The Policy Context of the Poor Progress of South Korea’s Pro-poor Policy


Shin, Young-jeon  MD. MPH. PhD.
Assistant professor of Hanyang University, Seoul, Korea

Assistant professor
Dpt. of Preventive Medicine, Hanyang Univ. College of Medicine
Sungdong-Gu Haengdang-Dong 17, Seoul, Korea 133-791
Tel 82-2-2290-0668, Fax 82-2-2293-0660, yshin@hanyang.ac.k
In 1998, Kim Dae-jung, a long-standing pro-democracy activist who had been sentenced to death under previous military governments, was elected President of the Republic of Korea. His victory had a special significance to the history of policies, especially, the welfare and health policy in Korea, because he had consistently stood for pro-egalitarian politics compared with the previous regimes and promised the expansion and reinforcement of the government’s welfare system including safety net and health care in his presidential campaign. Therefore, many people strongly expected the dramatic expansion of welfare programs during his reign. Medical-Aid, a public medical assistant program for the poor in Korea, was no exception. Unfortunately, the program did not fully realize the long-cherished dreams of pro-poor advocates, such as a significant increase in the program’s number of beneficiaries, the expansion of its benefits, the reduction of its co-payments, and the enforcement of measures to prevent discrimination against Medical-Aid enrollees.

Why didn’t Medical Aid progress as expected during Kim Dae-jung's reign, despite his pro-egalitarian position and his promise in his presidential campaign to expand welfare benefits? To answer this question, the historical background of Korea was briefly reviewed and summarized into "a triple burden". The study presented three major characteristics of the policy context as barriers of progress of the Medical Aid policy; overflowing ideologies against the pro-poor policy, the governance crisis, and immaturity of the civil society. It showed that the poor progress of Medical Aid policy in Kim Dae-jung’s regime was closely linked to these three contextual barriers. The paper argues that any discussion about health processes and consequences have to be placed on the understanding of their policy context. The future of pro-poor policies in Korea, such as Medical Aid will very much depended on how the Korean society muddled through such kinds of contextual barriers. The characteristics of the context of the Medical Aid policy that were seen can also partly help us understand the dynamics of other recently introduced health policies in Korea. Moreover, other countries that share a similar historical background with Korea, such as occupation by outsiders, military dictatorship, etc., could learn lessons from Korea’s experience.

Keywords: Policy context, pro-poor policy, Medical-Aid, the Republic of Korea

*Medical-Aid* is a public medical assistant program for the poor like Medicaid in the United States
In February 1998, the Republic of Korea (hereafter South Korea) changed regimes. Kim Dae-jung, a long-standing pro-democracy activist who had been sentenced to death under previous military governments, was elected President under Korea’s strong presidential form of government. Under his rule, it became clear that the principles and ideals of the President have a strong influence on the Korean political system. His victory, however, has greater significance to the history of policies in South Korea. First, it was the first-ever power shift from the ruling party to the opposition camp in the nation’s political annals. Second, Kim’s regime is the second civilian reign after a 30-year military dictatorship. The first civilian reign, however, was not in truth a civilian regime but a hybrid regime with the power group in the military dictatorship period. On the contrary, Kim’s major advocates were not only people who had fought more than 30 years of military dictatorship, but who were relatively politically more progressive than those in the previous regime. Third, just before Kim became President, an unprecedented economic crisis broke out in December 1997 in Korea. It was a time when strong leadership was needed. Kim’s regime also had special significance to the nation’s welfare and health policy because he had consistently stood for pro-egalitarian politics and promised the expansion and reinforcement of the government’s welfare program in his presidential election campaign (Kim 1997). In addition, he had to activate and reinforce a safety net with his moves to turn around the nation’s failing economy.

After Kim took office, he named his welfare policy DJ Welfarism or The Productive Welfare. It was known as “the welfare that contributes to production” or “the welfare that encourages participation in production (Chung 2001).” Many wide-ranging debates have arisen on the political characteristics of The Productive Welfare, from its being just a neo-liberalism of welfare, to its being “the third way,” to its wielding increased state intervention linked to neo-liberalism, and to its being a conservative welfare policy (Jung 2002; Kim 2002). Amidst all these opinions, it is true that Kim’s regime had a positive position and attitude towards the expansion of welfare programs, and many people strongly expected a dramatic expansion of such programs during his regime. Among these welfare programs was Medical Aid, a public medical assistance program for the poor in Korea. Unfortunately, the program did not fully realize the long-cherished dreams of pro-poor advocates, such as a significant increase in the program’s number of beneficiaries, the expansion of its benefits, the reduction of its co-payments, and the enforcement of measures to prevent discrimination against Medical Aid enrollees.

Why didn’t Medical Aid progress as expected during Kim Dae-jung’s reign, despite his pro-egalitarian position and his promises in his presidential campaign to expand welfare benefits? To answer this question, the Medical Aid policies and their consequences in Kim’s regime (1998.2~2003.1) were reviewed. Then, the historical background and the policy context of the poor progress of Medical Aid were explored. Finally, the political implications of the results of this study were discussed.
The Poor Progress of the Medical Aid Policy under DJ Welfarism

1. The Medical Aid Program of South Korea

Medical Aid (“Euryoboho” in Korean) is Korea’s public medical assistance program for the poor. It was implemented in 1977 not only as a part of Korea’s wider public assistance program but also as a main component of Korea’s health care safety net initiatives and pro-poor health policies. It is financed from the general revenues of the central and local governments. In 2002, Medical Aid had 1,446,925 beneficiaries who represent 3% of the country’s population (NHIC 2002). To be eligible for Medical Aid, an individual should meet the criteria pertaining to income and property ownership, which the government revises annually. Beneficiaries are classified into two types according to their ability to work: type-1 and type-2 beneficiaries. Type-1 beneficiaries are those with no capability to work, i.e., those below 18 or over 65 years of age or are disabled. Type-2 beneficiaries, on the other hand, are those who are capable of working, i.e., who are from 18 to 65 years of age and are physically able. Medical Aid applies differential co-payments for insured medical services. Beneficiaries are entitled to similar health care benefits as those provided by the National Health Insurance, without premiums.

Despite the government’s confident official announcement of the mission of Medical Aid, the program has not adequately played its role as a safety net. The poor and their advocates have continuously criticized and complained about its low coverage rate, its insufficient level and range of benefits, its unstable finances, and the various forms of discrimination against its beneficiaries in its health care service process. First, Medical Aid has covered only a certain percentage of the poor. Since 2000, the government has applied the national minimum cost of living (NML) as a criterion for enrollment in Medical Aid, but there are still debates on the adequacy of its number of beneficiaries. These debates arise from the lack of legitimacy and credibility of the formula for calculating the NML and of the selection process using the means test. The official number of beneficiaries of Korea’s public assistance programs in 1999 was about 1.2 million, but Ryu argued that the number of people who had to be covered by these programs was estimated at about 8.7~12 million, 7~9 times the programs’ actual number of beneficiaries (Ryu 2000). In addition, the number of the near-poor (According to Ryu’s criteria, this group has to be counted among the poor) was estimated at 2.5~4.3 million, but most of them have been disqualified as beneficiaries of the National Health Insurance due to their delayed premium payments, and neither are they qualified to enroll in Medical Aid, due to which they have become uninsured (Lee 2000; Kim 2001). Among the self-employed beneficiaries of health insurance, 8.6 million lost their membership and became uninsured in 2002. As previously mentioned, most of them were the near-poor and people who need public assistance programs like Medical Aid.
Another serious problem of Medical Aid is its narrow range of benefits. It does not offer high-priced services, such as magnetic resonance imaging (MRI) and sonography, as well as essential services for the old and for patients with long-term chronic diseases or chronic diseases that require home care, and rehabilitation equipment such as dentures. In addition, Type-2 beneficiaries have to pay 1,500 won for every visit at the outpatient clinic and 20% of the total inpatient medical charge. The average out-of-pocket rate usually reaches 30-50% of the total medical charge when the uncovered services are included. This has become a major barrier to the poor’s access to health care services (Lee, Kim et al. 1999; Kim, Kim et al. 2001). Delayed reimbursement, a high cutback rate, and the relatively lower profit rate from Medical Aid patients have also led most health care providers to refuse or discriminate against Medical Aid beneficiaries. In 1996, 33.3% of all medical facilities did not provide medical services to Medical Aid patients (Yeom, Shin et al. 1998). Those facilities that did provide medical services to Medical Aid patients did not provide them with the same volume and quality of medical services that they provided to other health insurance patients. The research conducted by Suh and his colleagues shows that based on the Appropriate Evaluation Protocol (AEP) for a sample of 13 hospitals, a greater proportion of Medical Aid acute care admissions are inappropriate (21.5%) compared to the admissions of the National Health Insurance (10.9%) (Suh, Lee et al. 1999).

It was against such a scenario that Kim’s regime buoyed up the hopes of advocates of the poor for the dramatic improvement of the Medical Aid program.

2. Medical Aid Policies in Kim’s Regime and the Program’s Poor Progress
The results of the evaluation of some policies are basically determined by the criteria used. Generally, there are two kinds of viewpoints on the consequences of Kim’s welfare policy. Some schools insist that the increase in the number of beneficiaries of social insurance, the enactment of the National Basic Living Security Act, the expansion of welfare revenues, and the transformation of the National Health Insurance Program into the single payer system are remarkable advancements under the external violent gale of neoliberalism and the internal opposition-dominated National Assembly (Seong 2001; Kim 2002). On the contrary, other schools argue that the improved indices in the initial period of Kim’s regime resulted from the regime’s temporary response to the economic crisis, and that even though there was some progress in the health policy and welfare area, it did not reach the level that Kim promised (Kim 2001; Cho 2003). This study is based on the latter viewpoint.

In relation to Medical Aid, Kim Dae-jung promised the following in his presidential campaign: first, the integration of Medical Aid into the National Health Insurance System; second, the increase in the number of Medical Aid beneficiaries; and third, the expansion of Medical Aid benefits to include not only
adaptive equipment, such as dentures and hearing aids, but also home services. Moreover, he pledged to increase welfare revenues 30% every year and to significantly raise the number of social workers in Korea (Kim 1997). Most of his promises, however, were not realized.

In the early period of Kim’s regime, the government followed the policies of the previous regime. It increased the level of Medical Aid benefits to the level of benefits of the National Health Insurance. For example, it increased the number of days covered by Medical Aid. In 1999, Medical Aid’s number of beneficiaries dramatically increased to 1.6 million because Kim’s government established a new Medical Aid category, namely “the temporary beneficiary group,” during the economic crisis and added 310,000 enrollees. The number of Medical Aid beneficiaries, however, has consistently declined after 1999. In particular, in 2001, Kim’s government announced the change of the Medical Aid policy to “the way to reinforce the autonomy of the Medical Aid program.” This meant that the government would focus on cost containment as a top goal of Medical Aid. In the same year, The Medical Aid Division was established in the Ministry of Welfare and Health. Cost containment became the main mission of the organization. The Division enacted a variety of policies for cost containment, as follows: organization of a special task force to audit Medical Aid claims and long-standing inpatient cases, application of a fixed rate to hemodialysis services, restriction of total days of reimbursement days to 365 days, and tightening of the eligibility criteria from 61 to 65 years of age. The Medical Aid policies in Kim’s regime are summarized in Table 1.

Table 1. Major Medical Aid Policies in Kim Dae-jung’s Regime

<table>
<thead>
<tr>
<th>Date</th>
<th>Development</th>
<th>Cost Containment</th>
<th>Security Reinforcement</th>
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<tbody>
<tr>
<td>1997.11</td>
<td>Breakout of the economic crisis</td>
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<td>1998.2</td>
<td>Launch of Kim Dae-jung’s government</td>
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<tr>
<td></td>
<td>Extension of total coverage days to 300 days per year</td>
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<td>O</td>
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<tr>
<td></td>
<td>Expansion of the coverage of some rehabilitation equipment</td>
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<td>O</td>
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<tr>
<td></td>
<td>Cessation of the approval of extensions of admission days</td>
<td></td>
<td>O</td>
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<td></td>
<td>Enrollment of temporary beneficiaries</td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>1999.1</td>
<td>Extension of total coverage days to 330 days per year</td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>1999.9</td>
<td>Enactment of the National Basic Security Act†</td>
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<td></td>
</tr>
<tr>
<td>1999.10</td>
<td>Implementation of the mandatory assignment of medical facilities to the Medical Aid program</td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>2000.1</td>
<td>Extension of total coverage days to 365 days per year</td>
<td></td>
<td>O</td>
</tr>
<tr>
<td>2000.10</td>
<td>Enforcement of the National Basic Security Act</td>
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<tr>
<td>2001.10</td>
<td>Amendment of the Medical Aid Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001.11</td>
<td>Establishment of a task force to audit hospitals</td>
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<td>O</td>
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</table>
There were, of course, other Medical Aid policies in Kim’s regime besides cost containment. In March 2002, the government decided to provide dentures to 4,760 beneficiaries who were older than 70 years. This number of beneficiaries was too small, however, compared to the estimated 100,000, and the move did not fare well due to the shortage of funds and the ambiguous guidelines for its implementation. Civic groups criticized it as an example of programs launched merely for political propaganda (SOPH 2002).

An example of the typical characteristics of Medical Aid policy in Kim’s regime was the amendment process of the Medical Aid Act in 1999-2000. The National Basic Living Security Act was enacted in September 1999, after which a request was made for the amendment of its sub-act, the Medical Aid Act. Advocates of the poor thought it was an opportunity to solve the problems of Medical Aid. When the government announced the amendment, however, it deeply disappointed the advocates. As a result, 29 civic and labor groups organized the Alliance for Getting the Amendment of the Medical Aid Act Right (AGAMAAR) and submitted an alternative bill containing their reformative requests. Their major requests were the expansion of Medical Aid’s coverage to include victims of sexual violence and violence inflicted by family members, as well as near-poor groups; the abrogation of co-payments for Type-2 beneficiaries or the merging of the Type-2 group into the Type-1 group; the inclusion of home and long-term care, other services, and adaptive equipment among the benefits; and the establishment of a fund to ensure the financial stability of Medical Aid and the subsidy of relatively poor districts. The government and the Parliament, however, rejected most of these proposals (Shin 2002).
In summary, despite Kim Dae-jung’s promises and many people’s expectations, his government failed to make remarkable progress in the Medical Aid policy. First, the number of beneficiaries of the program hardly changed at 1,446,922 (as of 2002) after its temporary increase early in the regime (NHIC 2002). It was still very low compared to the 8.7~12 million beneficiaries that the advocates had requested. Second, there was no abrogation or reduction of the co-payments for the Type-2 group. Third, important benefits for the poor, such as the provision of dentures, long-term care, and home care, were not included in the benefits package. On the contrary, the total number of benefit days was restricted to 365 days, and the age eligibility was raised from 60 to 65 years old. Fourth, no program was implemented to reduce discrimination against the beneficiaries. Kim’s promise to integrate Medical Aid into the National Health Insurance did not even reach the stage of a public discussion. Moreover, Kim’s government changed the major goal of the Medical Aid policy to cost containment in 2001. As the result, no visible improvements were observed in the Medical Aid program during Kim’s regime, and Medical Aid beneficiaries still suffered from limited access to health services (Kim, Kim et al. 2001). In brief, most of Kim’s promises turned out to be merely political rhetoric. What accounted for this poor progress of the Medical Aid program under Kim’s regime?

<table>
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<th>Table 2. The Medical Aid Program before and after Kim Dae-jung’s Regime</th>
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<tr>
<td><strong>Before Kim’s regime</strong></td>
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<tr>
<td>No. of beneficiaries</td>
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<tr>
<td>Out-of-pocket expenses</td>
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<td>Benefits</td>
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<td>Prevention of discrimination</td>
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The Historical Background and Policy Context of the Poor Progress of the Medical Aid Policy

Policy is not developed in a vacuum but in a complex context (Collins, Green et al. 1999). Health policy is no exception. A health care system cannot be understood without understanding the context in which it
operates. It is influenced by the political, socioeconomic, and cultural contexts within which it is acting (Saltman 1997). Collins and his colleagues emphasized the importance of understanding a policy’s context, and they also categorized the elements of a policy’s context into demographic and epidemiological changes; processes of social and economic changes; economic and financial policies; politics and the political regime; and ideology, public policy, and the public sector (Collins, Green et al. 1999). This paper summarizes the historical background and policy context of Medical Aid in Kim’s regime based on the ideas presented by Collins et al.

1. The Historical Background: The Triple Burden

The uniqueness of the Korean policy context is basically a product of its history. Therefore, to understand the politics of the poor progress of the Medical Aid policy, we have to know the historical background against which it was produced. The history of South Korea has been briefly summarized in Table 3 and was called “a triple burden,” i.e., the burden of the past, the present, and the future.

<table>
<thead>
<tr>
<th>Period</th>
<th>Event</th>
<th>Highlight</th>
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<tr>
<td>BC 2333</td>
<td>First nation in the Korean peninsula</td>
<td>Homogeneous ethnicity</td>
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<tr>
<td>AD 1392~1897</td>
<td>The Chosŏn Dynasty</td>
<td>The Confucian society</td>
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<td>1910-1945</td>
<td>The Japanese occupation</td>
<td></td>
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<tr>
<td>1945.9~1948.8</td>
<td>The United States Military Government</td>
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<td>1950-1953</td>
<td>The Korean War</td>
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<td>1953</td>
<td>The armistice agreement and the partition of the Korean peninsula into North and South Korea</td>
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<td></td>
<td>The military dictatorship</td>
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<tr>
<td>1993.2-1998.1</td>
<td>The first civilian government (under Kim Young-sam)</td>
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<td>1996.12</td>
<td>Inclusion of Korea among the OECD countries</td>
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<tr>
<td>1997.12~</td>
<td>Breakout of the economic crisis</td>
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<tr>
<td>1998.2-2003.1</td>
<td>The people’s government (under Kim Dae-jung)</td>
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<tr>
<td>2003.2-</td>
<td>The participatory government (under Roh Moo-hyun)</td>
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**Burdens of the Past**

A highly homogeneous society with a long history and the Confucian tradition: Koreans are bound firmly by their long (nearly 5,000-year) history, their single language and common legacy despite rapid
industrialization, and their strong sense of social equality (Chung 2001). The Chŏsun Dynasty (1392-1897) before the Japanese occupation was dominated by a Confucian society where paternalistic authoritarianism and hierarchical social relations were the dominant social discourses.

**Coerced social reconstruction by outsiders:** During the last century, there were two periods of reconstruction of the Korean society by outsiders: during the Japanese occupation (1910-1945) and during the American occupation (1945~1948), just after World War II. The common characteristic of these two periods of Korean social reconstruction was that such reconstructions by outsiders were based on their interests rather than on those of the Korean people. In particular, the United States and the Soviet Union divided the Korean peninsula after the Korean War. South Korea remained under the United States’ political influence.

**The Korean War as a proxy war between two giant ideologies:** Five years after the Japanese liberation, the Korean War (1950~1953) broke out, destroyed most infrastructures, and fixed the partition of the Korean peninsula. The war was a proxy war between two giant ideologies. This confrontation has not yet ended. North and South Korea have technically still been at war since the Korean War, which ended without a peace treaty. The strongest communist society and the strongest capitalist society in the world are still facing each other across the world’s most fortified border. The Korean War was a pivotal event that amplified the anti-communism ideology of the South Korean society. It also provided fertile soil for the long-term seizure of power by the pro-American military dictator regime. Meanwhile, the political, economic, and cultural areas were rapidly integrated in the infrastructure of the United States.

**More than 30 years of military dictatorship:** After the coup d’état in 1961, South Korea came under the power of military dictator regimes until the launch of its first civilian government in 1993. This era overlapped with a period of rapid economic growth, although it was a dark period when civil society was suppressed and innumerable abuses of human rights were committed.

**“The Miracle of the Han River” and the ensuing discontent:** In the early 1960s, South Korea stood at much the same level of economic development as Ghana. In 2000, the UNDP estimated South Korea’s GDP per capita (adjusted for purchasing power parity) at $17,380, and Ghana’s, $1,964. In 2002, the UNDP ranked South Korea 27th on its composite Human Development Index, and Ghana, 129th (UNDP 2002). Such rapid economic growth, however, which no other country has ever shown, produced a variety of consequences, among them the corruption of rural society and myriads of industrial accidents, environmental destructions, and violations of human rights.

**Burdens of the Present**

**Democratization without settling down of tradition:** Although Korean society has been rapidly democratized in recent times, democracy has not yet fully settled down in the country. The oppressed
public demands during the previous dictatorial regimes have been gushed out. Besides, the country still suffers from an imbalance of power. There are also serious deficiencies in the rule of law, and a need for a proper restraint on executive power (Shin and Shaw 2003).

**Rapid integration into the world market:** The Korean economy is rapidly integrating into the world market, especially after its crisis in 1997. All sectors of society—i.e., the social, political, and industrial sectors—are demanding adjustments in their economic structures and processes to make these compatible with global standards.

**Rapidly growing expectations of high living standards and preference for high-technology devices:** Korea’s rapid economic growth, the Koreans’ high level of education, the rapid growth of the country’s information technology (IT) industry, and globalization are rapidly increasing expectations of high living standards and preference for high-technology devices. In particular, broadband-IT-services subscribers per 100 people in South Korea are 21.3, the highest in the world, and the Internet penetration rate in the country is 62.0%, the 8th highest worldwide (ITU 2003). This has enabled easy access to information inside and outside Korea, and has increased people’s expectations. Sometimes, such expectations are already beyond the capacity of the Korean society. For example, the number of MRIs in South Korea is 7.8 per million people. This is higher than that of the United States (7.6), the United Kingdom (4.5), and New Zealand (2.6) (Park 2004). This has led to high health care expenditures in some areas.

**Widening gap between the haves and the have nots:** Korea’s rapid economic growth in the 1960s to the 1970s did not increase the wealth of all Koreans. It produced not only corruption in rural and agricultural communities and the expansion of the urban poor sector, but also the rise of a few giant conglomerates called *chaebol* (Koo 1987). There was especially a sharp increase in income inequality before and after the 1997 financial crisis, with a Gini coefficient of around 0.385 recorded in 2000, which was high compared to that of other OECD countries (Yoo and Kim 2003). This rapidly increasing gap between social classes has caused social conflicts in the country.

**High level of national defense expenditures:** South Korea has to spend a large amount of money for national defense expenditures (15.5% of its general revenues in 2002) (MOD 2002). This is a major financial burden of the South Korean government.

**Burdens of the Future**

Two major burdens that the South Korean society will face are the unification cost and the fast aging of the society. First, according to numerous researches, the unification cost of the Korean peninsula has already reached 200 billion~2 trillion dollars, an amount that South Korea cannot afford (ref). A large part of this cost will be for social services expenditures, including health care services. Second, the old-age dependency ratio of South Korea is still relatively low, ranging from 8 to 9%. This, however, is
projected to double over the next 20 years to reach the current old-age dependency ratio of OECD economies (1995), and to triple in 30 years, reaching 27% by 2030. This figure approaches the projected levels in Europe and Central Asia, and is well above that of other developing regions. This pace of “demographic aging” is extremely rapid by historical comparison. It took France 140 years, and Sweden 86 years, for their elderly population to double (OECD 2001). In particular, this incredibly fast aging has a special significance in Korea’s health policy, because old people are among the main users of health services.

2. Three Major Characteristics of the Policy Context as Barriers to the Medical Aid Policy
Korea’s history, as previously described, has produced three major barriers to the improvement of its Medical Aid policy.

1) Overflowing ideologies against the pro-poor policy:
In the last century, the ideologies that have governed the South Korean society were Confucianism, colonialism, anti-communism, and the “economy is first” ideology. These occurred interdependently rather than alone. In particular, they have barred the progress of pro-poor policies such as the Medical Aid policy.

Confucianism: Jones named Hong Kong, Taiwan, Singapore, and South Korea Confucian welfare states (Jones 1990). She pointed out the “emphasis on duty and obligation” and the “belief in order and social stability as the very bases of welfare” in these countries as a shared “Chinese-ness” in terms of common core beliefs, values, and priorities (Jones 1993). Two major characteristics that the Confucian tradition produced were paternalistic authoritarianism and hierarchical favoritism. Both characteristics contributed to the reinforcement of domination by the ruling class. Authoritarianism was used as a base-discourse to reinforce statism in the military dictator regimes. Favoritism contributed to the reinforcement of the internal solidarity of the ruling class.

Colonialism: During the Japanese occupation (1910-1945) and the period of the United States Military Government, the South Korean society was entirely restructured. Westernized social policies and infrastructure were coercively introduced. These were designed to further the control and exploitation of Koreans. One of the bequests of the Japanese to Korea was the military nature of the Japanese colonial administration, which ensured the transmission of a military hierarchy, with its attendant disciplinary codes and ethos, to the colonial society. The military dictators inherited such kind of tradition and style, and it is yet to have a new face (Cumings 1987; Henderson and Appelbaum 1992). The health area was no exception. For example, Tonggam-bu, the colonial office that Japan established to govern the Korean
society in Seoul in 1906, announced as its main mission the construction of an effective ruling system in Korea, with a public health program as one of its main programs (Shin 1997). Moreover, the medical society became the sector that was most rapidly integrated into the Western society throughout the period of the United States Military Government (Lee 2001).

Anti-communism: Anti-communism has been the most dominant ideology in Korea in the last 50 years. For the United States military governor and the ensuing military dictators, anti-communism was “a magic bullet” to suppress any kind of resistance against them. This situation has not changed since then. Any suggestion to expand the government’s welfare program and any effort to reduce the gap between the rich and the poor are immediately regarded as “a socialist or communist idea,” and are promptly rejected.

“Economy is first” ideology: South Korean social policy has always had a strongly productivist orientation (Holliday and Wilding 2003). Its social policy is embedded in its economic development policy in that its economic policy has intended welfare consequences or reflects implicit or explicit socioeconomic priorities (Deyo 1992). The rapid economic development of Korea in the 1970s was driven by the government’s strong economic plan. Any kind of skepticism over the idea that the “economy is first” was not allowed. Kwon sees the rationale for the government’s economic strategy between 1961 and 1987 as “legitimation through economic performance” (Kwon 1999). Since the 1980s, a new assertion, “the welfare sickness,” became persuasive to the public. This means that over-investment in welfare programs and the increased dependency of beneficiaries on such programs will be a barrier to economic development. This idea shared the same ground as the “economy is first” ideology. According to Kwon’s view, social policy development in South Korea has been shaped by the need for legitimization because “democratic deficiency engenders a need for social policy” (Kwon 1999). The birth of Medical Aid was a typical example of this process.

Under the influence of Confucianism, colonialism, and military dictatorship, the administration of social policy has adopted an authoritarian, one-way, and top-down style. Any kind of participation of the beneficiaries and their advocates was not allowed. One example of this authoritarian style of administration of the Medical Aid program pertained to the number of persons who were put in charge of the program. Before the Medical Aid Division was established in the Ministry of Health and Welfare in 2002, only one or two officers took charge of the program for 1.5 million enrollees in the Ministry. Likewise, only one or two officers in the local government had charge of the program for 200,000–900,000 beneficiaries. This means it was impossible for them to respond to any kind of request of the beneficiaries. They merely issued orders and delivered simple messages and ruled in a top-down and unilateral manner.

As previously mentioned, the National Basic Living Security Act was legislated in August 1999 in response to pleas from all sectors of society for reform of the former Living Protection Act. The passage
of the reform act marked a transformation in welfare policies from a policy of simple giving of alms, as provided by the Living Protection Act, to a policy stressing national responsibility based on the rights of welfare recipients (OOP 2000). The new act established a National Medical Aid Committee\(^1\) for the Medical Aid program of the Ministry of Health and Welfare, but the poor and pro-poor advocates were still not allowed to participate in the council.

Medical Aid still maintains the original form of Korea’s social program in its colonial era and in its military dictatorship period. The main principle of its policy, which reflects Korea’s sad history, is institutionalization. This was the cheapest and most effective way to control the people who could not participate in productive labor. This institutionalization-oriented policy for the poor, the homeless, and the mentally ill has not yet been changed. Demands by pro-poor advocates to expand benefits to include home care and community services, and to reform the payment system for the mentally ill to encourage de-institutionalization, were rejected by Kim’s government.

The anti-communism ideology also delayed the progress of the Medical Aid program. In 2001, 10 progressive medical doctors and nurses who had insisted on free medical services and on the dramatic expansion of Social Security were arrested for violating the National Security Act. The main slogan of the nationwide protest parade of the Korean Medical Association in February 2004 was “Stop the socialistic health insurance and other health policies.” Amidst such an atmosphere, it was not easy for the advocates to make their voices heard to demand for the extension of benefits for the poor.

Relative to the “economy is first” ideology, the most persuasive contention of those legislators who objected to the expansion of benefits in the amendment process of the Medical Aid Act in 2000 was that such expansion could increase the financial burden of the government and make the beneficiaries more dependent (Shin 2002). The skyrocketing of Medical Aid expenditures, i.e., the over-30-percent average annual increase in such expenditures in 1997–2001, backed such position. Furthermore, it played a crucial role in the change of the Medical Aid policy principle to cost containment in Kim’s government after 2001.

2) The Governance\(^2\) Crisis

The role of states is important in pro-poor policy (Johnson and Start 2001). If a nation is suffering from governance failure, it can experience a pro-poor policy crisis.

During Kim’s regime, he faced a variety of social conflicts due to the governance crisis. The number of demonstrations during his regime rose to 11,582, registering a 61% increase from the previous regime (7,075, 1994-1997) (OOP 2002). The characteristics of the clashes were also different from those in the previous regime. The major issues of the social conflicts in the previous regime were, in many cases, related to the legitimacy of the government and its undemocratic and authoritarian policies, whereas those
in Kim’s regime emanated from a variety of issues by a variety of interest groups. Faced with this increased number and changed context of social demands, Kim’s government could not respond effectively. For example, there were five nationwide strikes by medical doctors in 2000 to oppose the introduction of the separation of drug prescription and dispensing. Despite Kim’s use of the full force of his authority, he failed to effectively suppress the strikes and finally retreated with significant political damage, significantly increasing the fee schedule and compromising major principles of the policy (Cho 2003).

Where did this governance crisis emanate? First, Kim became President right after the economic crisis broke out. A year later, Korea’s real GDP dropped by 6.7% (IMF 2000). As a result of this economic contraction, real wages took a 12.5% dive between mid-1997 and the end of 1998, and the unemployment rate soared from 2.5% to a peak of 8.7%. Household purchasing power declined sharply, and the percentage of poor people among urban residents jumped from 7.5% to 23% (WB 2000). A drastic deterioration in income distribution followed, with the Gini coefficient changing from 0.28 in 1997 to 0.32 in 1999 (NSO 2000). Under such conditions, and perhaps due to pressures from the opposition-dominated National Assembly, Kim had to hand over authority to decide major economic policies to international agencies, such as the International Monetary Fund (IMF).

The governance crisis in Kim’s regime had more complicated origins, though. First, as Reich argued, modern states are being reshaped by multiple forces acting simultaneously. This argument says that the state is actively constrained by agreements promoted by international agencies and by the power of multinational corporations. The state is being reshaped from within by increasing trends towards marketization and by corruption problems. The state’s role is being diminished from below by the expansion of decentralization and by the rising influence of non-governmental organizations (Reich 2002). More generally, since the late 1980s, the relative strength of the state has continued to lessen in relation to social forces, as South Korea has been weakened both by democratic pressure from within and by the demands of globalization from without (Amstrong 2002). Kim’s government was no exception. The policies of the IMF and the International Bank for Reconstruction and Development (IBRD) on the Korean economy before and after its economic crisis in 1997 are good illustrations of this hypothesis.

Second, for a long time, the governance of Korea had relied on the omnipotent power that the military dictator’s regime enjoyed. As such, consensus and coordination skills and systems were not well developed among various interest groups. In addition, Korean society has a deep distrust of the government. This distrust arose from the country’s history of colonial and dictatorial regimes, of governors who were invaders or tyrants. This is also one reason why the public does not favor the expansion of public policies and programs.
Third, Korea’s rapidly increasing financial burden, especially in the welfare and health services areas, is another reason for its governance crisis. The rapid increase in its welfare and health services largely emanates from its present and future burdens, which have already been discussed, such as the high expectations in living standards and the preference for high-technology devices, the large national military defense expenditures, and the rapid demographic changes in the society.

The weakness of the public infrastructure of Korea’s social and health care systems is another reason for its governance crisis. For example, to this day, its health care system is market-focused and private-sector-dominated. Private-sector dominance of health care provisions is estimated at an overwhelming 90% (Kim, Jang et al. 2001). This poorness of Korea’s public health infrastructure has historical and contextual backgrounds. Two historical events played an especially critical role: first, the devastation and poverty caused by the Korean War led policy makers to leave health care provision mainly to market forces for many years, and to focus on promoting economic growth. Other social systems, such as education and housing, have similar stories. Second, the major framework of South Korea’s modern health care system was designed during its United States Military Government period. Even after the South Korean government was established, the influence of the United States on the society significantly persisted, and the American-style private health care system, then the dominant system, became an important model in South Korea’s health policy process.

Even if these previously mentioned factors could not fully explain the governance crisis in Kim Dae-jung’s regime, it is obvious that these played major roles in the crisis.

This governance crisis in Kim’s regime can also explain the poor progress of the Medical Aid policy. Even though bureaucrats and legislators had positive attitudes towards such policy, it was difficult to expand the Medical Aid program. Limited expertise, insufficient revenues, a poor delivery system, and public distrust of the government would have led to the poor outcome of reform initiatives. Private facilities, which accounted for over 90% of total medical facilities in Korea, were not willing to cater to Medical Aid beneficiaries due to the program’s delayed reimbursement, the government’s authoritarian-style management, and the cutback of medical claims. Moreover, the government did not have effective control and management of the private facilities, which further barred the promotion of the Medical Aid program. More importantly, even as Kim Dae-jung promised that he would increase welfare revenues by 30% every year, he could not raise additional funds for Medical Aid because the escalation of Medical Aid expenditures was too rapid. Although he established a new division for Medical Aid in the Ministry of Health and Welfare in May 2002, this move was intended for cost containment rather than the expansion of the Medical Aid program. The reinforcement of the public health delivery system and human resources for Medical Aid were likewise not realized during his regime.
3) Immaturity of the Civil Society

The third and last major characteristic of the policy context is the “immaturity of the civil society.” The role of the civil society in the development of the welfare system is crucial. The previous authoritarian ruling group, however, had attempted to subordinate the civil society to the state’s goals. Instead, the series of ideologies mentioned previously, i.e., Confucianism, colonialism, anti-communism, and the “economy is first” ideology, dominated.

The advent of the civil society in Korea in the 1980s was followed by the growth of the middle class due to economic development. The labor class, the middle class, and the intellectual group that arose from industrialization became potentially strong forces in confronting the authoritarian military government. Since the 1990s, the establishment of civic groups and their participation in politics have rapidly increased, and are generating various achievements. Korea’s civic groups, however, did not emerge as grassroots organizations, but were led by progressive academics or active members of former democracy movements (Kwon 1999), which reflects their limited role in the political field (someone criticized them as “civil movements without citizens”). Civil movements participated in by vulnerable groups are still rare.

In the 1960s and the 1970s, the military dictator regimes enforced highly intensive labor and poor working conditions on workers. The presence in Korea of vast reserves of cheap, unorganized, and disciplined labor was widely used to account for its “economic miracle” (Henderson and Appelbaum 1992). Since the 1980s, Korea’s continuous economic growth and the increase in the Koreans’ real income rapidly diminished the number of blue-collar workers in the country. On the other hand, the ratio of white-collar workers in the middle class, who generally did not think of themselves as workers, abruptly increased. In addition, the absence of leaders in the labor movement led to the undermining of the role of the labor force in the political field and in the drafting of the country’s welfare policy (Hong 1998). Moreover, the cynical view of the radical labor forces, that the welfare policy was regarded as “reactionary reformism,” caused the passivity of the labor force in the improvement of Korea’s welfare policy (Nam 2001).

In short, even if there was a dramatic growth in civic groups and labor power during Kim’s regime, these forces did not play a major role in the political arena, especially in the improvement of the country’s welfare policy.

The poor and the pro-poor advocate groups were likewise not well organized and did not play an active role in the decision-making process on the Medical Aid policy. The establishment of AGAMAAR in 2000 was a historical event in the history of the Korean pro-poor movement. Despite the event’s outwardly grand spectacle, however, most civic groups did not have enough capacity to manage their ranks, and the poor were not observed to have actively participated either. The situation of the labor
group was not different. They could not give priority to poverty issues in their labor movement. Therefore, only a few activists carried out AGAMAAR’s activities, and they could not fully mobilize themselves beyond announcing their opposition to the government policy, visiting policy makers, and writing in newspapers, etc. In short, their moves did not effectively put pressure on legislators and bureaucrats.

Concluding Remarks

In summary, despite Kim Dae-jung’s political will and promises, his regime failed to overcome the contextual barriers to the Medical Aid policy, and he did not deliver the remarkable progress that the poor and the pro-poor advocates expected.

Several important lessons can be drawn from this analysis. First, this paper suggests that health policies, as in the case of Medical Aid, are closely linked to their policy context. Therefore, health policy processes and consequences have to be understood in their policy context. In particular, even though the President had political will, his lack of consideration for the policy context and his incapacity to break through the contextual barriers to the Medical Aid policy led to the poor progress of the policy. The following case illustrates contention. The Medical Aid policy is a policy for the poor. Therefore, its results could not be directly applied to other policies. The health care sector of any society, however, is the best mirror of the power relations existing in that country (Navarro 2003). As the Medical Aid policy is a core social security program in Korea, the characteristics of its political context that were found can help us understand the political context in South Korea. Second, there are no significant changes in the political context and in the Medical Aid policy after Kim’s regime. Therefore, the future of pro-poor policies in Korea, such as Medical Aid, will depend on how the Korean society overcomes the three major contextual barriers to the improvement of these policies: how Korea overcomes the overflowing ideologies against the pro-poor policy, how it rebuilds its governance system, and how the pro-poor advocate groups increase their power in the policy-making area. South Korea has a very dynamic society. Few places in the world can match the speed and depth of political and social changes in the country in recent decades (Amstrong 2002). South Korea’s social and political achievements are no less remarkable than its spectacular economic growth (Chomsky 2003). Therefore, the policy context of its previous policies can provide only limited information to the interpretation of its present policies and the estimation of its future policies. The impact of the rapid increase of civic groups and labor power on health policies has to be watched with interest. Third, the characteristics of the context of the Medical Aid policy that were seen can partly help us understand the dynamics of other recently introduced health policies in Korea: the separation of drug prescription and dispensing, health insurance reform, etc.
Finally, every country has its own historical background and politics. Modern Korean history and politics, though, are unique. First, the Korean War, the country’s occupation by outsiders, and other important historical events were the results of international, rather than domestic, politics. Second, many countries have histories similar to Korea’s, such as occupation by outsiders, military dictatorship, etc. Third, due to the country’s rapid economic growth and its successful introduction of health policies, such as its National Health Insurance and its separation of drug prescription and dispensing, it has become a role model to many other countries. Therefore, these countries that share a similar historical background with Korea, such as occupation by outsiders, military dictatorship, etc., could learn lessons from Korea’s experience.

[Note]
1 Its main role is to review major Medical Aid policies.
2 Governance has a variety of meanings (Pierre and Peters 2000). In this paper, it is used in a general sense to refer to the government’s role of governing a country.

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