IMPROVING HEALTH SYSTEM EFFICIENCY

REPUBLIC OF KOREA

Merger of statutory health insurance funds

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CONTENTS

1 INTRODUCTION

The Republic of Korea achieved universal health coverage based on social health insurance in 1989. Before the merger of statutory health-insurance funds in 2000, health insurance in the Republic of Korea was fragmented and consisted of more than 350 quasi-public insurance funds (societies). There were three types of health insurance fund: for employees, for the self-employed, and for school and public employees. The insured were assigned to insurance funds based on workplace (for employees) or residential area (for the self-employed). Before the merger, many health insurance funds for the self-employed in rural areas experienced serious financial distress.

Gaps in fiscal status between urban and rural (or between rich and poor) insurance funds widened over the years. Furthermore, differences in the method of setting contributions and in the amount of contribution across insurance funds raised concerns about equity in contribution payment. Members of insurance societies in poor or rural areas had to contribute a greater proportion of their income, as compared to those in wealthy areas.

This study examines the merger of statutory health-insurance funds in the Republic of Korea. Based on a political- economy approach, it examines the context, main players, policy process, and impact of the policy reform. It will determine whether the merger achieved its objectives, such as improving the exercise of purchasing power of the insurer, savings in administrative costs, and improvement in equity in contribution payment.

The study will also identify key factors associated with the positive and negative impacts of the policy change. Because healthcare reform is inherently political, the role of key players associated with the merger will also be examined. The debate involving the issue of a single fund versus multiple funds has continued since the inception of health insurance in the Republic of Korea. The role of competition among stakeholders, including labour unions and civic groups, was also crucial in the reform of the merger.

The study will examine the challenges that the health-insurance system of the Republic of Korea faces even after the merger, such as the limited exercise of purchasing power by the single insurer and differential contribution-setting for employees and the self-employed. Following the merger, the health-insurance system of the Republic of Korea now has two agencies: the National Health Insurance Service (NHIS) and Health Insurance Review and Assessment (HIRA). The functional division of the single insurer into two agencies resulted from the politics of the reform process. The final section of the study will provide other countries with lessons learnt from the reform experience of the Republic of Korea.

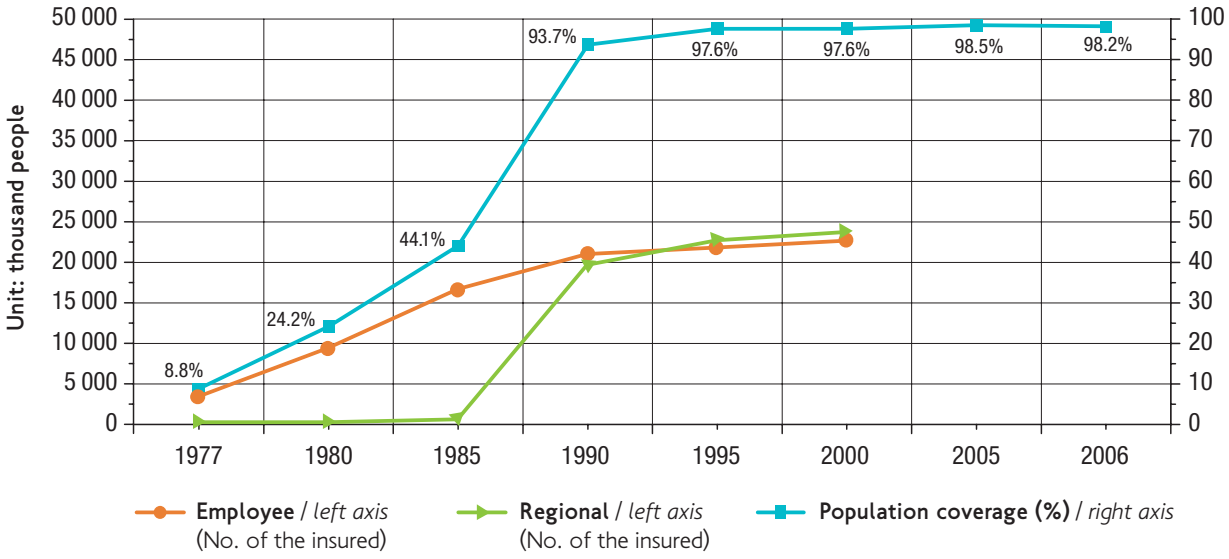
2 PATHWAYS TO THE MERGER OF STATUTORY HEALTH-INSURANCE FUNDS IN THE REPUBLIC KOREA

2.1 Historical development of the health-insurance system in the Republic of Korea

The Government of the Republic of Korea mandated health insurance first for employees, and then extended coverage to the self-employed. Employees of large businesses with more than 500 workers were the first group to be covered by health insurance in 1977; health insurance was then incrementally extended to employees of smaller corporations.

In 1988, the self-employed in rural areas joined the health-insurance system, and universal population coverage was achieved in 1989 by coverage of the self-employed in urban areas (Figure 1). Rapid economic growth in the seventies and eighties, and political legitimacy sought by the military and authoritarian regime, contributed to the rapid extension of population coverage.[1] From the beginning, health insurance in the Republic of Korea consisted of insurance funds based on employment (for employees) or residential area (for the self-employed).[2]

Figure 1. The road to universal coverage



Regional = health insurance for the self-employed.
Source: Kwon, 2009.

1 Some key economic and health indicators for the Republic of Korea are presented in the Annex.
2 See Kwon, 2009, for details.

The extension of health insurance to the self-employed elicited fierce debates concerning institutional arrangements for the universal health-insurance system. The discussions centred upon whether self-employed health insurance should adopt the then-pluralistic approach of multiple insurance funds or, alternatively, if a new single-insurer system should be created by merging with existing insurance funds for employees.

Through nationwide risk-pooling, the single-insurer system would have the potential benefit of a smooth extension of health insurance to the self-employed, with better prospects of fiscal sustainability. However, the difficulty in assessing income and collecting contributions from the self-employed was a potential barrier to a single-insurer approach. (The social consensus held that the self-employed should pay premiums based on the capacity to pay, just as employees did.)

Proponents of the merger maintained that the huge surplus of employee health-insurance funds could be used to extend insurance to the self-employed. As of 1997, the accumulated surplus of employee health-insurance funds totalled more than 113% of one year's health expenditure, while that of self-employed insurance funds was only 30% of one year's expenditure. Parliament, supported mainly by rural residents, passed the law on the merger of employees and self-employed insurance funds, but the President vetoed the law. The Government, especially the Ministry of Finance, wanted to keep the existing approach of multiple insurance funds (mainly to minimize the Government's role in healthcare financing).

2.2 Structure of the health-insurance system before the merger of statutory insurance funds

Before the merger of statutory health-insurance funds into a single insurer in July 2000 (universal coverage of the population was achieved in 1989), the national health-insurance system consisted of multiple not-for-profit insurance funds, which were subject to rather strict regulation by the Ministry of Health and Welfare (MOHW).

There was no competition among insurance funds to enrol the insured, and each fund covered a well-defined population group. Except for the review and assessment of claims submitted by providers, health-insurance funds did not actively exercise their purchasing power and there was no selective contracting with providers.

There were three different types of health insurance fund:

- health insurance for employees and their dependants (36.0% of the population);
- health insurance for school and Government employees and their dependants (10.4%); and
- health insurance for the self-employed (50.1%), which was also called regional health insurance (Table 1).

As of 1998, the Medical Aid programme for the poor, which was funded from the Government's budget, covered the remaining 3.5% of the population. In 1998, there were 227 insurance funds for the self-employed (92 in rural and 135 in urban areas), which were established in subdistricts of the city. There were 142 funds