

The Service Sector Advancement: Issues and Implications for the Korean Economy
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Key Reform Agenda for Medical Service Market in Korea

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C O N T E N T S

Medical service market in Korea

Policy Issues

Reform agenda



Medical service market in Korea

■ National Health Insurance

- Covers the whole population
- Single insurer
 - Fee-for-service
 - Tight control on service price and quantity
- All hospitals and clinics required by law to accept NHI patients

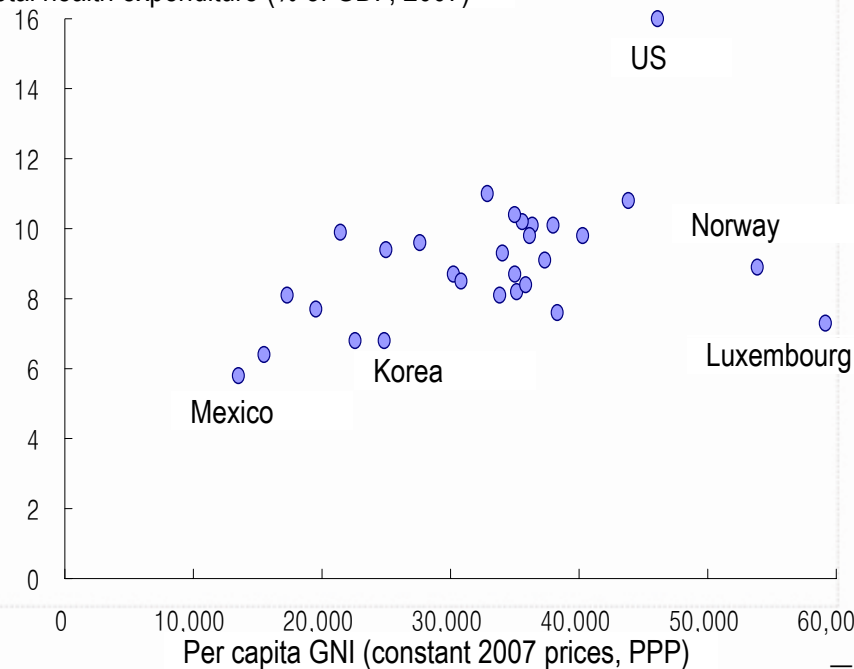
■ Relatively large amount of out-of-pocket payments

■ Relatively low level of total health expenditure

Public expenditure as a share of total health expenditure (%)

UK	France	Germany	Sweden	Switzerland	US	Korea
81.7	79.0	76.9	81.7	59.3	45.4	54.9

Total health expenditure (% of GDP, 2007)



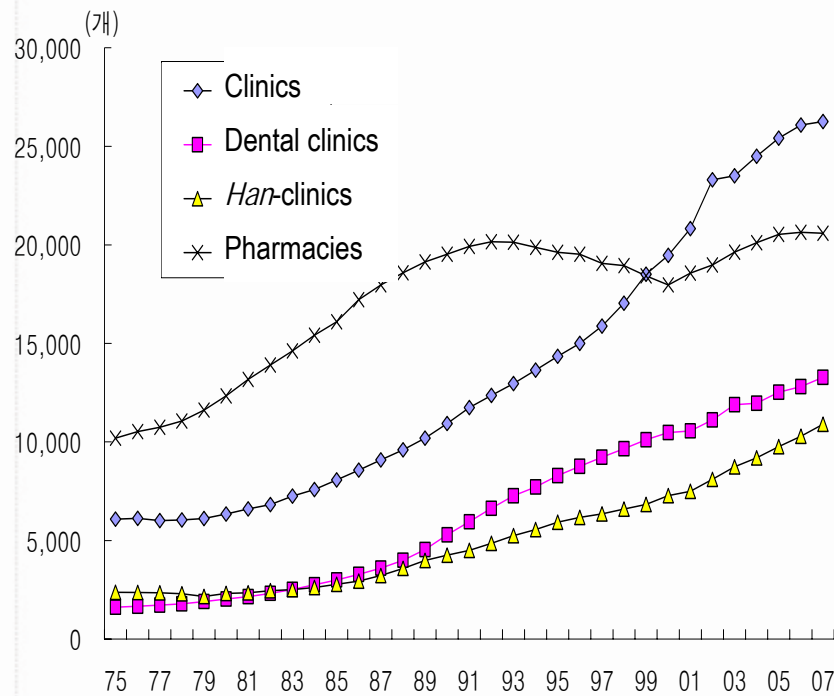
- Most of the hospitals and clinics owned privately by either natural or legal persons
- Gate-keeping non-existent
 - Patients preferring large hospitals to smaller ones

Number of hospitals by ownership

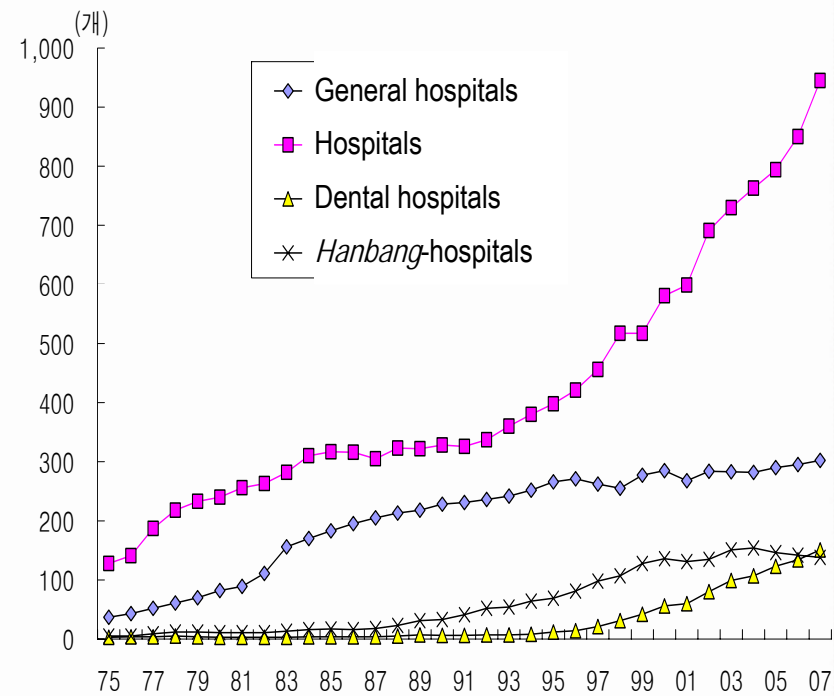
	General hospitals	Hospitals	Long-term care hospitals	Total hospitals	
				Number	%
Total hospitals	314	1,195	707	2,216	100.0
Public hospitals	60	45	43	148	6.7
Private hospitals	254	1,150	664	2,068	93.3
Legal persons	186	351	290	827	37.3
Medical legal persons	100	289	217	606	27.3
Natural persons	68	799	374	1,241	56.0

Increasing competition between service providers

Number of clinics and pharmacies



Number of hospitals



Note: Han and Hanbang refer to the traditional Korean medical practice.

Bankruptcy rates of hospitals

	(%)				
	2004	2005	2006	2007	2008
Total hospitals	8.1	5.9	5.9	8.0	6.8
General hospitals	1.4	0.0	2.4	1.0	1.6
Hospitals	10.4	7.7	6.5	9.1	5.3
Long-term care hospitals			8.8	9.6	11.8

- Increasing competition is strengthening the demand for capital and management skills

- Insufficient intervention in areas where the government should play an active role
 - Little information on the price and quality of individual service providers available to consumers
 - Poor quality assurance mechanism of health professionals
- Over-regulation in other areas
 - Monopoly of drug sales by pharmacists
 - Ownership restriction on hospitals and pharmacies



Policy issues

- Little information on the price and quality of individual service providers available to consumers
 - Consumers cannot make an “informed choice,” and often base their choice on the size of hospitals.
 - Hospitals compete for consumers not by lowering prices and improving qualities but by enlarging their sizes.

- Foreign example
 - The Netherlands: The government operates a national portal that enables consumers to compare medical institutions.
 - United States: In addition to the detailed results of hospital evaluation that are sent to hospitals, the hospital accreditation agency publishes a summary report for the general public to facilitate their choice of hospitals.

- No system for periodic revalidations of health professionals
 - Number of active doctors not known
- Continuing education requirements not really binding

Revalidation of the medical profession in European countries

Country	Time frame (years)	Types of revalidation		Compulsory
		Continuing medical education and continuing professional development	Peer Review	
Austria	3	Y	Y	Y
Belgium	3	Y	Y	N
France	5	Y	Y	Y
Germany	5	Y	Y	Y
Hungary	5	Y	Y	Y
Ireland	5	Y	Y	Y
Italy	3	Y	N	Y
Netherlands	5	Y	Y	Y
Switzerland	N/A	Y	N	Y
United Kingdom	5	Y	Y	Pending

Source: Merkur et. al.(2008).

■ Monopoly of drug sales by pharmacists

- Drugs such as pain reliever and digestive aid that pose little health risks cannot be sold in general stores.

■ No system for periodic reclassification of drugs

● Reclassification of drugs

- Prescription drug (at the time of introduction) →
- Non-prescription drug sold in pharmacies (after safety and effectiveness has been proven) →
- Non-prescription drug sold in general stores (with further proof of safety)

● No systematic reclassification mechanism in Korea

- The most recent reclassification in 2000 as a part of the separation reform
- Discussions on reclassification centered around the interests of doctors and pharmacists, not those of consumers

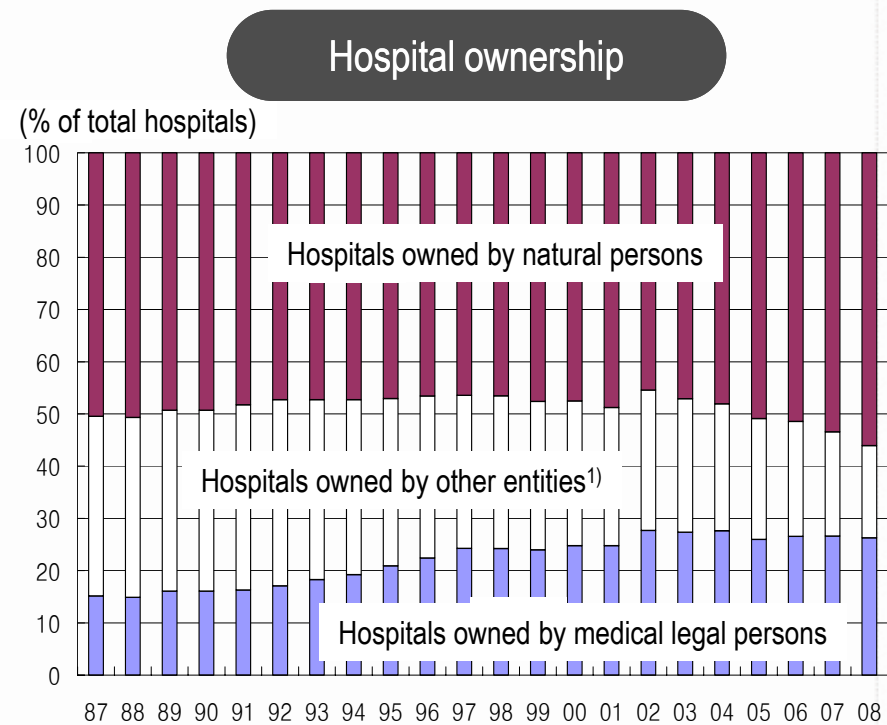
■ Types of medical institutions

- Clinics: Equipped with less than 30 beds, mainly for outpatient services, owned by doctors practicing alone or with hired hands
 - Private enterprise of owner-doctor
 - A doctor can open only one clinic.
- Hospitals: Equipped with at least 30 beds, mainly for in-patient services
 - Ownership allowed only to
 - Doctors
 - Central and local governments
 - Non-profit institutions (public agencies, medical schools, etc.)
 - “Medical legal persons”: A special type of non-profit hospitals specified in the Medical Law, introduced with the prohibition of for-profit legal persons (investor-owned hospitals) in the early 1970s

- Most countries do not prohibit the market entry by for-profit hospitals
 - United States
 - Initially, the American Medical Association (AMA) prohibited the corporate practice of medicine.
 - The Federal Trade Commission challenged this decision and won the case against AMA in the federal supreme court, which ruled the prohibition unconstitutional.
 - Japan
 - Investors do not receive dividends but their equity shares are recognized by the law.
 - Netherlands
 - For-profit activities are prohibited altogether for all forms of businesses.

■ Asymmetric regulation

- For-profit activities are allowed to clinics and hospitals owned by doctors, but prohibited to legal persons.
- All clinics and about half of the hospitals are already for-profit institutions.



Note: 1) Other entities include central and local government, medical schools, and other not-for-profit institutions.

■ Fostering non-transparent business practices

- Wide-spread efforts to evade the ban on profit-sharing
 - The *de facto* owner of a non-profit hospital sets up a separate supplier firm, and buys medical supplies at above-market prices.
 - A supplier or an investor hires a doctor, opens a clinic under his/her name, and shares profits.
 - A doctor hires a doctor, opens a branch clinic under his/her name, and shares profits.
- Non-profit hospitals are not really non-profit in nature.
 - No explicit requirements (e.g., “community services”) on non-profits to receive favorable tax treatment
 - Most of the non-profit hospitals are those converted from for-profit institutions to avoid inheritance taxes for the descendants of the original owner.
 - The original owner or his/her descendent usually works as the chairperson of the board of directors.

■ Still more restrictive

- Only type: Pharmacy owned by a pharmacist as a private enterprise
 - No legal person (for-profit or non-profit) is allowed.
 - A few years ago, the Constitutional Court declared the current regulation unconstitutional. But no legal change has been made yet.

■ Problems

- Cooperation between pharmacists (let alone with non-pharmacists) impossible except in the form of partnership
 - Difficult to mobilize a large amount of capital
 - Small scale, with an insufficient variety of medicines to meet the customer demand
 - Each pharmacist working a very long hour, with a poor quality of service



Reform agenda

- Enable “informed consumer choice” by producing and disseminating information on the price and quality of individual service providers
 - Will lead to a better functioning of the market
 - Low-cost and high-quality providers gaining larger market share
 - Of particular importance for a successful introduction of for-profit medical legal persons
- Introduce a periodic revalidation of health professional and strengthening their continuing education
 - Revalidation conditional on the completion of required continuing education

- Allow those drugs with sufficient records of safety and effectiveness to be sold in general stores
 - Establish a reclassification system of drugs
- Abolish ownership restrictions on hospitals and pharmacies
 - Allow the market entry by investor-owned hospitals
 - Allow a legal person type of pharmacies
 - Make non-profit institutions really non-profit
 - Set out explicit requirements to receive favorable tax treatment
 - Open exit paths for non-profits, including M&As
- Let doctors open branch clinics
 - On the condition that they hire pay doctors to work in branch clinics



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