

Society in Perspective

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Briefings

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Where Korea Stands

Thumbs up

Thumbs down

**Society in
Perspective**

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South Korea's Babybox Dilemma

Having experienced a radical metamorphosis from a nation of abject poverty to a manufacturing powerhouse, South Korea is no doubt a sheer prototype of the Asian Miracle. It even appears largely unscathed by this year's global recession, recording a 3.3% unemployment rate, the lowest of all OECD countries. Despite positive outlooks, sustained economic growth predicates on the productivity of its workforce. In this regard, South Korea's ageing population and low birth rate raise red flags to its growth prospects.

Fertility rate in Korea has remained an all-time low. The country's birth rate is 1.24 children per woman, which is lower than that of China (1.6 children per woman), a country with a restrictive one-child policy. According to a national survey conducted by the Korea Institute for Health and Social Affairs in 2012, one prominent reason for young Korean couples delaying childbirth was financial; skyrocketing costs of child rearing, especially education costs, have served as a major setback.

Since early 2000s, the government has released the "First Basic Plan for Low Fertility and Aged Society (2007-2010)," to increase support for childbirth through subsidies in childcare and pre-school education. The government even tried flexing its creative muscle; in addition to cash gifts and incentives, "Family Day," a national campaign was promoted to encourage staff to turn off lights in offices by 7pm every third Wednesday of the month, hoping at least one day is devoted to family. Even with all sensible and ludicrous efforts alike, Statistics Korea revealed fertility figures to have remained stagnant in 2012.

In light of endeavors to address Korea's demographic crisis, there is one figure worthy of attention. The Ministry of Health and Welfare released the number of abandoned infants to have increased from 218 in 2011 to 285 in 2013. Considering all unrecorded cases, infants abandoned, aborted, killed, and/or trafficked are suspected to be in significant numbers. In recent

years, many abandoned infants have instead sought refuge in a "baby box," where mothers can anonymously leave their newborns. Putting aside debates on the politics of the baby box itself, why is the country desperately promoting more births whilst babies already born out of wedlock are disregarded as rightful citizens? With appropriate support, aren't these infants rather a solution to the country's demographic challenge?

Baby Box: Last Resort or Easy Way Out?

Baby box, also known as baby hatch, is a place where people can leave newborns anonymously in a safe place to be found and cared for. The concept originated from Italy's old medieval foundling wheels ("ruota dei trovatelli") in 1198, when Pope Innocent III decreed that these facilities be installed to prevent infanticide. A foundling wheel was a wooden cylinder board with a revolving door set upright in the outside wall of a building. Mothers placed the child in the cylinder, turned it around so the baby was inside the church, and rang a bell to alert caretakers.

With a modern twist, the baby box in Seoul has a letterbox-style door in the side alley of a church in a hilly neighborhood of Gwanak. It is an insulated box with lighting and heating, and a bell rings when someone drops a baby in it. Since 2009, the sole baby box in Korea is run by Pastor Lee Jong-rak in his own church parameters. Pastor Lee shares how it all began.

One spring before the break of dawn, Pastor Lee received a phone call.

"I'm so sorry.. I left it.. at your door" gasped a desperate voice.

He stood aghast to find a cardboard box; in it laid a tiny newborn baby wrapped in cloth.

After stumbling upon the third child in the same way, he knew this was not a mere coincidence, but a life calling to protect and care for the abandoned infants.

He refers to the baby box as the “love box,” a box that delivers new life.

As of 2014, there have been 496 babies found in his “love box”, a rate of 23-24 a month.

He vehemently asserts that the baby box is ultimately the last resort and the only option available for mothers who have decided to save their children. Some have traveled 17 hours on ferries to come from as far as Jeju Island.

According to Pastor Lee, 60% of the cases received were teenage mothers and about 30% children born from extramarital affairs. He claims that most teenage mothers have not received proper sexual education in school nor at home; majority of them suffer from severe chronic depression and low self-esteem, which drive them into further isolation. What they require is a safe place to share their problems, and a loving community that would accept them the way they are without judgment.

The Ministry of Gender Equality and Family has also released survey results on single motherhood that echo this trend. As most teenage single mothers bear the brunt of pregnancy and birth alone in the absence of societal and family support, survey participants admitted to emotional turmoil, financial stress, and precarious relationship with family as three major challenges. In short, they are in dire need of financial support, delivery assistance, and counseling.

Pastor Lee’s church has been offering counseling support for single mothers and even convinced some to change their minds and raise their young. He has garnered support from various groups, churches, and individual donors to assist the livelihoods of single mothers and even liaised with 5 local hospitals to render free delivery services. When babies are dropped in the box anonymously, Pastor Lee refers them to the government’s foster homes or adoption agencies to seek permanent care.

In the context of the rise of babies received in baby boxes lies the controversial amendment of the Special Adoption Law. As of 2012, this new law stipulates mothers to register their babies with the government and remain with them for a minimum of seven days before putting

them up for adoption. This change was intended to reduce unregistered adoptions of children overseas by increasing transparency and accountability; yet, it is also known to further preclude mothers from seeking official routes of adoption.

In order to improve the rights and benefits of single mothers, the Ministry of Health and Welfare enacted a new law early this year on single parents and came up with a list of benefits entitled to them. However, recipients must reveal their status through birth and family registration, and also have to be below a certain threshold of income bracket to be eligible. Even after withstanding through this hassle, the subsidy is a mere KRW 70,000 per month for child care and KRW 50,000 for living cost, which is far below the amount required even for subsistence. With such ramifications, by all means, single mothers would rather bypass the risk of social stigma and grim employment prospects, and rather desire for anonymity. Hence, the baby box does offer them hope amid all dead ends. While baby boxes provide an effective short-term safety net, however, there is an outcry for a permanent policy solution.

The Babybox Tug of War

The baby box lies in a gray area as technically the practice has no legal basis of operation whilst its life-saving role grants them sacrosanctity. “It’s hard to apply a forceful closure to the baby boxes when there are still single mothers who cannot make ends meet and have no alternative means of support,” admits a child welfare official from the Ministry of Health and Welfare.

Nevertheless, contentious legal, political, and societal debates persist. With the government having the primary responsibility to protect vulnerable children, civil society and faith-based groups are becoming more vocal and proactive in filling gaps in the nation’s child protection system.

Proponents of the baby box argue that preservation and protection of life take precedence over any other rights at stake. “What is more important, protecting life or protecting roots? You need to be alive to have identity.” Pro-life

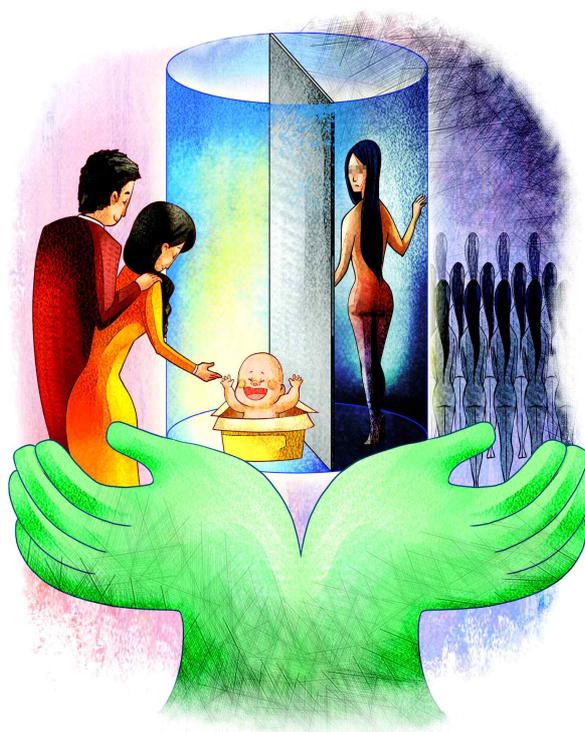
groups are most concerned about casting the safety net even if it means operating through the backdoor.

Opponents present the case that baby boxes conflict with article 7 of the UN Convention on the Right of the Child: “Children have the right to know their parents, and as far as possible, to be cared for by them.” The child is not only ripped of their birthrights to trace their own roots, but is also a victim of an easy way out for mothers to neglect their parental responsibilities. For these reasons, the UN is requesting all countries to ban baby boxes globally.

In Europe, nearly 200 baby boxes in 11 countries have been installed in the past decade, including Germany, Austria, Switzerland, Poland, Czech Republic, Italy, and Poland.

In Germany, child abandonment is illegal and considered a crime. The German constitution is clear about all citizens having the right to “know their origins,” and fathers having the right to be part of a child’s upbringing. Both are breached with the system of the baby box and anonymous births, but nevertheless, baby boxes are tolerated as all parties reckon that the absolute priority is to protect and safeguard the life of children in extreme conditions. With this principle, Germany has more than 200 baby boxes across the nation, with majority of them installed in hospitals supporting anonymous births.

In the case of Seoul, as the number of children dropped in the baby box is ever increasing as a result of its extensive media coverage, Gwanak district office is inundated with referred children and has surpassed its capacity to provide care services. Out of the 220 abandoned children last year, 208 were admitted in Seoul. The Ministry of Health and Welfare has now pledged to incentivize other district offices to take on these surplus children and share the burden. As is the case with baby boxes around the world, Korea’s sole baby box operates in a gray legal zone recognized by the authorities but at odds with the law of our land. Baby boxes have become the hot potato, with clashing rights and loopholes in formal protection apparatuses.



Way Forward: Policy Compromise?

Untangling the baby box dilemma requires a complete makeover in legislation and practice.

Korea’s endorsement for stronger legal frameworks to improve the quantity and quality of welfare for single parents reflects a significant leap forward. A tug of war is likely to continue between the two conflicting rights: the mother’s right to anonymity and the baby’s right to identity.

In France, it is required by law that birth registration takes place within 3 days of birth, which in most cases occurs in hospitals. Anonymous births are legal and mothers can choose to leave the hospital without having any of her records revealed. The hospital not only guarantees free health services from counseling, delivery, to hospital stay, but also provides linkages with external care services and adoption centers to offer the full spectrum of care, albeit respecting full anonymity. Every year 500-600 children are born under anonymous births, and activists claim that this robs 4 million people of the right to know their roots. Applying the French system would not be feasible in the

Korean context, where strong conservative family values prevail and teenage pregnancies are stigmatized as moral decadence. Yet, the country's values for transparency and accountability will be upheld if all birth registrations take place in hospitals.

Having toiled through the same conundrum, Germany has revised its legislation to increase support for pregnancies and birth based on trust ("Gesetz zum Ausbau der Hilfen für Schwangere und zur Regelung der vertraulichen Geburt"). The new law will increase support for pregnant mothers and allow protection for mother's anonymity which in effect will lead to more lives saved. The mother's personal information will be kept in a sealed envelope and sent to a government institution. After the 16th birthday, the child can request this information to be revealed, but the mother can also file a counter-suit for this case a year prior to the request. The court has the final say in which party's right will have the upper hand. This still means both rights are mutually exclusive. The new legislation provides the avenue to honor the mother's rights to confidentiality and still entertain the possibility of the children's right to identity with consent from the mother. It is a precarious but reasonable compromise, which provides food for thought for the Koreans.

As Korea is in the midst of addressing its most pressing population and demographic challenges through a series of policy reforms, it must not overlook that it can leverage the untapped potential of children born of single mothers. This would require a change in perception that embraces these children as potential agents capable of serving the country and contributing to the productive workforce.

There is no perfect scheme to strike the finest balance. If we are in agreement that it is our moral obligation to respect the basic rights to life and protection of all children, we must shift the focus of our debates from the baby box dilemma to building a creative system that provides all citizens with an opportunity to flourish.

What Big Hospitals Carry That Small Clinics Don't

Korea's health care system as we know it today traces back to July 1989, when the National Health Insurance, first introduced in 1977, was extended to all Koreans. People in this country receive health services from three different tiers of care providers. Local clinics, mostly run by freestanding solo practitioners, provide services involving treatment for such everyday health issues as sore throats, ankle sprains, common cold, and digestive disorders. Secondary care establishments are small to medium-sized hospitals having at least two specialties with beds numbering between 30 and 500. Tertiary care—services of greater and more wide-ranging specialties than would be available from primary or secondary care providers—is offered at hospitals that are large (with more than 500 beds) and mostly university-affiliated.

In the early years of the health care system, people were required to receive a referral from their primary care physician before they could move on to a secondary or tertiary care institution. This system of referral, however, proved to be extremely unpopular among consumers and was regarded by health care experts to have little effect in improving the conditions of patients. Then, with the regulatory reform in 1998, came the abolishment of catchment areas.

Now, all Koreans have virtually unconstrained access to the full gamut of health care providers ranging from a neighborhood doctor to university-affiliated medical centers.

Dispensing with local clinics

Over the past few years, the government has instituted a raft of policies in an attempt to reverse the trend of consumer preference for tertiary care hospitals. Although patient co-payment rate is fixed at 30 percent for services at all hall stripes of health care providers, those who make a beeline without a referral process to a higher-level care institution are required to pay as much as 60 percent of the fees out-of-pocket.

Also, copayment charges for prescription drugs have risen for those receiving services at tertiary care hospitals for day-to-day ailments (common cold, conjunctivitis, and the like.) or mild chronic illnesses (hypertension, diabetes, and arthritis). But the policy intent underlying Korea's health care system has caved in to people's right to choose where to receive care. Many Korean patients as a result continue to bypass clinics in their neighborhoods to seek care directly at higher-tier hospitals (besides, receiving a referral from a local general practitioner is all too easy in this country. You walk into a clinic and ask the doctor for a referral and pay a small amount for the issuance of referral form). In effect, small clinics have been growing at a much slower pace than tertiary hospitals.

Looking at National Health Insurance reimbursement data from 2005 to 2012, we find that medical fees paid for outpatient services to tertiary general hospitals increased by a whopping 140 percent, while clinics saw only a 55-percent increase. In the years from 2001 to 2012, the tertiary care sector saw an increase of 7.8 percentage points in their share in National Health Insurance reimbursement, from 9.9 percent to 17.7 percent, while the share of the primary care sector has declined by 18.2 percentage points from 74.6 percent to 56.4 percent.

One is led at this point to wonder whether an increasing number of Koreans are not paying more than they need to for illnesses that could easily be treated at primary care facilities. Does the concentration of outpatients in tertiary care hospitals bespeak irrationality on the part of consumers? Some argue that visiting tertiary care hospitals for minor ailments is a bad idea, that it's costlier not only for the patient himself but also for the National Health Insurance, which is financed by payroll contributions of workers and employers. The treatment you get for a common cold at a local doctor's office, they would continue, is the same as the service you get from a doctor at a tertiary care

institution. Even when that is so, Korean consumers as individuals may see good reasons for them to choose tertiary care institutions over their lower-tier counterparts.

What's in a brand name?

Presenting his theory of brand in his *Human Action*, the Austrian economic thinker Ludwig von Mises says that people tend to choose, if they can, "a store or a brand with which he himself or trustworthy friends have had good experience in the past."

It does not matter whether the good will is based on real achievements and merits or whether it is only a product of imagination and fallacious ideas. What counts in human action is not truth as it may appear to an omniscient being, but the opinions of people liable to error. There are some instances in which customers are prepared to pay a higher price for a special brand of a compound although the branded article does not differ in its physical and chemical structure from another cheaper product. Experts may deem such conduct unreasonable. But no man can acquire expertness in all fields which are relevant for his choices. He cannot entirely avoid substituting confidence in men for knowledge of the true state of affairs. The regular customer does not always select the article or the service, but the purveyor whom he trusts. He pays premium to those whom he considers reliable.

The development of the Korean health care system has been driven by and large by private investment. Here, a fee-for-service based delivery model has stoked and made for competition among health care providers of all tiers. In Korea, where all of its 43 tertiary care hospitals run sizeable outpatient departments (family medicine, ophthalmology, dermatology, otolaryngology, and rehabilitation, to mention just a few) to get hold of larger shares in the health care market, the primary and tertiary care sectors are not so much partners playing mutually complementary roles in health service delivery as competitors vying for consumers, each edg-

ing into what the other used to regard as its own turf. Patients crowd into large university hospitals that have invested in their own improvement, partly because they are perceived to offer higher quality services. Practically all tertiary care hospitals in Korea are prescribed by law as nonprofits. All medical establishments do operate for profit, to be sure, but one of the salient features of Korea's tertiary care hospitals is that most of them—except a few cases of publicly-run hospitals—have as their founders universities, which themselves are nonprofit entities. A nonprofit hospital's proceeds by definition must be invested back into the hospital, for the improvement of its system and administrative capabilities. Korea's tertiary care hospitals are branded by reputable universities, staffed with renowned doctors, many of them physician-cum-professors who appear in news programs and medical documentaries on TV; and there is more to Korea's tertiary care hospitals than brand names.

The rise of tertiary care hospitals may be assumed to be a natural consequence of the weaknesses and inefficiencies of primary care providers, who often leave consumers dissatisfied with their services. The problem with Korea's primary care sector is that it is largely kept from systemic advancement that is the hallmark of large hospitals. Over the past few decades, Korea's health care has been revolutionized technologically and, to a greater extent, in terms of coordination of services and effective collaboration between different specialty units. On the other hand, many primary care doctors often give off vibes of being inclined to do things to—not for—patients that are mostly out of sync with the rest of the health care service sector. The major dissatisfaction that Korean patients have with doctors constituting the primary care sector may be that few, if any, of them take responsibility for the results.

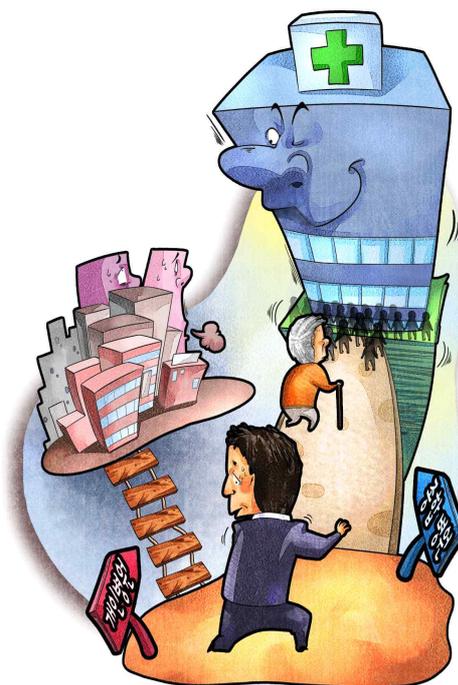
That visiting a tertiary care hospital for minor illnesses is a bad idea is a criticism not everyone can comfortably hold. A name-brand hospital does not eliminate the possibilities of misdiagnosis, but it does reduce the risk of uncertainties. The question at hand is one of making tradeoffs between, on the one hand, risks of receiving services they consider unreliable and, on the other, the amount

of money they are prepared to put into avoiding it. Take someone running a high fever accompanied by a severe headache. Here, he may understandably associate his condition with some serious viral infection, for instance, meningitis, a commonly reported, potentially lethal disease many of whose early symptoms could easily be mistaken for the symptoms of a common cold. As is the case with many other viral infectious diseases, meningitis requires difficult tests and complex treatments that are beyond primary and secondary care. The patient in question is likely to expect that doctors at a tertiary care hospital have enough clinical experience to decide whether he can go back home with a drug prescription or his condition should be escalated for further diagnostic tests and treatment before it becomes full-blown. Of course, a case initially suspected as meningitis, or any other serious disease for that matter, could just as easily turn out to be nothing more than a bad case of common cold. But as far as one's own health is concerned, safety seems to be something that one cannot get too much of, and it may be just as rational for one to seek expensive "rule-out" care at a prestigious tertiary hospital.

If big hospitals in Korea continue to draw more and more patients, it is also because they are capable of accommodating services in a greater variety in an integrated way. In a country with an aging population and an increasing number of co-morbid patients, this is all the more important. Rife with solo specialists, Korea's primary care sector as it stands does not quite square with the health care demand of a rapidly aging population. For aged patients with multiple chronic conditions, seeking care at large, tertiary care hospitals can be more rational than traveling around from one solo practitioner after another. Patients with multiple chronic conditions may rightly expect that doctors at a tertiary care hospital would do a better job than a bunch of independently practicing doctors of ensuring that the treatment regimen for each illness jibe with all the others.

Nor is visiting doctors at tertiary care hospitals as costly as the current copayment rules suggests, as private health insurance has become increasingly popular after it was first introduced in 2006. There are an estimated more than 30 million people in

Korea (or three-fifths of all Koreans) who are policyholders of one private health insurance plan or another, and the number is rising. Private health insurance is no substitute for the National Health Insurance, but it is generous enough to cover most of the out-of-pocket costs, the portion uncovered by the mandatory public program.



Worries remain

When people as individuals know that the National Insurance is going to pay for their health care, there is less incentive for them to limit doctor visits, and when they know that the private insurance company is going to pay the out-of-pocket portion, there is more incentive for them to get more expensive services. As out-of-pocket costs have become less of a concern, it makes less sense for individuals not to seek care at tertiary care hospitals.

The combination of the public health program and a privately-purchased plan may have led a growing number Koreans to believe that health care services are public goods up for grabs. The number of outpatient visits Koreans on average

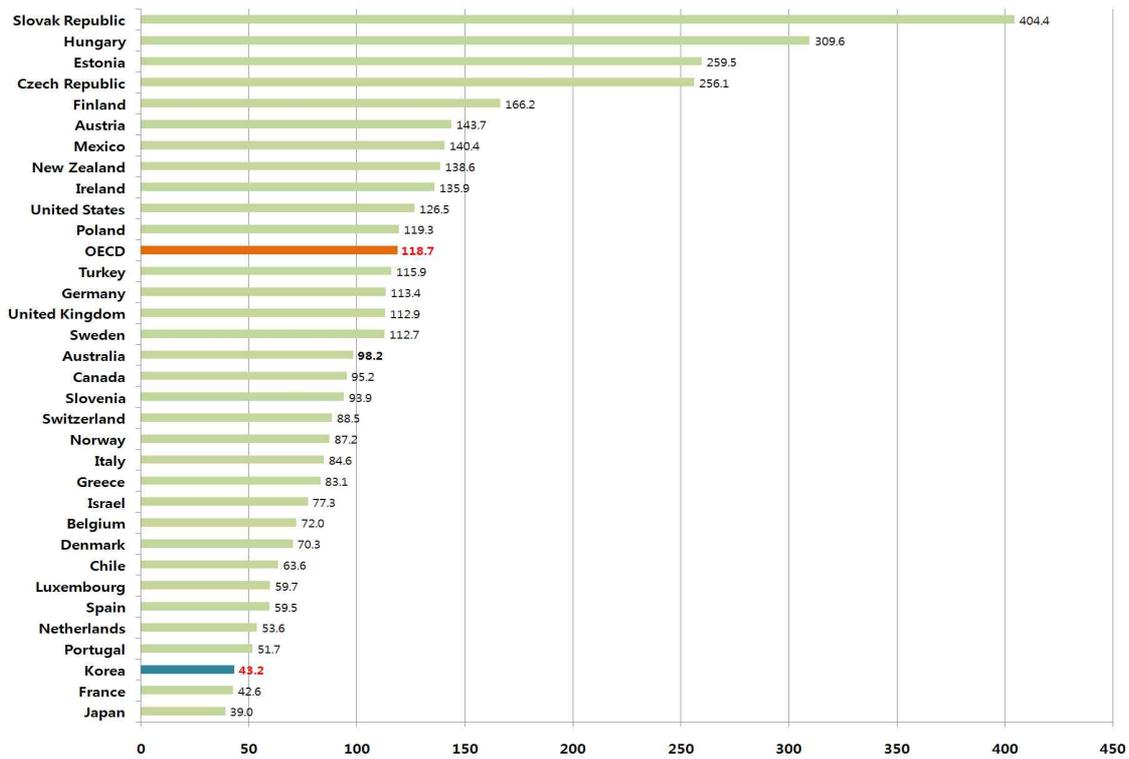
make each year have been increasing steadily over the past years to more than 13 in 2011, highest among OECD countries and about twice as high as the OECD average. A recent survey finds that of the most common outpatient conditions treated in the “Big Five” hospitals, the 2nd and 5th were diabetes and common cold, respectively. We may hope that some appropriate restriction might help reduce the problem. But health care regulations cannot generate good health services any more than food regulations can make good food.

More and more of us will choose to go to tertiary hospitals, just as we have moved away from our neighborhood groceries to superstore, from our next-door bakeries to conglomerate-run bakeries. This trend will eventually either push up health care taxes to the point where healthy Koreans may feel that the National Health Insurance is a bad deal, or raise the price of private insurance plans to the extent that will curb many from buying them. For this not to happen, primary care clinics in Korea will have to gain greater public trust in their services. For this to happen, policymakers may have to look into how the incentives that doctors, nurses and administrators employed in tertiary hospitals have are leading them to maintain their services as a system at higher quality standards than are required by the government.

Thumbs up

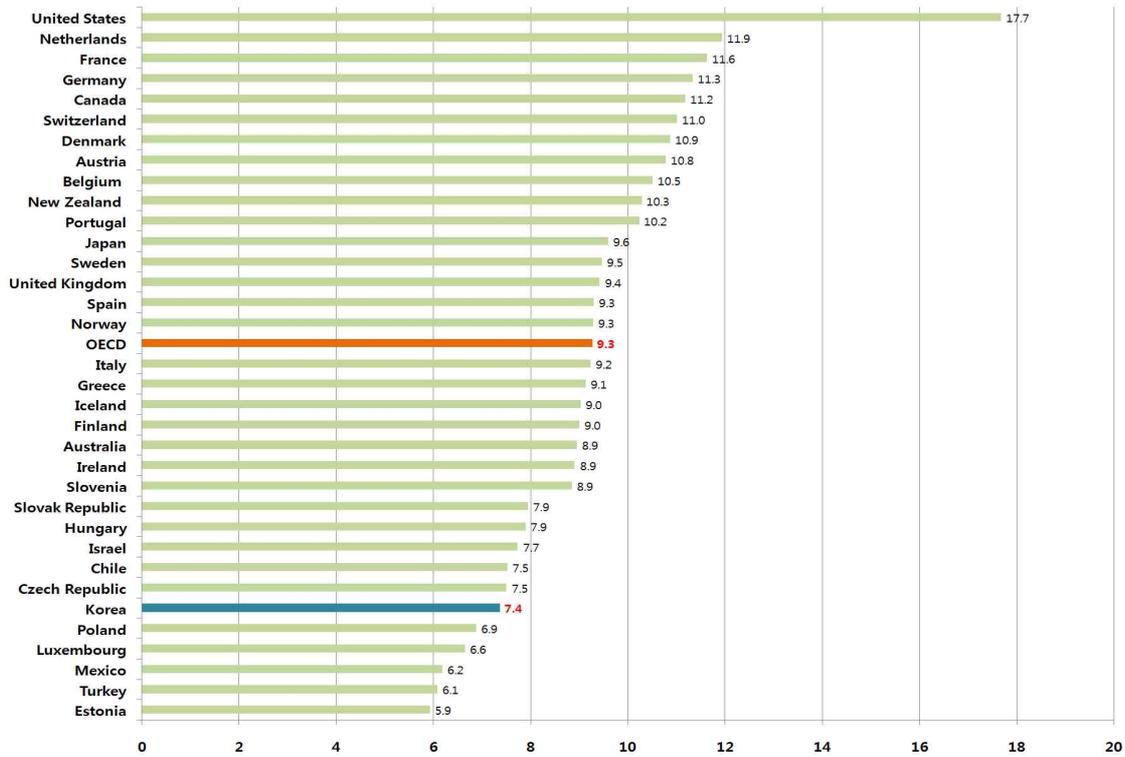


Death of Ischaemic Heart Diseases (per 100,000 population), 2012



Source: OECD Health Data 2013

Total Health Expenditure out of GDP, 2012

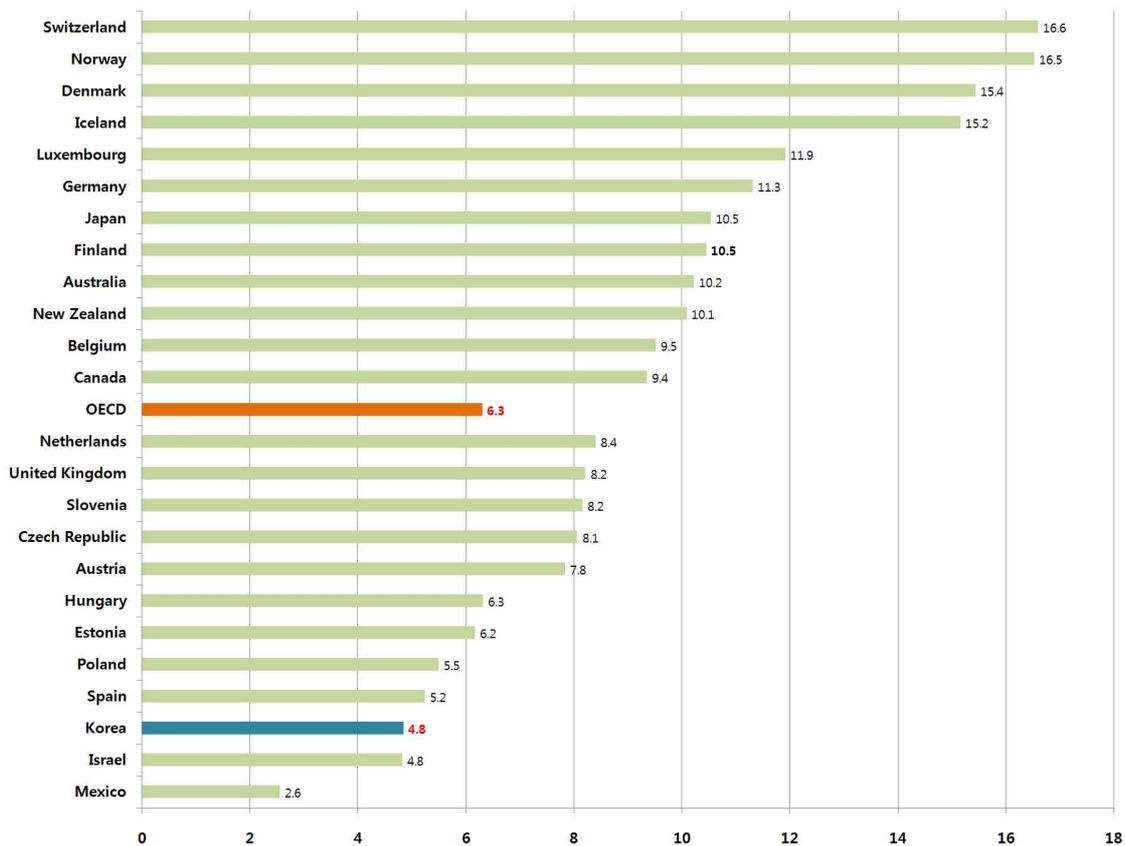


Source: OECD Health Data 2013

Thumbs down

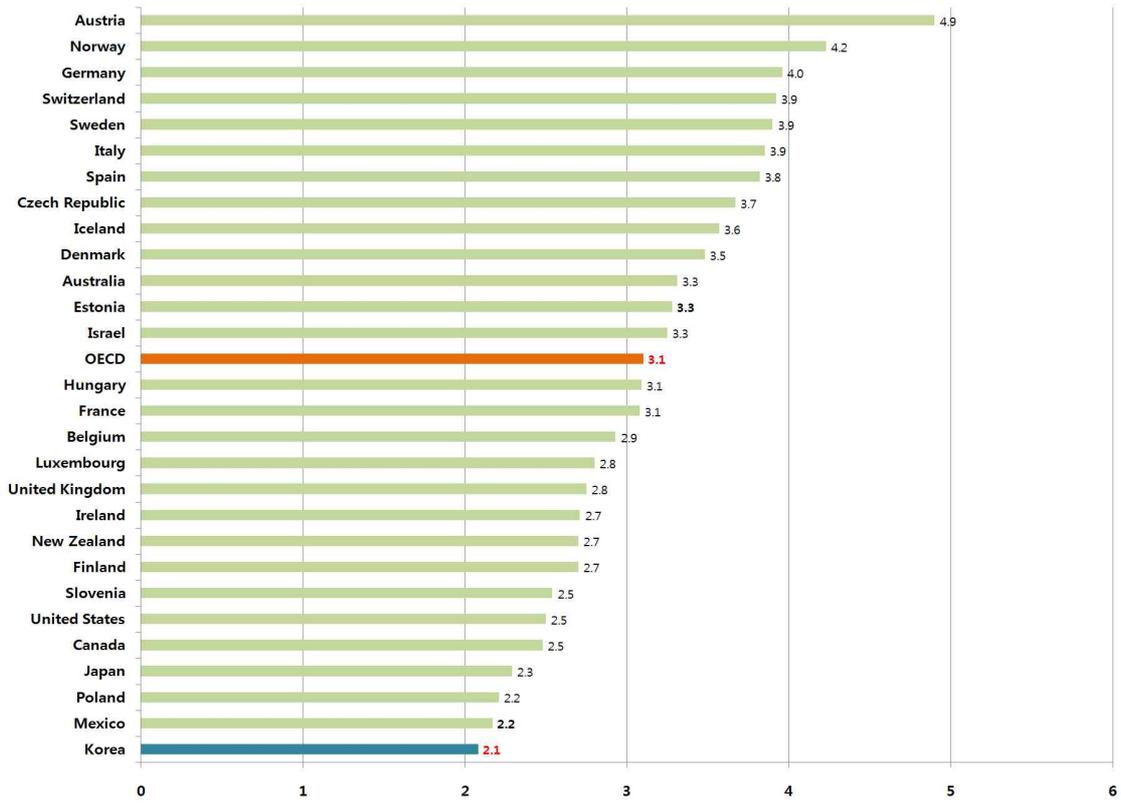


The Number of Practicing Nurses (density per 1,000 population), 2012



Source: OECD Health Data 2013

The Number of Practicing Physicians (density per 1,000 population), 2012



Source: OECD Health Data 2013