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# **THE WORKSHOP ON HEALTH PLANNING**

**Cheju City  
29—31 March 1978**

**Proceedings, Background Papers  
and Recommendations**



**Korea Health Development Institute**



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## FOREWORD

The Korea Health Development Institute and USAID/Korea wish to emphasize that it was not the intention of either sponsors or participants of the Health Planning Workshop to criticize existing health planning and data collection and analysis activities in the responsible ROKG Ministries. Rather, the Workshop's goal was to offer a set of recommendations to assist the Ministry of Health and Social Affairs in its efforts to bring about a continuing improvement in the health and well-being of all the people in the Republic of Korea.

The President, Korea Health Development Institute, and the AID Representative in Korea, wish to thank the Steering Committee members, the Group Session Chairmen, and the participants in the Workshop for their dedication to Workshop objectives and for their production of an excellent report. In particular, we wish to thank the Minister of Health and Social Affairs, His Excellency Hyun Hwack Shin, for his support and cooperation.



Hyung Jong Park, M.D.  
President  
Korea Health Development Institute



William E. Paupe  
AID Representative in Korea



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# I. INTRODUCTION

Many governments of developing countries face the challenge of growing popular demand to improve the general welfare, and particularly better health care services, despite scarce national resources.

In Korea, national planners have also been interested in the social development sector, and in 1974 the health sector was included as a major component of the Fourth 5 Year Development Plan.

The role of health planning officers in the national administration has become significantly important in seeking to accomplish social development. They must be able to identify and assess the most important problems and issues in the health sector, and formulate appropriate measures for their solution (in terms of both short and long term perspectives) to meet the nation's needs.

The concern of the national policy-makers to improve the health status of the Korean people has also been shared by AID/K for some time. In the past, USAID has provided a grant fund to strengthen planning capabilities by financing training, making consultants available, and by awarding grants for health surveys and research projects. This has provided impetus to developing the capabilities of planning administrators in the health and welfare sector in Korea.

In March, 1978, the Korea Health Development Institute and AID/Korea agreed to conduct a workshop on health planning for three days, to which planning administrators, researchers and educators, as well as advisors and consultants residing in Korea, were invited. This report has been produced as an outcome of that joint workshop.

The Cheju workshop is the first of its kind in Korea. This is a very innovative approach as it is the first opportunity for the free exchange of ideas between the economic, intellectual, statistical disciplines and the health sector. Previously, these professional interest groups had no occasion for collective discussion and sharing of opinions, which often resulted in frustration. Our findings, ideas, and suggestions will be formulated into a series of recommendations to the Korean government, as well as other concerned agencies, organizations, and institutes for further action.

## **II. SUMMARY & HIGHLIGHT OF THE WORKSHOP**

The Workshop on Health Planning was held at Cheju Tourist Hotel for three days from 29th to 31st March, 1978. The period was divided into the following three parts;

first day : Ceremonial and formal proceedings with opening remarks, congratulatory addresses, clarification of objectives and working method.

Second day: Keynote address and workgroup sessions.

Third day : Plenary session and reporting sessions.

At the opening ceremony, Dr. Hyung Jong Park, President of KHDI welcomed the group and delivered opening remarks, saying that Korea had been striving very hard to achieve economic development as rapidly as possible, and had reached one of the initial targets of ten billion dollars in annual exports. He, however, stressed the need of shifting national interests of social development sectors rather than going alone with the economic development sector exclusively. He further emphasized that health be regarded as a "basic human right" for all people, and the fulfillment of this kind of medical provision can only be assured through sound national health planning, supported by good quality research and studies.

Dr. Seung Hahm Park, Vice Minister of Health & Social Affairs, in his congratulatory speech on behalf of the government mentioned the importance of social development, including long-term plans for health care delivery services to all. He said that what is most important at this critical juncture is not the extent of awareness or the conceptual frame of developmental dimension, but the realistic program devices and ramification of phase-to-phase implementation schemes for those concerned in the field of health and welfare service provisions.

He pointed out the problems associated with the planning of health services to be considered, such as assessment of health needs, the question of financing methods, the equitable distribution and redistribution of service benefits, costs of operation or input and investment models, some revisions of insurance schemes and the problem of how to eliminate geographical congestion of service deliveries or social discrimination.

The speech by the Vice Minister was followed by Mr. Dennis P. Barrett, AID Representative in Korea. Mr. Barrett welcomed all the participants and congratulated the government's efforts to insure a comfortable and healthful environment and an improving level of health and well-being for all people of the Republic.

Finally Mr. William E. Paupe, General Development Officer, AID/Korea explained the objectives of the Workshop, as follows. He reminded the group that there are many research findings which provide some very valuable information and data, some very comprehensive and expert analyses of existing health programs; of morbidity and mortality; of epidemiological phenomena in Korea; about medical economics, insurance, the cost of medical care. However, these findings and recommendations become useless if they are not fully fed back to planners and utilized properly by administrators. The workshop, therefore, was planned in such a way that these documents be taken off the bookshelves, and be made living tools that Ministry of Health and Social Affairs could use to improve and to expand health care services in Korea without adding significant amounts of money, personnel, or resources to its existing organizational structure.

On the second day, the morning session was devoted to discussing the paper on "National Health Programs as Observed by an Economist".

Dr. Kyong Shik Chang, Director General of Medical Affairs Bureau, MOHSA, opened the session, introducing Dr. Jae Ik Kim, Director General, Economic Planning Bureau, EPB as a speaker.

Dr. Kim reviewed the progress of economic development accomplished in the past 15 years by the government, and stated that the goal of the government was to attain a high standard of living and more equitable sharing of the benefits of economic development. He admitted that it was inevitable, however, that only small portions of resources were devoted to the health sector in the process of economic development. As a result, a large number of people are still left without receiving adequate nutrition, clean water, safe housing, or adequate working conditions, which require continuous efforts to seek a higher income level and to design policies to help the low income group in Korea.

He expects the KHDI to help find an alternative approach to solving these problems by designing health care service strategies applicable to the rural areas as well as urban poor, so that in the next five year planning cycle, the government can take a more active role with confidence for the improvement of the health status of the people.

He also pointed out the need for expansion in the education and training of health personnel to meet the increasing health needs expected to come in near future. He sees a tremendous increase in the need for doctors, nurses, medical technologists and the whole health care sector, and immediate action was suggested to prepare for this change.

The speech was followed by comments and discussions by the participants. In brief, the following points were highlighted:

1. Government policy of transferring technical staff is disruptive, and should be modified.
2. KHDI has a future role as a National Health Planning Organization, and as a Health Service Research Coordinating Body.
3. Training of health planners, and development of health manpower in long term perspectives is required for the strengthening of national health services.
4. Taxation, or a tax-like revenue system is required to finance health service programs.
5. Clarification and redirection of future health service towards primary health care delivery is necessary.

After the discussion, Dr. Hyung Jong Park, KHDI presented guidelines for conducting three workshop groups with assignments and areas to cover during the coming two days session.

Dr. Park stated the objectives of the workshop and pointed out that in the past 2-3 years, many investigation reports have been completed by various individuals and institutions, but these findings have never been utilized. He requested the participants to review these documents, form conclusions, and consider their implications. He suggested that this workshop would be the first opportunity for face-to-face "get-together" between researchers and action-oriented policy makers, and also there would be the opportunity for free opinion exchange among administrators, researchers, medical personnel & other professionals. He requested the respective groups to develop recommendations specifically related to government, medical personnel, educational institutions, and voluntary or international agencies.

The later part of the second day and early part of the 3rd day was spent in the following three individual group sessions.

Group A: Economic Aspects.

Group B: Statistical and Epidemiological Aspects.

Group C: Medical Service Aspects.

In the afternoon of the 3rd day, the plenary session was held. In this session, each group chairman or rapporteur reported on their workgroup issues and problems, findings, and recommendations. The reports of each group compose the main body of this paper.

The floor unanimously adopted the reports, recommendations and resolutions as reported. However, many interesting observations were raised from the floor, highlighted as follows;

1. Comprehensive long term health policy planning is absolutely necessary and a planning advisory body should be organized.
2. Some legal changes or modifications may be required at this juncture to the National Health Insurance System.
3. A health maintenance system or health insurance scheme is required for rural people.
4. Some measures should be taken to insure the balancing of the utilization and participation of private medical sector entrepreneurs with the public health care sector.
5. A clarification and clear cut definition of the scope and concept of primary health care is necessary.
6. The inter-dependence of the Saemaul Movement and a rural health service needs special attention. Hospital building by industrial firms in various localities may need professional (medical and health sector) guidance.

### **III. GROUP SESSIONS**

#### **GROUP A: ECONOMIC ASPECTS**

##### **List of Participants**

- Dr. Chong Kee Park (Chairman): Secretary-General, National Health Secretariat, KDI\*
- Dr. Jae Ik Kim : Director General, Economic Planning Bureau, EPB\*\*
- Dr. Mo Im Kim : President, Korea Nursing Association
- Mr. Sae Jin Pyo : Director, Fourth Investment Division, Economic Planning Bureau, EPB
- Mr. Jin Koo Park : Director, Saemaul Planning Division, Ministry of Home Affairs
- Mr. Alan E. McBain : Representative, UNICEF/Korea
- Mr. Benjamin J. Kremenak : Representative, Asia Foundation/Korea
- Dr. Dal Sun Han (Rapporteur) : Assistant Professor, School of Public Health, SNU
- Mr. Kil Byoung Yoone : Chief, Manpower Development Division, KHDI

\* Korea Development Institute

\*\* Economic Planning Board

## **A. Research Subjects Presented**

1. *Analyses of Health Resources in Korea*, by Kong-Kyun Ro and Mo Im Kim.
2. *Research on Training in Health Planning*, by Dal Sun Han.
3. *Financing Health Care Services in Korea*, by Chong Kee Park.

## **B. Summary of the Papers Presented**

1. *Analyses of Health Resources in Korea*, by Kong-Kyun Ro and Mo Im Kim

The ultimate objective of this study was to provide insights and information for efficient allocation of health resources. The paper described the allocation of various components of health resources and mix, over time and between areas. It also examined interrelationships between socio-economic variables and the availability, mix and utilization of health resources.

The analyses indicated two major findings. First, there is a considerable departure from optimum in the allocation of health resources in Korea. Secondly, the allocative problem of health resources in Korea stems from the nature of the country's dual economy. There exist two distinct sectors within the nation, characterized variously as urban vs. rural, manufacturing vs. agricultural, high standard of living vs. low standard of living, etc. The distribution of health resources reflects their supply responses to differences in the socio-economic conditions of the two sectors.

These findings suggest a vicious circle. Rural socio-economic conditions result in lower demand for health services than in urban areas. Given this relatively weak demand for health services in rural areas and the less desirable environment for highly trained persons to work and live, a significant disparity between the two sectors in the availability of health resources as well as other resources develops. The resultant urban-rural difference in investment in health and other human and physical capital leave the socio-economic development of rural areas further behind. This, in turn, discourages the infusion of new health resources into rural areas, thus completing a circular chain of cause and effect.

It is believed that this vicious circle can be broken by a policy-induced, incentive-oriented infusion of a sufficient and sustained dose of health resources into rural areas. This would, in turn, lead to better working conditions, a more favorable environment, and strong demand, giving

further incentive for still more expansion of health resources into rural areas to augment the initial infusion.

From this point of departure, the following policy recommendations are proposed.

- (a) The financial barrier to health services should be reduced by sponsoring a comprehensive health insurance plan with premiums scaled to income.
- (b) As an essential component of a rural development plan, initiate an integrated program of health education, family planning activities, consumer education and the collection of vital and health statistics.
- (c) Policy priority should be given to altering the structure of health professions rather than to increasing the aggregate supply.
- (d) Attention should be given to redressing what we perceive to be departures from the optimum mix of physical resources and human resources in providing health care.
- (e) An intricate system of rewards and disincentives should be established by government to redress what we consider to be mal-distribution of health resources.
- (f) Rural health demonstration projects should be encouraged.

## 2. *Research on Training in Health Planning and Health Economics*, by Dal Sun Han

This study assessed the need for, and the availability of, training resources in health planning and health economics. In doing this, the paper tried to establish the educational background and qualifications of health planners, toward which the subsequent efforts are directed, and then assessed the educational background and experiences of potential health planners. With respect to supply sources of health planners in Korea, the curriculum contents of relevant institutions and the placement of their graduates were examined.

Recent experience in health sector plan preparation for the Fourth Five-Year Plan has painfully disclosed the lack of well-qualified health economists, among others, within the responsible government agencies. Since the

concept of a rolling plan has been adopted for the Fourth Five-Year Plan, there is very little lead time to train necessary health planning manpower. In this light, the momentum to train health planners, which has been initiated with the preparation of the Fourth Five-Year Plan, aided by the USAID Health Planning Project, must be sustained with continuous effort of the responsible ministry and educational and training institutes concerned.

In examining the supply sources of health planners both short-term and long-term, there are a number of formal educational and training institutions in existence from the late fifties. It is these institutions that trained and supplied the currently available manpower in health planning, although they did not completely succeed in meeting the manpower requirements in that field. The most efficient and effective way of meeting such manpower need is further strengthening of already existing educational and training institutions, and making legal and institutional changes to back them up. From this point of view, the following recommendations are proposed.

- (a) For the civil service examination of Grade III-B health administrator, an MPH degree should be required as a pre-requisite.
- (b) Elective courses in the civil service examinations for health administrators should be waived to the graduates of master's level schools of public health and/or both required and elective course for these examinations should be modified to include special courses corresponding to the levels of knowledge required by health planners and administrators.
- (c) There should be necessary measures to waive the two-year tenure regulation at one position for such technical and professional personnel as health planners and health economists.
- (d) Both short-term and long-term training should be encouraged and trained personnel should be fully utilized.
- (e) Short-term and intermediate-term training programs should be further developed to alleviate the shortages of health planners and to replenish them.
- (f) The graduate schools of public health should strengthen education in health planning and health economics.
- (g) The graduate schools of public health should make an effort to attract better calibre students with scholarship programs and to provide formal

training in health planning to younger government officials in collaboration with related agencies.

### 3. *Financing Health Care Services in Korea*, by Chong Kee Park.

This study reviews and analyzes the existing health care financing mechanisms in Korea to clarify the principles and issues involved and to assess the need for improvements in the broader context of the social security system. More specifically the objectives of the paper are to make an estimate of national health expenditures, to examine and analyze how successful the new medical insurance scheme is likely to be in meeting national health goals, and to assess how the scheme would affect particular groups of population such as rural residents, the poor, self-employed workers, and marginally employed workers.

Some of the major findings are as follows.

- 1) Korea spent an estimated ₩245 billion for health services in 1975. This amount represents 2.7 percent of GNP. The average per capita health expenditure was ₩7,000. Of the total amount Korea spent on health care in 1975, over 85 percent was made up of personal consumption expenditures. About 57 percent of all household health expenditures were for pharmaceutical products.
- 2) Much needs to be done to make the medical insurance system operate in an efficient and equitable manner. The extent of population coverage under the system varies considerably from province to province. The health insurance law does not make any provision for the victims of catastrophic illness and gives little attention to preventive and primary health care. Uniform cost-sharing places an exceptionally heavy burden on the low income person and deters him from seeking needed medical care, thus undermining a major goal of the insurance system. The system of large numbers of small insurance associations has many problems and disadvantages: inequalities in contributions and benefits, double standards, duplication of administration, limited risk spreading and resource pooling, and high administrative costs. Based on these findings, the paper proposes the following major recommendations.

- (a) In view of the fact that the workers employed by small marginal firms are more likely to be medically indigent than those in large establishments, compulsory coverage should be extended to smaller firms as early as possible.
- (b) It is premature to settle on any one particular form of financing rural health care services now. It is desirable to attempt as many experimental and demonstration projects as possible until, after careful analysis and evaluation, one or two acceptable patterns of financing mechanisms evolve. Several demonstration areas should officially be designated for this particular purpose.
- (c) There should be a new provision in the law so that the insurance scheme pays a part or all of the costs of preventive care services, such as prenatal care and periodic physical examinations.
- (d) An income maintenance mechanism should be developed for the victims of catastrophic illness. This issue underlines the urgent need for considering the relation of the medical insurance scheme to other branches of the social security system, specially the national welfare pension scheme.
- (e) One solution to the problem of heavy financial burden on the part of low income persons imposed by uniform cost-sharing would be to relate the cost-sharing provisions to income and set ceilings on how much any family would have to pay.
- (f) The range of contribution rate differentials (set at from 3 to 8 percent of payroll) should be reduced, and employers should be allowed to assume more than half of total contributions if they wish.
- (g) The achievement of social goals of the health care insurance program (namely, to ensure that all persons have access to medical care, to eliminate financial barriers, and to limit health care costs) requires establishment of a centrally administered health insurance system with a provision of more local initiative and more flexible deployment of voluntary effort at the community level.
- (h) Over the long run it would be much better to switch from administration by individual insurance associations to administration by central public agency. Such a system has several advantages such as more effective control of services and costs, easy portability of earned benefits, and the ability to negotiate favorable service contracts. It also

avoids duplication and waste and can thus direct health resources to where they are most needed.

### **C. Summary of the Group**

The group discussion centered around health resources and health insurance systems. The group identified problems and issues associated with each of the two components of the health care system and explored alternative approaches to their solution for the formulation of specific recommendations. In the course of such discussion some general recommendations also evolved. The summary of the discussion is presented below.

#### *I. Health Resources*

##### **A) Problems and Issues**

###### **1) Urban-rural disparity in the availability of health resources.**

The maldistribution of health resources is well-documented elsewhere. This distributional pattern appears to be the result of supply responses of health resources to differences in demand, which, in turn, can be traced to differences in the socio-economic status of residents and to regional differences in living conditions.

###### **2) Inadequacy in the mix of human and physical resources and in labor mix as evidenced in urban-rural differentials**

There were on the average 5.7 doctors and 5.4 nurses per 10,000 population in the urban areas, while there were 1.0 doctor and 0.9 nurse per 10,000 population in the rural areas in 1976. There were on the average 12 doctors and 36 nurses per 100 hospital beds and 2.0 doctors per private clinic in the urban areas, while there were 10 doctors and 27 nurses per 100 hospital beds and 1.1 doctors per private clinic in the rural areas in 1976.

###### **3) Underutilization of existing health facilities in rural areas**

The bed turn-over rate was 21 in the urban areas, whereas it was 15.0 in the rural areas in 1976.

- 4) Lack of community health personnel such as health planners, health economists, and health administrators.

Although there are educational and training institutions, they did not completely succeed in meeting the manpower requirements in these fields. Furthermore, trained personnel are not adequately utilized.

- 5) High risk of ineffective allocation and inefficient utilization of health resources because of urgent need for taking action in the absence of enough experience and sound long-range planning.

Hospital construction programs, both on-going and planned, were not preceded by a comprehensive feasibility study. Health manpower development is also carried out in the absence of a sound planning effort.

## **B) Alternative Approaches and Specific Recommendations**

- 1) Effective demand should be increased by reducing financial and social barriers to health services through expansion of health insurance coverage and improvement of health education programs.
- 2) High priority should be given to providing adequate primary care services to the rural and urban poor population. By so doing, the underprivileged population can obtain effective health services within the limit of cost and resources our society can afford.
- 3) Spatial distribution of health resources should be considered in terms of accessibility rather than in terms of administrative unit. Therefore, health facility planning should be an integral part of regional development planning.
- 4) Policy priority should be given to redressing what we perceive to be departures from the optimum mix of health resources rather than to increasing the aggregate supply. Also needed is restructuring of functional allocation among various categories of health personnel and corresponding changes in the curriculum for education of health personnel.
- 5) A system of incentive and disincentive should be established to redress mal-distribution of health resources; such as low cost housing for health professionals employed in rural health institutions, and rural practice as part of military service.

- 6) Appropriate action should be taken to develop managerial capability in the health sector. There should be institutional and legal changes for fuller utilization of existing trained personnel and for providing job opportunities for the graduates of formal educational institutions. Strengthening of various relevant training programs is also needed.
- 7) The feasibility of establishing a four-year college for training public health workers of wider calibre should be studied. In the context of the educational system of this country, a four-year college level course seems most appropriate for producing leading public health practitioners, in both technical and administrative fields.

## **2. Health Insurance System**

### **A) Problems and Issues**

#### **1) Regional variation in population coverage**

The extent of population covered varies considerably from province to province. Nearly 70 percent of the persons covered by an insurance program are concentrated in Seoul and Busan, where only 27 percent of the nation's population reside. In Chung Buk Province, on the other hand, only one percent of the population is covered.

#### **2) Inadequacy in benefit scheme in terms of service coverage**

There is no explicit provision in the law regarding personal preventive and primary health care. The law also does not make any provision for the victims of catastrophic illness.

#### **3) Uniform cost-sharing and contribution rates of wide range**

Imposition of uniform cost-sharing places a heavy burden on the low income persons and deters them from seeking needed medical care, thus undermining a major goal of the insurance system. The provision of the law which permits each insurance association to set contribution rates at from 3 to 8 percent of the payroll invites great variations in benefit levels.

#### **4) Multiple system of large numbers of small insurance associations**

It is something of an anomaly that a compulsory medical insurance scheme established by national law is to be administered by a large number of small, privately managed insurance associations. Such an organizational arrangement of the insurance system has many problems and disadvantages: inequalities in contributions and benefits, double standards, duplication of administration, limited risk spreading and resources pooling, and

high administrative costs.

- 5) Discouragement of experimental financing mechanisms other than current medical insurance system

The law restricts the experimentation for financing mechanisms other than two patterns of insurance schemes stipulated in the law. There is, however, no empirical evidence that those two patterns are the most appropriate to this country. Therefore, strict restriction on experimental approaches to the development of innovative mechanisms of financing health care services is undesirable.

### **B) Alternative Approaches and Specific Recommendations**

- 1) The compulsory coverage should be extended to smaller firms as early as possible. It may require establishment of a centrally administered health insurance system.
- 2) It is desirable to open avenues for attempting carefully designed experimental and demonstration projects on alternative patterns of financing and organization of health care services.
- 3) There should be a system of incentive or government financing so that the insurance scheme covers the costs of personal preventive and promotional care services.
- 4) Cost-sharing provisions should be related to income and ceiling should be set on how much any family would have to pay.
- 5) The range of contribution rate differentials should be reduced, and the employer should be allowed to assume more than half of total contributions if they wish.
- 6) The name of the insurance scheme should be changed from "medical insurance system" to "health insurance system."

### **D. Recommendations**

In the course of the discussion, several recommendations for overall development of health services were proposed.

1. An ad-hoc study group should be organized and funded as soon as possible to develop a long-range plan for the health sector which incorporates built-in mechanisms for adapting to social changes. In approaching this step by step, the following order seems appropriate in terms of urgency:

- a) A comprehensive feasibility study of hospital construction programs.
  - b) Planning for a delivery system including financing mechanism.
  - c) Planning for health manpower development.
2. There should be an institute with designated responsibility to perform more systematic analyses of health policy, health planning, and related research. It appears reasonable to develop KHDl toward being such an institution.
  3. Research activities should be strengthened to provide information needed for the analytical understanding of a health services system on both macro-level and micro-level. A prerequisite to the conduct of such research studies is, of course, establishing a health data and information system.

## **Group B: STATISTICAL/EPIDEMIOLOGICAL ASPECTS**

### **List of Participants**

- Dr. Jae Mo Yang (Chairman)** : Dean, School of Health Science and Management, Yonsei University
- Dr. Harriet Kim** : Assistant Professor, College of Home Economics, SNU
- Dr. Seung Hum Yu** : Assistant Professor, School of Health Science and Management, Yonsei University
- Prof. Kyung Kyoon Chung** : Assistant Professor, School of Public Health, SNU
- Sister, Jae Yoon Park** : President, Korean Medical Record Association.
- Dr. Yun Chul Koo** : Professor, College of Medicine, Ewha Women's University
- Mr. Seung Kun Park** : Director General, Statistics Bureau, EPB
- Dr. Joo Hwan Kim** : Chief, Planning and Research Division, KHDI
- Dr. Sei Kyung Kim** : Superintendent, Korea University Hospital
- Mr. Byung Jin Kwak** : Deputy Director General, Statistics Bureau, EPB
- Mr. Hak Yeung Kim** : Research Associate, Korea Development Institute
- Dr. Joung Soon Kim (Rapporteur)** : Associate Professor, School of Public Health, Seoul National University

## **A. Research Subjects Presented**

1. *“A Feasibility Study of a National Health Data and Information System for Korea,”* by Hak Yeung Kim.
2. *“Morbidity Survey of Rural Koreans by Means of Interview and Medical Examination,”* by Joung Soon Kim.
3. *“Assessment of the Nutritional Status of Korean Villages,”* by Harriet Kim.
4. *“Initial Evaluation of ROKG Medical Aid Program for the Poor,”* by Seung Hun Yu.
5. *“Research on the Behavioral Determinants Affecting the Non-participation of the Recipients in ROKG Medical Assist Program for Low-income People,”* by Kyung Kyoong Chung.  
*“Feasibility Study for a Standardized Hospital and Clinical Statistical Data and Medical Record System for Korea,”* by Jae Yoon Park.

## **B. Re-categorization of Research Studies**

Six research studies were divided into three categories as follows to discuss problems and issues and formulate recommendations:

### **Topic 1: Health Statistics and Information**

1. A Feasibility Study of a National Health Data and Information System for Korea
2. Morbidity Survey of Rural Koreans by Means of Interview and Medical Examination
3. Feasibility Study for a Standardized Hospital and Clinical Statistical Data and Medical Record System for Korea

### **Topic 2: Nutrition**

1. Assessment of the Nutritional Status of Korean Villages

### **Topic 3: Medical Aid Program in Korea**

1. Initial Evaluation of ROKG Medical Aid Program for the Poor

2. Research on the Behavioral Determinants Affecting the Non-participation of the Recipients in ROKG Medical Assist Program for Low-income People.

### **C. Research Findings of Each Subject Presented**

#### **Topic 1: Health Statistics and Information**

##### *1. A Feasibility Study of a National Health Data and Information System for Korea, by Hak Yeung Kim*

###### **A) Purpose of the Study:**

To seek feasibility of developing better health data and information by evaluation and analyses of current health data and information system.

###### **B) Problems and Issues:**

- 1) The Statistics Division of MOHSA can not act as a central health statistical agency effectively because of lack of manpower and funds, and because MOHSA does not have an organizational structure which reaches down to the grass roots level throughout the nation.
- 2) The present health data and information show a lack of reliability and consistency because:
  - the health sector has been neglected during the last decade.
  - health statistic servicing activities are divided among numerous organizations with limited coordination.
  - the MOHSA does not have an organizational structure or network throughout the nation: no regular field workers to conduct its surveys.
  - survey designing, terminologies, data processing are inconsistent and purposes for which producer's and user's data are collected are different.
  - sample sizes are inadequate and inappropriate.
- 3) The lack of useful health statistical data and information for various fields of users
  - due to a lack of foresight on the part of data producers.

— due to lack of qualified personnel and absence of health statistical servicing activities network.

4) Requirement of a comprehensive health statistical data and information

— the globally accepted definition of health by the WHO should be considered in designing comprehensive health indicators.

**C) Summary of the Group Discussion**

Among many items discussed, the main points may be summarized as follows:

Statistics and information on health are of vital importance in problem identification, priority determination, and evaluation of health planning and/or health programs. Despite the unanimous recognition of its importance, health statistics and information currently available from the MOHSA are fragmentary and unreliable.

Causes identified for the faulty health data were:

- 1) Lack of organizational structure extending to the grass-roots level.
- 2) Lack or deficiency of qualified manpower to undertake the function competently at various levels for designing surveys, collecting routine health information, processing the data, and follow-up evaluation.
- 3) Inability to efficiently use health-relevant data collected by other governmental agencies — such as EPB, Ministry of Internal Affairs, Ministry of General Affairs, Ministry of Agriculture and Fishery, Office of Labour Affairs, etc. — because of deficient inter-agency coordination.
- 4) Poor administrative management of registration and reporting system for vital statistics and communicable diseases.

To overcome the problems stated above, the following alternative plans were proposed by the group:

- 1) Expand and improve the existing system of the MOHSA by reinforcement of personnel with qualified manpower and by consolidating organizational structure.
- 2) Establish a new health statistics agency, similar to the National Center for Health Statistics in the USA, which may undertake necessary manpower training, in addition to the assigned function — collection, processing, distribution, and storage of health data.

- 3) Strengthen inter-agency coordination for efficient utilization of available data relevant to health information.
- 4) Enforce legal constraints on registration of vital events and reporting communicable diseases, accompanied by community education to enlighten the people.
- 5) Collect necessary health data in co-operation with census surveys conducted by EPB.
- 6) Establish an expert or ad-hoc committee on events of special surveys within the MOHSA.

#### **D) Recommendations**

- 1) Reforms of administrative and organizational settings by:
  - a. the expansion of a central health statistical agency with two or three divisions, or a bureau. The agency should be supported by a team of about 30 to 50 full-time workers.
  - b. Developing training programs for local health personnel in health statistics to enhance their Technical Capabilities.
- 2) Technical improvements:
  - a. In order to secure the reliability and consistency of the health statistical data, the central health statistical agency should suggest necessary changes of contents of censuses and surveys conducted by EPB and/or other Ministries.
  - b. Sample sizes should be large enough for reliability and consistency, and developed appropriately.
  - c. If availability of funds is a problem, then a reduction in survey frequency rather than a smaller sample is appropriate since health characteristics of the population change very little within a span of a few years.
  - d. The central health statistical agency should establish a multipurpose sample to avoid repeated survey efforts for identical socio-demographic information.
- 3) Priorities for health data and information development:

The following three basic conditions should be considered in determining the list of priorities.

- a. Data and information relevant in the context of current conditions and future Korean development.
- b. Data and information sensitive to relatively short-run changes and development.
- c. Data and information essential for plan preparation and policy formulation.

2. *Morbidity Survey of Rural Koreans by Means of Interview and Medical Examination*, by Joung Soon Kim

**A) Purpose of the Study:**

- 1) To provide accurate health information to guide administrative planning and evaluation of the health care delivery system.
- 2) To validate health interview survey data which may extend the utility of available data for measuring the health status of Koreans, and also may be applied to the larger scale health survey.
- 3) To provide information relevant to health manpower needs and demands by determining the health care needs and demands accurately by trained professionals.
- 4) To obtain experience and develop methodology which may help to determine the scope and depth of the study, the quality and level of the participating personnel, operating costs and operating difficulties when the national health survey is planned.

**B) Problems and Issues:**

- 1) The validity of the interview survey measured in terms of adequacy and accuracy proved to be sufficient to reflect the true morbid pattern of a community, when the questionnaires were constructed with structured and probing questions.
- 2) The age-adjusted morbidity rate per 1,000 persons interviewed per month was 428.8 for males and 472.1 for females respectively. Teenagers, 10-19 years of age, showed the lowest rate, whereas infants and older ages showed higher rate. Adult females, 25-39 years of age, had a markedly higher morbidity rate with a larger number of ill-health conditions per sick person. The morbidity or ill-health condition was defined as any condition which departed from health as defined by WHO.

- 3) The most frequent diseases were neuralgia and pterygium, acute respiratory infection, and diseases of teeth and supporting structures.
- 4) Of all conditions reported in the interview, 72.8% were chronic and 27.2% acute in their nature; only 18% of the acute conditions were classified as mild in their severity, while 52.7% of the chronic conditions were classified as such.
- 5) 64.5% of the conditions reported never got treated, 25.7% were treated by pharmacists and/or druggists, and only 9% were attended by a physician.
- 6) Morbidity (as determined by the medical examination for those conditions which required physician's professional care) was 257.8 per 1,000 persons examined for males and 299.0 females; when all conditions were included the morbidity rate become 641.8 for males and 573.6 for females.
- 7) The disease frequency was about the same as that found in the interview survey, except for higher frequency of infectious diseases in the medical examination than interview. The majority of the conditions were preventable ones.
- 8) The breakdown of the severity of the conditions classified by the physicians was: 20% did not need any treatment, 50% could be treated by medical auxiliaries, 23% should be treated by physician for less than one week, 5.4% should be treated by physician for more than one week, 0.4% needed immediate hospitalization, and 1.5% needed further diagnostic studies by specialists.
- 9) The proportion of conditions that needed a physician's care varied widely according to the diseases; 90.9% for pulmonary tuberculosis to only 1.5% for avitaminosis and nutritional deficiencies.
- 10) The gap between the needs and demands for medical care was unexpectedly great. For example, among those conditions for which physician's care was prescribed by the examined doctors, only 9.5% had been treated by a physician, 11.7% by medical auxiliaries, and 77.1% had not been treated.
- 11) The community health program undertaken by the School of Public Health, SNU showed most striking effects on infectious diseases of the digestive system, respiratory tuberculosis, and diseases from nutritional deficiencies, when compared with the data before the program for the

same area, and also when compared with the data from the control area for the same period of time. Nevertheless the overall morbidity rate was hardly affected by the program.

- 12) The dental examination survey revealed tremendous needs as well as demands for dental care, which appeared to be a more serious for the rural community, if one considers even more limited accessibility of dental care facilities.
- 13) The nutrition study for preschoolers showed that the rural children's nutritional status is catching up to the national standard.
- 14) The major difficulty in the study was recruiting the sampled people for the medical examination.

### **C) Summary of Group Discussion**

- 1) A modification of the disease classification may be better for the interview on morbidity. 50 or 70 classification with some sub-tabulation for frequent diseases, would be more suitable than 150 classification.
- 2) About half of the ill-health conditions may be managed by trained medical auxiliaries under the necessary supervision of medical doctors. This is more desirable than the current situation where most sick people seek medical care from drug stores.
- 3) The utilization of pharmacists and/or druggists for primary health care has some value because they have contributed a great part to the primary health care.
- 4) Even though the examining doctors judged that about a half of the conditions are mild enough to be managed by medical auxiliaries, a serious problem may ensue when the consumers demand higher quality professionals regardless of their financial ability. For instance, on many occasions they refuse to utilize public doctor and/or private generalist but seek specialists when they have a choice.
- 5) The program of dispatching residents compulsorily to doctorless rural communities has resulted in a waste of medical manpower, and alienation of people from doctors. The doctors are not trained for rural practice and are generally lacking in motivation and sense of responsibility in this temporary situation.

- 6) The great need and demand for dental health service and preventive measures (including community health education) should be particularly emphasized in an implementation plan.
- 7) The methodology of morbidity research and/or survey needs immediate standardization to make morbidity data comparable to each another, current survey methods are so variable depending on researchers that the studies are not comparable.
- 8) A national health survey should be planned in the near future to provide an accurate morbidity pattern of Korea since the data available currently are too fragmentary and variable to represent whole nation.
- 9) Slum morbidity studies are urgent because the information is rarely available despite the fact that the government stressed urban poors and the rural population; as the primary target for improved health care according to some available information urban poor appear to be worse off than rural people, in the living environments, socio-economic status, and general health status.
- 10) The terminology, "Low-cost quality medical care" needs to be substituted by "Adequate medical care."

#### **D) Recommendations**

- 1) The morbidity survey by interview with structured and probing questions may be applied to a larger scale health survey because it is proved to be sufficiently reliable and valid enough when validated by medical examination.
- 2) Program of public health and dental health services with special emphasis on preventive measures should be enforced.
- 3) A special type of health care delivery system peculiar to the Korean rural population should be established to minimize the gap between need and demand of medical care; utilization of medical auxiliaries under M.D.'s supervision may be desirable since about a half of the conditions diagnosed by M.D. were mild cases that may be managed by auxiliaries.
- 4) Organize a research committee to devise standardized research methodology so as to compare one result with other similar ones.
- 5) Conduct a national health survey in the near future for better health planning.

6) A community health education campaign should precede any other services. If people do not seek medical and/or health facilities for care because of ignorance and mis-conception of ill-health, no matter how excellent the system may be, it would be useless.

3. *Feasibility Study for a Standardized Hospital and Clinical Statistical Data and Medical Record System for Korea*, by Jae Yoon Park

(Oral presentation on proposed study plan)

**A) Purpose of the Study**

- 1) To develop a standardized recording system.
- 2) To develop and maintain medical statistics of hospitals and clinics.
- 3) To design a standardized format for recording.

**B) Summary of the Group Discussion**

- 1) Establishing objectives for utilizing a medical recording system that should precede any other items.
- 2) The work on the subject should be carried out collaboratively with the hospital association.

**C) Recommendations**

To Government:

- 1) Reform and strengthen administrative and organizational setting by expanding the organization with training programs for health personnel and financial support.
- 2) Attempt to get valid and reliable survey data by technical improvement — Ex. 1) quality oriented rather than quantity 2) establish multi-purpose sample.
- 3) Enforce disease reporting and registration system.
- 4) Dental care services integrated to general health service should be provided.
- 5) Preventive measures should be stressed in primary health care.

To KHDI:

- 1) Organize research expert committee which may devise standardized research methodology and synthesize the research results into meaningful data for feedback to the operation.
- 2) National Health Survey may be planned in near future (Slums).

To KMA:

- 1) Status evaluation of the current medical recording system should be carried out to allow full utilization of medical records or reliable health statistics.

## **Topic 2: Nutrition**

### *1. Assessment of the Nutrition Status of Korean Villages, by Harriat Kim*

#### **A) Purpose of the Study**

- 1) To assess nutritional status of vulnerable groups of the rural population, pregnant women and weaning children.
- 2) To assess the communal feeding program.
- 3) To assess the possibility of utilizing available data on nutrition by reviewing literatures.

#### **B) Problems and Issues**

- 1) The communal feeding program provided to farmers during intensive work of harvesting was supplying enough calories and all other nutrients riboflavin.
- 2) Food and nutrient intake survey on pregnant, lactating women and weaning children of rural Korea indicated that, in general, a large unbalanced diet was consumed regularly; mean daily intakes of calories, niacin, thiamine and ascorbic acid exceeded the recommended allowances for pregnant and lactating women but vitamin A, riboflavin and protein intake was low. All nutrient intake by the weaning children in rural Korea were deficient.
- 3) The food expenditure portion of the Farm Household Economy Survey conducted by the Ministry of Agriculture and Fishery in 1976 was analyzed to obtain an average daily food and nutrient intake level of rural residents. The results compared well with the National Nutrition

Survey result of MOHSA, the food balance sheet and with other reported values, suggesting that the annual data of the Farm Household Economy Survey could be utilized for indirect estimation of nutrient intake level.

### **C) Summary of the Group Discussion**

- 1) It is agreed that better nutrient intake is important to improve people's physical build-up as a whole.
- 2) Deficient nutrient intake was frequent among weaning aged children, pregnant, and lactating women. The major contributing factor found was unbalanced diet, rather deficient quality than deficient quantity.
- 3) According to the anthropometry study (measurements of height, weight, arm and chest circumference etc.) children of preschool age in rural Korea (Kangwha and Chunseong) did not have malnutrition problem in contrast to the result of the nutrient intake study. Nevertheless in the anthropometry study on the slum population of Seoul, the malnutrition problem appeared to be more serious problem especially among infants and weaning aged children than those in the areas of agriculture and fishery.
- 4) A manual of nutrition education is in progress for the purpose of community education.
- 5) The school feeding program has to be strengthened in comparison to Japan; recent anthropometry on Korean teenagers revealed inferior growth and development to that of Japanese teenagers, which seemed to be attributed to the inexpensive well planned regular school feeding program.
- 6) An effort to develop a commercial weaning diet may be of value.
- 7) Communal dining practice proved to be an efficient way of feeding.
- 8) The analysis of the food expenditure portion of the farm household economy survey was found to be an excellent data source for nutritior studies.

#### **D) Recommendations to Government**

- 1) All health workers should be trained in nutrition and assigned to carry out nutrition education activity as part of their routine work.
- 2) Utilize the existing data of Farm Household Economy Survey for food and nutrient intake level of rural population, which has been accumulated during the last two decades.
- 3) Encourage and develop further the community dining practice.
- 4) A National Nutrition Policy Planning Board at national level should be set up.

#### **Topic 3: Medical Aid Program in Korea**

1. *Initial Evaluation of ROKG Medical Aid Program for the Poor*, by Seung Hum Yu

##### **A) Purpose of the Study**

To identify the magnitude and pattern of medical care utilization, necessary medical care costs, and the characteristics of both the patients and their diseases.

##### **B) Problems and Issues**

- 1) Utilization rates were lower than expected whereas the average number of physician visits for primary care and hospital stay were more frequent and longer than expected.
- 2) The utilization rate among the indigent group were about 3-5 times higher than among the low income group.
- 3) Medical care expenditure was higher among the indigent for primary care and the low income group for secondary care.
- 4) Public facilities were more frequently utilized than private ones.
- 5) In primary care, 80-90% of the diagnoses were made on clinical findings only, without laboratory assistance.
- 6) Less than half of referred patients from primary care units were accepted by secondary care units.

### **C) Summary of the Group Discussion**

- 1) The expansion of target medical aid recipients may be unavoidable with re-adjusted criteria: only a part of indigents and low income groups who need the aid were the recipients because the program was limited to only those who had lived in the same place for more than one year with civil registration.
- 2) Simplification of administrative process for the medical aid program is urged to facilitate the utilization of the program by the needy people; the administrative process is so complicated and time consuming that the recipients are reluctant to utilize the program.
- 3) A capitation system (doctor's service fee based on the number of recipients assigned regardless of care rendered) may be better than the current system (fee for service), although there is risk of under-treatment.
- 4) Medical doctors in practice are becoming more cooperative recently with positive attitudes toward the medical aid program and/or insurance program than during the beginning period, and showing gradual increase of participation.

### **2. Behavioral Determinants Affecting Non-Participation of the Recipients in the Korean Government Medical Assistance Program for Low-income People, by Kyung Kyoong Chung**

#### **A) Purpose of the Study**

This study is intended to evaluate the Medicaid Program launched by the government in January, 1977, through a survey on the characteristics of the target groups of indigent and low-income population and their utilization or non-utilization of the Medicaid Program, and also is intended to enhance the effective program operation and utilization.

#### **B) Problems and Issues**

- 1) No essential difference was disclosed in their ability to afford the medical expenses between the two groups (yellow card holders or the indigent and green card holders or the low-income people). The survey revealed that only 23.6% of the low-income group would be able to repay the installment payment for hospitalization, and the remaining 70% would be unable or find it difficult to repay the installment payment of 70% of the hospitalization expenses.

- 2) Regarding the age and sex distribution of the heads of the target population, it was found that 24.3% were female among the low-income group, particularly, in the case of the indigent group, about one-third of the heads of house-holds were in their seventies and another one-third were in their sixties. The indigent were mostly helpless and aged single females.
- 3) The educational level of the heads of the interviewed target population was so low that 32.5% of the total target population is illiterate; 22.3% for the low-income group and 61.3% for the indigent group.
- 4) Only 61.9% of the total respondents knew that the primary care services are provided free of charge to both the indigent and low-income groups. Among the indigent group entitled to free hospitalization, only 66.4% knew about this free service and the remaining persons knew nothing about the program, or thought that the services are only partially charged for a cash.
- 5) Many complaints were received from the target population stating that the bearers of the Medicaid Cards were given unworthy medicine and discriminatory treatment. Twenty eight percent of the total respondents believed that they were discriminated, against 41% did not know, and 31% responded that there was no discrimination.
- 6) The indigent respondents had utilized the Medicaid program services 23.1 times per 100 persons per month, while low-income population utilized it 8.9 times, thus the average frequency of utilization was 11.0 times per 100 persons of both groups per month. When we tabulated the monthly utilization rate in terms of number of persons, 3.9% of the indigent group and 2.6% of the low-income group utilized the Medicaid services.
- 7) The Medicaid services had only been sought by 59.6% of the rural respondents and 56.3% of the Seoul respondents during the period from the beginning of the program to the time of interview (about the middle of August, 1977). The outstanding reasons for non-utilization were 1) because they had no knowledge of how to use the Medicaid Card (27.2%) and 2) because they had minor illnesses.
- 8) The significant variables among these that affected utilization of the Medicaid services 1) distance to the closest designated medical institutions, 2) attitudes toward treatment discrimination, 3) awareness of

usage of the cards, and 4) perspective of one's life among the low-income people, while the awareness of the usage of the Card was the most significant variable for the indigent group.

### **C) Summary of the Group Discussion:**

- 1) The medical aid program needs improved coordination between the health center and Gun Administration Office; health workers are indifferent to the medical aid program because the responsibility of the program belonged to the Welfare Section of the Gun Office, and the health center is merely carrying out the patient care mechanically when the patients are sent to them by the Gun Office. If the administrative responsibility is shared with the health center, the health workers may participate in the program more actively.
- 2) The medication for one visit may be extended from three days to ten days to save time and bus fare for the patients, even though there encounters some problem of abuse of the program in such case.
- 3) Some medical aid recipients (34% of indigents and 54% of the low-income group) prefer larger hospitals paying their own expenses to the assigned medical institutes free of charge, mainly because the recipients feel that they get inferior quality medical care when they get free care.
- 4) Comprehensive health education is strongly recommended to the government since most of the recipients are illiterate and ignorant of the program.

### **D) Problems and Issues Identified**

- 1) Utilization rate of the service program was lower than expected mainly because of ignorance, prejudice, and distrust of the unit.
- 2) No essential difference were recognized in their ability to afford medical expenses between indigent and low income groups — in other words, only 23.6% of the low income group was expected to have the ability to repay the installment payment for hospitalization.
- 3) Most of medicaid recipients were characterized by old, single, helpless persons with a low educational level.
- 4) Public sectors were more frequently utilized than private sectors, and apparent shortage of medical personnel in the public sector was identified as a serious problem.

#### **E) Recommendations**

- 1) Improve quality of medical care by means of strengthening personnel and facilities of health centers and subcenters.
- 2) Simplification of the reporting system and procedure of payment request.
- 3) Comprehensive health educational activities are strongly desirable to be carried out by the government with due consideration of the low level of educational attainment of the needy population.
- 4) Gradual enlargement of the size of the recipient population of the medical program is desired to be seriously considered.

#### **D. Recommendations on the Overall Health Program**

1. A major policy revision is needed in the health care system in Korea. The direction to move toward is health and medical care as a part of social security.
2. The expense for the proposed health care system may be met with tax revenue or compulsory health insurance. It will be a component of the national social security scheme projected in the future.
3. The primary health care delivery system with emphasis on preventive and promotive service should receive the highest priority.
4. Setting up the patient-referral system is necessary to establish an efficient operational scheme which includes limitation of expensive hospital and specialist's care to those patients referred. The private resources, particularly manpower and facilities should be integrated.

## **GROUP C: MEDICAL ASPECTS**

### **List of Participants**

- Dr. E-Hyock Kwon** : Professor, College of Medicine, SNU  
(chairman)
- Dr. Kyong Shik Chang** : Director General, Medical Affairs Bureau,  
MOHSA
- Dr. San Cho Chun** : Professor, College of Nursing,  
Yonsei University
- Dr. Alexander M. Rankin** : Representative, World Health  
Organization/Korea
- Mr. Byung Hun Chun** : Policy Coordinator, MOHSA
- Dr. Byung Kuk Kim** : Secretary-General, Korean Medical  
Association
- Dr. Il Soon Kim** : Professor, College of Medicine,  
Yonsei University
- Dr. Sung Kyu Ahn** : Chief, Health Project Division, KHDI
- Dr. Ok Ryun Moon** : Assistant Professor, School of Public Health,  
(Rapporteur) SNU

## **A. Research Subjects Presented**

1. A Study of the Demand and Need for Medical Care in Rural Areas in Korea, by Jong Huh and Ok Ryun Moon.
2. Health Services Outcome Data — A Survey of Data and Research Findings on the Provision of Health Services in Korea, by Ok Ryun Moon and Jae Woong Hong.
3. Development and Organization of Myun Level Health Care Services in Korea, by Il Soon Kim and Dorothea Sich, et al.

## **B. Summary of Research Findings**

1. *A Study of the Demand and Need for Medical Care in Rural Areas in Korea*

This study was conducted to identify the magnitude of need and demand for health services and factors affecting utilization of medical care in rural areas. A survey was made during November, 1974, by utilizing Myun health workers as interviewers. This study examined the morbidity status and medical care utilization of 9,826 sampled people from 1,789 households nationwide, which was equivalent to 0.06% of the total rural population.

The study revealed that fifteen percent of the population experienced morbid conditions during the study period. Monthly incidence rate was 7.8%. Among those with perceived need of care, average number of treatments per episode was very low, 1.3. Roughly forty percent of the reported illnesses were not treated at all. Unmet need of care, defined as the difference between the magnitude of health services used and that of perceived illness, amounted to fifty-three percent when those treated but not cured were added.

More than sixty percent of those utilizing health service chose pharmacies for their primary source of care. This study, however, showed that the role of pharmacists decreased with subsequent care. Eighty percent of total medical care took place in private clinics if medical care provided at health centers was excluded. It became fifty-nine percent if that portion was included. One thing is noteworthy—that two thirds of the inpatient care occurred in private clinics. It means that the role of solo private practitioners is quite prominent in inpatient care in rural areas.

This study attempted to identify the determinants of health care utilization by applying multiple regression analysis. A conceptual analytical framework was drawn which was a modified version of Ronald Andersen's

behavioral model of health service utilization. Significant gains in variance explained resulted from application of the additional predictors instead of applying the basic demographic variables and income variable. Ten percent was gained on the average.

The following variables were found to be the most powerful indicators in each regression equation: perceived health status in ambulatory care, activity restriction in inpatient care, duration of illness in drugstore visits, and initial symptoms perceived as requiring medical attention in total number of utilizations. In general, clinical conditions are most significant in explaining health service utilization. Therefore, an indepth study is needed to analyze the effect of disease entities on medical care utilization. The explained variance, however, was not sufficient for a full understanding of health services utilization. The study indicates that further elaborations of the working model as well as of study variables are called for.

## *2. Health Services Outcome Data: A Survey of Data and Research Findings on the Provision of Health Services in Korea*

This study was intended to collect the data and research findings on the provision of health services and compile them into a volume. The study dealt with four kinds of data from the existing publications: mortality, morbidity, utilization of health care, and medical expenditures. Major findings are as follows:

### **A) Mortality Data**

Obviously, various death rates were declining. But sizable differences were found among the registered data estimates and sample survey data. The rates from the estimated data were highest on the average. The recent estimates of crude death rate are approximately 10 per thousand population. However, crude death rates surveyed in urban areas are around 5 per thousand population, and those in rural areas are 7 to 8. The sample surveys show that infant mortality rates in recent years are around 30 to 35 per thousand livebirths in urban areas, and 40 to 60 in rural areas.

The age specific death rates abruptly decline after the infant period, and continue at a lower level until the early forties. The increment of age specific death rate is gradual during the forties and fifties, but is quite sudden after the age of sixty. The male has a higher death rate than the

female in all ages, especially in older ages. The difference is 1 to 2 per thousand. Recently, the life expectancy at birth is over 60 years for both sexes. The life table based on the 1966 census shows a life expectancy of 61.9 years for both sexes, with 59.7 years for the male and 64.1 years for the female.

All of the maternal mortality data were based on the records of several general hospitals. Because tremendous variations exist among the studies, the findings cannot be generalized.

### **B) Morbidity Data**

Teenagers and the productive age group, 20-40, show lower morbidity rates. The mean value of prevalence rate per 1,000 people is around 160. The female has a higher prevalence rate than the male by 15 to 20. The prevalence rate of urban people seems to be higher than that of rural residents, but more information is required to verify this finding.

The average number of annual sicknesses per person is 1.9 to 2.0, days of activity restriction per person per month is 0.5, and those of activity restriction per patient is 3.4.

Seasonal variations are noted in the ten leading causes of morbidity. Diseases of the digestive system are the leading cause in the summer, and those of the respiratory tracts in the winter. The government statistics indicate that the incidence rates of acute communicable diseases are rapidly decreasing, except for typhoid fever. The statistics reveal the increment of infectious tuberculosis cases despite the reduction of non-infectious ones.

### **C) Utilization Data**

Generally, males use more health services than females except for visits to pharmacists. Rural residents tend to use health centers and herb-doctors more frequently than urban people who use physician visits and hospitalization most frequently. The number of hospitalization increased significantly from 2.8 per 1,000 population in 1963 to 6.2 in 1974 in the rural areas.

Drugstores are the primary source of care for more than fifty percent of all Koreans. Pharmacists are more frequently visited by the urban dwellers than the rural. Dentists are rarely consulted. The total number of dentist visits is equivalent to only one fiftieth of that of physician visits. This is evidence of the need for increasing dental care in Korea. On the average, the older the patients, the more likely they are to use all kinds of health services if those less than five years old are excluded. It can safely be

estimated that the need for medical care is not met for at least half of the total reported episodes of illness.

The data from the national census on medical institutions suggest that the average length of inpatient stay was reduced from 16.7 days in 1966 to 12.4 days in 1973. The level of education seems to be positively correlated to hospitalization, physician and dentist visits, and negatively correlated to herb-doctors and herb-druggist visits. Almost ninety percent of deliveries still occur at home in rural areas.

#### **D) Expenditures Data**

The total amount of national health expenditures was 191.2 billion won in 1974 which was three times the 64.7 billion won spent in 1970. As a percentage of the GNP it increased from 2.5% in 1970 to 2.8% in 1974. Per capita medical care expenditures increased from 2,000 won in 1970 to 5,700 won in 1974.

In 1974, the public sector consumed only 11% or 21 billion won, of the total national health expenditures. The private sector consumed 89%, or 170.2 billion won. The sources of health expenditures are increasingly private. In 1970, 48.2% public health expenditures came from the central government, and the remaining 51.8% came from the local governments. In 1974, the proportion from the local governments increased to 54.7%. The public sources are increasingly local government. The proportion of out-of-pocket expenditures on health and medical care increased from 2.3% total private expenditures in 1970 to 3.5% in 1974.

It is predicted that if the proportion of national health expenditures to GNP remains at 2.8%, the gross national health expenditures will increase from 250 billion won in 1975 to 662 billion won in 1981. It is predicted that if the rate of national health expenditures to GNP increases annually by 0.1% to 3.5% in 1981, the gross national health expenditures will increase from 259 billion won in 1975 to 828 billion won in 1981. It is predicted that the private consumption expenditures of health and medical care will increase from 213 billion won in 1975 to 583.3 billion won in 1981, if the income elasticity of private consumption expenditures remains at 1,036.

Review of the existing literature shows that the male spent slightly more than the female in terms of per patient and per treated case. Monthly medical care expenditures consist of four percent of the total monthly household income. The urban family spent more than the rural in terms of

proportion of household income. Health plan subscribers spent more on medical care than non-members. The medical care expenditures increased proportionally to age.

### *3. Development and Organization of Myun Level Health Care Services*

The specific objective of this study is to build a model Myun health service system for the rural population. The basic concepts underlying this study are as follows: 1) the whole community population should be the target of health care services, 2) a referral system should be set up for effective utilization of the scarce resources, 3) the service should be a comprehensive one, 4) a voluntary participation by the community people should be induced, and 5) health resources should be developed based on the community health needs.

Three different models of referral system are designed: The first model, most ideal but impracticable, is to place a health post in each village in a myun, and to establish myun health service at a convenient location in the myun. At the gun, a small hospital will be built so as to integrate the existing health center activities of the Public Hospital which are separated from those of the Public Health Department as it is.

The second model is to integrate public health organization and curative service organization on a new health region basis. A region is meant in this study to be a larger health service district covering two or three guns. The researchers indicate that this model is hardly being implemented because the region does not accord with the boundaries of general administration.

The third model is to integrate public health activity and curative service at the myun level, but to separate them at the gun level and above. A regional hospital is placed in each health service region. The researchers indicate that the chance for the model to be implemented is quite high from economic and administrative reasons, although this model would be inconvenient for the residents in the gun.

The researchers adopted the third model for the organizational set-up of this study. The functions of the proposed model myun health service were determined by using the survey data of the Kang Wha Project. They are 1) curative care, 2) child health care, 3) maternity care, 4) family planning service, 5) tuberculosis control, 6) environmental sanitation, 7) health education, 8) community and government relations, 9) health planning and internal management, 10) training of health personnel and supervision. Of these, from 1) through 6) can be said the major functions, and the remaining four, auxiliary functions.

Quantification of the basic target of a model myun health program was made for a standard population of 1,000 persons. For example, the expected total number of patient visits was estimated to be 5,800, and the administration of 1,987 vaccinations per year would be required to cover all the eligible children, and so on.

Recommendations as measures for recruiting health personnel were that the existing health manpower be fully utilized, less technical works be delegated to less specialized workers, and high priority be given to accomplishing the functions of a health subcenter even though it might not be presently feasible to obtain the required manpower. The researchers suggested that a model myun health service should have a physician, a public health nurse, a midwife, multi-purpose health workers (nurse-aids), a multi-purpose technician aid and curative service aid. Based upon the result of a time — activity study undertaken on the 35 myun health workers, 2 physicians, 2 public health nurses, and 2 midwives in the Kang Wha Community Health Demonstration Project, it was recommended that a model myun health service be staffed with a physician, a public health nurse, a midwife, five multi-purpose workers (MPW), a multi-purpose technician aid and a curative service aid. However, if each village has a voluntary health worker, the number of MPWs could be reduced to three.

In an effort to develop an organization of curative services, data were collected on the demographic characteristics of the patients, most commonly encountered disease entities, and the diagnostic and therapeutic techniques most frequently utilized, by analyzing the out-patient records of the health subcenter in the Kang Wha Demonstration Project in 1975-1976. For diagnosis of diseases, laboratory studies were required by 9.2% of the patients and radiological study was required by 6.5% of the cases. It was estimated that a total of 13.6% of the patients required either radiological studies or laboratory studies or both. The average fee per outpatient visit was estimated as 870 won at the 1976 price for the cases with three days of prescription. The estimate came from the assumption that 42% of the total cases required simple medications, 12.8% special drugs such as antibiotics, 12.5% needed low-cost injections, about 10% special injections and dressing. Approximately 5% of the patients received minor surgery or were referral cases.

The amount of physical resource requirements and medical supplies was estimated for the implementation of a myun health service. As for drugs, 27 kinds of orally administered drugs, 15 kinds of injections, (8 for external

use, 2 for intravenous use) and 6 kinds of antiseptics and disinfectants were listed. It was also estimated that 582 X-ray examinations and 1,899 simple laboratory tests would be required annually, but when a health insurance program expands, the estimates will be increased to 933 and 2,395 respectively. The size of the present health subcenter is about 20 pyong which is too small to carry out the activities of the proposed myun health service. It is indicated that a new design calls for a total floor area of 140m<sup>2</sup> (42.4 pyong).

This study gave the estimated figures of annual operating expenses and capital investment to run the program. The former was about 14,710,000 won, of which 50% would be used for the provision of curative services, 45% for public health services and the remaining 5% for general administration. The latter was about 5,000,000 won for remodelling the existing building and purchasing X-ray equipment and a motor-cycle, etc. The cost of the curative service will be underwritten by medical fees from the patients, while it is suggested that the Government will subsidize the expenditures for public health service and facilities.

### **C. Summary of the Group Discussion**

After the presentations the group members expressed their views concerning the issues raised by each researcher. The highlights are summarized as follows:

1. It is a problem that data and information essential in planning health services is not readily available. What is worse is that the range of data available is too broad to use. In fact the reliability produces another problem.
2. Data are so fragmentary that planners and administrators have difficulties in explaining the underlying circumstances which have given rise to the problem, and in providing a means for predicting the likely outcome of alternative health policies. Furthermore, data are not adequate in geographical detail and lack continuity.
3. Even good research findings have not been utilized. In connection with this matter both researchers and administrators are responsible. Therefore, increasing control over the research and evaluation process was strongly advocated.
4. Planning implicitly means a rational decision making process. It was

generally agreed that health planning has, so far, lacked rational approaches.

5. It was pointed out that health service research had not played a significant role in the health planning process. The discussion focused on how to apply research findings in health policy formulation.
6. There is a wide gap between the primary care ideal and the reality. Some members pointed out the ambiguity of primary health care itself.
7. A consensus was reached that restructuring the health service delivery system should start from the myun health service as a point of entry by combining preventive, curative and promotive health service into comprehensive health care.
8. The need for myun health service being integrated into community development was well appreciated. It was indicated as an example that the Saemaul Movement has pursued the same objectives as the health service program, but they have lacked integration.
9. There is a great need for national health manpower policy to replace the present unresponsive and uncoordinated training of personnel. Without recognition of the need for health manpower policy revision, it is hardly possible to dispatch qualified health personnel to the areas of need, and to control the recent trend of super-specialization.
10. We are confronted with the problem of how to provide adequate health care to all the rural neighbors who cannot afford to pay, and how to improve the delivery of health service at a reasonable cost to all who can afford it.

With respect to the above discussion, the group chose two topics for presentation at the plenary session:

Topic 1: Use of Research Findings in the Formulation of Health Policy.

Topic 2: Strengthening Primary Health Care at Myun Level.

### **Topic 1: Use of Research Findings in the Formulation of Health Policy**

#### *1. Problem Identification*

It is well-known that formulating health policy requires much information on the existing health status of people to be served. In Korea, such

data are available only on a limited basis and are not collected in such fashion that planners and administrators can easily utilize.

It has become increasingly evident that although there are many critical testimonies about the difficulties which individual Koreans experience in getting health and medical care from a doctor, there is a distressing lack of solid information about the magnitude of the problem, its distribution, or the actual number of people whose need for medical care is not met to their satisfaction. Therefore, it is fair to say that, up until now, very little research has really had an impact on the formulation of health policy in Korea.

Some of the issues raised during the discussion session are as follows:

- 1) Some information deemed to be indispensable to the health planning cycle are, in fact, nonexistent. For example, maternal mortality rate, infant mortality rate by social class, cause-specific mortality rate by area, and medical care expenditures by occupation, etc.
- 2) The quality of data was found to be a big problem in practical application. Tremendous variations in the range of health service statistics were reported among different researchers. It is unfortunate that planners and administrators have difficulties in choosing appropriate data despite the abundance of morbidity and health service utilization studies.
- 3) Administrators' and policy-makers' views on research (the providers of research funds) are likely to differ quite frequently from those of the researchers (the recipient group). For example, the sizable research funds from the Ministry of Education have little utility in facilitating the health planning process since the funds were not spent for health and medical research. Efforts should be made to coordinate the two.
- 4) On some occasions, precious research findings fail to reach the relevant administrators and planners. This indicates there is a problem in the circulation of research publications. The group C emphasized the importance of intimate communication between administrators and researchers in the health planning process as well as in conducting health service research evaluation.

## 2. *Several Approaches Discussed*

- 1) It was unanimously agreed that the Health Service Research Council should be established within the arm of the Ministry of Health and Social Affairs. The Indian Medical Research Council would be a good example.

The Council, if it is created, would decide the information the government needs in planning for health services, resource people most appropriate for conducting such research, how much it would cost, etc.

- 2) It is unlikely that the Policy Coordinating Office of the Ministry of Health and Social Affairs would carry out the above mission, unless the whole budget for health service research now available in the Ministry was transferred to that office, which is impracticable at this point. An alternative solution is that an independent or semi-independent organization, such as the Korea Health Development Institute (KHDI), perform the coordinating function.

The group urged strongly that the Ministry and all the health professionals together do their best to help the KHDI carry out such a function. The original contract agreement made between the Korean Government and USAID/Korea should be amended if it is a constraint to the Institute in heading toward that direction. Also, it was indicated that KHDI should expand its role in health policy analysis and health service data provision.

- 3) The administrators occasionally allege that the research findings have been presented in an unnecessarily frustrating, abstract manner so that the findings have little utility in solving the difficult problems faced. Therefore, it is recommended that the efficacy of communication between researchers and administrators be involved as an integral part of research evaluation. Such evaluation would focus on the ability to translate research findings into a set of altered behaviors of key personnel in the program implementation as well as on the extent of usefulness in helping them in problem solving.
- 4) An expert committee meeting on survey research in the health service field is required to standardize the research methodology and upgrade the quality of data. Studies on morbidity, health care utilization and expenditures are some of the examples urgently calling for such measures.
- 5) One of the major difficulties in formulating a rational health policy is the scarcity of performance indicators which are sufficiently specific so

that a particular model can be constructed with known inputs and outputs. With such technical limitations in the health service area, more efforts need to be poured into development of a set of sensitive performance indicators — for instance, various fertility rates in family planning services for the fulfillment of formulating a rational population policy.

- 6) Health planners play a crucial role in health policy formulation by providing decision makers with a series of alternative strategies and their respective implications. It is, in fact, a kind of educational process for planners to assist a policy decision maker in arriving at a certain policy. The more planners there are, and the better their quality, the greater will be their influence on policy makers. Therefore, emphasis should be laid on enriching the health planning curriculum of teaching institutions and strengthening teaching capability of the instructors concerned.

### *3. Recommendations*

- 1) We recommend that a Health Service Research Council be established under the aegis of the MOHSA in order to solve and coordinate the problems related to health service research.
- 2) We recommend that the KHDI expand its role in health policy formulation by analysing the implications of various health programs and their strategies, performing the function of coordinating relevant researches and serving as an information center on health service data retrieval.
- 3) We recommend that an effective communication channel be set up between administrators and researchers as a process of research evaluation.
- 4) We recommend that an Expert Committee Meeting on Survey Research be organized to standardize health service research methodology.
- 5) We recommend that further research be made on the development of performance indicators which are able to facilitate the process of formulating rational health policy.
- 6) We recommend that the Government invest a substantial amount of resources in professional development in planning and the development of health planning curriculum in order to produce more qualified health planners.

## **Topic 2: Strengthening Primary Health Care at Myun Level**

### *1. Problem Identification*

The emerging concept of health as a public duty as well as a citizen's right creates an enormous amount of demand for health care. A society should prepare a system of health services provision to cope with the soaring demand. Obviously, the constraint is in organizing and financing an appropriate health care delivery system to assure for all access to health care that is both adequate and within the means of society and the individual.

So much has already been publicized on the weaknesses of the present health care system in Korea. Central to the issues is the absence of or non-functioning health care system in peripheral government hierarchy as well as the ministerial incoordination due to bilateral cumbersome organizations. In fact, the country's awareness of the growing inadequacies of health care has produced a number of proposals stressing in particular the myun-level health infrastructure.

Some of the rationale for strengthening the myun-level health care delivery system are that 1) almost half of the Koreans are living in the myun or eub, and of those, nearly fifty percent are not receiving adequate modern medical care; 2) the myun health subcenter is worthwhile to be focused on as a primary source of care because of its easy geographical accessibility; 3) it is impossible in the Korean context to build a patient referral system without taking the myun health subcenter into consideration. Major issues raised by the Group during the session are as follows:

- 1) Myun health service is so inappropriately organized that it cannot meet the need of the people.
- 2) Poor allocation of resources to health subcenter activities is a major cause of inadequacies in the rural health services in Korea.
- 3) Most myun health personnel currently are not working at the health subcenter, but at the myun office where they frequently carry out other duties.
- 4) Almost one fourth of health subcenters do not possess their own facilities.

### *2. Several Approaches Discussed*

- 1) It was indicated that a rational approach to building a national health

network should start from the grass-root level. It is similar to a construction process that a building is doomed to fall down without a sound basement.

- 2) It was pointed out that restructuring rural health care should begin from building a patient referral system with the concept of regionalization. Many models are already in our hands. For example, the Kang Wha model and the Choonseong model are taking advantage of modifying the existing patterns of delivery with a minimum amount of supplementation of health resources. Obviously, it should be borne in mind that geographical characteristics and distribution of private practitioners have to be cautiously considered in implementing such models.
- 3) It was proposed to develop some packages of health service provisions in order for a health subcenter to meet the need of a community. The consensus is that basic health service requirements are such as curative service, maternal and child health services, family planning program, tuberculosis control program, basic environmental health program and general health education.
- 4) Personnel required in the operation of such a health sub-center in a myun with 10,000 population are approximately eight or nine. They are one physician, one nurse practitioner if available, one public health nurse, one midwife and five multi-purpose workers.
- 5) The health subcenter must be reorganized so that scarce resources can be used to the level of their capabilities in bringing care to people. Thus, steps must be taken to improve internal management of the organization. For instance, detailed job descriptions should be spelled out according to health workers' qualifications and experience, and a system of technical supervision should be adequately developed.
- 6) An effective administrative structure at the myun level or regional level is needed to bring both financing and delivery of health care together. It was pointed out that increasing public funds should be made available for reforming health subcenter provisions of health services.

The group maintains that merely to pour a large amount of resources into the present system without some organizational rearrangements particularly at the myun level, would undoubtedly create further distortions in demand and resource allocation.

### *3. Recommendations*

- 1) We recommend that it is a must to strengthen primary health care at the myun level, if we are to achieve the goal of assuring access to quality health care by all members of our community.
- 2) We recommend that an effective health care referral system be developed at the myun level. Several models have already been experimented and the results are available.
- 3) We recommend that the basic service requirements of such a health subcenter include curative services, child care services, maternity care, family planning program, tuberculosis control program, basic environmental health program, and general health education.
- 4) We recommend that the myun health subcenter be reorganized and a system of technical supervision be developed so that the resources can be used to the maximum in bringing care to people.
- 5) We recommend that development of an appropriate financing mechanism at the myun level accompany the restructuring of organizational framework of the health subcenter.
- 6) We recommend that national health manpower policy be designed with the intention of developing the requisite personnel and skills to alleviate the general manpower shortage, overcome the geographic maldistribution, and provide primary health care.

## **Annex #1**

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### **USAID/KHDI HEALTH PLANNING WORKSHOP PROGRAM SCHEDULE**

#### **WEDNESDAY, MARCH 29**

- 0900-1400 Arrival of Participants
- 1400-1500 Registration  
— Hotel Lobby
- 1500 Plenary Session I Moderator: Mr. Chong Myun Chung  
Opening Ceremony Secretary-General, KHDI  
'Rose of Sharon Room'
- Opening Remarks Dr. Hyung Jong Park  
President, KHDI
- Congratulatory Address His Excellency Hyun Hwack Shin  
Minister, MOHSA
- Mr. Dennis P. Barrett  
Representative, USAID/Korea
- Explanation of Objectives of the Workshop Mr. William E. Paupe  
General Development Officer  
USAID/Korea
- 1830 Reception Hosts: Workshop Steering Committee

#### **THURSDAY, MARCH 30**

- 0900-1000 Plenary Session II Chairman: Dr. Kyong Shik Chang  
Director-General  
Medical Affairs Bureau,  
MOHSA
- "National Health Program 'The Economist's Role in National Health Planning' Observed by an Economist "
- Dr. Jae Ik Kim  
Director General  
Economic Planning Bureau,  
EPB

Assignment of Participants to Groups and Workshop Guidelines  
Dr. Hyung Jong Park  
President, KHDI

1000-1200 Individual Group Sessions

Group "A"  
(Economic)  
"Rose" Room

Chairman: Dr. Chong Kee Park  
Secretary-General  
National Health  
Secretariat, KDI

Rapporteur: Dr. Dal Sun Han

Group "B"  
(Statistical/  
Epidemiological)  
"Camellia" Room

Chairman: Dr. Jae Mo Yang  
Dean, Graduate School of  
Health Science & Management,  
Yonsei University

Rapporteur: Dr. Joung Soon Kim

Group "C"  
(Medical)  
"Lily" Room

Chairman: Dr. E-Hyock Kwon  
Dean, Graduate School of  
Public Health, Seoul  
National University

Rapporteur: Dr. Ok Ryun Moon

(General Rapporteur: Prof. Kil Byong Yoone)

1200-1330 Lunch

1330-1700 Continue Individual Group Sessions

**FRIDAY, MARCH 31**

0900-1200 Continue Individual Group Sessions

1200-1330 Lunch

1330-1700 Plenary Session III  
"Rose of Sharon"  
Room

Chairman: Mr. William E. Paupe  
General Development  
Officer, USAID/Korea

1900 Dinner & Closing

Remarks: Dr. Seung Hahm Park  
Vice Minister, MOHSA  
Dr. Hyung Jong Park  
Mr. William E. Paupe

## **Annex #2**

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### **Opening Remarks**

by Dr. Hyung Jong Park  
President, KHDI

Mr. Vice Minister Park, the Governor of Cheju Province, and ladies and gentlemen:

It is our great honour for KHDI to sponsor this workshop on Health Planning today! We have been striving very hard to achieve our economic development as rapidly as possible and last year reached the initial target of one billion dollars export. The 10 billion dollars summit is the view in front of us.

Now it is certainly time for us to divert our interests to the socio-developmental sector rather than to the economic development sector exclusively.

I am sure many of you appreciate the problems that have existed in the past when developed countries have been unable to render ample health services to their people even though their economic growth soared.

We plan scientifically with economic development programs step-by-step. Planning technology is also an integral part of social development which is equally important for health sectoral planning.

It is regarded as a "basic human right" for ordinary people in the contemporary era to have health services delivered where they are, when they need them. The fulfillment of this kind of medical provision can only be assured through a sound national health planning technology.

As is universally known in planning methodology, sound technique must be based on well planned surveys and research to support phase-by-phase program details of the health plan. However, in many cases that I know of, researches and studies are being carried out by either universities, colleges or professionally organized research institutes and remain there without being actively able to influence either lawmakers or policymakers at all.

The encounter of researchers with government policymakers at this workshop therefore will be an epoch making opportunity for the history of public health service in Korea.

It is particularly important because the solution of health problems is not only closely related to community development and other development activities but because the health sector is an integral part of national socio-economic development.

The development that has been manifested in the economic sector in Korea during the past 10 years is great. I hope, with better technological know-how, we shall be able to carry out the national health program for further advancement.

The KHDI has been founded to explore a new medical care delivery system for the rural people and is presently promoting such a demonstration project. This project should be developed as an integral part of a national program without being separated from the entire national health program.

This kind of inter-disciplinary "get together" is extremely useful for economists, public health doctors, statisticians and administrators who are discussing with each other problems of mutual concern, and thus makes this event a very resourceful endeavour.

I expect this Seminar to undertake the very crucial task of analysing the current health situation and presenting some new guidelines for future development in planning of national health programs. This will make a historical landmark in the health service of Korea.

Thank you again.

## **Annex #3**

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### **Congratulatory Address**

by Dr. Seung Hahm Park  
Vice Minister, MOHSA

Your Honorable Mr. Il Hoon Chang, the Governor of Cheju Province, Mr. Dennis P. Barrett, Representative of USAID, ladies and gentlemen!

It is a great pleasure for me to deliver the congratulatory speech on the occasion of the Health Planning Workshop today.

As the growing importance of the health sector is recognized by policy makers, along with the higher priority placed on all social development sectors in the developing countries, Korea, being no exception, is working to devise some scientific, long-term plans for health care delivery service to all people.

What is the most important at this critical juncture is not the extent of awareness or the conceptual frame of developmental dimension, but the realistic program devices and ramifications of phase-to-phase implementation schemes for those of us concerned in the field of health and welfare service provisions. This requires concerted effort and technical know-how, in addition to resources appropriately allocated throughout the country, without geographical gaps or residential discrimination.

As it has been announced through mass-media, His Excellency the President, Park Chung Hee, emphatically pointed out the importance of social development goals for the future as major policy objectives, at the time of his New Year's press conference. These goals will ensure protective measures for the people against disease by making available quality medical care to all, as well as the provision of a comfortable environment in which people can work and live pleasantly as beloved citizens of a developing nation.

His Excellency the President, Park Chung Hee, further pointed out that over 800 health centers and sub-centers should be better equipped so as to assume the prompt functions of providing primary medical care in rural areas, in addition to strengthening 22 municipal or provincial hospitals with the function of providing secondary and tertiary medical care for rural areas.

The modernization of infrastructure and social overhead capital investments in the past has been conspicuous and it is attributed to progressive economic development and the Saemaul movement. It brought tangible growth to the supply of electricity, potable water, and sanitary

services up to some 15-20%, and housing renovation of some 1.6 million homes in rural areas. These improvements will be playing an indispensable and fundamental role in the betterment of the health status of rural folks.

I may be presumptuous to claim that some of these infrastructures achieved through Saemaul-undong constitute core material-resource ground work and that they are welfare-oriented attributes to dynamic social improvement.

It is a universally accepted notion that better provision of health services for the entire population of a nation presents many problems. These include not only maximum utilization of scarce resources but also structural changes in organization, in delivery mechanism, in end-user motivated financial resource mobilization, as well as quality and cost control and so forth.

Enactment of the Medical Insurance Law of 1977 offered tangible benefits to some 3.1 million family members and workers of industrial firms and establishments. The medicaid system, implemented last year, cared for some 1.1 million persons — those who are listed on welfare, the needy, and those in the lower income brackets. This is a most decisive stride toward the protective goals of the health of the people.

The government, through an AID loan, has entrusted to KHDI some very meaningful research and experimentation projects closely associated with health planning and innovative health care measures. However, it will require some time from its development to the time when some scientific ramifications of involved answers can be supplied.

Some of the areas to be involved in the planning of health services are, as all of you are aware, assessment of health needs, the question of financing methods, the equitable distribution and redistribution of service-benefits, costs of operation or input and investment models, some revisions of health insurance schemes and the problem of how to eliminate geographical congestion of service deliveries or social discrimination.

I extend my personal congratulations to those who made this academic venture possible today, and wish you every success for the various productive and significant outcomes as the results of your deliberations.

The government will be bound to utilize these precious results for further effective planning in-so-much as they bear most significant data and ideas for the primary and secondary health care service programs for the country.

On the occasion of today's workshop, I really hope that your discussions and ideas will contribute to the future government's health planning and I sincerely hope this workshop will be successful.

Thank you.

## **Annex #4**

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### **Congratulatory Address**

by Mr. Dennis P. Barrett  
Representative, AID/K

Ladies and Gentlemen! I am very pleased to have the honor, on behalf of the USAID in Korea, to welcome you to this important health planning workshop which I consider both timely and appropriate for Korea's continued progress and success in the field of health services. There is general agreement among the developing countries throughout the world that a higher priority must be assigned globally to the expansion of social development programs, designed to meet the basic human needs of the poorest elements of the developing populations. Health and medical care is of course a critically important sector of overall economic and social development planning. It is the hope of USAID/K that this important Workshop will address its attention to the basic human health needs of all the people of the ROK and that it will view health planning as an integral part of the ROK's national planning efforts to insure a comfortable and peaceful environment and an improving level of health and well-being for all of the people of the Republic. I should like also to express my best wishes to each of you for a successful and rewarding participation in this Workshop and my sincere appreciation for your attendance.

Thank you very much.

## **Explanation of Objectives of Workshop**

by Mr. William E. Paupe  
General Development Officer, AID/K

Distinguished Speakers, Ladies and Gentlemen, I must tell you that I came here with some very specific and very idealistic thoughts about what the objectives of this Workshop should be. But after experiencing the very gracious hospitality of the Governor, and viewing the beautiful weather, this beautiful hotel, and this beautiful island, I'm very much tempted to throw all this away and just say our objectives should be to enjoy ourselves for five days. But I suppose we have to do some work to justify our being here. So, in a more serious vein, I would like to say, in addition to the very well-expressed thoughts of the Vice-Minister, Dr. Park and Mr. Barrett about the objectives of this Workshop, I hope all of you will participate in this workshop in a very relaxed and friendly atmosphere, and that everybody will be given the opportunity to speak freely and frankly, and to express their thoughts in the individual sessions.

I think we explained the principal objectives to you in the letter that we sent when we first announced this Workshop, but I would like to elaborate on those just a little.

As you know, most of you here are principal investigators or co-investigators of a series of research studies that were financed through a USAID health planning grant. These studies were analyzed and approved by the Interagency Coordinating Committee which has representation from AID, EPB, KDI and MOHSA.

We believe that these research studies yielded some very valuable information and data, and made some very comprehensive and expert analyses of existing health programs, of morbidity and mortality, of epidemiological phenomena in Korea, about medical economics, insurance, and the cost of medical care. We believe that some very valuable recommendations have been made by the investigators. But unfortunately these studies seemed to be destined to become another item to stick on our bookshelves. They looked very nice but they weren't doing much good. So the ICC committee decided, since it is all of our duties to support and to assist the MOHSA in the development of effective health care programs, that we should get these documents off the bookshelves and make them

living tools that the Ministry of Health could use to improve and to expand health care services in Korea, without the requirement of adding significant amounts of money, personnel, or resources to existing MOHSA organizational structures. In other words, we should come up with a series of recommendations indicating how we all could assist the Ministry of Health, within existing administrative and financial limitations. As most of you know, during the time of the first three 5-year Development Plans in Korea, covering the period 1962-1976, only about  $\frac{1}{2}$  of 1% of total national budget allocations were devoted to health. Fortunately, in the 4th 5 Year Plan, there were recommendations and allocations for the provision of about 4-5 times the previous allocations. But that still isn't very much, and so the funds available need to be used wisely.

We believe that this group of experts, who have participated in the development of the very meaningful data and recommendations that are expressed in their individual research studies, can propose a series of recommendations which will be designed to assist the MOHSA and government of the ROK to expand and to bring about a more effective utilization of existing personnel and resources for the delivery of better health services to all the people of Korea.

Now, to do this, health planners need more effective tools. First of all, they need reliable health data and information systems. I believe that one of these studies in particular, a very excellent study done by Dr. Choo of KDI, made some very good analyses of existing health data systems, and some very excellent recommendations about how to improve the collection of health data. Additionally, Dr. Stanley Music, a recent WHO consultant, carried out an outstanding epidemiological surveillance study, which I hope Dr. Rankin will make available to all of you in the near future.

Secondly, we believe health planners need to have an appreciation for the fact that health planning cannot be viewed as a single entity in national planning for social development. Health planners will have to start thinking of themselves as an integral part of a team of national planners, which includes those with responsibilities in the economic development sector, the agricultural planning sector, etc. That is why we have brought together as participants in this workshop a group of experienced and knowledgeable experts who represent the economic, statistical and medical interests in the health planning process.

May I extend to each of you my sincere best wishes for a rewarding and satisfying workshop experience.

Thank you.

## **Annex #6**

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### **Closing Remarks**

by Dr. Kyong Shik Chang

Chairman, Steering Committee of the Workshop

Ladies and Gentlemen!

It has been a most impressive opportunity for me to have attended this epoch-making workshop, which is about to close in a few minutes.

I am extremely happy to extend my heartfelt congratulations to you all on your painstaking contributions to the solidifying of health planning methodology for future application by this government.

To my knowledge and observation, you have covered, as has been finalized at the closing plenary session, practically all aspects of the themes of economic aspects of health planning, statistical and epidemiological aspects of health services, and medical and curative aspects of planning in the context of rapidly developing countries like Korea, on the basis of numerous research materials and supportin data.

I would like to assure you that each and all of the recommendations and deliberations at this workshop are valuable and crucial for the planning function of the government. They will be channeled to the Ministry staff who are charged with the planning of health care services to eliminate health problems in neglected social and geographic areas of the country.

I would like to extend also my appreciation, on behalf of the government, to all those who served behind the curtain to make this workshop a substantially meaningful and productive one, and also for the kind cooperation and assistance extended by AID/K for this academic convention.

Thank you.

## **Annex #7**

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### **Summary of the Discussion of the Plenary Sessions II :**

#### **1. Session II**

*Dr. Alexander M. Rankin, WHO/Korea* questioned the government's policy of shuffling the Ministry staff at such frequent intervals that it is impossible to build up a core of knowledgeable and experienced persons in any one field.

*Dr. Jae Ik Kim, EPB* answered that EPB was fortunate to have KDI supply trained and experienced government officials in their posts. Such a system is being discussed for public health but may not be implemented for 5 years.

*Dr. Hyung Jong Park, KHDI* was concerned about KHDI's ability to live up to Dr. Kim's expectations. He explained that KHDI is bound by certain agreements under the terms of the AID loan, and that KHDI's major function at this time is to conduct the health demonstration in the 3 Gun sites. Dr. Park acknowledged that KHDI cannot be isolated from the future national health program planning, and suggested that KHDI put more emphasis on overall health planning in addition to the current health demonstration program. This will be brought up at KHDI's mid-term review meeting in July.

Dr. Park also commented on Dr. Rankin's statement regarding personnel changes in government. He pointed out that sometimes this is necessary, but it happens too frequently and is not a new problem to the field of public health. He suggested a relation between KHDI and MOHSA be established similar to that of KDI and EPB.

*Mr. William E. Paupe, AID/Korea* stated that health planning is entering a new dimension, where health planners should be more concerned with competing sectors, inter-related sectors, and the demands on scarce financial resources. Education is very important because the most modern facilities will not be used by people unless they are educated to use them. Mr. Paupe also stressed that it is as important to improve existing facilities as it is to build new ones, as there are limited resources.

*Dr. Il Soon Kim, Yonsei University* stated that the objectives of manpower training will depend on what type of medical & health services will be carried out in the future.

*Dr. Jae Mo Yang, Yonsei University* commented that mere increase of health personnel will solve neither the rural health care services, nor medical insurance problems. Korea must be ready to accept a radical change in the system.

*Dr. Kyung Shik Chang, MOHSA* mentioned two major points. One was tax revenue to finance health; the other was necessity for more investment in health manpower. He is convinced that more health manpower is necessary, but he cannot say how or how many will be required.

## 2. Session III

*Dr. Hyung Jong Park, KHDI* pointed out that group A's recommendations, particularly those with regard to the insurance system, cannot be accomplished without changing the law as it stands. He suggested setting up a mechanism whereby these recommendations would be accepted and acted upon. Maintaining frank and open lines of communication with MOHSA, EPB, other relevant government agencies, and members of the National Assembly would facilitate the effect.

*Dr. Jae Mo Yang, Yonsei University* warned against repeating past mistakes rather than profiting from experience, especially in regard to health insurance. He cited, as an example, the Japanese system, where each scheme is separate — workmen's compensation, old age pensions, family health, etc. Because each scheme is separate, the total system is inefficient and confusing. He sees the Korean health schemes as beginning to follow this pattern, and suggests better planning now to avoid further problems.

Dr. Yang pointed out that all the studies reviewed in the past sessions showed common phenomena, especially the gap between rural and urban health needs, and the fact that half of the present health need is being filled by pharmacies. He warned against medical aid programs whereby poorer patients feel discriminated against; and that few plans could be carried out without building up manpower.

Dr. Yang urged that current resources, both public and private, be taken into account. Public and private sectors should not be developed separately. He reviewed the failure of the existing program of attaching a doctor to every myon. This practice has persisted for 20 years, despite the fact that the disadvantages far outweighed the advantages, and the confidence of public in so-called public doctors has been lost. Taking into account present international experiences, Dr. Yang warned that Korea's current fee-for-service payment system in rural areas is doomed to failure.

He recommended discarding the "idea of at least one doctor for every myon" system for the time being, and instead incorporating two four myons into one group practice health clinic area with several specialists (internal medicines, pediatrics, Ob-Gy, X-ray & clinical laboratory) working together and paid either by salary or on a capitation pre-payment system, according to the population served. In this way, private practitioners could be utilized as well as government medical personnel, and the system would have much better qualified manpower and equipment, and could provide better services than a solopractice clinic could. This would improve the quality of care and restore the public confidence.

To avoid complications, red-tape and feelings of discrimination as to fees and payment of the health personnel, Dr. Yang suggested forming health committees drawing from people in the communities served, medical and laymen, to decide salaries and employment conditions. He also suggested a general revenue, such as a health tax, to finance such ventures. These group practice clinic directors should be appointed directly by each health committee and not by the Gun chief or province. Dr. Yang felt that the fee-for-service payment system has many defects. It discriminates against poor patients, and results in a commercial ceiling of health care. It can also lead to unscrupulous medical practices whereby doctors keep patients under treatment unnecessarily to obtain more money.

Concerning KHDI's future role, *Dr. E. Hyock Kwon, Seoul National University* suggested that KHDI act as a health service research council. Secondly, he suggested further efforts toward defining exactly "primary health care". Thirdly, he pointed out that there is very poor research on a health manpower development plan. He stressed the need for a comprehensive manpower development plan that can remain flexible to reflect new research findings and creative solutions. He was concerned about government acceptance of such a plan, urged that it be realistic, and submitted carefully to win approval and acceptance.

*Dr. Hyung Jong Park, KHDI* responded with some observations on primary health care. He said that in developed nations, leaders recognized the importance of primary health care. This idea should prevail in Korea's national health service program. The government as well as many private industries are building modern hospitals, and this could have harmful effects. He pointed out that new hospitals with well-paid qualified staff will upset existing private practitioners who simply cannot compete. They would be wiped out, leaving patients no alternative except to pay the higher prices a large modern hospital would charge. Medical costs would spiral.

Dr. Park felt that certain government rules and requirements to these hospitals could help curb this trend. These hospitals should be required to extend primary health care to surrounding communities. Without this, no patient would be referred to the hospital, and its only business would come from patients who could afford to pay.

Another point he made was that primary health care depended on community participation and the Saemaul movement should be employed to further this end. His third point concerned "grass roots" level medical care. He emphasized that non-medical health personnel can only be effective insofar as they are supervised and supported well by the community, and only if the patient referral system is well-utilized. A problem is how to finance the referral system. There must be some provisions devised. Fourthly, recommendations must be made for health education of the public.

Dr. Park also questioned the wisdom of socialized medicine at a time when Korea's health care is performed 80% from the private sector. He agreed with Dr. Yang's per-capitation fee basis rather than a fee-for-service system, but suggested that the new system may require a great deal of effort.

*Dr. Jae Mo Yang, Yonsei Univ.* commented that people prefer coming directly to hospitals (especially in Seoul) rather than seeking primary health care from local solo-practice clinics. In reference to Dr. Park's suggestion that every industry-built hospital be required to have a primary care program attached, he felt it was unfeasible and likely to produce friction with local practitioners rather than cooperation as health care team members. He felt therefore patients would still by-pass it and come directly to the hospital. He suggested a system whereby everyone should be under a primary care obligation, and could only go to a hospital by referral of a primary care doctor.

Regarding socialized medicine, Dr. Yang stressed that "socialized" doesn't mean that every doctor is an employee of the government, but it means that the government takes responsibility for health care of every citizen of the country. The socialized medical care system, therefore, could utilize existing private practitioners and private institutes, and Korea, particularly, should not ignore these resources in the private sector.

*Dr. Sei Kyung Kim, Korea Univ.* praised the group practice idea, but noted there would be some difficulties in getting doctors to these areas. Why not incorporate 2-3 Guns instead of 2-3 Myuns, as it would be easier to find doctors? The guiding factor should be the size of the area or

population covered not the per capita ratio. Although the idea seems good, already there are complaints on both sides, from doctors and patients.

*Dr. Jae Mo Yang* answered by clarifying the character of the group-practice type primary medical care center. The goal would be to have one group practice clinic for every several townships, or 2-3 per Gun; until such time as resources are available so that one per township is feasible. The doctors in these clinics would be paid either based on a salary or on flat rate per capita of people served. Financing will be either by general local revenue (health tax) or compulsory insurance and this fund would pay for personnel salaries, medical supplies, and hospital fees for the patients referred. This avoid would doctors overtreating patients to make money, and doctor's over-referring patients to avoid working too hard. In case of compulsory insurance, really poor people should be exempted from the contribution though. There is no difference as consumer of medical care service between those who pay a contribution and those who do not.

*Dr. Chong Kee Park, KDI* emphasized that primary or preventive health care ought to receive the highest priority, so the pattern of allocation of health resources must also change. But presently so much data is lacking in regard to exactly what Korea spends on health and how this expenditure is divided among different health activities. Without this kind of data it is very difficult to plan logically.

*Mr. William E. Paupe, AID/K* reminded the group that KHDI is currently exploring a health-maintenance system or rural insurance scheme similar to Dr. Yang's proposal. The purpose of KHDI is to explore several methodologies in the hope that one will prove workable. He thanked everyone for their participation.

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