# The Health Status and Health Care Use of Koreans: A Glance Through OECD Statistics

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## Introduction

The OECD requires that its 34 member countries submit data every year on a range of categories of key indicators, including those pertaining to health. The data collected thus is compiled into a series of yearly reports, among which is the *OECD Health Data* which serves as a basis for comparison of health and health care use in OECD countries. This study is based on statistics as presented in *OECD Health Data 2015*.

## Objective and self-rated health in Koreans

Although life expectancy—an indicator widely used to gauge the health status of a population—is higher at 81.8 years in Korea than in most OECD countries and higher than the OECD average by 1.3 years, the rate of those who regard their health as "good" is lower in Korea than in just about any other OECD country.

Healthy life expectancy also is higher in Korea (73 years) than in most OECD countries. The rate of those aged 15 and over who reported their health as "good" is lowest (35.1 percent) in all the OECD countries and much lower than the OECD average of 69.2 percent (see Figure 1). The difference between life expectancy of health life expectancy is among the smallest in all OECD countries (see Figure 2). Japan's case bears a close resemblance to Korea's, showing a combination of high objective health scores and low subjective health levels.

<Figure 1> Subjective health levels and life expectancy
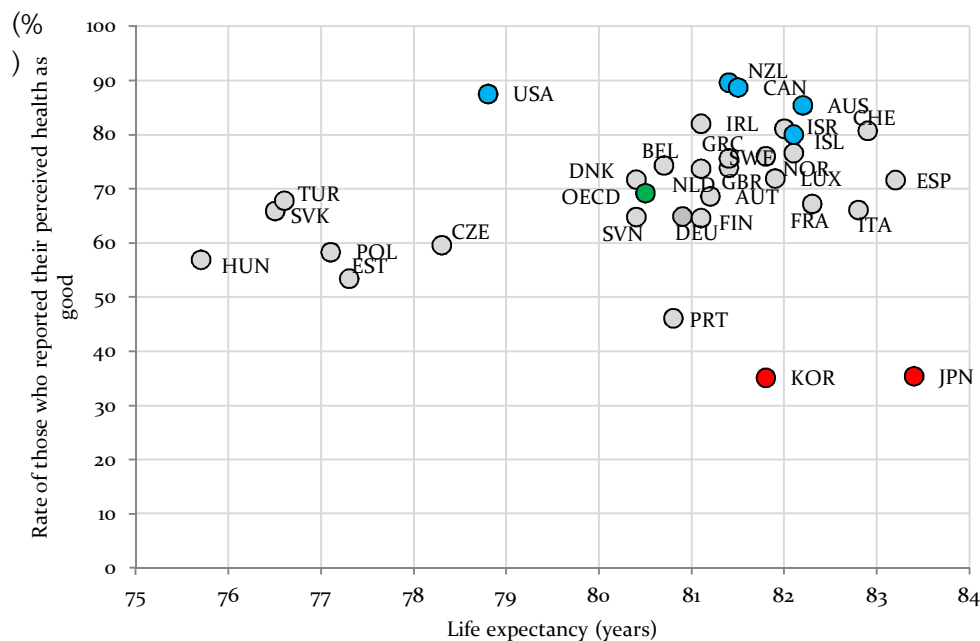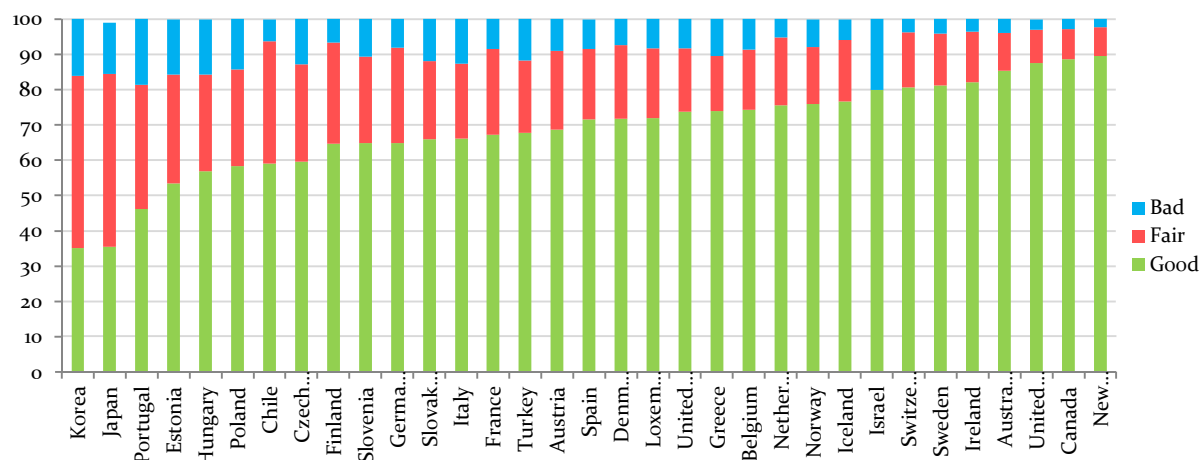


Source: OECD Health Data 2015

<Figure 2> Subjective health levels and the difference between life expectancy and healthy life expectancy
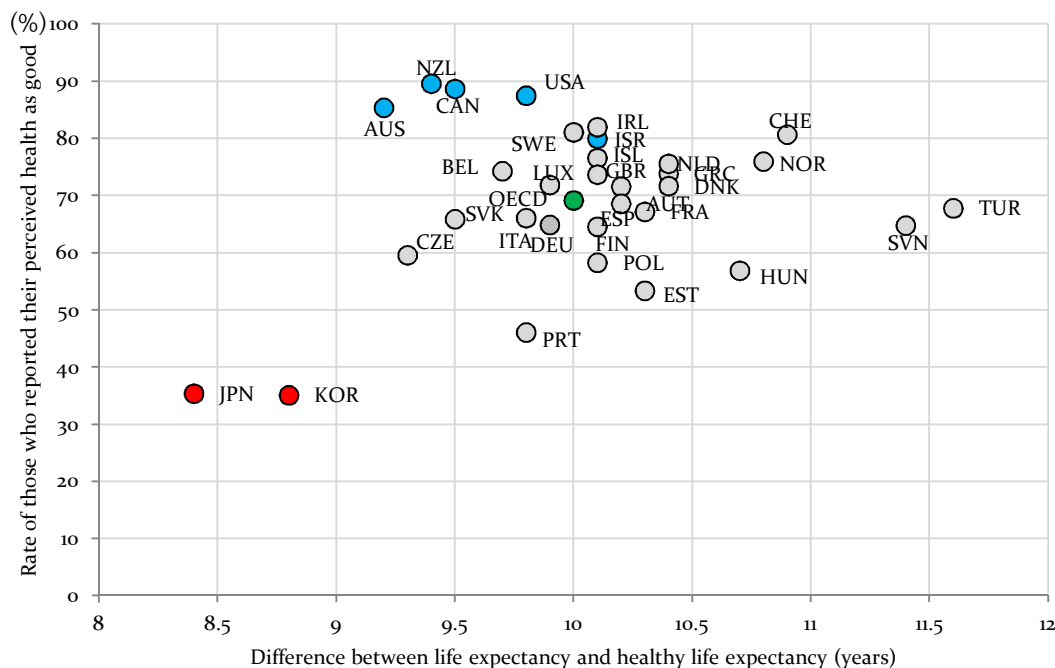


Source: World Health Organization

The gap between self-rated health status and objectively measured health indicators may in part be attributed to socio-cultural factors and how the response categories are arranged. The OECD has since 2013 requested the member countries to submit the rate of those who regard their health as "fair" and "poor." The percentage of those rated their health as "fair" was high in Korea and Japan compared to other OECD countries. On the other hand, people in such countries as the US, New Zealand, Canada and Israel, where the response categories are asymmetric ("excellent, very good, good, fair, bad"), tend to report their health more positively than do those in countries using a set symmetric categories.

<Figure 3> Self-reported health in OECD countries



Source: OECD Health Data 2015

In a comparison of self-rated and objectively measured overweight (and obesity), we found that the prevalence of overweight (and obesity) was lower in self-reported data than in actual

measures across all OECD countries. The OECD defines "overweight" as having a body-mass index (BMI)—the value calculated by dividing body weight by the square of height—greater than or equal to 25 and less than 30, and "obesity" as having a BMI greater than or equal to 30. The measurements of height and weight indicated that the prevalence of overweight (and obesity) in Koreans was 31.5 percent, which is much lower than the OECD average of 56.2 percent and the second lowest among the 12 OECD countries that submitted their data, next only to Japan's 24.1 percent. Self-reported data suggests a much-lower prevalence of 24.4 percent. The discrepancy between measured and self-reported overweight (and obesity) is larger in Korea than in any other OECD country and is larger in women than in men. The self-reported prevalence of overweight (and obesity) in Korean women is so low that it amounts to as little as 67 percent of the prevalence of measured overweight (and obesity). Such a disparity, which in part is attributable to Korea's appearance-oriented culture, stands in line with the findings from previous research (Shapiro and Anderson, 2002; Gorber *et al.*, 2007) that suggest that under-reporting of weight tends to be more prevalent in those who are female, overweight or obese, and on diet.

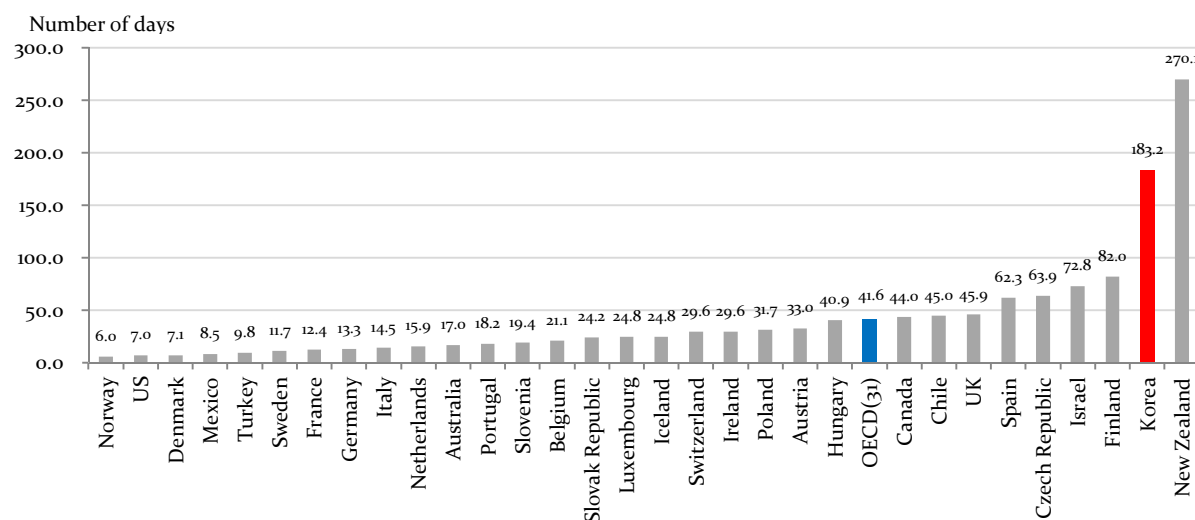<Table 1> Prevalence of overweight or obesity in selected OECD countries

|  | All | | | Men | | | Women | | |
|---|---|---|---|---|---|---|---|---|---|
|  | Self-reported (A) | Measured (B) | A/B | Self-reported (A) | Measured (B) | A/B | Self-reported (A) | Measured (B) | A/B |
| US | 63.2 | 68.6 | 0.92 | 70.5 | 71.3 | 0.99 | 48.3 | 54.7 | 0.88 |
| Australia | 56.0 | 61.2 | 0.92 | 63.3 | 67.7 | 0.94 | 56.1 | 66.1 | 0.85 |
| Germany | 52.4 | 60.0 | 0.87 | 61.5 | 67.1 | 0.92 | 43.8 | 52.6 | 0.83 |
| Canada | 52.1 | 60.3 | 0.86 | 60.2 | 68.0 | 0.89 | 43.4 | 52.9 | 0.82 |
| Finland | 48.9 | 59.2 | 0.83 | 56.7 | 65.9 | 0.86 | 42.8 | 52.4 | 0.82 |
| Korea | 24.4 | 31.5 | 0.77 | 30.9 | 36.5 | 0.85 | 17.8 | 26.4 | 0.67 |

Source: OECD Health Data 2015
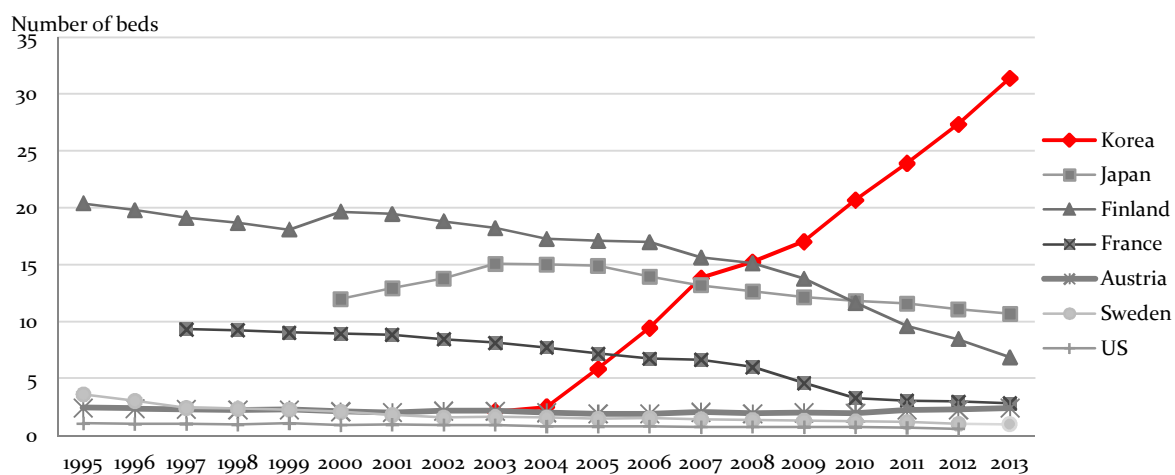
## Use of health care and health resources in Korea

The average length of stay in hospitals for Koreans was 16.5 days, almost twice as long as the OECD average of 8.3 days. The long hospital stay of Korean patients can be traceable at least in part to the policy of "social admissions," whereby hospitals allocate a considerable share of their beds for long-term care. The average length of stay in hospitals for dementia patients was an estimated 183.2 days in Korea, longer than in most of the other OECD countries and 4.4 times longer than the OECD average of 41.6 days. The number of long-term care hospital beds per 1,000 population aged 65 and over has increased dramatically from 2.5 in 2004 to 31.4 in 2013, which stands in contrast to the trends observed in many other OECD countries, where, as a way to curb the use of high-cost hospital beds, there have been increases of late in non-hospital long-term care facilities intended for people who no longer need acute care.

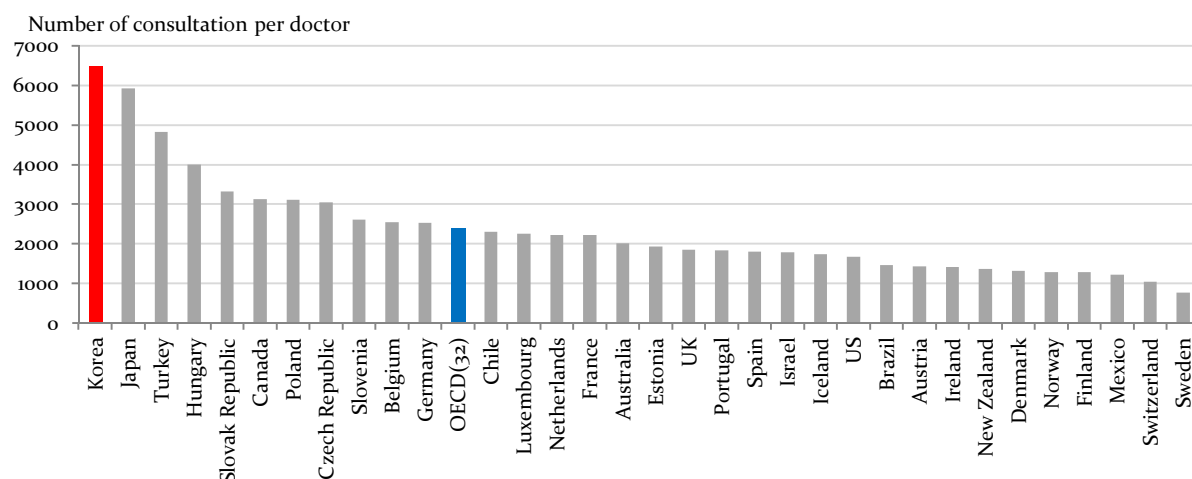<Figure 4> Average length of hospital stay for dementia patients in OECD countries

Number of days

| Country | Value |
|---|---|
| Norway | 6.0 |
| US | 7.0 |
| Denmark | 7.1 |
| Mexico | 8.5 |
| Turkey | 9.8 |
| Sweden | 11.7 |
| France | 12.4 |
| Germany | 13.3 |
| Italy | 14.5 |
| Netherlands | 15.9 |
| Australia | 17.0 |
| Portugal | 18.2 |
| Slovenia | 19.4 |
| Belgium | 21.1 |
| Slovak Republic | 24.2 |
| Luxembourg | 24.8 |
| Iceland | 24.8 |
| Switzerland | 29.6 |
| Ireland | 29.6 |
| Poland | 31.7 |
| Austria | 33.0 |
| Hungary | 40.9 |
| OECD(31) | 41.6 |
| Canada | 44.0 |
| Chile | 45.0 |
| UK | 45.9 |
| Spain | 62.3 |
| Czech Republic | 63.9 |
| Israel | 72.8 |
| Finland | 82.0 |
| Korea | 183.2 |
| New Zealand | 270.1 |

Source: OECD Health Data 2015

<Figure 5> Number of long-term care hospital beds per 1,000 population aged 65 and over in selected OECD countries

Number of beds

Source: OECD Health Data 2015

While the number of health professionals per population in Korea is below the OECD average, Koreans use health services more often than people in most of the other OECD countries. The number of clinical physicians, including oriental medical doctors, per 1,000 population was 2.2 in Korea, less by 1 than the OECD average of 3.2 and, among all OECD countries, the second lowest, higher only than in Mexico. On the other hand, the yearly number of outpatient visits per person in Korea, at 14.6, is higher than in any other OECD country and 2.1 times higher than the OECD average. As a result, Korean doctors in 2011 provided, on average, 6,487 consultations, a figure 2.7 times the OECD average. These differences we see between countries may to some extent have to do with cultural factors, but they may also be due in part to differences in health systems. For example, the trend has been that in such countries as Korea and Japan, where fee-for-service is the predominant method of reimbursement, the rate of consultations with doctors is higher than the OECD average, while the rate in Mexico and Sweden, where doctors are paid on a salary basis, is found to be lower than the average.

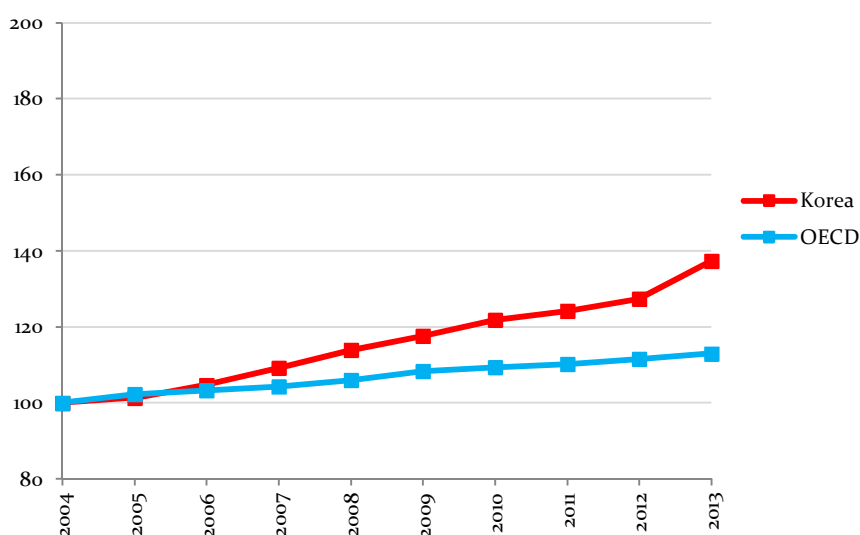<Figure 6> Number of consultations per doctor in OECD countries

Number of consultation per doctor

The increase in the number of hospital beds in Korea has been more rapid than the increase in the number of health care professionals. However, the number of clinical nurses (including nursing assistants) per 1,000 population increased by a factor of 1.4 from 3.8 in 2004 to 5.2 in 2013, while the OECD average increased by 1.1 times. Meanwhile, during the same period, Korea saw the number of hospital beds double while the rest of the OECD countries on average gained a 10 percent increase in their hospital beds. The result for Korea is a decrease in the number of clinical nurses per hospital bed, albeit to a small extent, over the 10-year period.
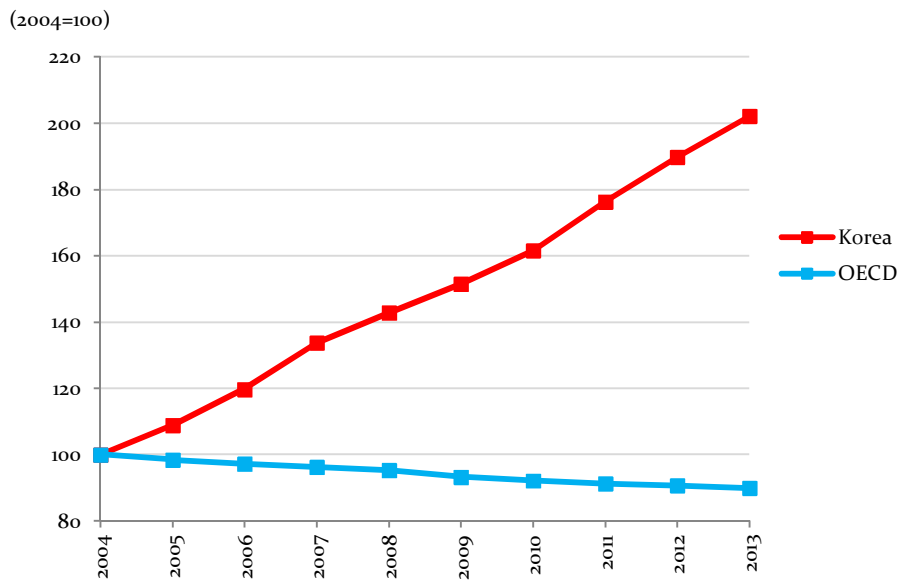
<Figure 7> Changes in the number of clinical nurses in Korea compared to the OECD average
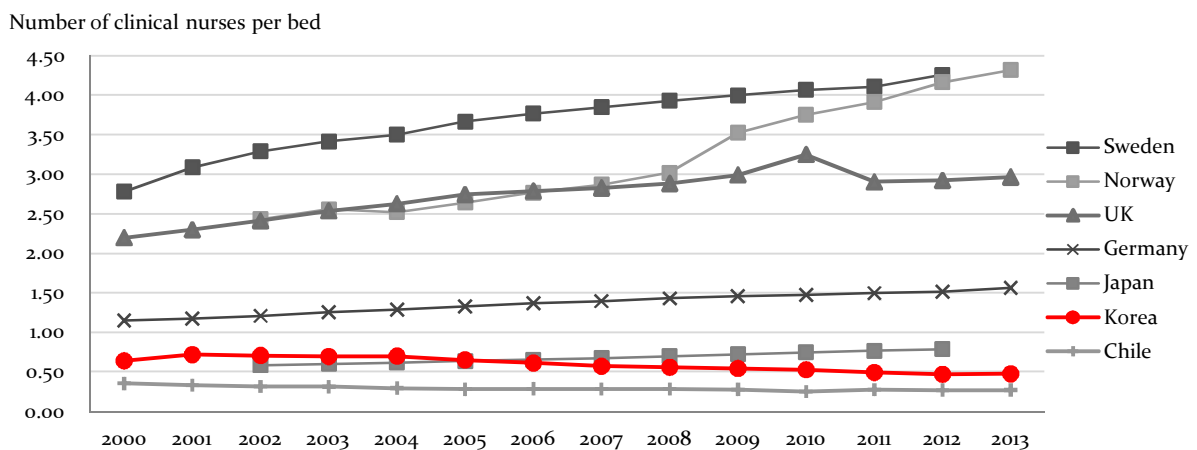
(2004=100)

<Figure 8> Changes in the number of hospital beds in Korea compared to the OECD average

(2004=100)



Source: OECD Health Data 2015

<Figure 9> Changes in the number of clinical nurses per bed in Korea compared to selected OECD countries

Number of clinical nurses per bed



Source: OECD Health Data 2015

## Conclusion

The self-rated health status of Koreans stands in stark contrast to their increasing life expectancy. This is where there is a need for paying heed to socio-cultural factors when analyzing the statistics. Also, Koreans are highly prone to report their weight and height as they desire. The discrepancy between the prevalence of measured overweight (and obesity) and the prevalence of perceived overweight (and obesity) is particularly large in women, with the latter as low as 67 percent of the former. Such a wide difference, which is seen as arising at least in part from a strong looks-oriented culture, calls for efforts to better inform the public regarding the health risks of overweight and obesity.

Korean patients tend to spend twice as many days in the hospital as the OECD average. For dementia patients, in particular, the duration of hospital stay is 4.4 times longer in Korea than the OECD average, a trend expected to decline somewhat as it is likely that the Long-term Care Insurance, with its newly added tier for dementia (Tier 5), will extend to cover more patients with the disease. Still, the number of hospital beds devoted to long-term care has increased in the past decade by 12.6 times to 31.4 per 1,000 population aged 65 and over, which is contrary to

the direction in which many OECD countries have been moving in recent years. As keeping more number of hospital beds than necessary will likely make for increases in the number of days spent in the hospital, there is a clear need for deciding the optimal number of hospital beds. While Korea has more hospital beds per 1,000 population than any OECD country except Japan, it has fewer doctors and nurses than necessary. The result has been that Korean doctors in 2011 provided an average of 2.7 times more consultations than the OECD average. As an inordinate workload on the part of health care professionals may lead to negligence of their duties with respect to patients, policy efforts will need to focus on how to reduce the number of consultations and services each health care professional has to deliver and enable them to ensure the quality of their services.