NOTES ON THE GENERAL SITUATION IN THE REPUBLIC OF KOREA

— with special reference to health services —

KOREA INSTITUTE FOR POPULATION AND HEALTH
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FOREWORD

This booklet was compiled for overseas visitors who come to the Korea Institute for Population and Health (KIPH) to discuss health services and related polices of Korea. I hope it will help our visitors in understanding the national and health policies in the Republic of Korea.

It consists of five sections. The first section deals with general information of Korea; the second, with the national policies on socio-economic sectors; the third, with the health situation; the forth, with the situation of health services; the last, with the national health policies and strategy.

The main sources of this booklet are the "Fifth Five Year Economic and Social Development Plan," EPB and "Development Strategy and Policy Priorities for the Fifth Five Year Development Plan," KDI.

The views expressed in this booklet are those of Kong-Hyun Kim, Senior Researcher, and Hyun Oak Kim, Researcher, and should not be attributed to KIPH or the Korean Government.

June 1983

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1. General Information

1.1 Geography and Climate

The Korean peninsula area is 221,325 Km^2, or about 86,000 square miles, consisting principally of mountainous peninsula with numerous islands scattered around the mainland. It is flanked to the east by the East Sea and to the west by the Yellow Sea. The land is presently divided into two parts by a military demarcation line—Communist North Korea and free South Korea (the Republic of Korea). The Republic of Korea's administrative control covers 98,992 Km^2 or about 45 percent of the total.

Average annual precipitation of 1,160 mm varies from a low of 800 mm in the east-central highlands to maximum of 1,600 mm along the southern coastal region. About two-thirds of the annual total rainfall falls during the summer months of June-August when temperatures also reach a maximum of about 86°F. During the winter months of December-February, temperatures throughout the country often fall to below freezing level for extended periods.

1.2 Population

The population growth rate has dropped to 1.57 percent in 1980 from 2.84 percent in 1960. Since there were 25,012,000 people in 1960, the population grew 1.5 times by 1980 when 38,124,000 people were living in this country. With this figure, Korea registered the third highest population density of 385 persons per Km^2 in the world. The government plans to lower the natural population increase rate to 1.34 percent by 1990, 1.0 by 2000, and 0.0 by 2050.

Under such a comparatively slow growth, the average number of child-birth per mother will decrease to 2.1 in 1990.

If no population control measures are practised and natural population growth is continued, the number of people in Korea will increase to 55 million by 2000 and 73 million by 2050.

Successful implementation of family planning, however, will bring significant changes in the structure of the nation's population.

A conspicuous change will be the increased proportion of older aged population, 65 years or more to the entire population. In 2000, the ratio will reach 6 percent compared 3 percent in 1960s, calling for due welfare measures for the "grey"

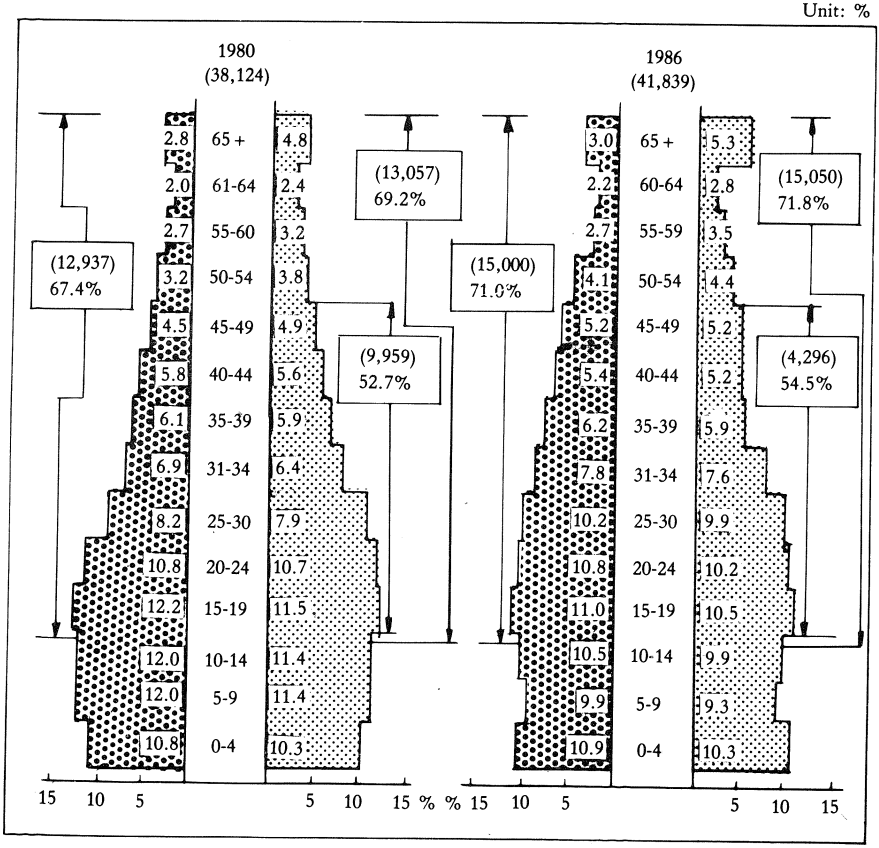
population.

The most recent blueprint the government handed out in a serious effort to solve the population problem, includes giving various favors to small-size families with one or two children.

Under the government family planning demonstration project during July

The Age Structure Composition of Population

Unit: %



Note: Numbers in parentheses are the population size in thousands.

Source: EPB, The fifth five-year economic and social development plan 1982-1986, 1982

1982-June 1983, couples who are sterilized after having two children are given a special allowance of 100,000 won. Pre-school children of such small-size families are provided with free primary health care at health centers across the country. Heavier resident taxes will be imposed upon families having three or more children commencing from 1983. The family allowances which have been paid to government officials regardless of the number of children will be granted to only those with one or two children.

Simultaneously with these measures for population control, the government is required to implement a variety of projects to enhance welfare of the aged population who will make up an increasing portion of the entire population.

There has been heavy migration from the rural to the urban areas because of rapid urbanization and industrialization. As of 1980 the population distribution by urban and rural areas is as follows.

Category	Population	%
Urban	21,441,000	57.3
Rural	16,008,000	42.7
Total	37,449,000	100.0

Urbanization, however, will be less rapid during the 1980's and will be stabilized during the 1990's, levelling off at about 80 percent of the total population.

1.3 Economy

Korea has maintained a remarkable growth rate since her First Five Year Economic Development Plan commenced from 1962. In the 19-year span between 1962 and 1980, the gross national product (GNP) has increased 4.5 fold from 12.7 to 57.4 billion US dollars at 1980 prices. This growth has been propelled by the rapid expansion of exports whose value increased from 50 million to 17.2 billion US dollars at current prices, and by domestic saving with its share in normal GNP rising from 2.9 to 21.6%. With this rapid economic growth, employment opportunities have also increased: the employed population nearly doubled from 7.7 million to 13.7 million. The percentage of people below the absolute poverty line has reduced considerably from 40.9 to 12.3%, and income distribution, as a whole,

has been improved.

Performance of Past Development Plans

	Unit	1962(A)	1980(B)	(B)/(A)
Gross National Product (1980 prices)	Bil. $	12.7	57.4	4.5
Per Capita GNP (1980 prices)	$	477	1,506	3.2
Commodity Exports (current prices)	Bil. $	0.05	17.2	315
Domestic Savings Ratio	%	2.9	21.6	—
Employed Population	Thous. Persons	7,662[1/]	13,706	1.8
Employment Structure				
Agr. Forestry & Fisheries	%	63.1[1/]	34.0	—
Mining & Manufacturing	%	8.7[1/]	22.6	—
SOC & Other Services	%	28.2[1/]	43.4	—
Ratio of Wage & Salary Earners	%	31.4[1/]	47.3	—
Incidence of Absolute Poverty	%	40.9[2/]	12.3[3/]	—

Notes: Superscripts 1/, 2/ and 3/ denote figures for 1963, 1965 and 1978, respectively.
Source: EPB, A summary draft of the fifth five-year economic and social development plan 1982-1986. Sept. 1981

The three main factors, which allowed Korea to improve income distribution while rapidly expanding the economy, were rural land reform which prevented the creation of a landless class, specialization on labour-intensive industries which

expanded employment, and achievement of universal literacy and universal access to primary education. These three factors created equal access to the three main factors of production: land, capital (in productive employment), and knowledge.

But in the last few years, some trends have become apparent in the Korean economy which threaten to reverse the steady improvement in income distribution and in human resource development which was achieved in the past. Equal access to land has become less important as the relative importance of agricultural employment and agricultural production has declined. The expansion of employment and agricultural production has declined. The expansion of employment has slowed down with the gradual replacement of labour-intensive technology with capital-intensive methods used in "second-generation" export industries such as steel, shipbuilding, chemicals, and passenger cars. Lastly, universal access to literacy and primary education has become less important at this stage of Korean economic development than the present unequal access to high forms of education and training.

The sensitivity of the Korean economy to increased prices of energy imports and other raw materials, the vulnerability of its large export sector to increasing protectionism among the developed market economics, its repayment burden for external loans which has been adversely affected by the current high interest rates, and the high proportion of its GNP which has to be spent on defense expenditures are factors which will tend to limit increased financial allocations for social development in the immediate future.

2. National Policy and Strategy

2.1 Economic Growth and New Challenges

Since the launch of the First Five-Year Development Plan, Korea has achieved a high level of economic growth. However, the economy is facing new challenges at home and abroad. Rapid economic growth was accompanied by various internal & structural problems. Expansionary demand of management and increase in imported oil prices led to high inflation. Excessive government intervention discouraged private initiative and caused inefficient resource allocation. This, combined with high inflation, weakened industrial competitiveness. Also, as economic growth tended to favor certain sectors and urban regions, income disparities

widened.

Coupled with these internal issues, uncertainty in the world environment is increasing. One of the most potentially disruptive factors is instability in the world oil market. Oil prices are generally expected to increase about 10% annually, implying $60 per barrel in 1986. Hence, the world economy is only expected to grow 3.5% annually in the first half of the 1980s, and world trade only about 5% per year. Due to delays in industrial restructuring and increasing world-wide protectionism, Korean economy is now facing new challenges which should be properly overcome in the fifth five-year economic and social development plan period.

2.2 New Approach Toward Development

To cope with these challenges, the Fifth Plan is adopting a new approach toward development. This, it differs from its predecessors in a number of respects.

First, the formulation of the plan involved broad participation of the general public in identifying a national consensus on issues and policy priorities for the 1980s. Second, it emphasizes its character as an indicative plan, thus representing the changing role of the government vis-a-vis private economic activities. To stimulate the private sector, overall economic management will rely increasingly on the market mechanism and gradual reduction of direct government intervention in the market. Third, while the private sector will assume greater responsibility for economic activities, the government intends to play an increasing role in social development , technology and manpower development.

The basic objective of the Fifth Plan is to achieve sustained growth with stable prices and equitable income distribution. The highest priority will be given to price stabilization since that is vitally important both in ensuring the stability of living standards and in strengthening industrial competitiveness. Measures will be taken to reduce inflation ultimately to single-digit levels by 1986. along with price stability, a steady economic growth rate of 7-8% per year is necessary to absorb the increasing labor force and raise income levels. Also, the government will strive to ensure a more equitable distribution of income.

To realize these objectives, the following strategies will be employed, namely, restraint of inflationary pressure, efficiency enhancement, export promotion and strengthening of industrial competitiveness, and social development.

The Fifth Plan pays more attention to the well-being of ordinary citizens than any of its predecessors. The basic direction of social development will be to provide

more jobs and assure equal opportunities in economic activities and upward social mobility. Emphasis will be made to expand employment opportunities and enhance the quality of human resource through promoting education and manpower development. Also, policy measures will be taken to meet basic needs for housing, health care, nutrition and other essentials, and to develop a social security system.

However, recognizing that an excessive social development would result in inefficient resource allocation, the government will promote social development within the country's financial capabilities and in such a way that it will be complementary to rather than competitive with economic growth.

2.3 Government Role in Social Development

The Government will increase its role to devote a greater proportion of the overall budget to social development. About 28.6% of the overall budget will be allocated in this area. This represents 1.8 times the amount allocated during 1977-81, contrast with expenditures on economic development which will only grow 1.2 times.

Changes in Budget Allocation

($ Bil. in 1980 prices)

	1977-81(A)	1982-86(B)	(B)/(A)
Overall Budget	49.0	71.3	1.5
Economic Development	11.0	13.5	1.2
Social Development	11.3	20.4	1.8
(% of Overall Budget)	(23.1)	(28.6)	
Education	8.3	15.1	1.8
Housing	0.6	1.0	1.6
Water Supply & Sewage	0.3	0.9	2.7
Social Security	1.2	1.9	1.6

Source: EPB, Fifth Five-Year Economic and Social Development Plan (1982-86), Slide presentation, 1981.

Expenditures on education will be increased 1.8 fold to broaden educational opportunities and promote manpower development, and budget allocation for public housing programs for low income families and water supply and sewage program will be expanded by 1.6 and 2.7 times respectively.

In addition, expenditures on social security will be increased 1.6 times for expanding medical and industrial accident insurance and public assistance programs.

2.4 Major Indicators

The successful implementation of the Fifth Plan will enable the Korean economy to attain a more advanced stage of development. During the Plan period, in terms of 1980 prices, GNP is forecast to grow at 7.6% annually to 90 billion dollars, and per capita GNP will increase to 2,170 dollars in 1986.

In order to support this planned growth, investment will amount to 32.5% of GNP by 1986. This will be financed mainly by domestic saving which will account for 29.6% of GNP. The current account deficit will be descreased to 3.6 billion dollars.

As stabilization gradually takes root, increases in the GNP deflator will decelerate from 27.7% in 1980 to less than 10% in 1986. Total employment will increase to 16.3 million persons, and due to rapid growth of employment relative to the labor force, the unemployment rate will decline to 4% in 1986.

Major Indicators

	1980	1986
GNP ($ Bil. in 1980 prices)	57.4	90.0
Per Capita GNP ($ in 1980 prices)	1,506	2,170
Investment Ratio to GNP (%)	31.0	32.5
Domestic Saving Ratio (%)	21.2	29.6
Current Account ($ Bil.)	−5.3	−3.6
Increase in GNP Deflator (%)	27.7	9.5

The policy directions of the social development component of the plan are summarized below. They represent a significant addition to previous plans.

Policy Directions	Major Indicators	Unit	'80	'86
o Expansion of Employment Opportunities	Employed	1,000 persons	13,706	16,540
	(Unemployed Ratio)	(%)	(5.2)	(3.6)
o Stabilization of Living Cost	C.P.I.	%	34.6	8.0
o To Lessen Income Disparity	Lowest 40% Shares of Household Income	%	15.5	17.5
o Expansion of Housing Construction	Housing Supply Ratio	%	74.5	78.6
o Stabilization of Housing Price	Ratio or Avr. Housing Price to Avr. Household Annual Income	Times	7.3	6.0
o Upgrading the Dwelling Condition	Avr. Floor Space per Person	Pyeong[1/]	2.9	3.2
o Improvement of Nutrition	Avr. Calories Intake per adult/day	Kcal	2,668	2,816
o Extension of[2/] the Compulsory Education	Enrollment Ratio among Eligible Age	%	15.2	31.1
o Expansion of Opportunities for Higher Education	Advancement to Upper School	%	45.0	66.8
o Expansion of Pre-school Education	Kindergarten Enrollment Ratio	%	8.0	50.0

Policy Directions	Major Indicators	Unit	'80	'86
o Upgrading Quality of Public Education	Primary School[3/] (Avr. Class Size)	Person	65.0	50.0
	Middle School[4/] (Avr. Class Size)	Person	70.0	60.0
o Greater Investment for Technology Development	R & D/GNP	%	0.8	1.5
o Expansion of Vocational Training	Vocational Trainees	1,000 Persons	105	120
o Establishment of Foundation of Employment Security Programme	No. of Employment Security Office		35	214
o Expansion of Health Insurance	Beneficiaries of the Health Insurance Programme	% of Total Population	36.4[5/]	65.9
o Implementation[6/] of Pension Scheme	Beneficiaries	% Economically Active Population	—	29.8
o Upgrading the Living Environment	Piped Water Supply Ratio	%	53.0	70.0
	Sewerage Extension Ratio	%	8.0	25.0

Policy Directions	Major Indicators	Unit	'80	'86
o Alleviation of Urban Transportation Problems	Subway Utilization Ratio	%	9.8[7/]	37.2
o Expansion of Telephone Supply	No. of Telephone per 100 person	Telephone	10.6[8/]	19.2
o Expansion of Medical Resources	Population per Physician	Persons	1,485	1,275
	Population per hospital bed	Persons	1,132[9/]	428
o Elimination of Chronic Diseases	T.B. Prevalence Ratio	%	2.5	1.0
	Parasite Infection Ratio	%	15.4	2.0

Notes: 1/ 1 Pyeong = 3.24 m^2
2/ Gradual implementation from rural areas in 1985.
3/ Seoul, Busan
4/ Seoul, Busan
5/ As of 1981
6/ Gradual implementation from 1983
7/ As of 1981
8/ As of 1981
9/ As of 1979

Source: EPB, A preliminary draft of the fifth five-year economic and social development plan 1982-86, June 1981.

3. Health Situation

3.1 Health Status

The rapid economic development of the Republic of Korea has brought about

dramatic improvement in the health status of Koreans in general. Economic development has been accompanied by rising food intake and consequently a mitigation of disease and illness related to dietary deficiency. Substantial investment in water supply systems, sewage disposal facilities, and housing improvements has had a generally desirable impact on health by reducing the incidence of communicable disease caused by water, crowding, and environmental sanitation.

Life expectancy at birth as of 1980 was estimated at 69 years for females and 63 for males. This is roughly 15 years greater than the average life expectancy during 1959-69. Concurrently, the crude death rate decreased from 12.8 per 1,000 people in 1956-1960 to 6.7 in 1976-80. As can be seen in the following table, the primary cause of death in Korea in 1953 was communicable and infectious diseases such as tuberculosis, pneumonia, bronchitis, gastroenteritis. In 1979, however, the primary cause was noncommunicable disease such as malignant neoplasm,

Ten Leading Causes of Deaths in Korea

Rank	1953[1/]	1979[2/]
1.	Tuberculosis	Cerebrovascular Disease
2.	Gastroenteritis	Malignant Neoplasm
3.	Cerebrovascular Disease	Other Diseases of Circulatory System
4.	Pneumonia, Bronchitis	Hypertensive Diseases
5.	Nervous System Disease	Accident
6.	Senility	Tuberculosis
7.	Heart Disease	Liver Cirrhosis
8.	Infectious and Parasitic Diseases	Accidental Poisoning
9.	Malignant Neoplasm	Pneumonia
10.	Unspecified	Emphysema, Bronchitis & Asthma

Source: 1/ Kim, K.D., Preventive Medicine, 1974.
2/ Office of Statistics, EPB, Mortality rate by causes of death, 1979.

cerebrovascular diseases and hypertensive diseases, etc. The most sensitive index, i.e., the infant mortality rate, has also decreased rapidly. In 1965-1970, there was 107.9 deaths per 1,000 children, but by 1980 the infant mortality rate had fallen to 32.0 per 1,000.

Despite the reduction in mortality, morbidity still remains a serious problem. Surveys indicate that at least 15 percent of the population lose an average of 3.4 days of work per month because of illness, primarily among the rural population. Gastroenteritis and respiratory diseases are still the most common, and about 23 percent of the population surveyed suffered from parasite infestation. While malaria and cholera have practically disappeared and not the problem, typhoid fever, diphtheria, poliomyelitis, Japanese B. encephalitis, whooping cough, measles and leprosy are still seen. Tuberculosis still continues to constitute an important public health problem. The National Sample Survey in 1980 revealed pulmonary tuberculosis amog 2.5 percent of population.

3.2 Health Problems

The problems related to the health of the people in Korea are two-fold. The one is the disease pattern, which can be controlled or treated with presently known technology through personal hygiene, early diagnosis and treatment, immunization, improvements in water supply and waste disposal, and careful preparation of food, etc. The other is health care system and approach to combat this situation. The health care system of Korea has been patterned after those found in the United States of America and Japan, focused on the institutional care of the sick often in highly sophisticated hospitals and dominated by physicians who are supported by fewer auxiliary health workers. This causes limitation in quantity of services and little access and availability to essential health care for the majority of people. In addition, as a result of changing consumption patterns and the accelerated drive for social development, it can be anticipated that the demand for health care and health care cost will rise rapidly as they have done in most of the developed nations.

In achieving the goal of health for all by 2,000, the crucial issues in the health care of Korea today, therefore, is the improvement of accessibility and availability to the health care for the majority of the people, and health care cost containment.

Major Health Indices

Indices	1970	1975	1980
Life Expectancy at Birth			
Male	59.8		62.7
Female	66.7		69.1
Crude Birth Rate	31.1	25.1	23.4
Crude Death Rate	9.3	7.2	6.7
Infant Mortality Rate (per 1,000 births)	53.0	41.0	32.0
Maternal Mortality Rate (per 10,000 births)	8.3	5.6	4.2

Source: 1) Korea Statistical Yearbook ('70, '75 and '80)
2) The 5th Five-Year Economic and Social Development Plan

4. Situation of Health Services

4.1 Organization of Health Services

Among 2 Boards and 18 Ministries of the Korea Government, 4 Ministries such as Economic Planning Board, Ministry of Home Affairs, Ministry of Health and Social Affairs and Ministry of Education have function related with health affairs.

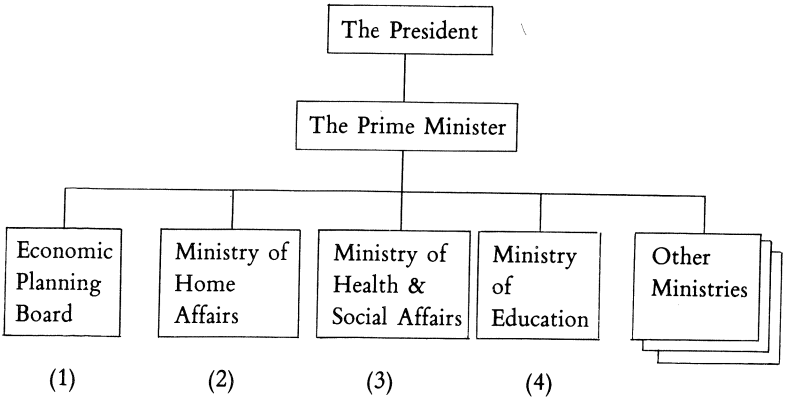
First, the Economic Planning Board takes responsibilities on planning, budgeting and allocation of resources for health services. Second, the Ministry of Home Affairs administers the local governments to which local health organization such as health centers or subcenters belong. Third, the Ministry of Health and Social Affairs deals with all matters related to health and social affairs, and the last, the Ministry of Education is responsible for training and education of health manpower.

Local organization of health services is controlled administratively by the Ministry of Home Affairs (except Seoul Special City which is directly controlled by

the Prime Minister) and technically by the Ministry of Health and Social Affairs.

Each of the local governments of Seoul Special City, 3 self-controlled cities and 9 provinces has a division of health responsible for health related matters and one or more city or provincial hospitals.

Central Government Organization of Health Services

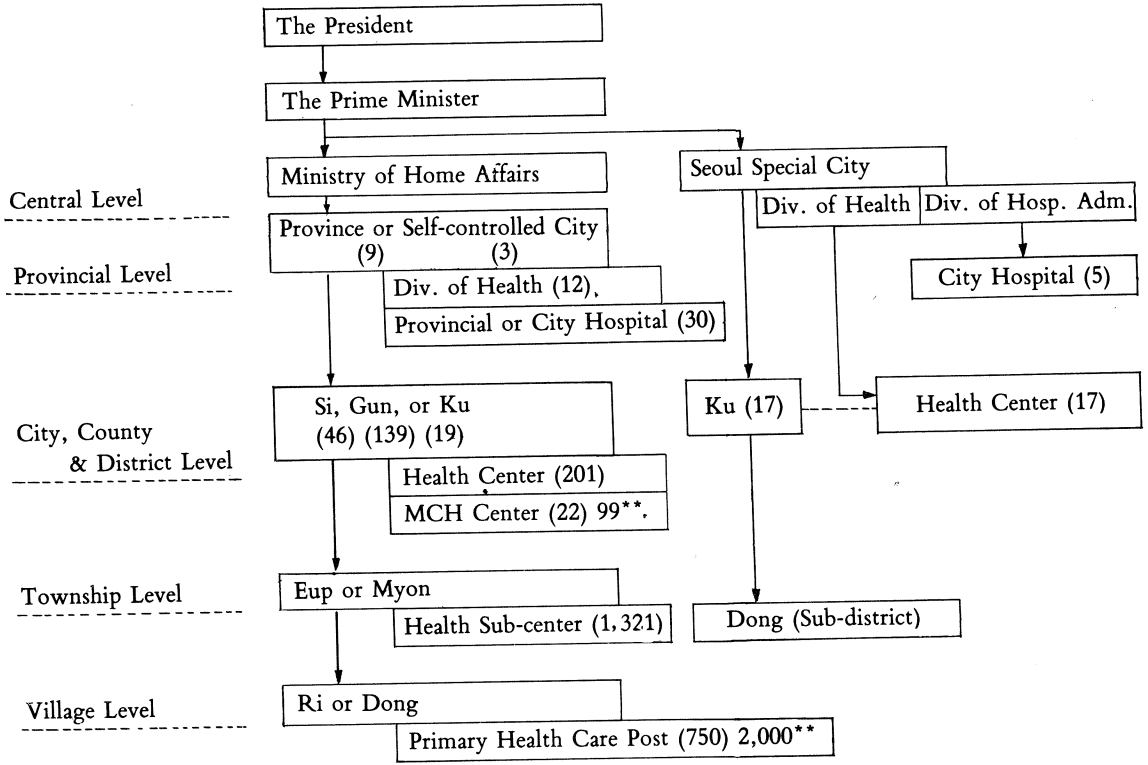


(1) EPB: Execution of Budget and Mobilization of Resources
(2) MOHA: Control of Local Government
(3) MOHSA: All Matters Related to Health and Social Affairs
(4) MOE: Training and Education of Health Manpower

Seoul Special and self-controlled cities are composed of districts, and provinces are composed of small cities and counties respectively. Each small city, county and district has one health center which makes total of 218 at present. In addition, 22 MCH Centers are provided at this level, the number of which will eventually increase to 99 in the future.

Again at township level, there are 1,321 health subcenters, and at villages, there are 750 Primary Health Care Posts which will be finally total 2,000 in 1984.

Local Government Organization of Health Services



4.2 Trends of Health Facilities and Manpower

In the last decade, health facilities and manpower of the country have been continuously augmented to meet the health needs of the population. The number of general hospitals, which must have more than 80 beds and have at least eight departments such as Intenal medicine, General surgery, Pediatrics, Obstetrics and Gynecology, Radiology, Pathology, Anesthesia, and Dentistry, changed from 12 in 1970 to 37 in 1975 and 82 in 1980. The number of hospitals, which must have more than 20 beds, has fluctuared as 220 in 1970, 128 in 1975 and 233 in 1980. That is because of a revision of the Medical Law in 1975 through which many hospitals became clinics. Clinics have also been increasing in same line with other facilities from 5,402 in 1970 to 6,344 in 1980, however, herb clinics are a little bit decreased from 2,443 in 1970 to 2,328 in 1980. Along with the increase of facilities, the ratio of hospital beds per 100,000 persons improved very much from 51.3 in 1970 to 99.7 in 1980.

The increase of health manpower has kept pace with that of health facilities during the period. As seen in the figure, as of 1980, 25,579 physicians have been licenced, 3,620 dentist, 24,366 pharmacists, 3,015 herbal doctors, 8,955 technicians, 40,373 nurses, 4,833 midwives, and 61,072 nurse-aides, though not all of them are employed. Community Health Practicioners which had been developed as a new category of health workers in Korea are deployed in remote areas and serve the rural people as one of key manpower dealing with primary health care services.

Health Facilities

Classification	1970	1975	1980
General Hospital	12	37	82
Hospital	220	128	233
Clinic	5,402	6,087	6,344
Dental Clinic	1,344	1,614	2,028
Herb Clinic	2,443	2,382	2,328
Pharmacy	8,439	10,197	12,337
Beds per 100,000 persons	51.3	60.2	99.7

Source: Korea Statistical Yearbook ('70, '75, '80)

Health Manpower

Classification	1970	1975	1980
Physician	18,184	19,588	25,579
Dentist	2,122	2,595	3,620
Pharmacist	14,648	19,750	24,366
Herbal doctor	2,828	2,788	3,015
Technician	2,403	4,295	8,955
Nurse	17,958	23,632	40,373
Midwife	6,182	3,773	4,833
Nurse-aid	3,452	43,433	61,072

Source: Korea Statistical Yearbook ('70, '75, '80)

4.3 Sectoral and Regional Distribution of Health Resources

The Korean health system is heavily dependent upon the private sector. Private clinics and hospitals account for more than 95% of all medical facilities, employ 72% of the physicians, and include 72% of the total beds. Private clinics, therefore, have a greater impact on the availability of medical care. However, most of the private sector is distributed in urban areas.

In Korea, only about 57% of the population live in the cities, but 90.0% of the physicians are urban dwellers and 82% of hospital beds are located in the cities. This means that access to health care for the rural populations is yet somewhat difficult. The trend of maldistribution of health resources has been the result of a laissez-faire policy in the development of the private health care sector. As is prevailing in other countries, the private sector tends to invest more in health care in the cities where the economic demand for health care is higher than in rural areas. As an inducement to the expansion of private health sector resources to rural areas, financial incentives, e.g. long-term, low interest loans are provided to those who establish health facilities in rural communities and areas with industrial complexes.

Therefore, Government health services, especially, the program activities of

the public health centers and subcenters should be strengthened in order to increase the availability of health care services to rural residents.

4.4 Health Insurance and Medical Aid Programme

The nation's compulsory health insurance scheme introduced since July 1977 currently covers over 12.7 million persons, about 32.9% of the population as of July 1982. However, the scheme is limited to employees of industries employing 16 or more workers (Class I), government employees, private school teachers, military personnel and their dependents, and residents living in six local areas where community health insurance project are implementing (Class II).

With the start of the Fourth Five-Year Development Plan (1977), the Government initiated a public medical aid program for the lower income group. The program covers over 3.7 million persons, about 9.5% of the population as of July 1982. Medical aid beneficiaries received outpatient care without any charge, but receive inpatient care divided into 3 categories; that is, care for 1st category beneficiaries is free of charge, care for 2nd category beneficiaries is paid the half by the government and paid the other half partitionally by the patients after prepayment of the government, and care for 3rd category beneficiaries is paid the half by

Medical Security Status

(Unit: Thousand)

Classification	Total Pop. (I) + (II)	Health Insurance				Medicaid (II)
		Sub-Total (I)	Class I	Class II	Gov't Emp. & Private School Teachers	
Beneficiaries	16,407	12,679	8,049	825	3,805	3,728
Coverage (%)	41.5	32.9	20.3	2.1	9.6	9.5

Target Population: 39,535
As of July 1982

the government, paid 30% partitionally by the patients after prepayment of the government and paid the remaining 20% by patients at the time received care.

4.5 Expenditure of Health Services

It has been estimated that Korea spent about 571.2 billion won on health in 1977, equivalent to 3.4 percent of gross national product and to about 15,861 won per capita. Of this amount, 58.7 billion won was financed by the central government and 36.3 billion won by the provincial governments. The remainder represented private consumer expenditures. Out-of-pocket health expenditure accounts for about 83 per cent of gross national health expenditures. In 1981, the proportion of the national budget allocated to health was 2.4 percent.

National Health Expenditure in 1977

(Billion Won)

Item	Amount	Percent Distribution
Public Expenditures	95.0	16.7
Central Government	58.7	10.3
Local Government	36.3	6.4
Private Expenditure	476.2	83.3
Total Health Expenditure	571.2	100.0
Health Expenditure/GNP (%)	3.4	
Per Capita Health Expenditures (Won)	15,861	

Source: Chong Kee Park: Medical Insurance System of Korea, The Korea Development Review, Vol. 1, No. 3, KDI, 1979

5. National Health Policy and Strategy

5.1 Objectives

To cope with the major health problems in Korea the following objectives have been established for the health sector in the 5th Five Year Economic and Social Development Plan.

a. Establishment of health care delivery system through the development and expansion of low-cost health services for the urban poor and rural residents, and a more even geographical distribution of medical resources,
b. Intensified public health measures, particularly in preventive medicine including disease control and MCH,
c. Better sanitation and water supply in rural areas and minimization of industrial pollution,
d. Increased productivity of labor through the improvement of health.

5.2 Strategies

To realize the above objectives, the following strategies will be employed; i.e., expansion of preventive and promotive services, and strengthening of health care system by utilizing primary health care approach, rational distribution of health resources, rational utilization and training of health manpower, and improvement of health data and information.

a. Expansion of preventive services:

Outlays that prevent illness have a greater cost/benefit ratio than those which involve treatment of illness that has already occurred. Therefore, preventive and promotive health services should be geared toward the overall health of the people.

b. Establishment of health care delivery system:

To rationalize the utilization of health resources and to improve health care delivery to residents in every location, the division of functions between general hospitals and clinic level health care facilities should be established. Serious and special cases should be referred to general hospitals for treatment, while clinic level health care facilities should be responsible for primary care.

c. Utilization of primary health care:

To provide adequate primary health care services to the rural residents and the

urban poor, the primary health care services, using intermediate health personnel, should be accompanied by an effective health care referral system, and integrated with the Saemaul Movement to best achieve its goal. The comprehensive primary health care services in rural areas should be provided by strengthening the role and the function of the health centers and sub-centers. This calls for the expansion of health facilities and the establishment of a referral system between health sub-centers and centers, and between health centers and municipal hospitals.

d. Rational distribution of health resources

Measures to induce the extension of the private health sector into rural areas should be reviewed. Methods to encourage branches of private general hospitals or university hospitals to open in rural areas, and the provisional prohibition of opening new clinics in large cities where medical resources are heavily concentrated, should be considered until geographical distribution is improved.

e. Rational utilization and training of health manpower.

In the process of providing health care services, the utilization of manpower has been inadequate. In training health personnel, specialist training has been over-emphasized while general physicians have not been sufficiently encouraged. Considering that more well trained primary care practitioners are needed, residency training in primary care and family practice is essential. Training of intermediate level health personnel, with greater capabilities than nurses, such as the community health practitioners is necessary to meet the present and future demand for health care in rural areas. This new type of health personnel could be supplied by the retraining of nurses.

f. Improvement of health data and information

The existing organizational structure and administrative mechanism for the gathering of health statistics are far from adequate in terms of staff, budget, hierarchical structure, and internal administrative collaboration. It is, therefore, emphasized that an expanded central health statistical agency should, at minimum, be supported more strongly and should be reorganized.

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