coverage of Korea, applying experience of Taiwan and England －Moderator: Ju-Hwan Oh(Professor, Seoul National Univ.) －Panels: Hsueh-Yung Tai, Rakesh Marwaha, and 4 from Korea
	16:10~16:30	Q&A
	17:30~19:00	Dinner

參、會議內容摘要

韓國健保署長 Yong-IK Kim 及衛生部長 Neung-Hoo Park 於致詞時，均提到文在寅總統就任後，致力推動 Moon Care，希望將實施近 41 年的韓國健保給付範圍再大幅擴增到 70%，涵蓋 CT、超音波，2 人/3 人病房及老人最需要的失智症、假牙照護，但來自醫界強大的反對聲浪及外界對健保財務是否能夠負荷的質疑，成為韓國政府最大挑戰。

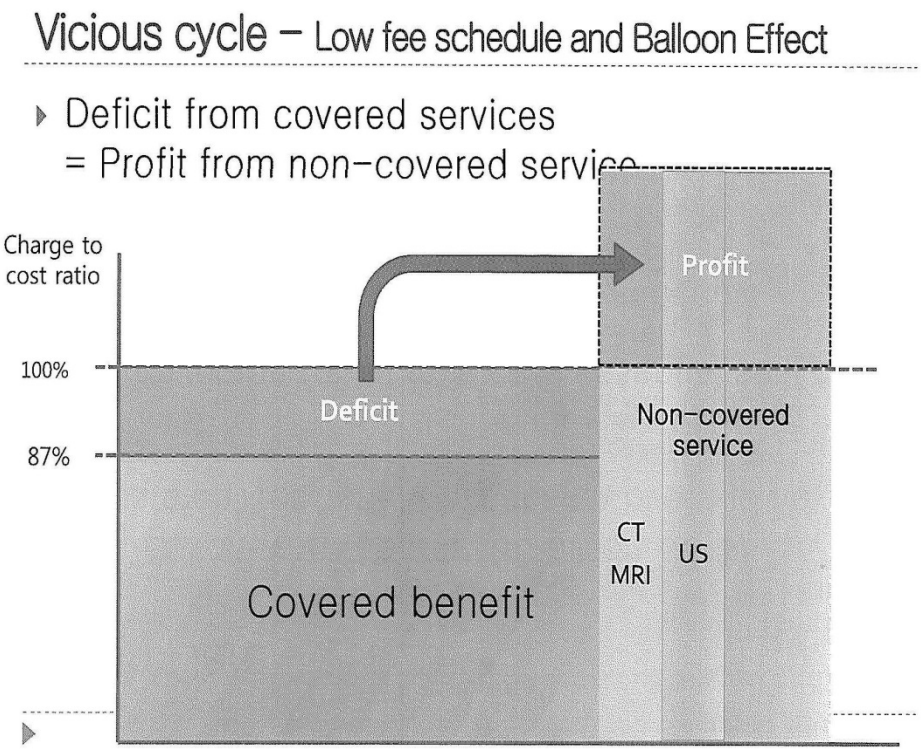
衛生部長 Neung-Hoo Park 更指出韓國政府已努力多年希望降低醫療費用，但韓國家戶所自行負擔的醫療支出，仍高出歐洲經濟合作組織會員國(OECD)平均醫療支出的 1.6%。

韓國首爾大學名譽教授 Ok-Ryun Moon 於專題演講則明白指出，韓國健保自 1977 年開辦後，韓國醫療系統由原先之公共衛生為主流，改變為由私人醫療機構主導，目前韓國私人醫療服務體系已佔全國醫療服務的 80-85%，這也是為何 Moon Care 一推出就遭遇醫界強力反彈，醫界憂慮收入降低，醫療機構容量無法滿足擴增健保給付範圍後之龐大需求。

韓國首爾大學教授 Yoon Kim 在以「韓國醫療照護改革之未來」為題之演講中指出，韓國人民在整體醫療照護及癌症治療中自付費用比率高達 63.4%及 76.1%，而 2012 年重大傷病之醫療費用成長率韓國為 4.5%，而 OECD 國家之上升率為 0.7%，為韓國的 1/6。

Yoon Kim 提出了氣球效應(Balloon Effect)理論，亦即健保不給付，醫療服務就會成為自費市場的獲利區塊(如圖)。根據 Moon Care 的推動時程，將以 5 年時間逐步擴增給付範圍，為節省支出，先調降 65 歲以下被保險人之假牙等支出，擴大 DRG 實施範圍及調高指定醫師費之自付額上限。

Yoon Kim 教授特別提醒韓國政府應有下列配套措施，包括醫療服務支付費用差異化及精進醫療科技評估，以引導各級醫療機構提供適切之教學、研究及醫療服務，Yoon Kim 也指出為避免 balloon effect 造成民眾過度負擔醫療費用，應嚴格禁止混合醫療(mixed care)，病患應在被提供自費項目時被充分告知相關資訊。



延世大學教授 Kyoung-Sun Jeong 在「韓國長期照護體系如何迎接高齡社會」為題之演講中指出，2017 年韓國超過 65 歲以上人口已佔全體人口 14%，到 2025 年將高達 20%，2017 年超過 80 歲以上人口為 153 萬人，到 2025 年將達 246 萬人，而人口老化引發之失智症及癌症治療將為終其一生之花費，而非僅完整治療而已。

韓國長期照護體系面臨的三個主要問題是缺乏整合的急性、次急性與長期/復健服務體系，長照醫院及長照機構的過度競爭，以及長照機構中缺乏健康及護理照護。

Kyoung-Sun Jeong 教授指出韓國長期照護的長程目標應該是能持續評估老人的健康狀態，讓醫院、長照機構能無縫接軌，最終應該是老人能在他最熟悉的社區或家中接受最適當的照護或復健服務。

基於此，韓國政府應重新調整支付制度，活化醫師/護士之居家照護服務，並提供誘因引導醫院及長照機構間鏈結出院整合性照護。

在開放問答時間中，韓國聽眾熱烈提問如下：

- 台灣為何能以如此低的 GDP 佔比費用，而仍能確保健保不破產。職回答因為在 2002 年實施總額支付制度(global budget system)及收支連動機制，讓醫療支出不超過設定之支出目標，又根據支出成長率，設定健保費率調整目標，所以健保能永續經營。
- 台灣醫界為何能接受總額目標制，而沒有反對。職表示當時總額支付制度是由牙醫界主動率先實施，而後再中醫、西醫基層、西醫醫院為最後順勢推動，一切過程尚稱平順。
- 台灣雲端醫療系統展現之效益相當驚人，醫療機構資訊系統是如何配合跟上政府腳步。職回答台灣健保為單一保險人制度，健保體系措施均先設定好規格及配套機制，讓醫療機構資訊人員得以調適及配合，22 年來，台灣醫療機構善於運用電腦科技整合及管理醫療服務，民眾高達 86%滿意健保醫療機構之服務效率。

英國國民保健署前任官員 Paresh Marwaha 應邀以公眾及素人參與(Public & Lay Paticipation)為題，介紹英國 Erewash 區，如何透過公眾治理、素人及病患團體參與，獲得醫師及病人良好的醫療服務滿意度。

Erewash 區約有 97000 個病人，預估至 2020 年 85 歲人口將增加 33%，有 4 分之 1 病人屬於應接受長照服務。依法律 Erewash 區成立醫療管理團隊(Clinical Commissioning Group，CCG)，該團隊有 4 位醫療人員、4 位經理及 3 位素人代表(Lay member)。CCG 每個月會與 12 個病患團體開會，每 2 個月會與相關利害團體開會，聆聽各界意見並分享決策意見。CCG 的目標是如何減少不必要之急診醫療服務，轉而增進社區照護結構及提升虛弱老人之長照服務。

由於是公眾治理及病人全部投入，所以在資源重分配中更具效益及平順，且效果驚人，75 歲以上老人急診使用率降低 2.5%，超過三個月之長期住院率顯著降低，長照狀態病人急診率降低 11%。

肆、心得與建議

韓國文在寅總統在 2017 年宣布推動 moon care，預定投注 268 億美金直到 2022 年，將現行偏低的健保醫療給付範圍擴增到 70%，含括 MRI、超音波、二/三人病房及假牙等尚未獲韓國健保給付之項目，不過政策一出就引發了三層面的衝擊效應：

- 醫療器材產業舉雙手歡迎該政策。因為他們預期有近 10 萬名需要假牙的老人，健保介入照護後，可以減輕老人約 30%-50%的財務負擔，可以帶動整形相關產業。
- 醫界反對，甚至走上街頭。2018 年 5 月 7000 名韓國醫師走上街頭，反對 moon care，這些醫師認為該項政策會讓醫療服務品質下降，要求政府要提高醫師診察費 35%，在韓國，小型及中醫醫院的收入約有一半依賴非健保給付之醫療服務，遠高於大型醫院的 25%。
- 各界不看好韓國政府之財務負擔能力。韓國 65 歲人口已佔 14%，出生率也是 OECD 國家中最低的，工作人口急速下降，政府預估每年保險費率必須增加 3.2%，否則 2026 年時健保會破產，而到了 2027 年時韓國被保險人必須付出比現在高 37%的保險費。

韓國自 1977 年開辦健保，至 2000 年時，已完成整合多個保險團體為單一保險人(Single payer)，目前有 97.1%的韓國人口納保，另 2.9%為低收入戶，透過 medical benefit system 享有醫療照護。但韓國健保較大的缺憾，在於有大多數的醫療照護並未納入給付範圍，導致全國約有 3500 萬人需再購置私人保險。

台灣健保以單一保險人制度，及實施總額支付及收支連動共 3 個主要機制，創造出 6% GDP 之醫療費用支出，高達 85%民眾滿意度的台灣奇蹟，而醫療資訊雲端查詢系統(Medi Cloud System)更帶動健保醫療服務朝向更安全，及更具品質效率，這也是在研討會上韓國媒體記者盛讚台灣健保模式是韓國健保終極目標，而在韓國英文報紙 Korea Biomedical Review 更以大篇幅報導台灣健保健康存摺運用遠遠超過韓國，並引述韓國健保署官員驚嘆台灣充分運用雲端分享醫療資訊及醫療影像，已超乎韓國所能想像的境界。

由韓國及英國經驗有以下兩點建議：

- 差額負擔需小心氣球效應

韓國健保雖然有 100%人口覆蓋率，但民眾自掏腰包之醫療支出高達 63.4%，且健保不給付

之 CT、超音波服務，成為自費市場獲利最多之區塊，亦即韓國學界所稱之氣球效應，這個現象由健保自付差額特材已可看到同樣現象，故針對外界建議健保新藥尤其是癌症用藥可採行差額負擔，以加速健保給付之建議，應審慎評估其負面效應。

- 病人團體參與健保給付決策

  由英國 Erewash 區 CCG 經驗，公眾治理及病人團體參與，比純粹由醫療人員或經理人進行決策，更具效益而且減少行政壓力，因為這些利害關係人在了解資源有效的現實面後，更可以透過討論達到資源重分配的共識。如何透過病人團體之漸進式參與給付決策，例如建立教育訓練及溝通平台，以及列席健保共擬會議，應是可行方向。

伍、附件

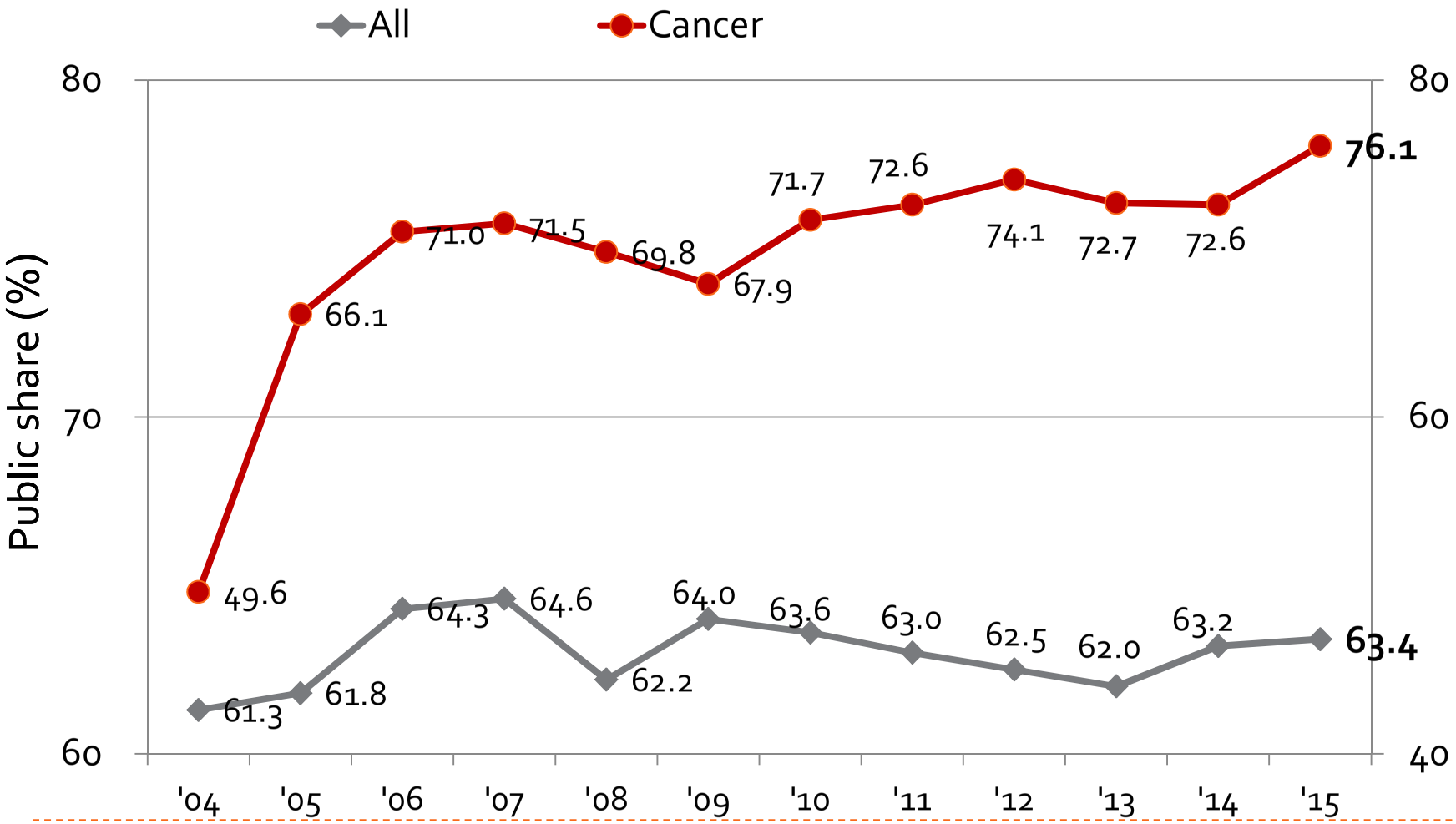
Future agenda for Korean healthcare reform

Yoon Kim, MD, PhD

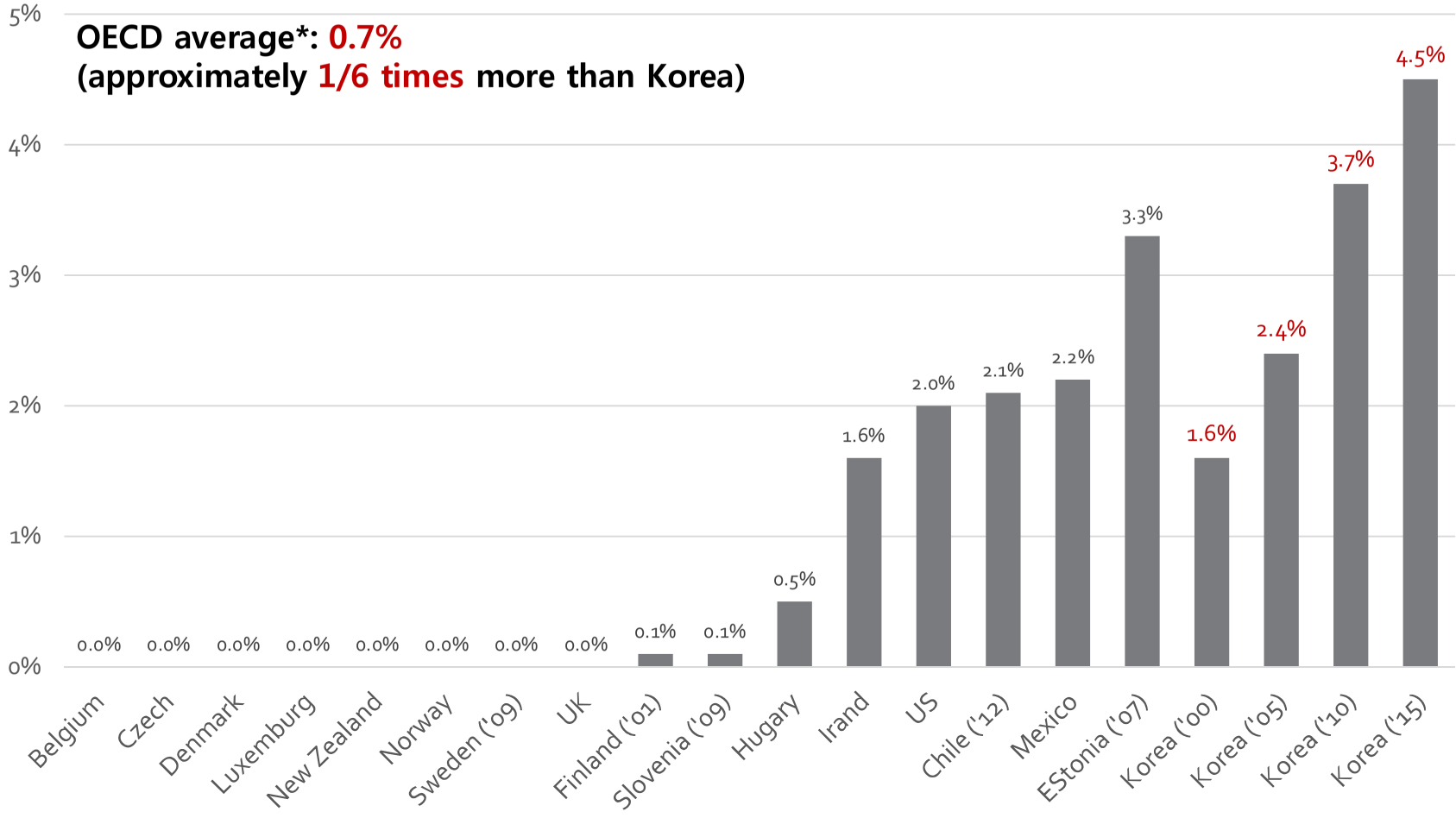
Department of Health Policy and Management,
Seoul National University College of Medicine
November 23rd 2018

MOON CARE

% public share of medical expenditure



Increasing catastrophic health expenditure (%)

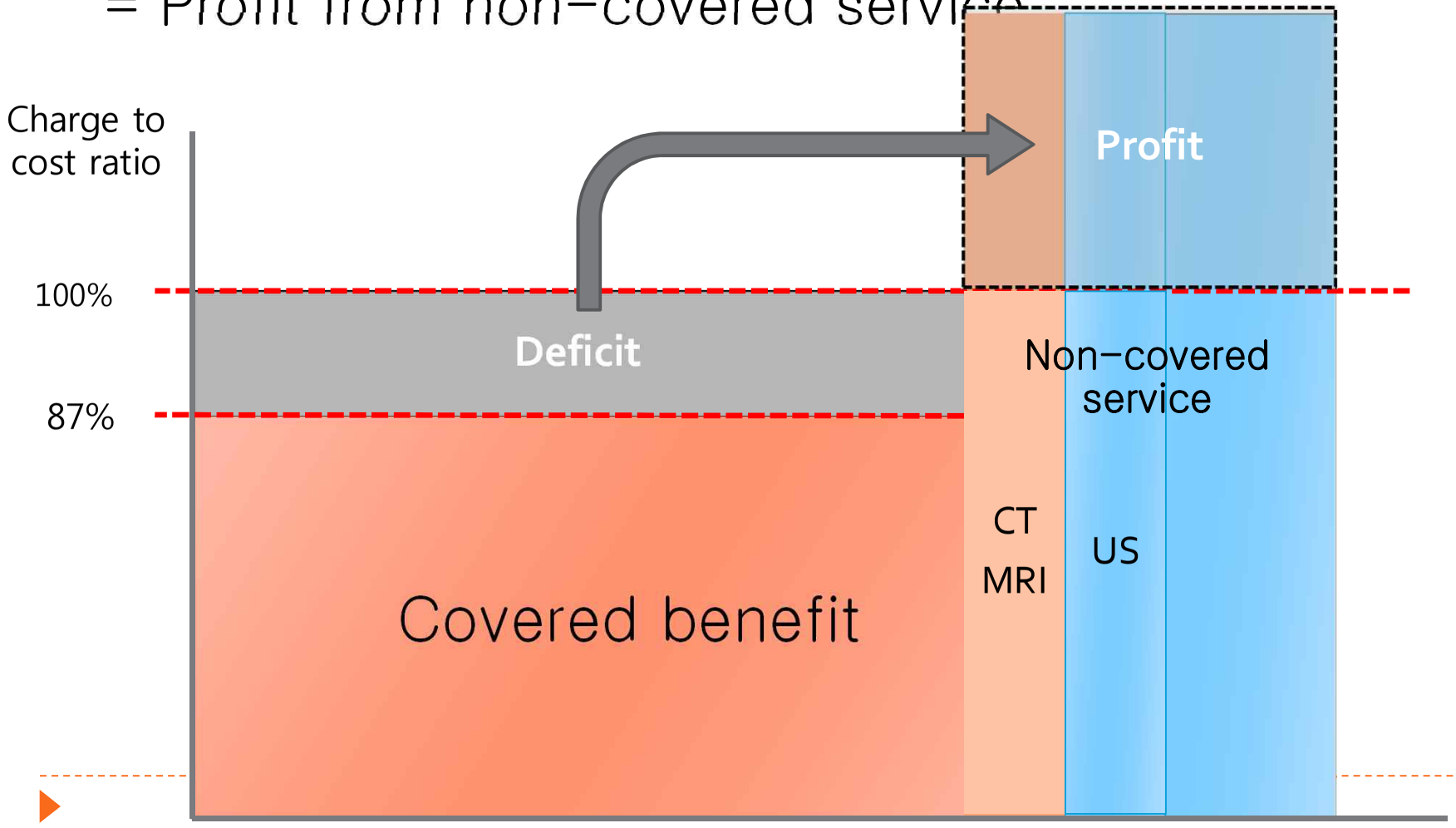


Unless marked otherwise, the year of data is 2010; *the average of OECD countries excluding Korea

Source: OECD Health system characteristics Survey 2012
Ke Xu et al., Equity and Financial Risk Protection of National Health Insurance in Republic of Korea: 1995-2007. 2009

Vicious cycle – Low fee schedule and Balloon Effect

- Deficit from covered services
  = Profit from non-covered service

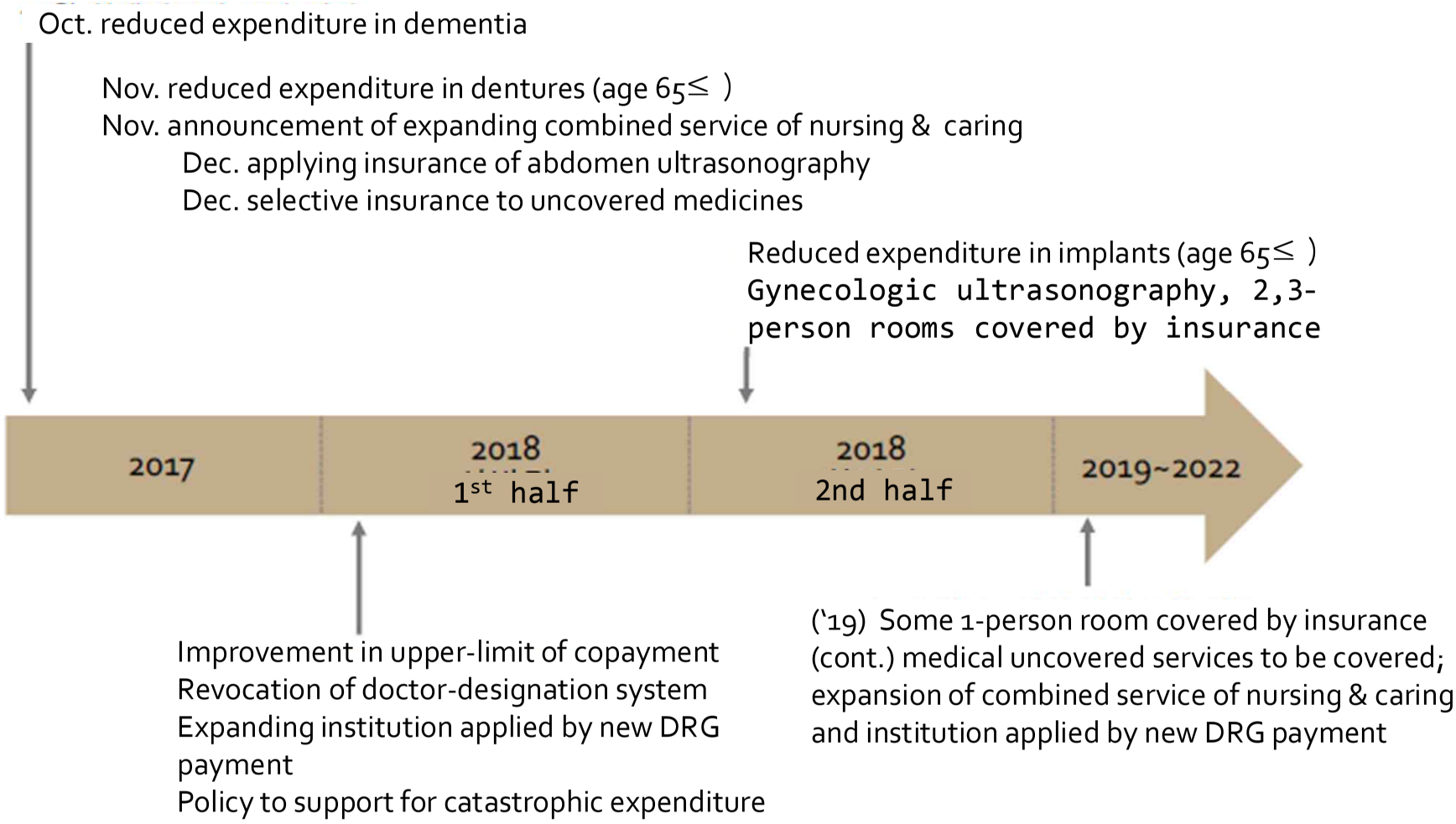


Moon Care

- 30.6 trillion won (approx. 30 billion US $) investment for benefit expansion over the next 5 years
- Full coverage for all medically essential services
- Increase in health insurance fee schedule

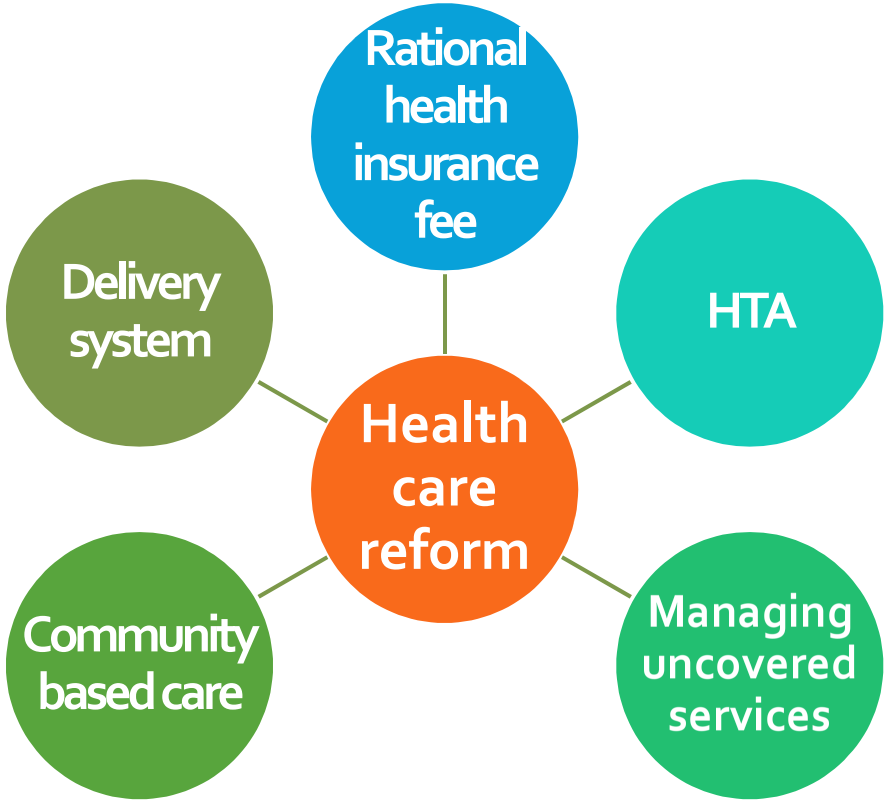
- 70% of health insurance coverage rate + decrease of catastrophic health expenditure

Promoting process



AGENDA FOR HEALTH CARE REFORM

Health care reform agenda
under Moon care era

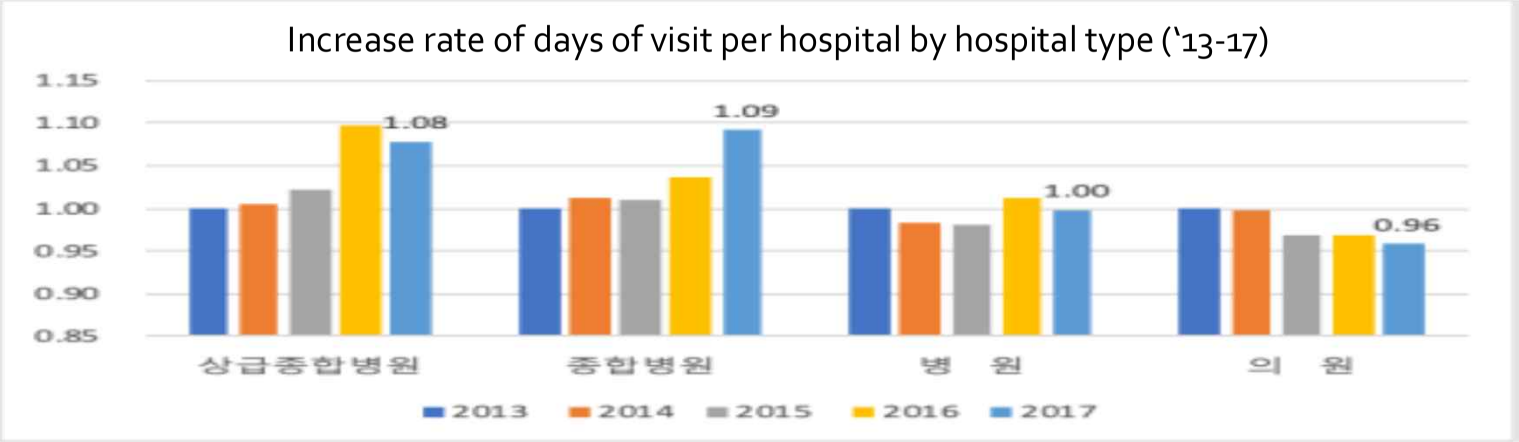


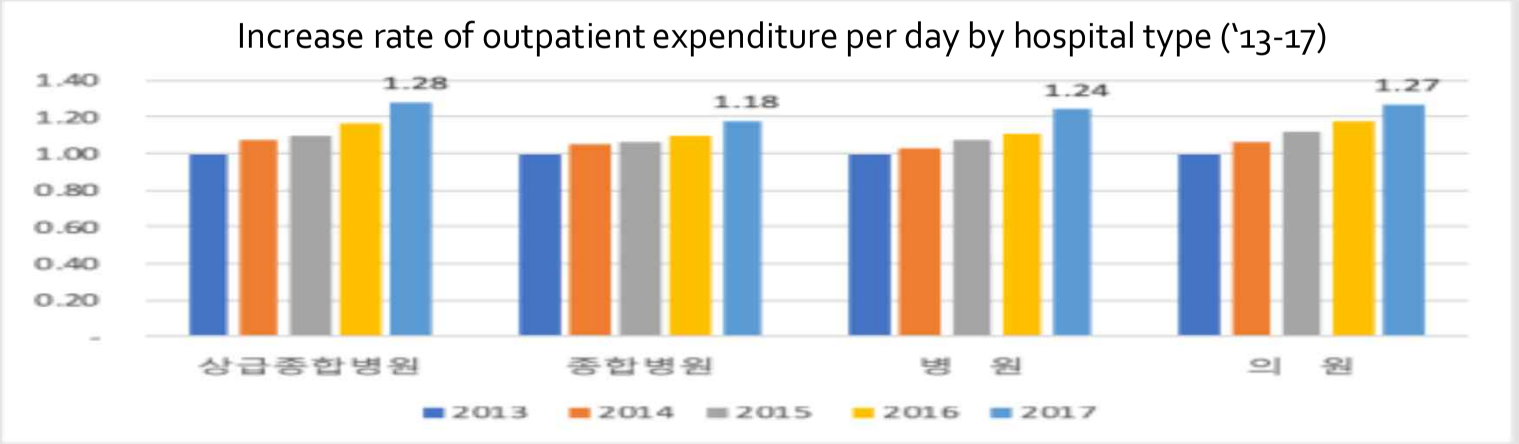
DELIVERY SYSTEM & RATIONAL INSURANCE FEE

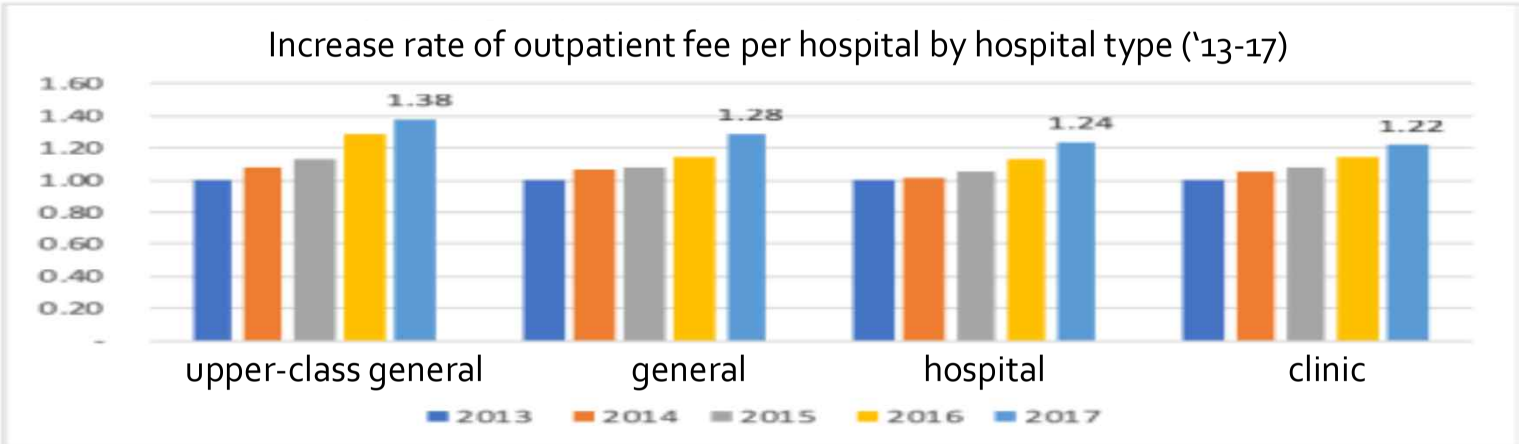
Concentration of patients in large hospitals

Change of in- and out-patient numbers by hospital type

	Inpatient			Outpatient		
	2011(A)	2016(B)	B/A	2011(A)	2016(B)	B/A
Upper-class general	1,928,191	2,517,540	**1.31**	35,588	41,205	**1.16**
General	2,803,359	4,047,126	**1.44**	59,336	71,745	**1.21**
Over 500 beds	1,119,216	1,687,406	1.51	24,182	28,107	1.16
300-499	754,757	1,003,283	1.33	16,844	18,380	1.09
100-299	929,386	1,356,437	1.46	18,310	25,258	1.38
Hospital	2,681,265	3,297,756	**1.23**	58,253	71,500	**1.23**
Over 100	1,363,282	1,553,536	1.14	24,674	28,305	1.15
30-99	1,317,983	1,744,220	1.32	33,579	43,195	1.29
Clinic	1,765,490	1,582,201	**0.90**	541,441	565,395	**1.04**
With beds	-	-	-	157,699	141,397	0.90
Without beds	-	-	-	383,742	423,998	1.10
Total	9,178,305	11,444,623	**1.25**	694,618	749,845	**1.08**


Increase rate of days of visit per hospital by hospital type ('13-17)
1.15
1.10
1.05
1.00
0.95
0.90
0.85
1.08
1.09
1.00
0.96
상급종합병원
종합병원
병 원
의 원
2013
2014
2015
2016
2017


Increase rate of outpatient expenditure per day by hospital type ('13-17)
1.40
1.20
1.00
0.80
0.60
0.40
0.20
-
1.28
1.18
1.24
1.27
상급종합병원
종합병원
병 원
의 원
2013
2014
2015
2016
2017


Increase rate of outpatient fee per hospital by hospital type ('13-17)
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
-
1.38
1.28
1.24
1.22
upper-class general
general
hospital
clinic
2013
2014
2015
2016
2017

Consistency of hospital type & patient severity

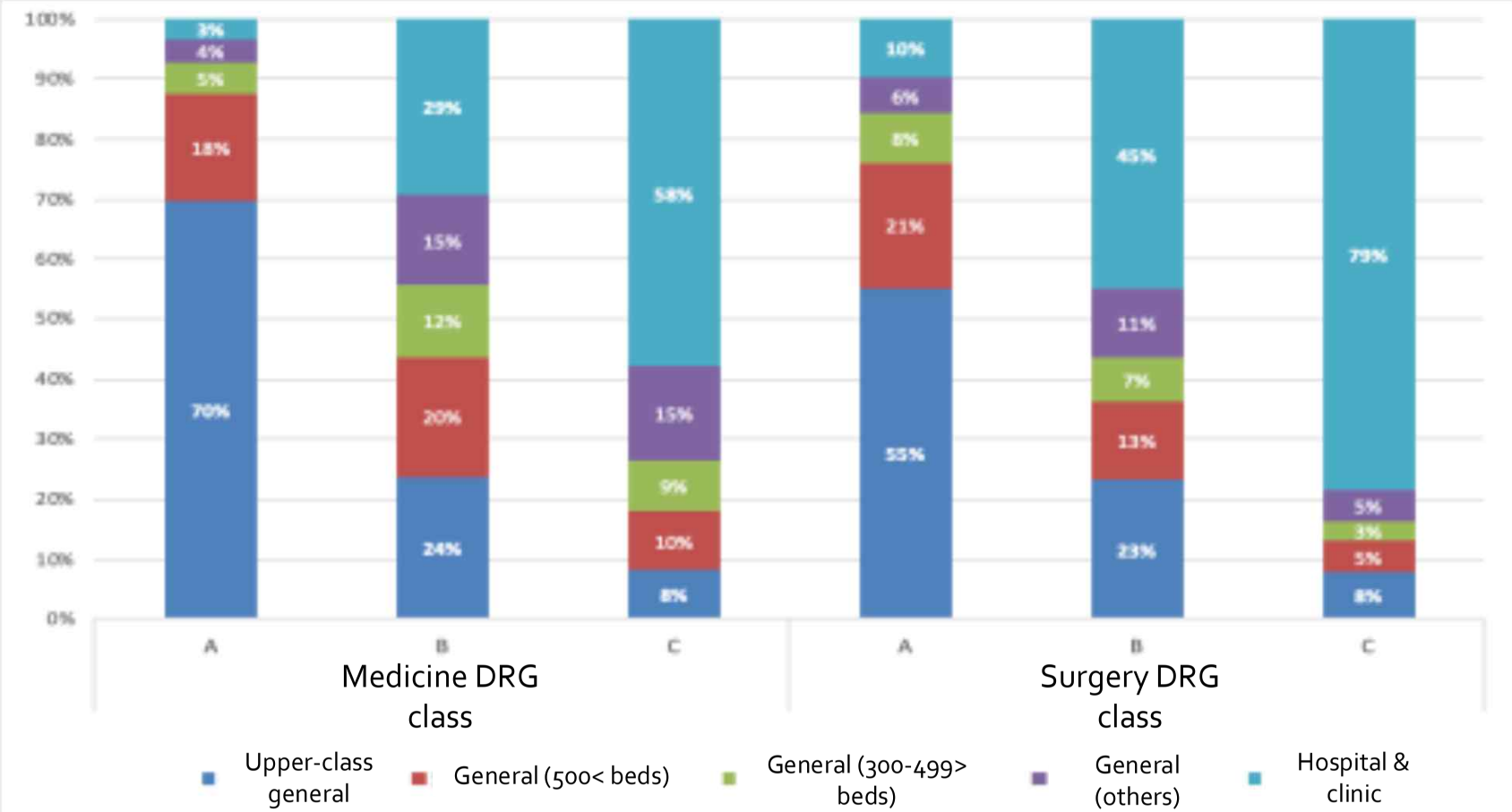


Figure. Distribution of patients by hospital type and DRG class

Morality rate by hospital type & patient severity

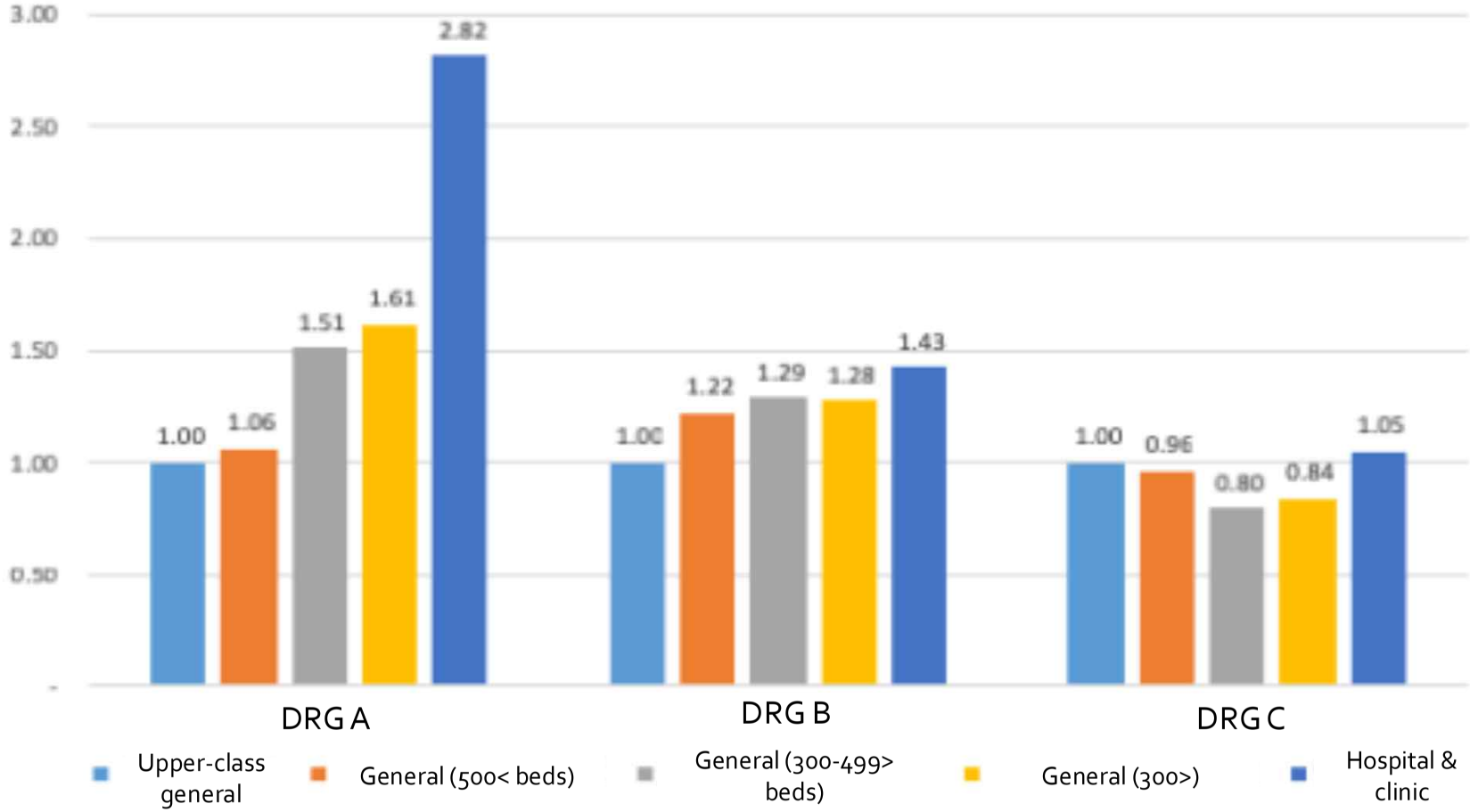
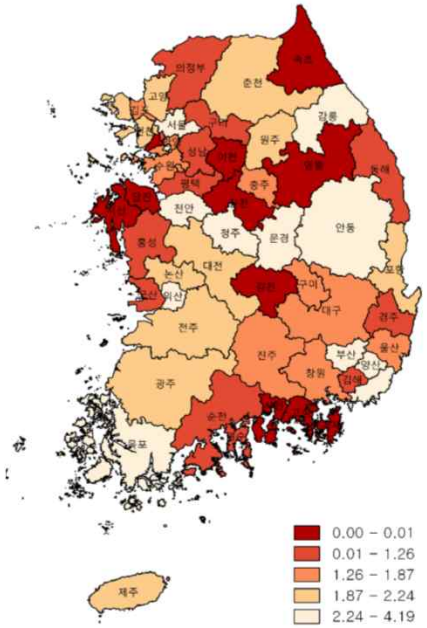


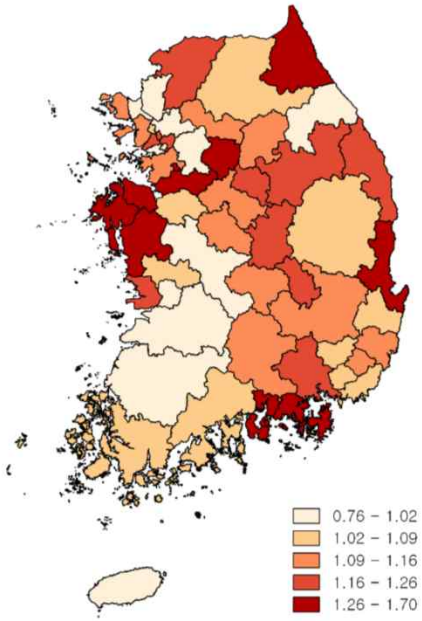
Figure. Comparison of mortality rate by hospital type & patient severity (Surgery DRG)

Supply structure of acute care beds – correlation with outcome (spatial correlation analysis)

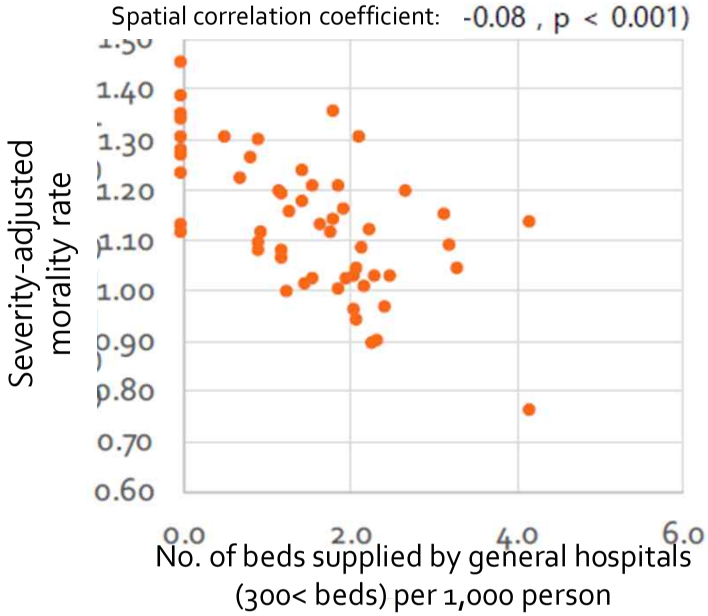
- Increase of 1 bed supplied by general hospital (300< beds) was associated with 9% decrease of mortality rate



No. of beds supplied by general hospitals (300< beds)

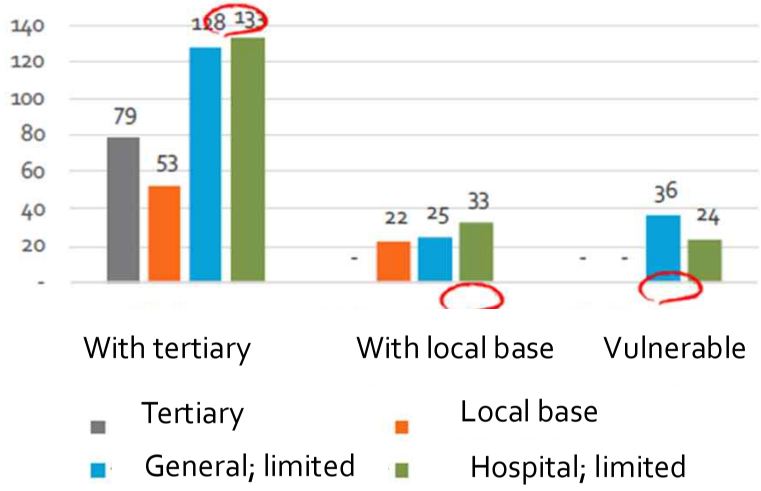


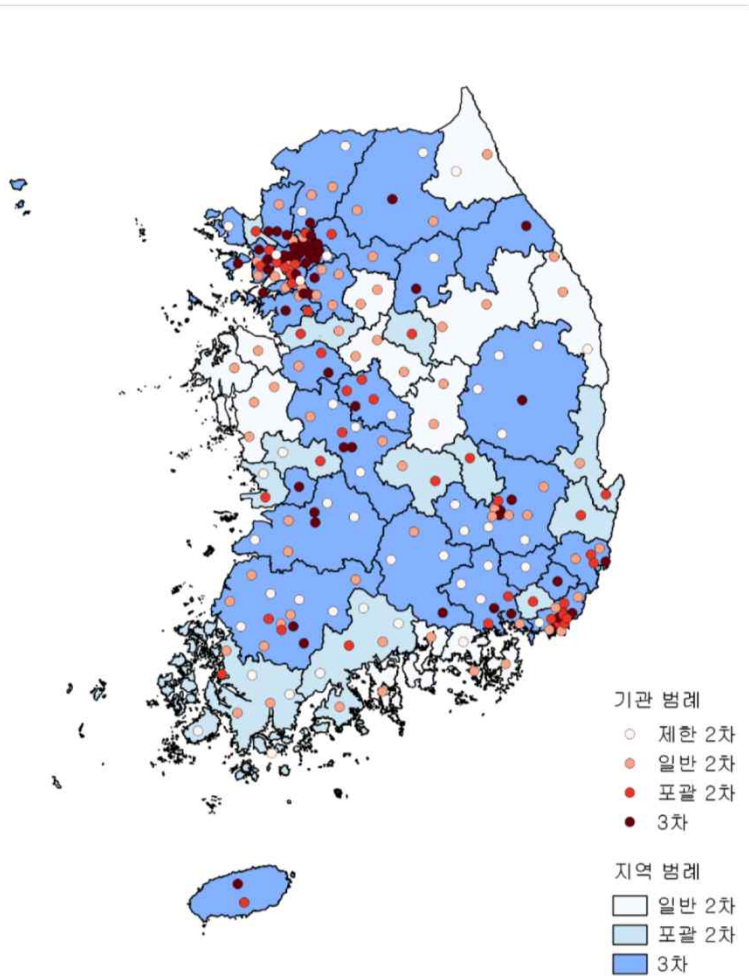
Severity-adjusted morality rate



Distribution of hospital-by hospital type: Fact sheet

- Not all hospitals under the rational size locate in vulnerable areas.
  - Hospital → functional transformation
  - General hospitals with limited scope (mostly 300< beds) → vulnerable area: facilitation, non-vulnerable area: division





Heterogeneity of production cost by hospital type – performance, patient, efficiency

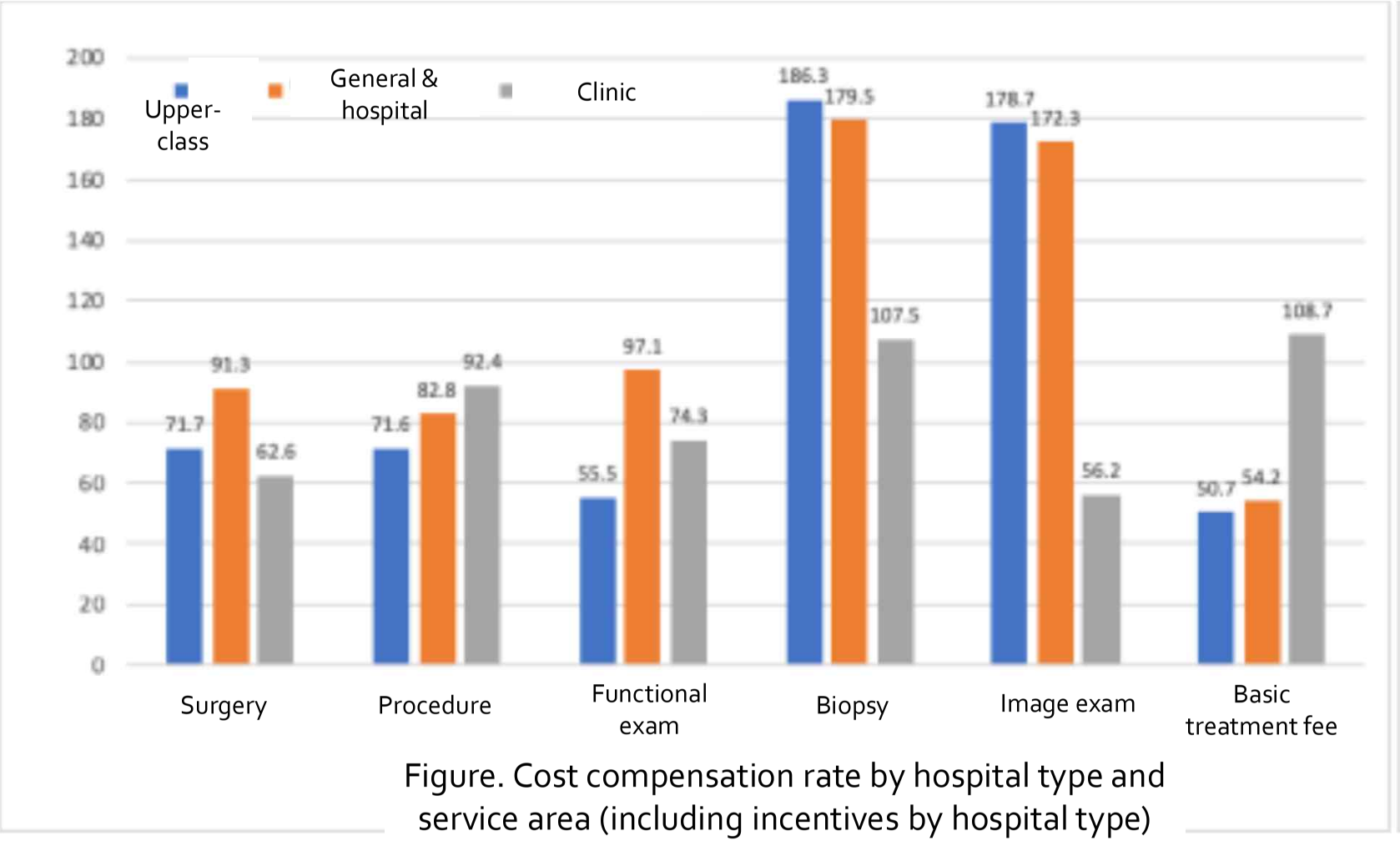


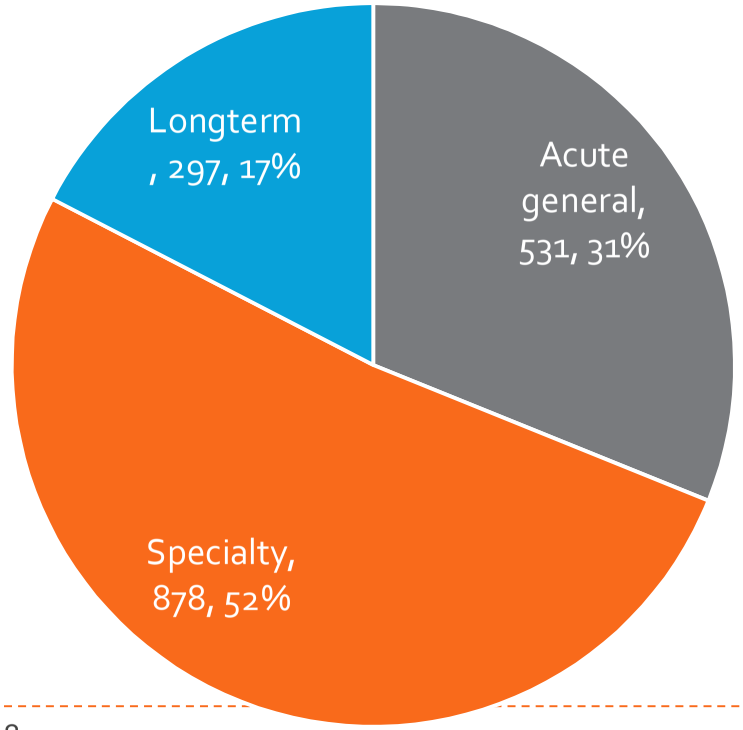
Figure. Cost compensation rate by hospital type and service area (including incentives by hospital type)

Functional analysis of Korean general hospitals & hospitals

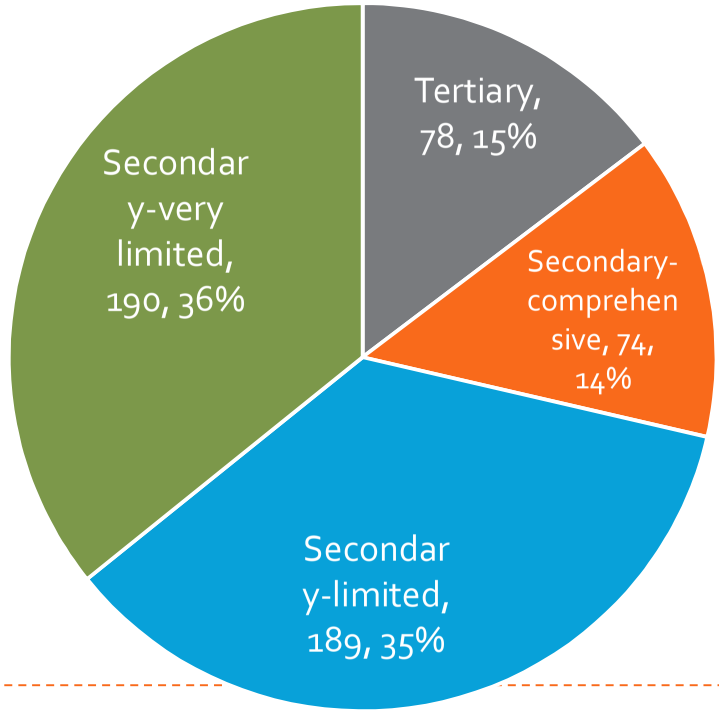
Analysis of functions of general hospitals and hospitals for the segmentation of insurance fee by function

- Result: acute 31%, specialty 52%, long-term 17%

(General) Hospitals by function
(N=1,706)

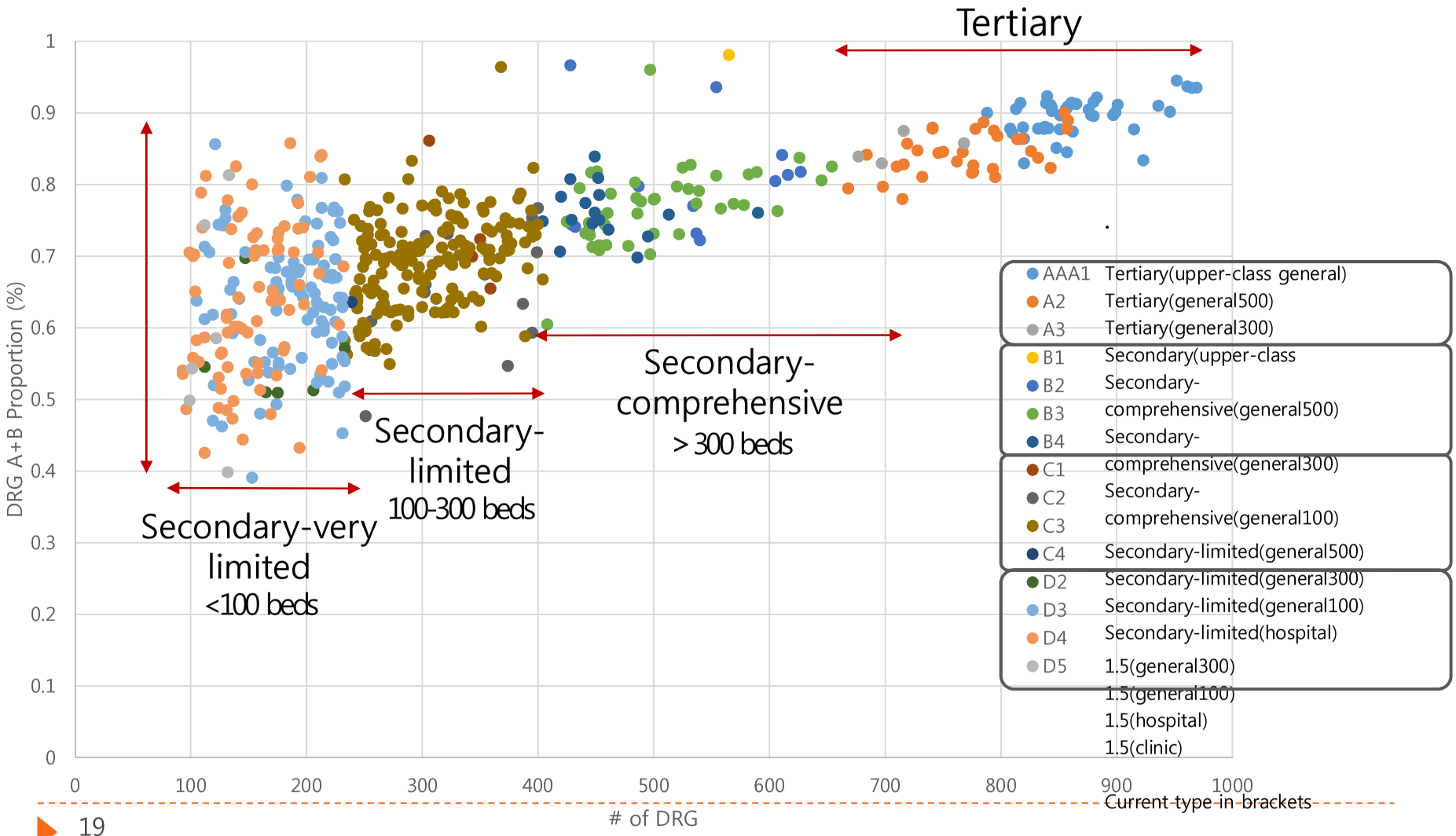


Acute hospitals by type
(N=531)



Functional analysis of acute hospitals

– based on practice scope (no. of DRG) & patient severity (rate of DRG A+B)



Functional analysis of acute hospitals

변수	군집															
	3차			2차-포괄적				2차-일반				2차-제한적				
현행종별기준	상급 종합	500 이상	300~ 499	상급 종합	500 이상	300~ 499	100~ 299	500이 상	300~ 499	100~ 299	병원	300~ 499	100~ 299	병원	의원
의료기관수(개)	42	32	4	1	13	44	18	4	11	132	65	1	21	342	7
병상수(개)	1,072	691	425	683	587	398	278	620	394	231	190	400	192	125	29
입원진료기능															
입원건수(건)	57,940	39,887	19,073	33,201	22,667	17,257	13,722	7,790	9,562	7,358	5,348	4,603	3,175	2,426	1,110
DRG 종류수(개)	867	770	715	565	526	505	457	340	357	319	270	233	192	158	115
평균재원일수(일)	6.4	6.3	6.8	7.0	8.1	7.5	6.6	15.5	11.8	9.6	9.0	22.0	11.4	9.9	7.7
수술비율(%)	29.9	24.3	29.5	25.3	21.8	20.3	20.6	14.5	16.6	19.5	18.3	3.3	20.9	19.0	4.8
DRG A 비율(%)	29.5	16.6	21.8	60.0	14.4	9.1	9.0	5.4	5.2	4.2	2.1	1.2	2.0	1.4	1.5
DRG C 비율(%)	9.3	14.4	13.3	1.2	17.9	21.3	22.2	25.6	31.2	29.7	33.1	42.3	36.4	43.3	39.5
최빈 MDC 비율(%)	15.7	17.4	14.7	31.8	20.5	22.4	24.1	20.9	28.0	27.8	28.6	20.8	40.8	46.3	33.1
병상이용률(%)	91.6	95.3	77.9	93.2	79.1	83.1	84.5	53.9	72.2	78.5	68.8	69.4	47.6	50.2	75.9
인력															
의사수(명)	506	240	188	234	92	75	50	42	38	26	15	16	20	7	4
간호사수(명)	1,078	571	411	480	370	250	164	180	164	104	46	73	60	20	4
100병상당 의사수(명)	46	35	44	34	16	19	18	7	10	12	8	4	12	6	14
100병상당 간호사수(명)	96	83	97	70	63	64	59	30	43	45	24	18	37	16	13

Function of hospitalization care of specialty hospitals

Most frequent MDC-5 MDC specialty hospitals were 82.0%

최빈 MDC	종별 기준				합계(%)
	종합병원(%)	병원(%)	의원(%)	요양병원(%)	
근골격계	1(100.0)	364(48.9)	1,651(32.7)	5(8.1)	2,021(34.5)
안과계		14(1.9)	1,046(20.7)		1,060(18.1)
소화기계		58(7.8)	670(13.3)	8(12.9)	736(12.6)
이비인후과계		39(5.2)	527(10.4)		566(9.7)
산과계		116(15.6)	301(6.0)		417(7.1)
비뇨기과계		2(0.3)	236(4.7)		238(4.1)
피부유방계		9(1.2)	181(3.6)	14(22.6)	204(3.5)
호흡기계		94(12.6)	85(1.7)	2(3.2)	181(3.1)
순환기계		3(0.4)	95(1.9)	3(4.8)	101(1.7)
여성생식계		8(1.1)	92(1.8)	1(1.6)	101(1.7)
남성생식계			66(1.3)		66(1.1)
정신계		12(1.6)	34(0.7)	14(22.6)	60(1.0)
신경계		13(1.7)	23(0.5)	13(21.0)	49(0.8)
내분비계		6(0.8)	15(0.3)		21(0.4)
간담도췌장계		1(0.1)	11(0.2)	1(1.6)	13(0.2)
화상계		4(0.5)	7(0.1)		11(0.2)
손상 및 중독계		1(0.1)	5(0.1)		6(0.1)
기타			6(0.1)		6(0.1)
감염 및 기생충계			3(0.1)		3(0.1)
약물알코올계		1(0.1)		1(1.6)	2(0.0)
외상계			2(0.0)		2(0.0)
합계	1	745	5,056	62	5,864

단계	기능유형	수	기능정의
1차 의료 (외래진료)	일차진료기관	15,941	• 만성질환을 포함한 가벼운 질병에 대한 포괄적 외래 진료과 건강관리 주로 내과, 가정의학과, 소아과, 산부인과, 일반의와 만성질환을 주로 하는 전문과
	내과계 전문의원	3,767	• 신경과, 정신과, 산부인과, 마취통증, 재활의학과 등 • 해당영역의 전문외래진료
	외과계 전문의원	5,522	• 외과, 산부인과, 신경외과, 정형외과, 흉부외과, 이비인후과, 피부과, 비뇨기과 • 해당 진료과 영역에서 전문화된 외래 진찰, 처치 및 통원 수술
2차 의료 (입원진료)	단과의원	4,863	• 해당 진료 연역에서 전문화된 외래 이외에 수술과 입원진료 수행 정형외과, 안과, 대장항문외과, 이비인후과 등 주로 외과계 의원
	단과병원	919	• 전체 환자 중 특정 분야(DRG의 MDC 기준) 환자가 50% 이상을 차지 진료하는 질환과 수술은 전문진료의원에 비해 약간 포괄적
	지역병원	190	• 경증질환 입원진료(150~190개 질환)를 하는 100~300병상 종합병원과 병원 수술비율이 낮고(10%) 중증환자는 1-2%에 불과하나 입원일수는 김(8~18일) 환자당 의사비율이 낮은(의사 1인당 연간입원환자의 약 300건 이상)
	지역거점병원	264	• 경증질환 입원진료(300~500개 질환)를 하는 300~500병상 종합병원과 병원 수술비율이 높고(20%) 중증환자가 5~15%를 차지하나 입원일수는 짧음(약 7.5일) 환자당 의사비율이 높은(의사 1인당 연간입원환자 약 250건)
3차 의료 (중환자진료)	권역거점병원	79	• 포괄적인 입원진료(700~900개 질환)를 하는 500병상 이상 병원 수술비율이 높고(30%) 중증환자가 20~30%를 차지하며 입원일수가 짧음(약 6일) 환자당 의사비율이 높음(의사 1인당 연간입원환자 약 100건)
아급성 (회복, 재활, 노인)		158	• 주로 내과, 정신과, 신경과, 정형외과 환자의 회복, 재활, 낮은 중증도 입원서비스를 제공 • 평균재원일수 1개월 이내로 항암치료 안받는 암환자, 정신질환, 수술 안받는 관절 및 척추질환
장기요양		1,736	• 정신질환, 알콜 의존, 회복기 암환자 같은 특정 질환에 회복 및 요양 서비스 • 병원 병상수는 약 200병상 규모로 입원일수 가 김 (약 70일)

Implementation of differentiated insurance fee

- Method (1) Medical field-approach: considering functions by hospital type, selectively increase to medical fields with low insurance fee compared to production fee
- Method (2) Disease-approach: Increase when hospitals treat patients with conditions corresponding to their functions
- Method (3): Combination of (1) and (2). When hospitals treat patients with conditions corresponding to their functions, selectively increase medical fields that corresponds to the functions

Estimation of required finance

	수술	처치	기능	검체	영상	입원료	진찰료	기타	응급관리료	계
진료비										
병원										
상급종합	7,463	7,687	4,463	16,161	14,917	10,922	5,318	2,226	1,145	70,302
종합	4,908	9,498	3,663	14,020	11,165	13,045	8,484	963	1,882	67,628
병원	3,739	14,411	1,861	4,964	4,005	9,205	8,375	179	104	46,843
계	16,110	31,596	9,987	35,145	30,087	33,172	22,177	3,368	3,131	184,773
의원										
내과	997	9,257	1,732	5,537	1,047	726	35,238	840	0	55,374
외과	3,555	13,164	4,718	2,357	2,828	1,092	29,046	97	0	56,857
기타	12	10	14	54	525	1	147	1	-	764
계	4,564	22,431	6,464	7,948	4,400	1,819	64,431	938	0	112,995
총계	20,674	54,027	16,451	43,093	34,487	34,991	86,608	4,306	3,131	297,768
적정수가 인상 방안 : 기능유형 적합 진료비 규모 30%										
중증도 적합 10% 인상	620	1,621	494	1,293	1,035	1,050	2,598	129	94	8,933
진료영역 적합 10% 인상										
병원										
상급종합	746	769	446			1,092				3,054
종합	491	950	366			783				2,590
병원	374	1,441								1,815
의원	456		646		440		6,443			7,986
총계	2,067	3,160	1,459	-	440	1,875	6,443	-	-	15,444

Reform of the designating criteria for upper-class general hospitals

- Regional base hospital = upper-class general hospitals
- Comprehensive evaluation including severity care, delivery system, education and research
- (Severity care & delivery system)
  - [Current] Rate of hospitalized severe diseases
  - → [Future] Proportion of out- and in-patient, minor vs. severe
  - Receiving patient referral transferring, participating in coordinated care
  - Providing education & training to local hospitals
- (Education)
  - For example, reflecting evaluation on medical school education & resident training
  - For example, education & training for hospitals in regions.
- (Research)
  - For example, research fund per professor & research preformance

Policy for rationalizing supply

Regulation on bed supply (1) Total bed in a local area	• Regulating bed supply by region and bed type (type) acute: acute hospital – tertiary, secondary, specialty / sub-acute / long-term)
Regulation on bed supply (2) Bed criteria for foundation	• General hospital – ex: 300≤ (current – 100 beds) • Hospital - ex: 100≤ (current – 30 beds)
Financial support (1) Division, transformation	• 300< - transformation: incentives correspond to functions ex. 100≤: recovery hospitals, 100-300: local base or recovery hospitals • 300≤ - division: emergency, cardio-cerebrovascular, children hospitals
Financial support (2) Investment on hospital foundation	• Vulnerable area of hospitalization (1) no candidates for 300≤ - extended support • Non-vulnerable: (2) no candidates for 300≤ - foundation of a public hospital

HEALTH TECHNOLOGY ASSESSMENT (HTA)

Preliminary : Coverage with Evidence Development (CED)

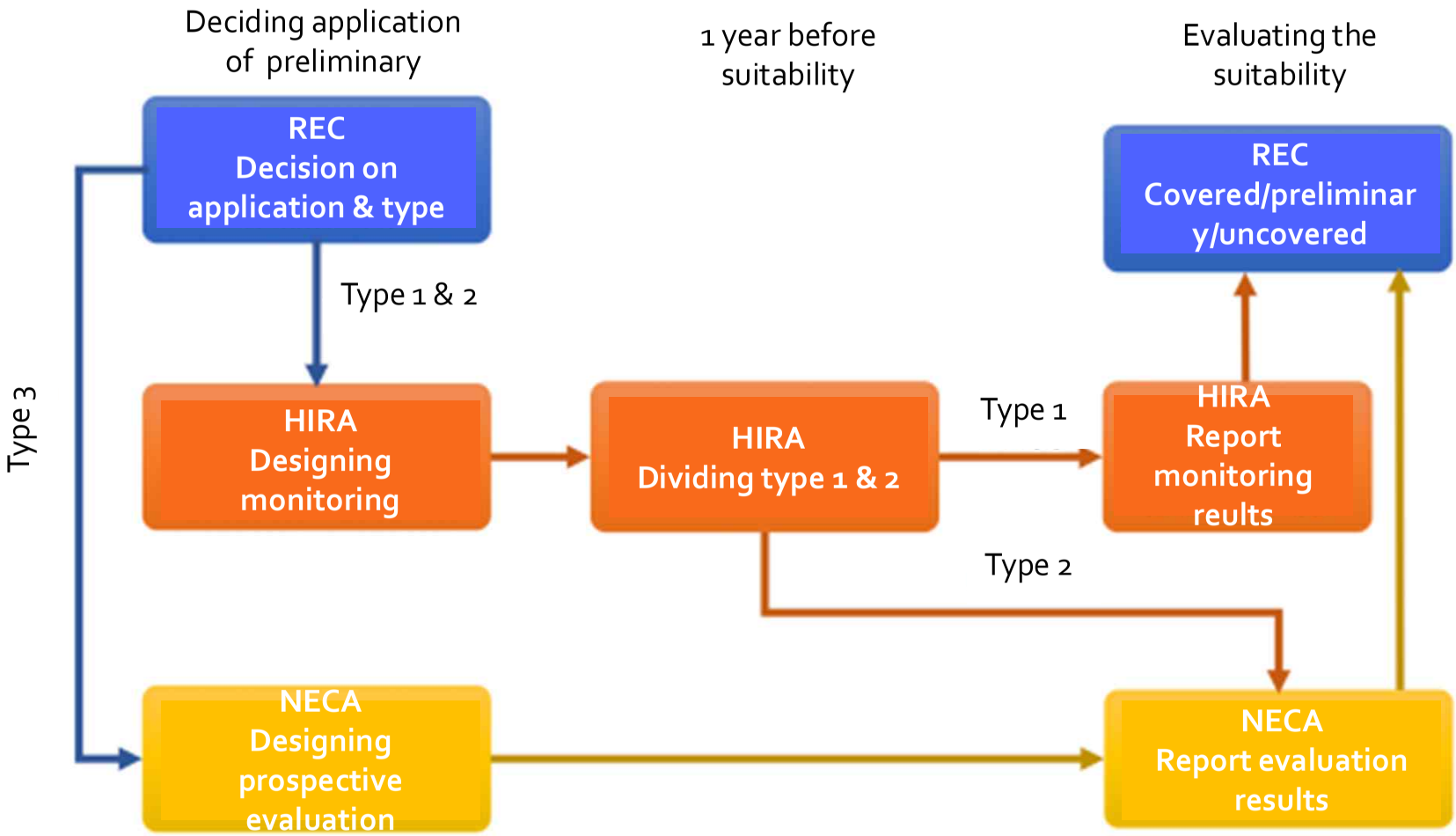
- Apply insurance with precondition of evidences
  - New HTA (nHTA) with insufficient evidences on effectiveness and economics
    - Ensure fast access to nHTA
    - Adopted in numbers of North American and European countries (the U.S., Canada, Swiss etc.)
  - Conditional – a few prospective nHTA
  - Preliminary – Numbers of uncovered services with insufficient evidences
- Promoting factor
  - Clear criteria for decision making
  - Transparency of decision making process
  - Clear subjects of decision making
  - High-quality research designs & public fund for research
    - Post-management system; research design, conducting institution, public fund, restriction on procedural institutions

Table 38. Matrix of benefit consistency

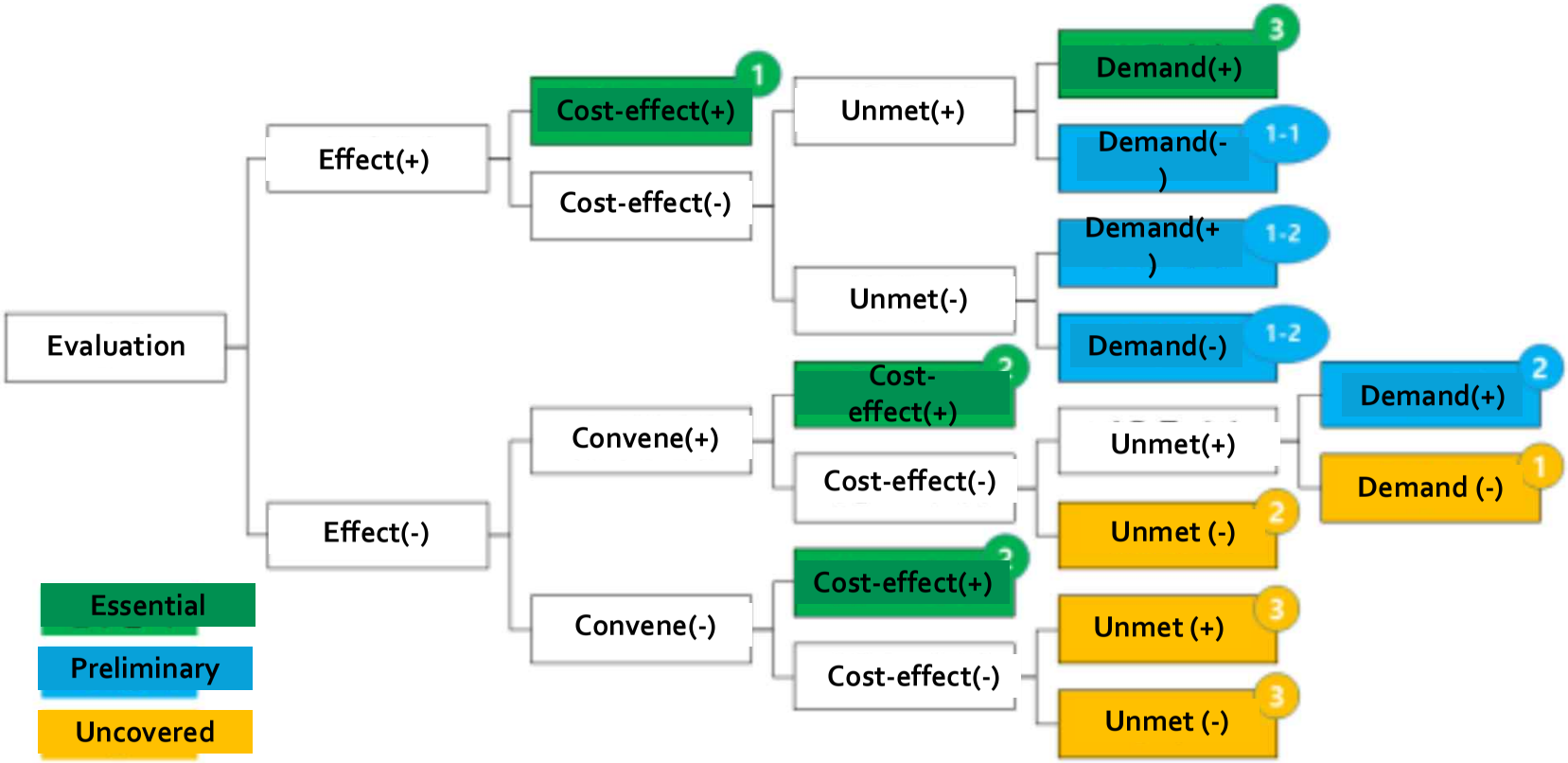
<table>
<tr><td colspan="2" rowspan="2"></td><td colspan="3">Level of risk</td></tr>
<tr><td>Class I: Low</td><td>Class II: Medium</td><td>Class III: High</td></tr>
<tr><td rowspan="3">Level of evidence</td><td>High</td><td colspan="3">Covered or uncovered
Post market surveillance</td></tr>
<tr><td rowspan="2">Low or uncertain</td><td colspan="3">Preliminary</td></tr>
<tr><td colspan="2">Type (1): low use & cost
- Simple monitoring
Type (2): high use or cost
- Retrospective literature review or expert decision making</td><td>Type (3) : prospective evaluation</td></tr>
</table>

Dotted: covered or uncovered; bolded: preliminary

Preliminary – Evaluation on suitability



Decision making after suitability evaluation



*Effect(+): improvement in treatment; convene(+): improvement in clinical process; cost-effect(+): cost-effective compared to alternatives; unmet(+): presence of unmet needs with no alternatives; demand(+): socially demanded

**No. in tabs: type of insurance decisions

Decisions on insurance benefit by suitability

- Insurance benefit
  - 1) Improvement in treatment effect & cost-effective
  - 2) No improvement in treatment effect but cost-effective
  - 3) Though not cost-effective, clinically essential
- Preliminary
  - 1) Improvement in treatment effect but not cost-effective
  - 1-1)No alternatives but a social need is low
  - 1-2)Alternatives
  - 2) No improvement in treatment effect but in clinical process (e.g. convince of procedure providers), not cost-effective but high social need with no alternatives

Decisions on insurance benefit by suitability

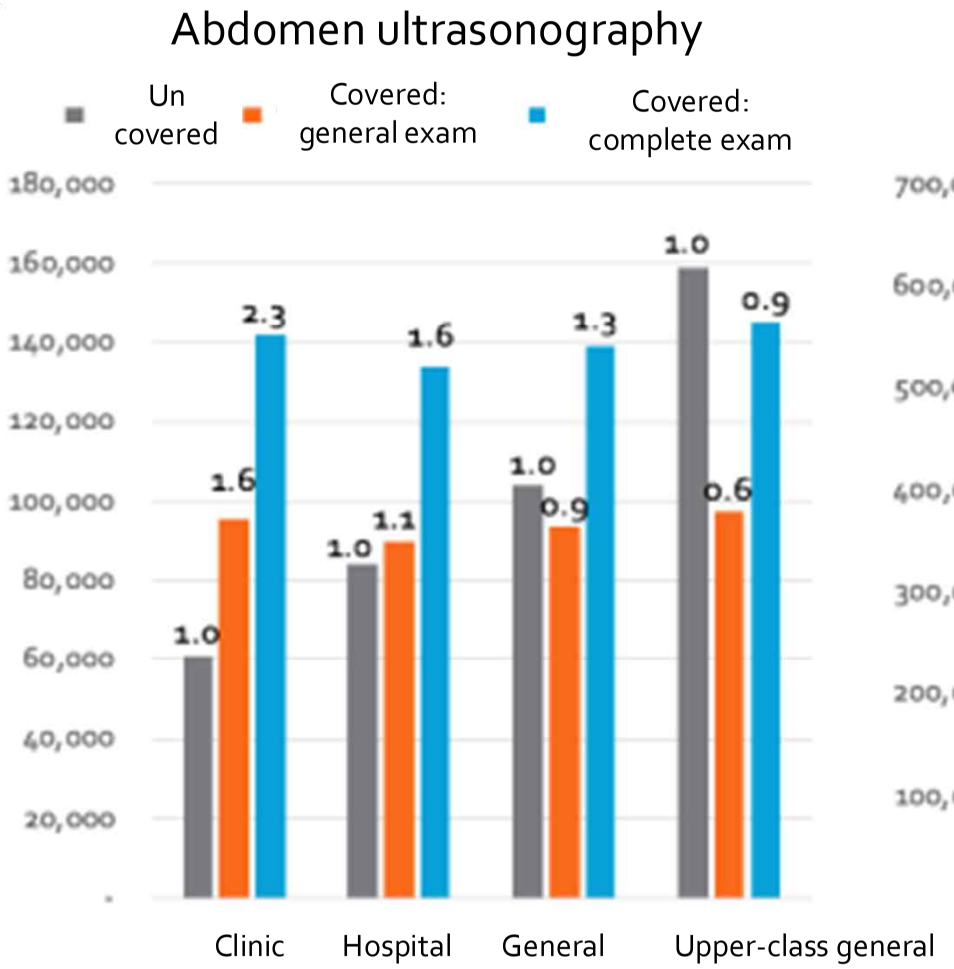
- Uncovered
  - 1) Similar to CED 2) but with low social needs
  - 2) Improvement in clinical process (e.g. convenience of procedure providers) but not cost-effective and with alternatives
  - 3) No improvement either in treatment effect or clinical process and not cost-effective
- Withdrawn
  - If with safety problems, the MFDS or nHTA agent cancels the approval of the nHTA so that it can not be used in the market

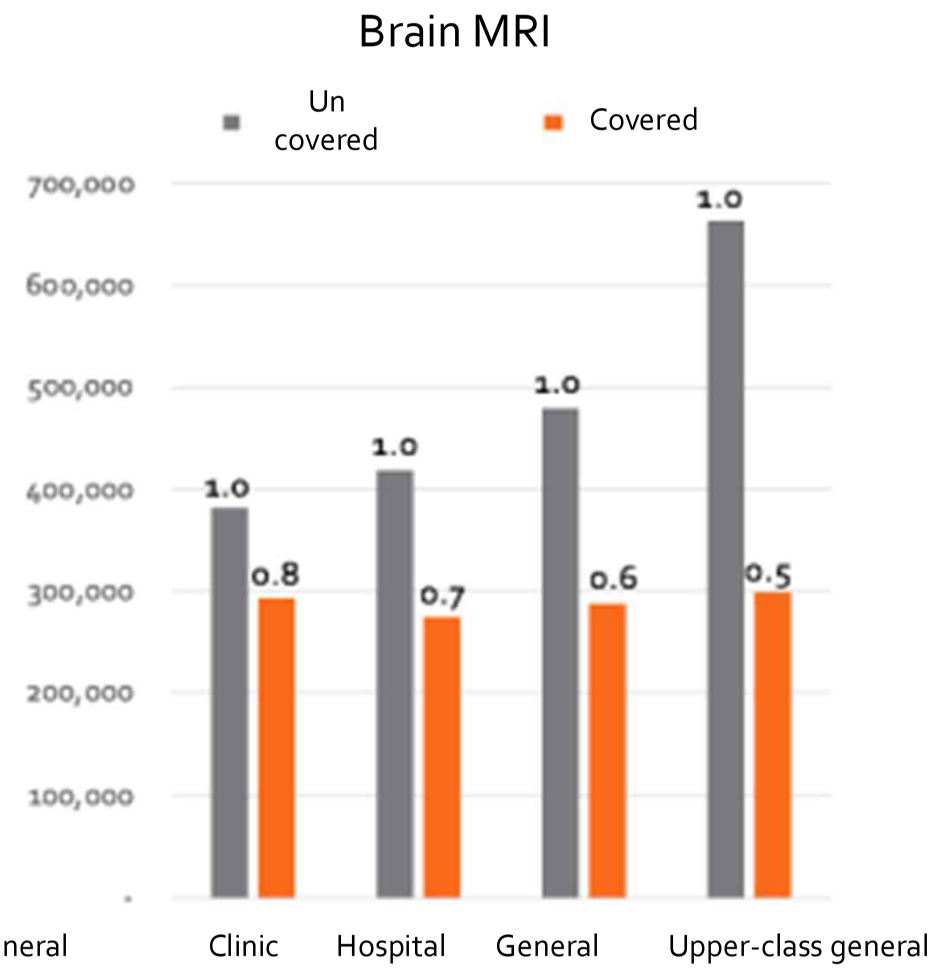
Preliminary: value-based insurance design

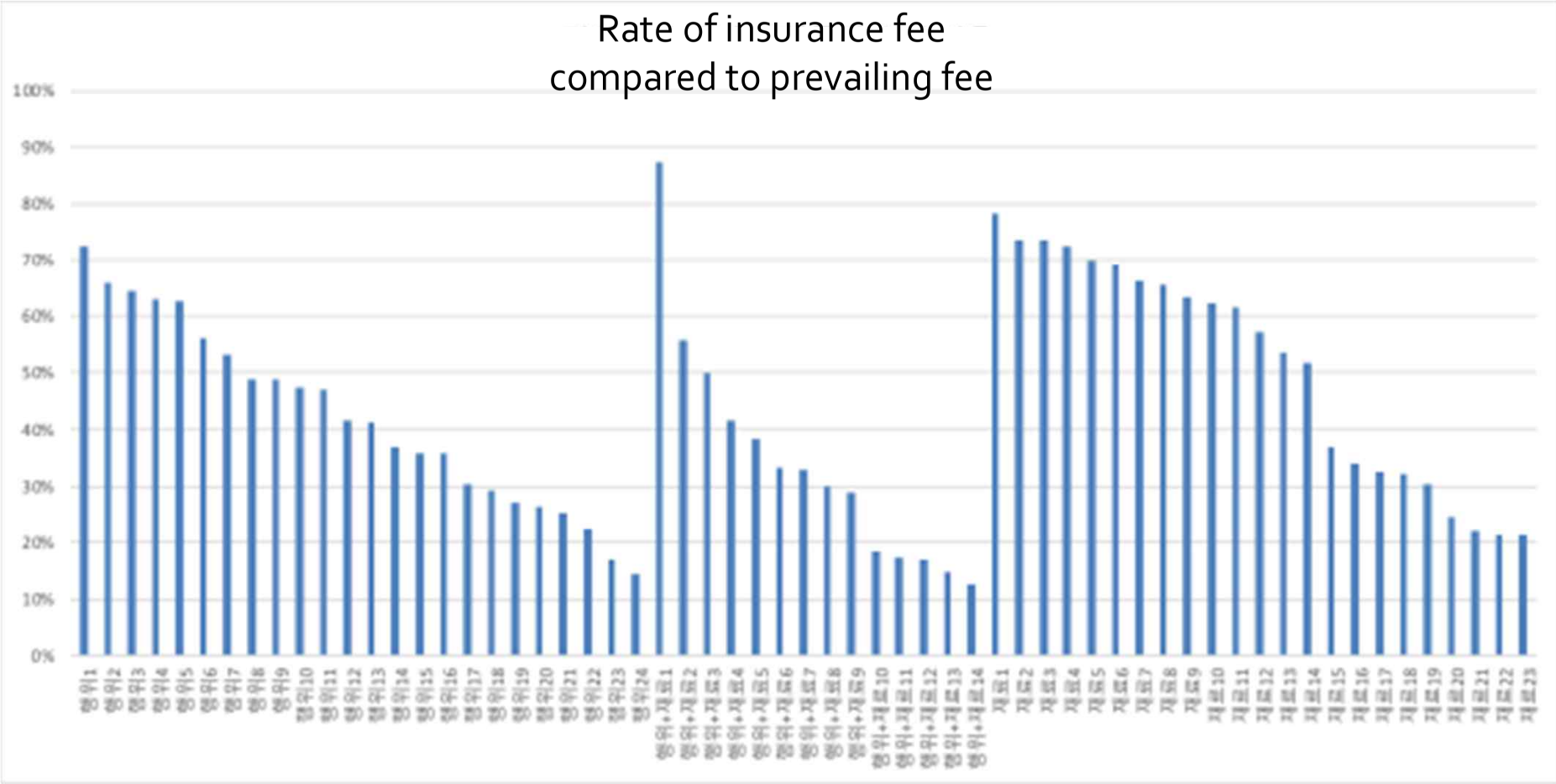
- High-value care – low rate of copayment
- Low-value care – high rate of copayment
- Demand-side strategy
  - Inducing utilization of high-value care – improvement of quality and efficiency
  - Reform of payment and delivery system – supply-side strategy
- Effectiveness
  - High value medicine – increase of use, improvement of a treatment compliance; low value medicine – decrease of use
- Systematization of copayment rate – in- and outpatient, value level
  - Value level – individual technology, organization of care: institution level, system level

Preliminary: effect of managing uncovered services

- Expected effect of preliminary insurance benefit
  - Repressing the balloon effect and reduce patient copayment
- Items among the 4 serious illnesses converted to the selective insurance benefit; the before-after comparison
  - Increased use in 3 items
  - No changes in 11 items
  - Decreased use in 7 items
- Interpretation –
  - Decrease of supplier-induced demand due to the declined prices of uncovered services
  - Increase of utilization due to the declined prices
  - Coordination by evaluation – few


Abdomen ultrasonography
Un covered
Covered: general exam
Covered: complete exam
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
1.0
1.6
2.3
1.0
1.1
1.6
1.0
0.9
1.3
1.0
0.6
0.9
Clinic
Hospital
General
Upper-class general


Brain MRI
Un covered
Covered
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
1.0
0.8
1.0
0.7
1.0
0.6
1.0
0.5
Clinic
Hospital
General
Upper-class general


Rate of insurance fee
compared to prevailing fee
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Conversion to selective insurance benefit: before-after comparison of price, utilization, cost

Table 1. Conversion to selective insurance benefit by type: before-after comparison of price, utilization, cost

	Utilization			Expenditure (100 million KRW)			Cost		
	Before	After	B/A*100	급여 이전(A)[1]	급여 이후(B)[2]	B/A*100	급여 이전(A)[1]	급여 이후(B)[2]	B/A*100
Overall	360,272	130,633	36%	5,370	885	16%	1,490,513	677,164	45%
Performance	48,923	30,381	62%	2,540	320	13%	5,191,832	1,053,290	20%
Material	311,349	100,252	32%	2,830	565	20%	908,916	563,181	62%

1) 관련 학회 제출 자료를 근거로 추정한 비급여 사용량, 가격

2) 선별급여 적용 이후 사용량과 가격

3) '15년 말 선별급여 고시항목(행위 12개, 치료재료 9개)을 대상으로 분석

*자료 : 건강보험심사평가원. 선별급여운영평가. 2017

Utilization change by type of selective insurance fee

Div.	Increased	Decreased	No change	Total
Type				
Performance	1	4	4	9
Material	2	3	7	12
Copay rate				
50%	3	2	6	11
80%	-	5	5	10
Effect				
Proved	-	2	4	6
Expected	2	4	5	11
Not expected	1	1	2	4
Alternatives				
Totally	-	4	2	6
Partially	-	1	6	7
Complemented	2	2	2	6
No alternatives	1	-	1	2
Total	3	7	11	21

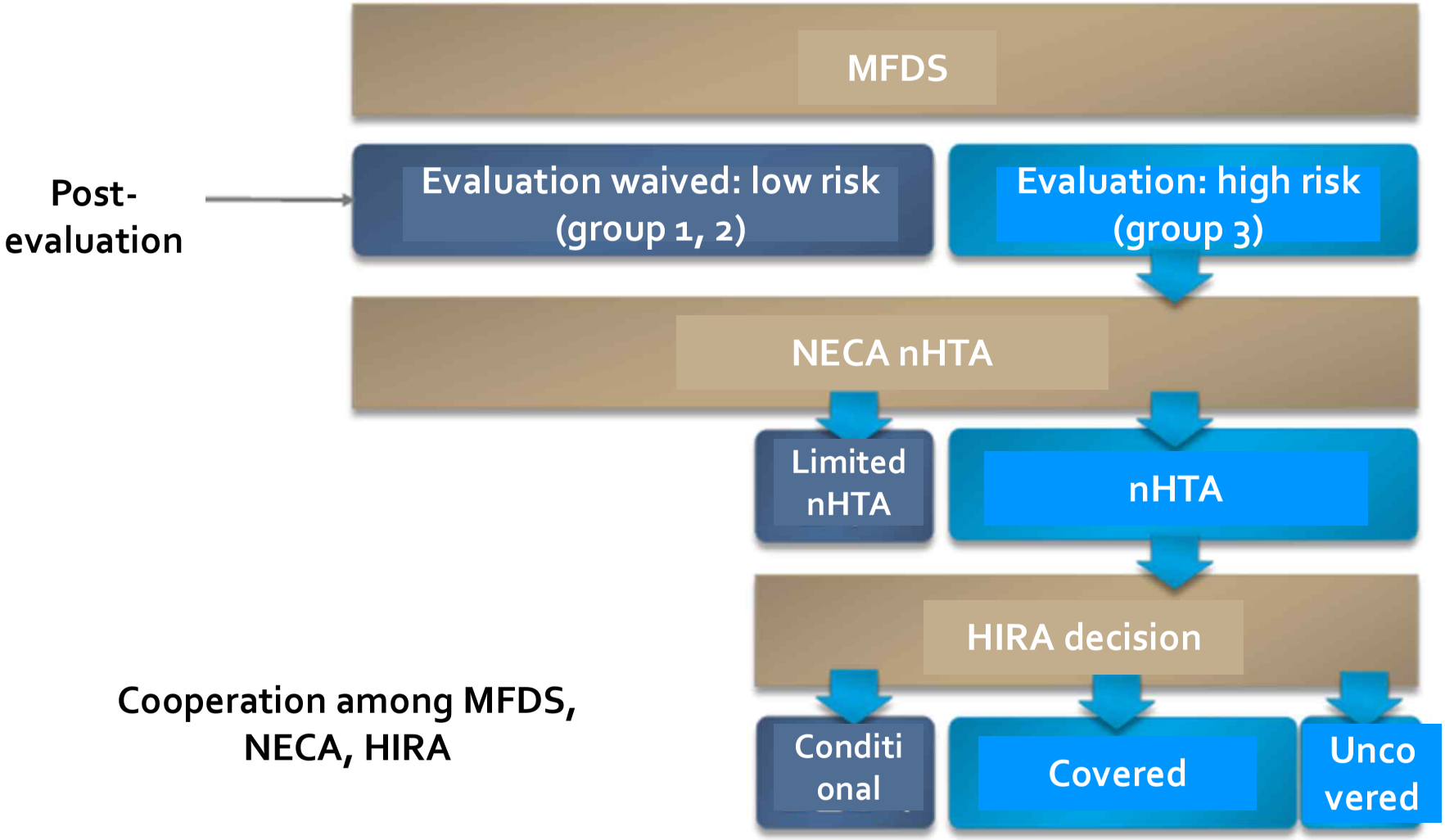
Reform of health technology regulation

- Additional fee for innovation therapeutic materials
  - Improvement in adverse events, function, and procedure convenience etc.
- Conversion to entrance first – evaluation later
  - Safe health devices (e.g. vitro-diagnostic devices)
- Resolving gray zone (unpredictability) in regulation process
  - Improving transparency in HTA process
  - Practical one-stop service system of approval and permission

Improving HTA system

- Risk category based evidentiary requirement
- Coverage with evidence development
- Value based purchasing

Improving HTA system



Risk category based evidentiary requirement

	Risk level	Required evidence
US	Class I: no risk to possibly disregarded (e.g. stethoscope)	Not required
	Class II: low risk (e.g. syringe, ECG)	Equal to the preexisting ones – not required Not equal – ask for setting grade 1 or 2 through de novo process (FDA homepage)
	Class III: medium to high (e.g. heart defibrillator, cardiac pacemaker)	Evidence on safety and effectiveness Probation for rare diseases
EU	Class I: no risk to possibly disregarded (e.g. thermometer)	Not required
	Class IIa: low (e.g. IV) Class IIb: medium (e.g. hemodialyzer, artificial joint)	Literature (clinical or non-clinical) on safety and performance
	Class III: medium to high (e.g. cardiac pacemaker)	Evidence focusing on safety

Coverage with Evidence Development (CED)

- Application of health insurance
  - Limited HTA
- Clear criteria for application
- Explicit and transparent management system
  - Decision making (e.g. suspension of insurance) according to protocol, limitation on institution to conduct nHTA, evaluation process and result
  - Predetermination of size of finance for insurance and research

Value-based purchasing

- Adopting value-based (including health outcomes) purchasing
  - UK: Provides incentives based on patient reported outcome measures (PROM) reflecting quality of life in the joint replacement
  - NHS England, 2015
- Elastic system of pricing
- Controlling overuse of nHTA and wasful expenditures
  - Characteristics of technology and financial inducements
  - Care culture, characteristics of hospital organization, attitude of a leading clinical doctor

MANAGEMENT OF UNCOVERED SERVICES

Prevention of the balloon effect of uncovered services

- Benefit expansion is necessary to resolve the balloon effect
- Absence of institutional strategies to control emergence and expansion of new covered services in essential medicines
- Prohibition of mixed care
  - Mixed care is practically prohibited in plastic surgeries and uncovered health screening because all expenditures are uncovered
  - Inconsistency in robotic surgeries where insurance is applied for covered services (hospitalization)

Management policy of uncovered

- (Steps for decision making)
  - Management system of preliminary insurance: 항목비급여, 기준비급여
- (Steps for care)
  - Prior consent of patients for uncovered services
  - Prohibition of mixed care
- (Management system of uncovered system)
  - Management of information of uncovered services: code, bill
  - Management of price
  - Reinforcement of disclosing uncovered service information

Prohibition of mixed care

- (Type 1: disease)
  - Care of diseases which do not interrupt work or daily life
- (Type 2: service)
  - High price service of which primary is uncovered service

별표 2의 1에 규정된 업무 또는 일상생활에 지장이 없는 다음 질환

가. 단순한 피로 또는 권태
나. 주근깨, 다모(多毛), 무모(無毛), 백모증(白毛症), 딸기코(주사비), 점(모반), 사마귀, 여드름, 노화현상으로 인한 탈모 등 피부질환
다. 발기부전(impotence), 불감증 또는 생식기 선천성기형 등의 비뇨생식기 질환
라. 단순 코골음 마. 질병을 동반하지 아니한 단순포경(phimosis)
바. 검열반 등 안과질환
사. 기타 가목 내지 바목에 상당하는 질환으로서 보건복지부장관이 정하여 고시하는 질환

혼합진료금지 적용 예시	혼합진료금지 적용 제외 예시
◆ 친자확인을 위한 진단 ◆ 치과의 보철 및 치과임플란트를 목적으로 실시한 부가수술 ◆ 급여결정 이전 신의료기술 ◆ 경제성이 불분명한 검사,처치,수술,치료재료 ◆ 한방첩약 및 기성한의서의 처방등을 근거로 한 한방생약제제	◆ 상급병상 ◆ 요양병원과 호스피스 등의 비급여 병상 ◆ 비급여 보장구와 관련된 진료 ◆ 장기이식을 위한 장기 운반 비용 ◆ 마약류중독자의 치료보호에 소요되는 비용 ◆ 제한적 의료기술 ◆ 장기이식 또는 조직이식에 사용하는 의료기기 ◆ 한방물리요법 ◆ 허가초과 약제

Prior consent of patient for uncovered services

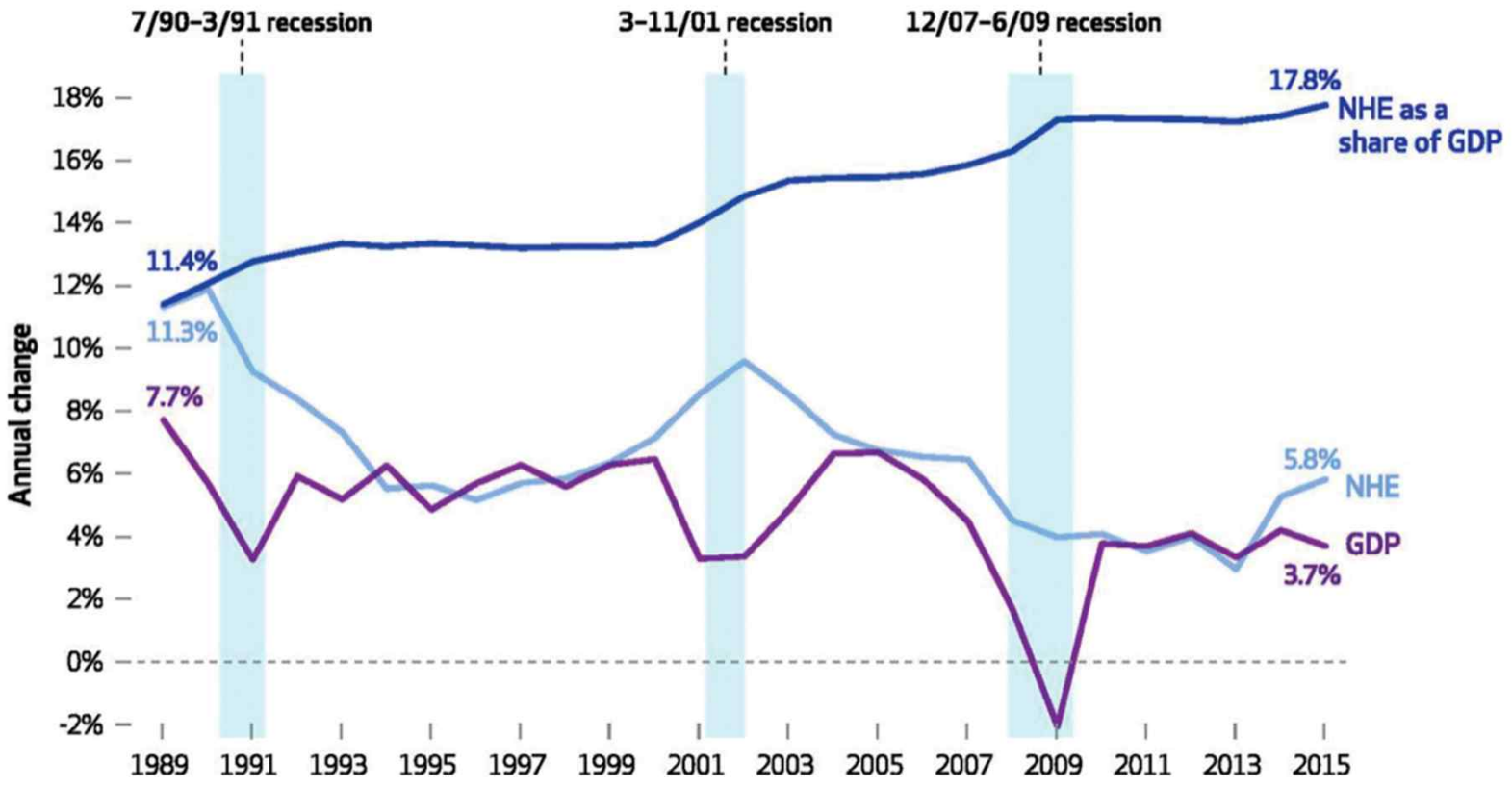
Type of uncovered services		Prior consent	Claim for medical fee	Prior single payment by patient
Covered: excessed	Medically essential (+)	O	O	O or X
	Medically essential (-)	O	Δ	O
Uncovered	Items prohibited for mixed payment (+)	O	X	O
	Items prohibited for mixed payment (-)	X	X	O

A PIOLT FOR INNOVATION

Subject and motivation of innovation

- US: CMS Innovation Fund
  - In Obama Care Act, the investment of approximately 10 trillion KRW for the US health care innovation for 10 years is stated
  - Center for Medicare and Medicaid Innovation under CMS
  - Large-scale pilot projects (e.g. ACO, PCMH, CPC, PICORI)
- UK: New care models
  - Large-scale pilot projects for new delivery system and financial mechanism
- German
  - Innovation fund under federal association
  - Development and expansion of nHTA

Figure 1
Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989–2015.



Source: Martin et al., *Health Affairs, 2016*

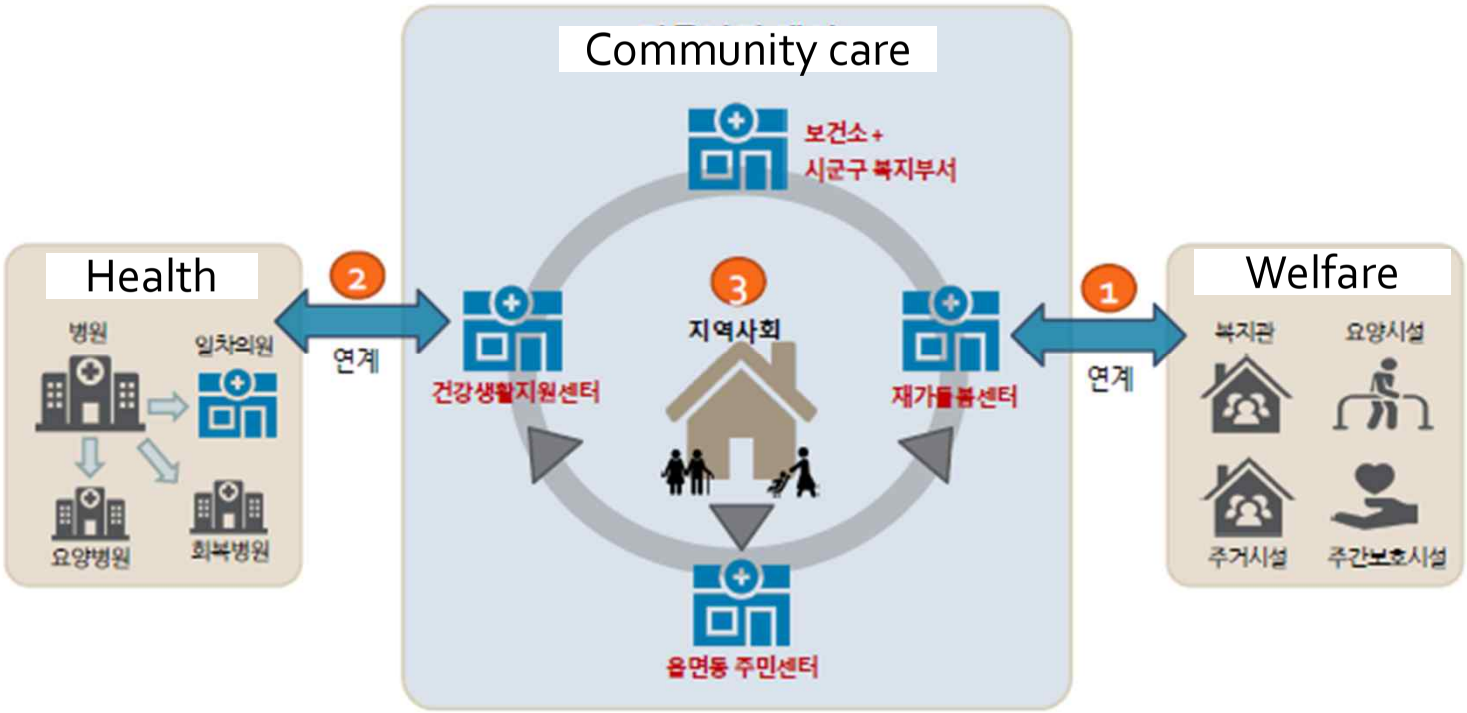
Common factors of pilots for innovation

- Raising fund for large-scale pilot projects for innovation
  - Learning new payment and delivery system model through pilots
- Continuous expansion of large pilots and advancement models
- Improvement of patient care process and service model through continuous learning
  - Learning network
- Promoting pilots based on voluntary participants of health providers and patients

Pilot of accountable care organization (ACO) using region base hospitals

- Composing regional ACO – comprehensive service
  - University hospital + medium- & small size hospital + clinic + sub-acute hospital + long-term hospital & facility
  - Motivating participation of national university hospitals – linking to national university transfer
- Object – Medicaid patients+voluntary participants
  - US: Medicaid Managed Care = Social HMO
- Mixed payment system
  - Fee for primary care patient management – per patient : waive of copayment
  - Saving sharing
- Support – financial support for initial investment & participation incentive 5%
  - Financial support for adopting EMR – exchange of patient information
  - Financial support for running administration – education, group purchase, managing information
- Duration of the project – evaluation after 3 years

Community care model: Object



Linking-combining NIH and long-term care insurance

- Comprehensive service based on the same criteria for benefits
  - Reinforcing link of long-term care hospital-long-term care facility-community social services
- Expansion of long-term care beneficiary & improvement of community services
  - Community service-group home, daytime recovery, nurse visit, home help service etc.

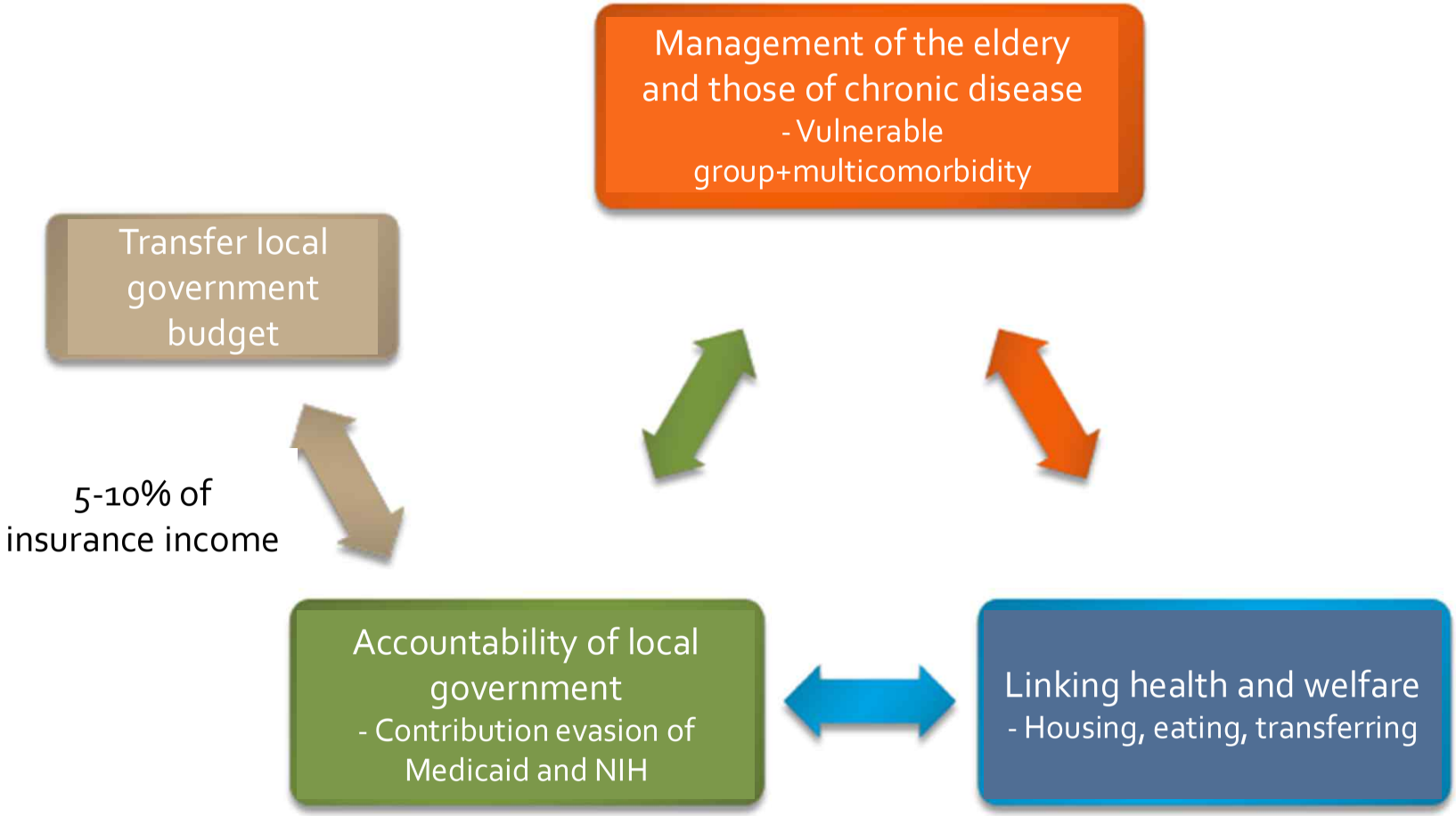
[Current]

Severity	Grade 1-2	Grade 3-5
Severe	Long-term care hospital (long-term hospitalization) Long-term care facility (long-term hospitalization)	Long-term care hospital (long-term hospitalization)
Minor	Long-term care facility (long-term hospitalization	Long-term care hospital (long-term hospitalization)

[Reformed]

Long-term care hospital (short-term hospitalization then, transfer to long-term care facility)	Long-term care hospital (short-term hospitalization)
Long-term care facility (long-term hospitalization	Community Management-expansion (group home etc.)

Link of health & welfare by accountability of local governments for public health



Thank you.

yoonkim@snu.ac.kr

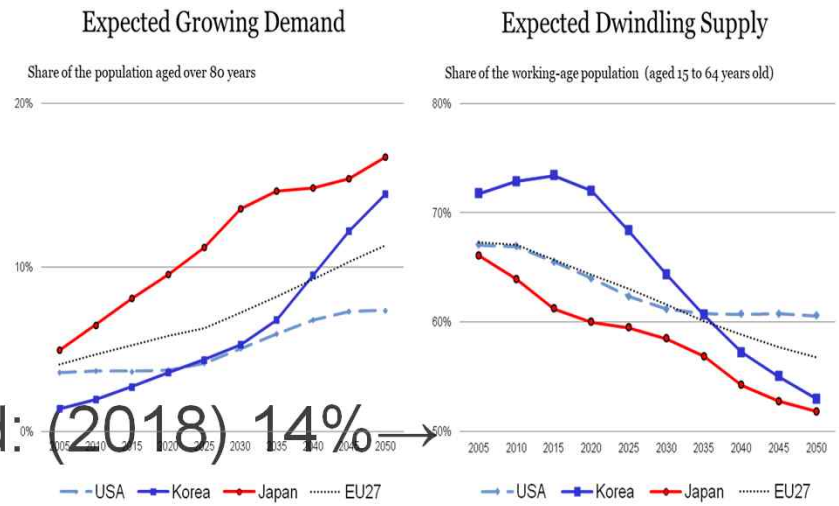
<NHIS International Symposium, 2018.11.23 >

Strategies of Health and LTC Insurance in response to Population Ageing

JEONG, Hyoung-Sun
Professor
Yonsei University, Korea

Challenges of Ageing

Population

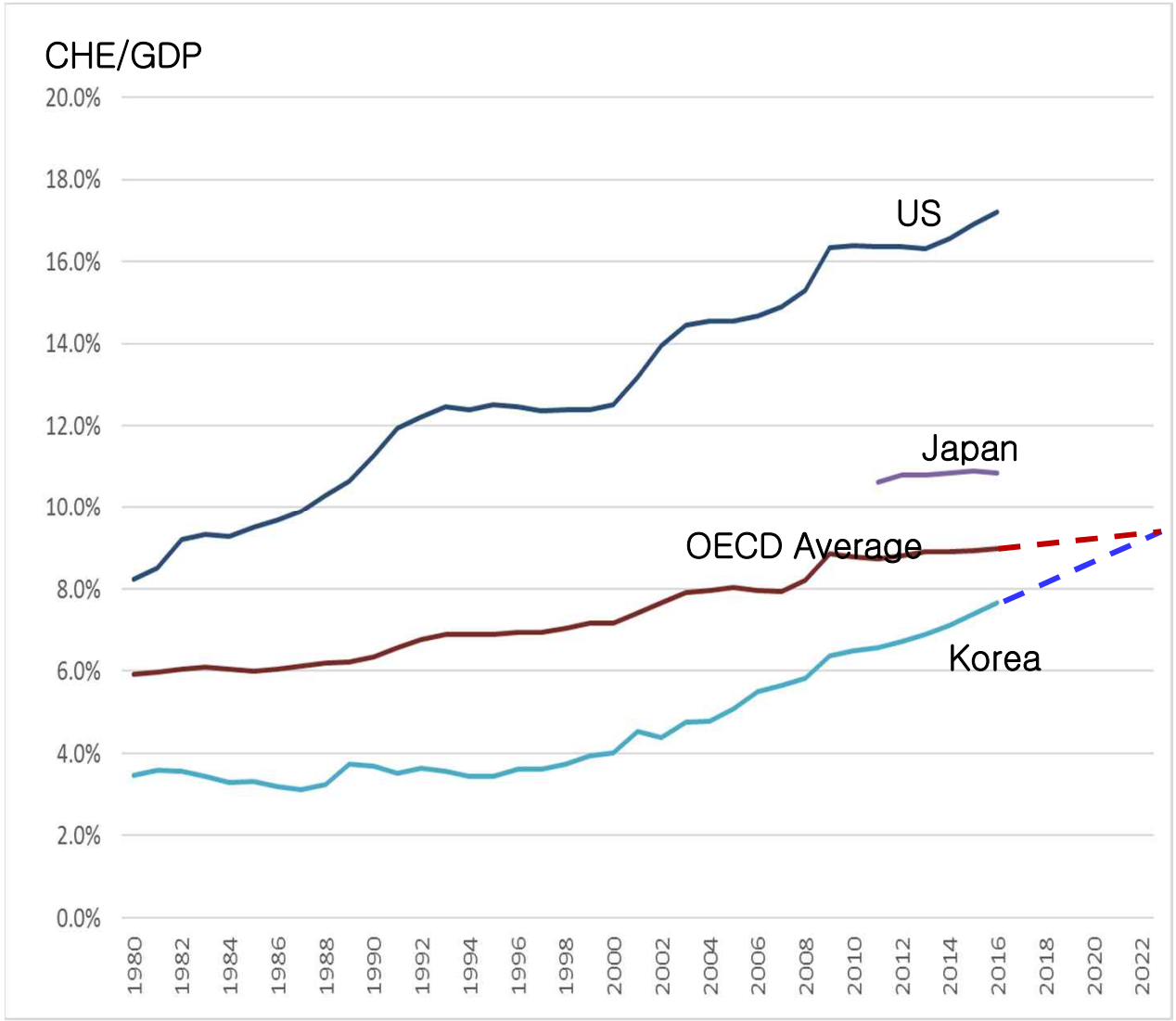


rapid increase of the aged: (2018) 14%→

(2025) 20%

- baby boomers entering aged population group in 2020
- rapid increase of the aged in 80 or over : (2017) 1.53M→ (2025) 2.46M
- rapid increase of ageing-related diseases including cancer and dementia : for-life management rather than complete treatment

Burden of Cost



No service delivery system to fulfill diverse

No system to provide consistent and

1. Lack of linkage among welfare(life)-LTC-public health-medical care
2. Fragmented provision of acute service, sub-acute service (convalescence rehabilitative service) and maintaining/living rehabilitative service
3. Over-competition between health-insurance-financed LTC hospitals and LTC-insurance-financed LTC facilities
4. Dead zone of health/nursing care in LTC facilities and group homes

Counterstrategies

0 Counterstrategies

『Healthy Ageing』 through community care

What is “Community Care”?

- Focus is put on not only the ‘services’ delivered but the “community” where such services are delivered

지역 중심의 서비스는 ‘지역을 중심으로 살아가는 개인’에게 주어지고, 개인은 ‘지역에서 그러한 서비스에 쉽게 접근할 수 있어야’한다.

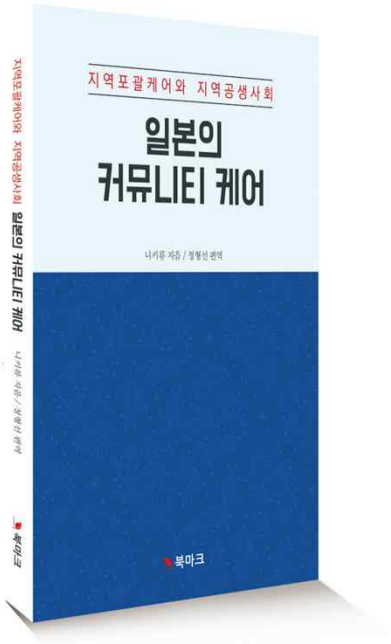
커뮤니티 케어는 ‘지역’이라는 필드를 중심으로 다양한 케어 또는 서비스가 제공되고 이용될 수 있는 상황을 전제로 한다.

- The gist is that diverse services are linked and coordinated centered around a community

⇨ Integrated care, one-stop service and linked care are needed

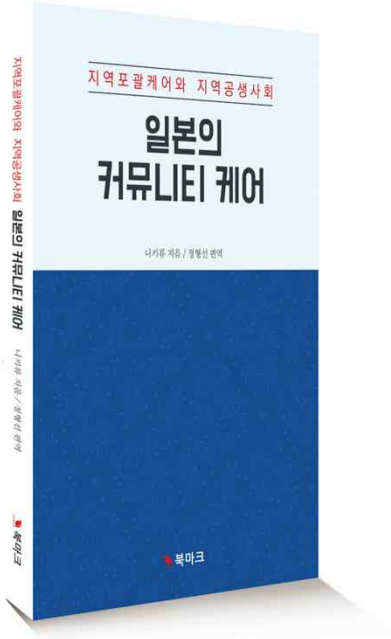
What ‘community’ indicates?

- My living home?
- My living town? apartment complex?
- As administrative units, my living EupMyonDong? ShiGunGu(localities)? or



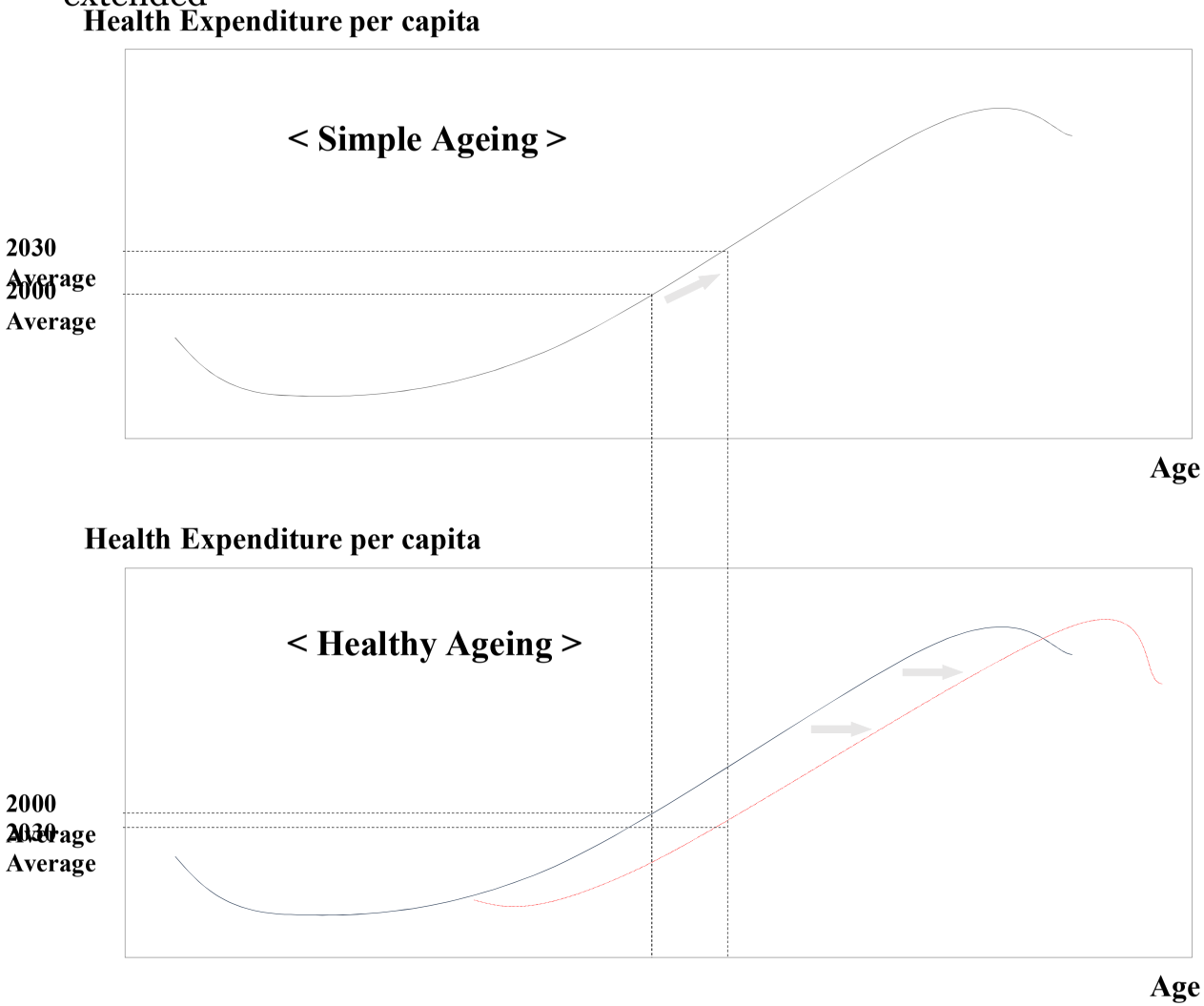
좁은 의미의 '커뮤니티 케어' 는 '<병원이나 시설>에서 나와 가정에 머물면서 지역을 중심으로 생활을 하고 지역을 단위로 연계된 서비스를 받는 것'을 의미

- ‘ Community ’ as opposed to ‘cities’?
- ‘ Community ’ as opposed to ‘hospitals’?
- ‘Community’ as opposed to ‘LTC



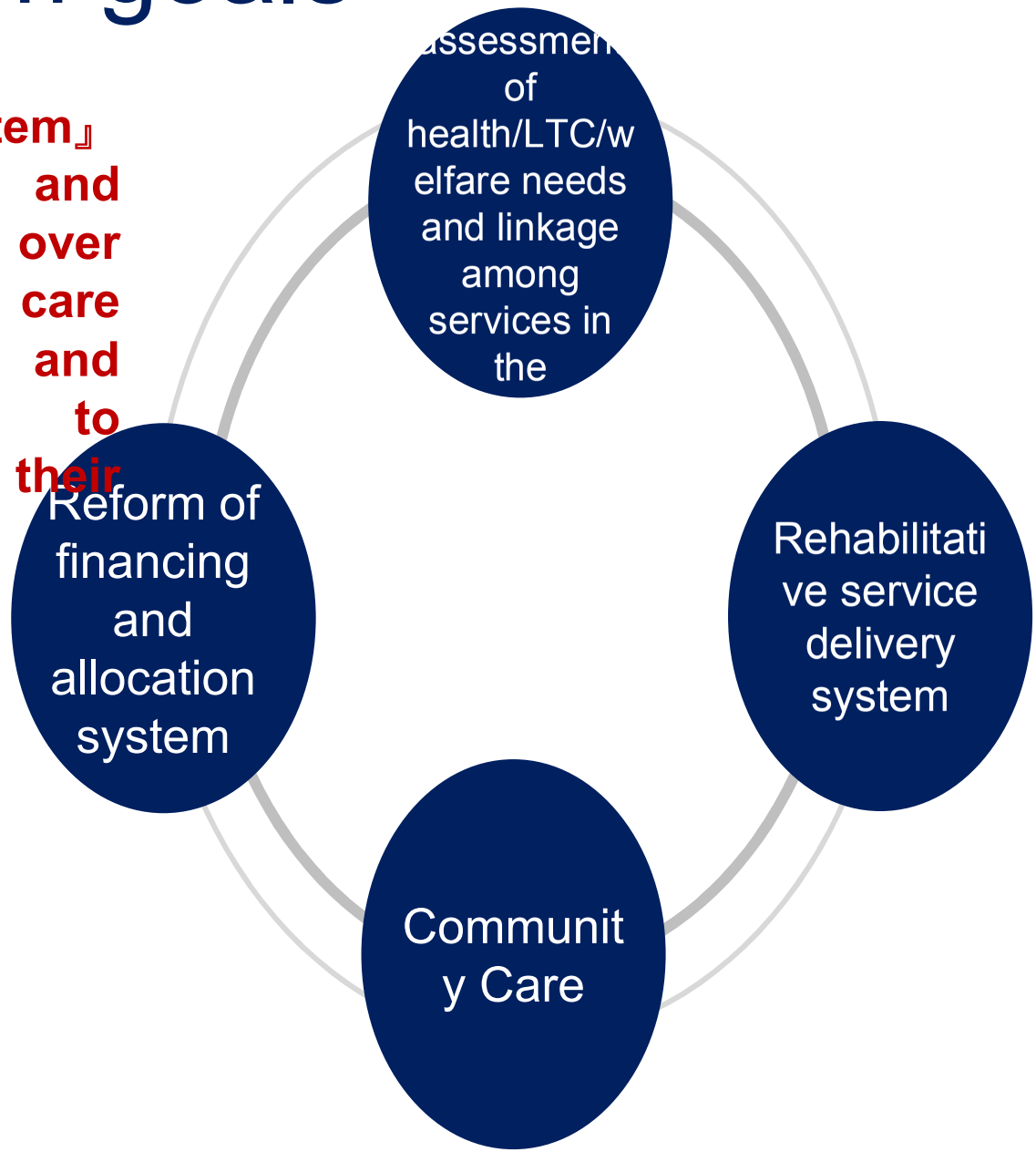
Healthy Ageing

- healthy Ageing: average lifespan being extended => improvement in people's health and functional status => potential working years being extended



0 Long-term goals

『Service Delivery System』 with consistent and comprehensive services over premorbid-to-terminal care and 『 Financing and allocation system』 to appropriately incentivize their delivery



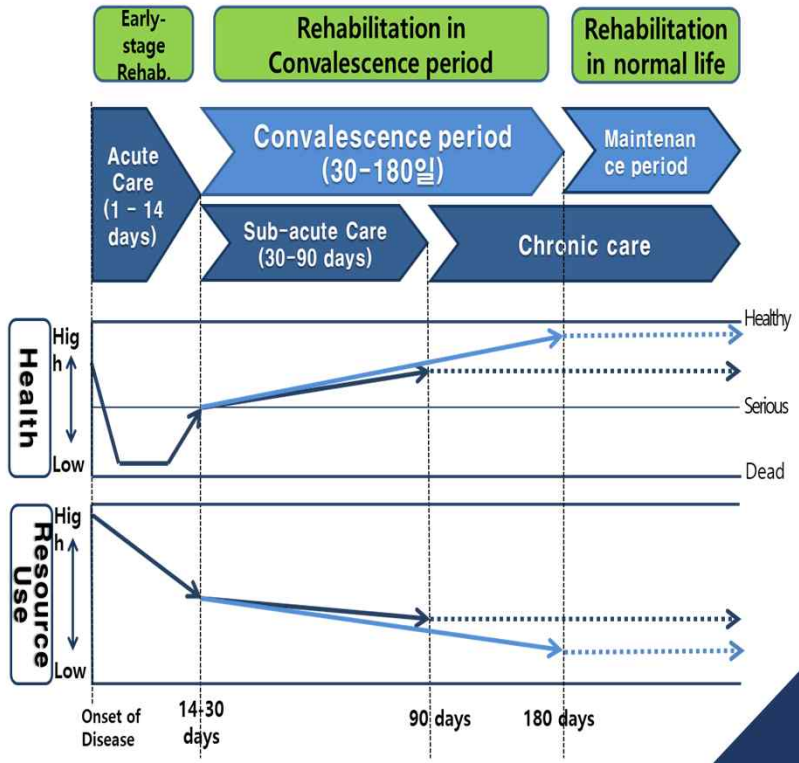
Pre-assessment of each elderly's health/LTC/welfare needs and helping patient discharging from

1. Pre-assessing each elderly's health history and current conditions and allocating him/her to appropriate health/LTC/welfare facilities
2. Care team's consistent assessment of patient's conditions while they are in hospitals or facilities
3. Care team and care managers of the community helping patients leaving hospitals/facilities to adapt to their home life.

Delivery system for rehabilitative services : appropriate provision of medical and LTC beds and

1. delivery of rehabilitative services appropriate for each episode of disease
   a. early rehabilitation at acute care ward/hospital
   b. convalescence rehabilitation at sub-acute care ward/hospital
   c. maintenance rehabilitation at intermediary institution

2. education and provision of enough medical and LTC personnel including doctors, nurses, helpers etc.



Community Care

1. Elderly can visit hospitals/facilities for curative/rehabilitative care while living at community including home or facilities.

2. Doctor’s home visit, nurse’s home visit, and day/night care are provided so that patients with serious medical and nursing care needs can live at home if they want.

3. Basic medical and nursing care can be supported in the LTC facilities : “professional nursing care units” and tele-care support.

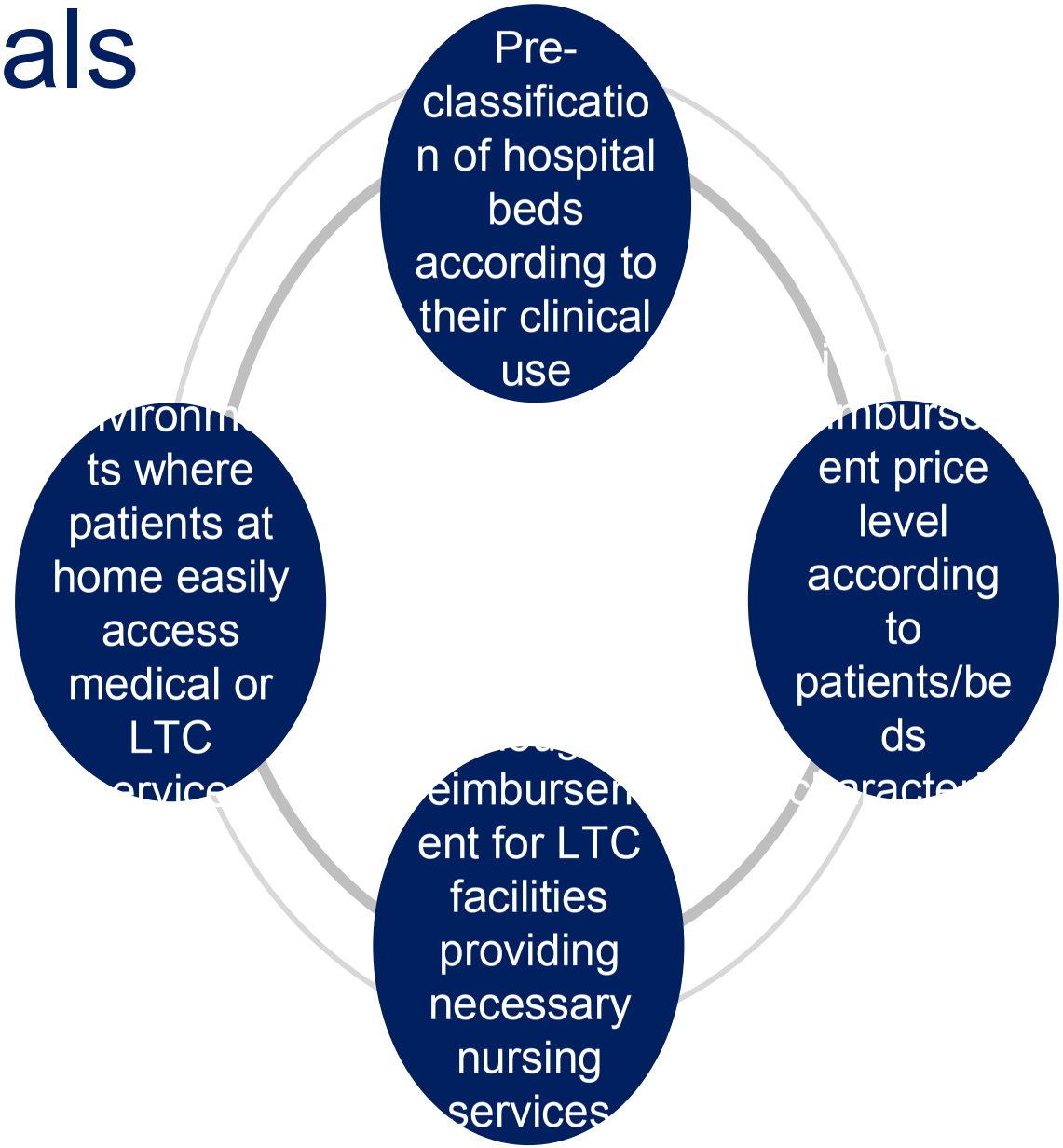
Reform of financing and

1. In the short- or mid-term run, health insurance finances LTC hospitals while LTC insurance finances LTC facilities, but merge of two insurances could be called into play in the long run.

2. Both LTC hospitals and LTC facilities should be reformed with insurance reimbursement mechanism being used as a pecuniary incentive.

0

Mid- or Short-term goals



Pre-classification of hospital beds according to

1. Hospitals can select in advance among acute care beds, rehabilitative care beds, chronic care beds which respectively have different obligations and different reimbursement payments.

2. To avoid over-competition between LTC hospitals as intermediary institution and LTC facilities

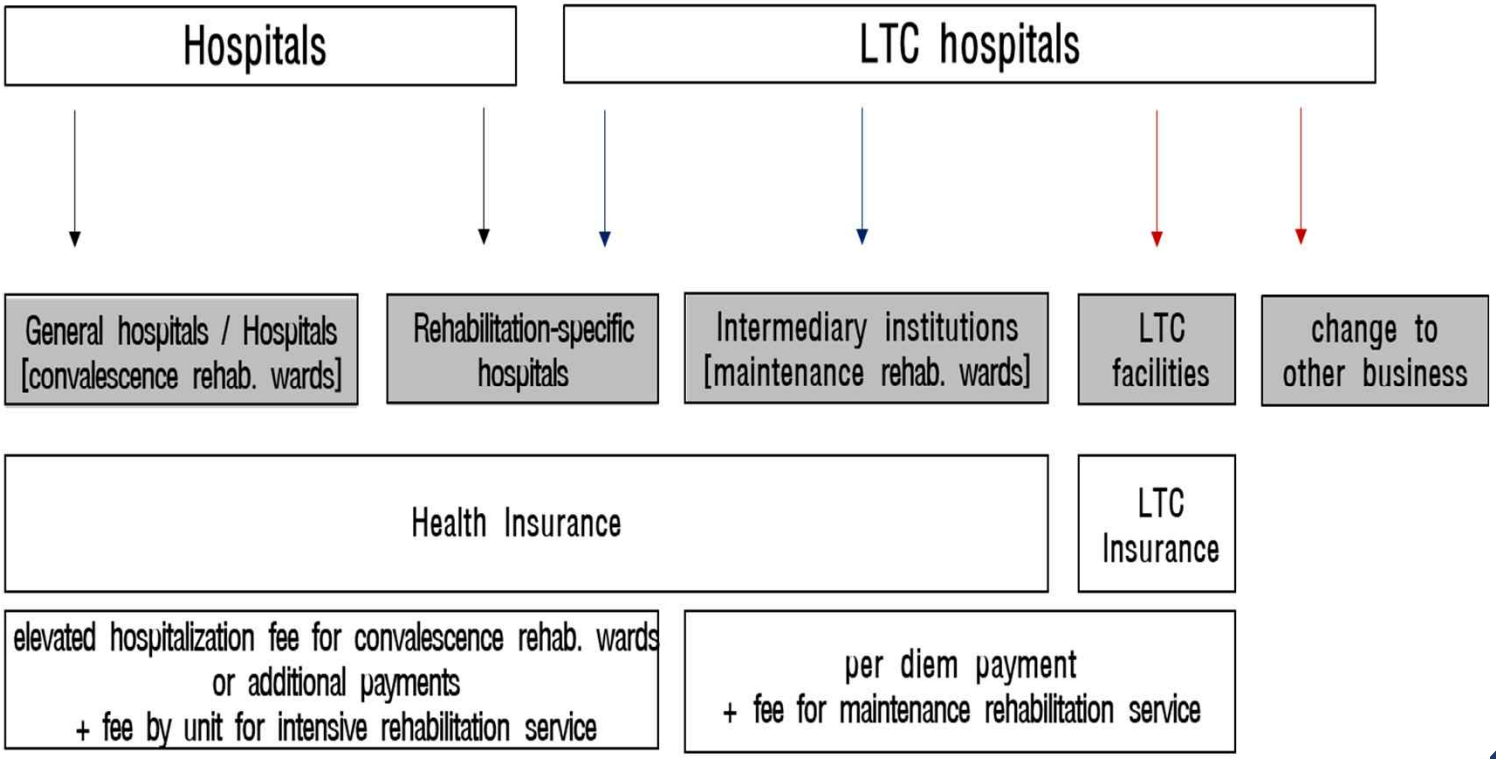
Reorganizing health insurance reimbursements to activate rehabilitation services

1. Additional payments for equipping with nurses or rehabilitation staff for early rehabilitation services

2. Higher payments for convalescence rehabilitation beds/wards/hospitals with intensive rehabilitation services

3. Extension of health insurance reimbursement for ambulatory rehabilitation services used by patients residing in the community including home and facilities

Reform of LTC hospitals



Enough reimbursement for LTC facilities providing

1. In the short run, elevating payments for necessary nursing care provided for LTC insurance recipients who reside in the LTC facilities

2. In the long run, resetting of financing mechanism between health and LTC insurances for doctor's visit and on-line services

Environments where patients at home easily access

1. Resetting of Health and LTC insurance payments to activate doctor's and nurse's home visit, day care service etc.

2. Extending Health and LTC insurance reimbursement items to activate 'critical path' in the community

   - additional payments for linkage and information provision (discharge plan, care coordination etc.) between hospitals and facilities or between hospitals/facilities and home