Health System and Financing for COVID-19: Lessons from South Korea

P4H
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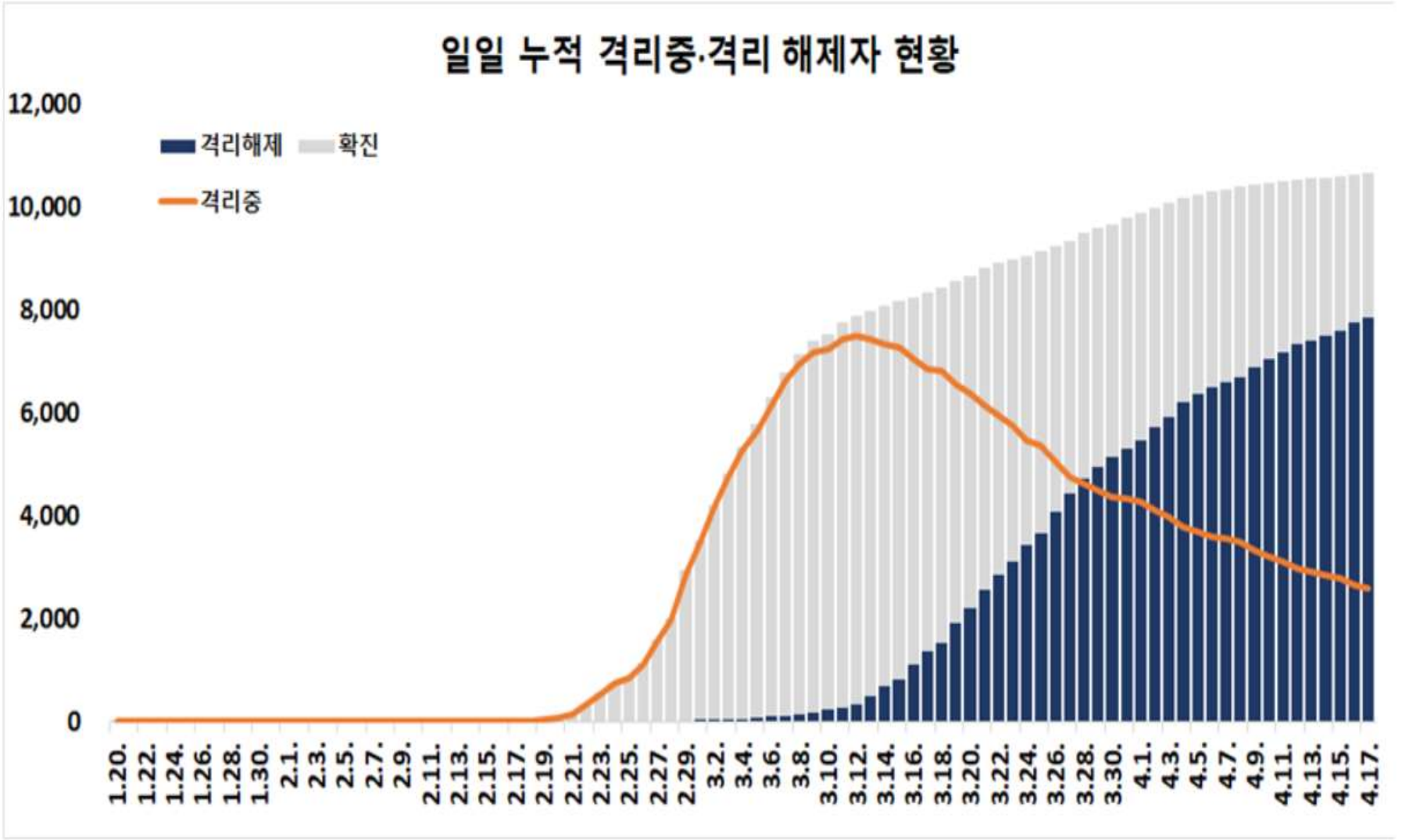
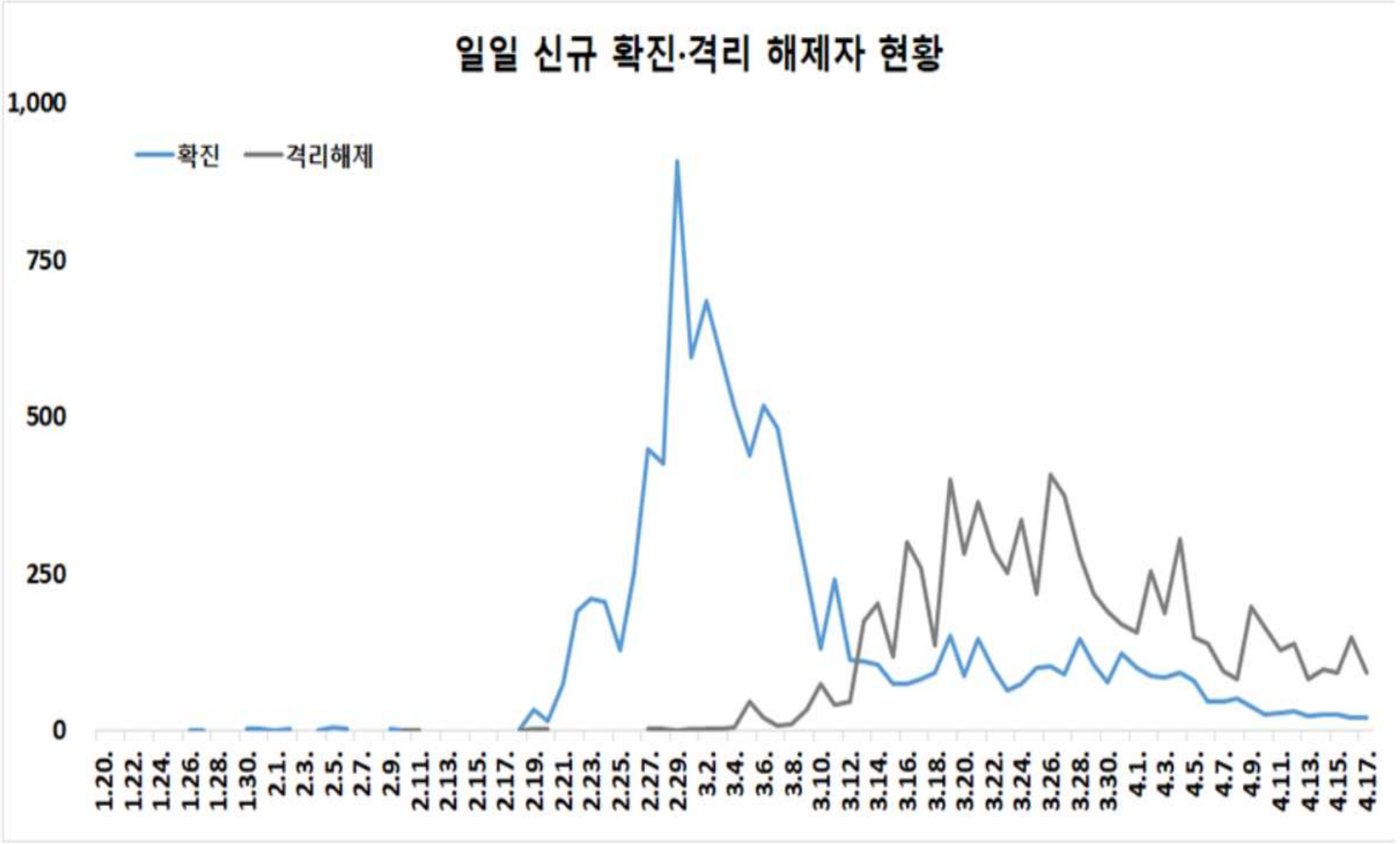
Accumulated Number of Confirmed Cases



Daily Confirmed Cases and Discharged Cases



1. Rapid Response

Policy learning from the past: MERS in 2015

- Strengthen KCDC
- Aggressive tracing of contacts: interview, credit card use, mobile phone location, CC TV -> With social consensus

Test kits: swift approval for mass scale testing

- Drive-thru, outdoor walk-thru: rapid testing, avoid the potential infection of health facilities and personnel

-> Early detection and isolation

- Prevent the infection by asymptomatic patients
- Avoid painful lockdowns

Results: Minimum restrictions, No lockdowns

Learning by Doing

Mass testing resulted in many cases tested positive

- Initially all those who tested positive were hospitalized
- Overload the health system with a shortage of beds for severe COVID-19 patients and other severely ill patients

Patients were prioritized based on severity

- Residential treatment centers for milder patients: Large suburban residential buildings, which had been used by public enterprises or large private firms for education, training and short-term residence of their employees
- Attended and regularly checked by health personnel

2. Governance

Transparency in communication

- Trust in the government

Social capital and trust: personal hygiene (face masks, hand washing), social distancing

Landslide victory of the ruling (progressive) party in the recent general election (April 15):

smallest number of seats for conservative party in the National Assembly in 30 years

-> Political economy of disease control:

inter-relation between health and politics

3. UHC (Universal Health Coverage)

Low financial barrier to access, organization of health care delivery through purchasing

Cost of treatment

- NHI with universal coverage of population
- Copayment is free (paid by government budget in case of communicable diseases)

Cost of testing

- Ex-ante free for those who traveled abroad, exposed to contacts, or with doctor's prescription
- Ex-post free if tested positive

Exemption/discount of NHI contribution for the vulnerable

4. UHC and Purchasing (from Providers)

UHC: entire population, all providers, unique ID

Mobilizing private providers (90% of hospitals in Korea)

- Testing in a large scale
- Treatment of patients: surge of patients

NHI law mandates all providers (public and private) to join NHI in Korea: controversial for private providers

- History of NHI in Korea

Advance payment by NHIS to hospitals

- Pay first, review and assessment later

Lessons for H Financing in LMICs

Public Financial Management (PFM)

- Need emergency budgets to provide medicines and equipment to public providers
- Need emergency budget support to health insurance

Q: How to mobilize private providers

- Contractual measure is not feasible or not enough in an emergency situation
- May need a legal framework for government to mobilize private providers in a pandemic situation

5. Health Service Delivery

Allocation of patients based on severity to avoid the over-burdening of health system

- Severe patients: Inpatient care
- Milder patients: Support/accommodation centers monitored by a smaller number of health personnel

Number of beds per capita: very inefficient system, second highest after Japan among OECD countries

- Paradox of (too) many beds but flexibility to respond to the surge of patients?

6. Challenges and Lessons

1) Vulnerable population

- Mass infection in geriatric hospitals, long-term care facilities
- Poor, daily workers: cannot work from home, job loss
- No school or internet-based classes have differential impacts on students with different socioeconomic status

2) Role of public hospitals: little incentive for private providers to invest in the special ward with low profit

- Leading role of public providers in the PPP for COVID-19

6. Challenges and Lessons (continued)

3) Mass testing: cost-effective? Over-burden on hospitals?

- Capacity of LMICs?

4) Privacy issues in the tracing of contacts

- Widely supported by the public in Korea (especially after the experience of MERSE)
- Should be based on social acceptability and consensus
- Should avoid the potential abuse (in case of authoritarian regime)

5) Exit Strategy: When and what sequence?

e.g., public transportation in LMICs

6. Challenges and Lessons (continued)

6) Policy Process

Decision making process has been medical-driven

- Should pay more attention to socioeconomic benefits and costs of various intervention measures

Need a new paradigm

- Evidence: nature of the epidemic, benefit/cost/risk of various intervention measures, provided by experts
- Value judgment to determine the RISK that a society can or is willing to accept, through citizen participation

e.g., school closure