The Effects of Economic Crisis on Health: An Overview of the South Korean Case*

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This article examines the social and individual implications of the recent economic crisis in South Korea. It argues that although people's experience with economic crisis may differ considerably depending on a variety of circumstances, prolonged economic hardships, nevertheless, cause a serious threat not only to their health, but also to their quality of life in general. It goes on to suggest that the social policies designed to respond to the current economic instability in Korea are both narrow in scope and ineffective. This article concludes with a recommendation of some necessary factors which must be considered in formulating a long-term future policy, placing special emphasis on the reform of social services.

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I. INTRODUCTION

The 1997 economic crisis along with the International Monetary Fund (IMF) bailout fund that soon followed, have been responsible for much of the social instability found today in Korea. Although on the surface, the crisis appeared to be a financial one in nature, it was, in fact, a crisis that challenged the very fabric of Korean society. The profound influence the crisis has had and still has on Koreans is illustrated clearly by some of the economic figures presented by the National Statistical Office (NSO). As of February 1999, more than 10,000 firms have filed for bankruptcy and the number of unemployed due to financial and corporate restructuring have reached 1,078,000 persons, meaning that 8.7 percent of the workforce is unemployed. Even with the optimistic estimations of a two percent economic growth in 1999, the unemployment rate is expected to climb for some time to come. Not only has the unemployment level experienced a serious rise, but the length of the unemployment period has also increased. In 1998, the average length of unemployment was between four and five months. In 1999, however, it extended to approximately six to seven months. Furthermore, the percentage of long-term unemployment for more than one year is expected to increase from 1.2 percent in 1998 to 7.1 percent in 1999 (NSO 1998).

The social unrest deriving from such an economic crisis surfaces in various forms. An increasing crime rate, widening disparity between the poor and the rich, and intensifying conflicts of interest between business and labor are some of the major identifiable social problems. The government policies designed to remedy problems such as social unrest are mostly directed at economic issues. Although it may be possible to address these problems by directly tackling the economy and thereby eliminating its side effects, the nature of social unrest experienced by Korea is such that short-term economic policies will fail to adequately and sufficiently deal with the depth and scope of the crisis. The deterioration of the quality of life for Koreans since the economic crisis becomes a major problem in a country where social policies, or social safety nets, are inadequate to say the least.

In light of the state's historically strong emphasis on "growth first" policies, the government can not be expected to sufficiently allocate its scarce resources to welfare policies to create an effective and meaningful social safety net. As shown in Table 1, the share of social development-related expenditure is particularly small. The Korean government has, thus far, allocated less than ten percent of its budget to welfare services. Due to the small percentage of budget allocated to welfare, the state has to prioritize welfare services - medical care protection, pension for those who are able and willing to join (for example, government employees or workers in big firms), state support for the handicapped, the poor and the old, and housing - in order. The result of this policy is summarized in the outline of the social security system in Korea in Table 2. There have been virtually no social programs for those who need it most.

TABLE 1. GOVERNMENT EXPENDITURE BY SECTOR IN KOREA (1975-1995)

Sector	(unit: percent)				
	1975	1980	1985	1990	1995
General Administration	11.3	9.7	10.1	10.2	10.8
Defense	8.8	35.6	30.6	25.2	23.0
Economic Development	26.7	21.5	16.1	19.2	22.2
Education	12.7	17.7	20.1	20.4	18.8
Social Service	6.7	6.4	6.8	8.9	8.3
Other	13.8	9.1	16.5	16.1	16.9

Source: Seo, 1998.

TABLE 2. OUTLINE OF THE SOCIAL SECURITY SYSTEM IN KOREA, 1998

Social Security Program	When Commenced	Coverage (%)
1. Social Insurance		
Pension Insurance	1960	
(National Pension Insurance)	(1989)	(47.4)
Industrial Accidents Compensation Insurance	1964	62.4
Health Insurance	1977	100.0
Employment Insurance	1995	51.8
2. Public Assistance	1961	3.3
3. Social Welfare Services		
(Welfare programs for senior citizens, women and children, the handicapped, etc.)	1961	-
4. Social Security Related Programs		
(Scholarship for needy students, housing support for the poor, etc.)	1954	-

Source: Pascha and Kwon, 1998.

A limited amount of budget also requires the dependency of social welfare services on the private sector. Although virtually the entire Korean population is covered either by the compulsory National Health Insurance or by Medicaid, Table 3 shows that it is mostly funded by private sources. Under the current system, 75 percent of physicians and hospitals are also in the private sector, as shown in Table 4. They are reimbursed for their services by third parties such as Health Insurance Societies, and are supplemented by the patient's co-payments. The reimbursing scheme, called fee-for-service-schedule, sets a fixed point for each medical service performed, and providers of medical services are then reimbursed in proportion to the sum of the total points. It has been generally argued that the schedule tying points to the fee is set excessively low so that physicians sometimes over-treat (provide unnecessary but more profitable treatment) patients with low quality service.

TABLE 3. NATIONAL HEALTH EXPENDITURES AS A PERCENT OF GDP AND PERCENTAGE DISTRIBUTION OF NATIONAL HEALTH EXPENDITURE BY SOURCES OF FUNDS (1985-1994)

Year	Percent Of GDP	Sources of funds								Total
		Public				Private				
		Gov't	SHI	WI	Total	OOP	PI	Others	Total	
1985	4.65	8.6	16.6	2.2	27.4	55.0	4.5	13.1	72.6	100.0
1986	4.45	10.0	14.7	2.3	27.0	56.7	4.6	11.7	73.0	100.0
1987	4.29	9.3	15.2	2.2	26.7	57.7	4.8	10.8	73.3	100.0
1988	4.46	10.2	16.4	2.1	28.7	55.2	5.0	11.1	71.3	100.0
1989	4.93	10.4	16.9	1.8	29.1	56.7	5.2	9.0	70.9	100.0
1990	5.07	11.3	19.7	1.9	32.9	53.9	4.3	8.9	67.1	100.0
1991	4.94	11.8	16.5	1.7	30.0	57.1	4.7	8.2	70.0	100.0
1992	5.32	10.5	16.9	2.0	29.4	55.9	4.5	10.2	70.6	100.0
1993	5.37	10.1	17.1	1.6	28.8	56.2	5.0	10.0	71.2	100.0
1994	5.34	9.6	17.4	1.5	28.5	53.5	5.3	12.7	71.5	100.0

Note: SHI : Social Health Insurance

WI : Workers' Compensation Insurance

OOP : Out-of-pocket

PI : Private Insurance

Source: KIHM, 1998.

TABLE 4. NUMBER OF HOSPITAL BEDS IN PUBLIC AND PRIVATE SECTOR (1985-1995)

Sector	1985	1990	1995
Public	17,385(25.0)	21,068(26.0)	35,241(25.1)
Private	52,168(75.0)	68,658(74.0)	105,380(74.9)
Total	69,553(100.0)	92,726(100.0)	140,621(100.0)

Source: Korea Hospital Association, Annual Report, various years.

Although the shift in emphasis from economic growth to a higher quality of life has become a critical issue in recent years, the state's efforts in welfare development have not improved much since the economic crisis occurred in 1997. Individuals and families have been largely responsible for their own quality of life. This fact presents an extremely daunting prospect in overcoming the negative impact that the crisis has had on the mental and physical health of the Korean people.

Unfortunately, there has not yet been a systematic analysis of the true effects of economic crisis on the individual, community, and society as a whole in Korea. The United States and Europe, on the other hand, have managed to accumulate research that sheds light on the relationship between economic recession and quality of life. Among the voluminous worldwide literature on economic hardship and health, there has been a general consensus that a large majority of the unemployed suffer from

physical and psychological impairment. The Great Depression and the early 1980's recession both in the United States and in Western European countries stimulated extensive research on the effects of unemployment (Fryer and Payne 1986; Svensson 1987; Liem and Rayman 1982). Compared to Great Depression literature where qualitative case studies were the predominant mode of analysis, the more recent works tend to rely on statistical analysis of individual data (Jahoda 1988).

These studies on economic recession and health can be categorized into two different research approaches. One is the traditional social and psychological approach which relies on interviews and questionnaires as the main source of research. It can be referred to as the micro-study of economic recession and health, for it focuses on the personal experiences of unemployed individuals (Jahoda 1988; Iversen and Sabroe 1988; Liem and Liem 1988; Dooley and Catalano 1988). Another research approach on economic recession and health is the social epidemiological approach, which uses aggregate data to analyze the effects of large-scale economic changes on the quality of life of the whole population. A well acknowledged work at this level is that of Brenner's, who raises the question of how mass unemployment is related to various indicators of social pathology (Brenner 1987a,b,c).

This study aims to evaluate whether the common results of the past studies mentioned above can be found in today's Korean society through the currently available figures and social problems afflicting quality of life and the status of health. Considering that Korea has not experienced a severe economic recession let alone a crisis since it began its development efforts in the 1960s, studies and data on unemployment and its relation to health are scarce. Another reason behind this scarcity is that the effects of economic recession on health require years to emerge, particularly in the form of aggregate data, and in the case of Korea, it has been under two years since the government officially requested the IMF bailout fund. However, there have been hundreds of cases reported everyday indicating possible negative influences of the economic crisis on the health of the people. Thus, the need for discussion of the relationship between economic hardship and health in order to determine the social implications of economic crisis is urgent.

In the following section, social changes in people's daily lives since the economic crisis that may negatively affect their health status will first be examined. Then, the effects of economic crisis on health will be explored in both demand and supply dimensions of health care. As a means of investigating the demand for health care, available macro data and micro-level studies on social psychology will be reviewed. Also, the way in which the health care system is evolving to meet this challenge in demand and the social implications of such a process for people's health will be discussed. Due to the nature and limitation of the data available so far, this study does not attempt to make a definite conclusion about the negative effects of the economic crisis on health. It will rather focus on various implications of the social and health problems that have been emerging from, and the harmful social effects of, the economic crisis. Finally, the paper will critically scrutinize the current policies being implemented, and suggest possible

policies necessary to enhance the quality of life in the midst of economic crisis.

II. ECONOMIC CRISIS AND SOCIAL CHANGES

Unemployment and Living Conditions

The most prominent change in Korean society as a result of the economic crisis is rising unemployment. Unlike Western countries that have experienced regular and cyclical economic recessions, Korea has experienced continual economic growth until the recent crisis. Thus, the sudden and rapid increase in unemployment has become a major social problem as shown in Figures 1 and 2. Examining the unemployment situation in detail, statistics show that in the past year the rate of unemployment has quadrupled from a pre-IMF rate of 2.3 percent, and such a trend is expected to continue for some time to come. Unemployment in Korea is due to a shrinking demand in the labor market and massive layoffs as a result of restructuring efforts in the business sector. Of those unemployed for a period of less than a year, 43.7 percent have responded deteriorating business performance to be the reason behind their loss of work. Other reasons include early retirement, honorary retirement and layoffs for 16.8 percent, and shutdown or closure of workplace for 12.6 percent, all of which are direct consequences of IMF-guided business sector reform (Yoo 1998). In addition, the length of the unemployment period has increased. Those unemployed for a period of longer than six months is approximately 24.1 percent this year. Unemployment is expected to quickly spread from the less educated and unskilled to the highly educated and skilled. The

FIGURE 1. UNEMPLOYMENT DURING THE PAST 35 YEARS IN KOREA

Source: Lee and Kim, 1998, 23.

FIGURE 2. RECENT DEVELOPMENT IN EMPLOYMENT IN KOREA

Source: Lee and Kim, 1998, 24.

labor market is experiencing a situation where the latter is undergoing downward mobility in work, squeezing the former out of the job market. Hence, a greater increase in the number of unemployed of the less educated and unskilled workforce is also expected (Korea Labor Institute 1998).

This situation decreases the living standards of the overall population in general, but those who are most affected are from the low-income class. According to the National Statistical Office, household earnings in the lowest 20 percent income strata have decreased by 14.9 percent, while those of the highest 20 percent income strata have slightly increased by 2.4 percent, as presented in Table 5. Due to a decrease in income, household consumption has also significantly reduced an average of 16.8 percent for the low income group. The average consumption level of the middle class has experienced the steepest decline with 18.9 percent (NSO 1998b).

TABLE 5. CHANGES IN URBAN HOUSEHOLD INCOME
(THE FIRST HALF IN 1997 VS THE FIRST HALF IN 1998)

Household's Income Quintile	Total Income	Labor Income
1 st quintile	-14.9	-13.0
2 nd quintile	-8.8	-5.6
3 rd quintile	-6.9	-4.2
4 th quintile	-5.5	-2.2
5 th quintile	2.3	-0.6

Source: National Statistical Office, 1998b.

Another health-related factor that has experienced deterioration is the quality of the living environment. A 1998 study of residents of Seoul City and the suburban areas showed a continual rise in the ratio of home owners, an increase in living space per family, and an improvement in living facilities in pre-IMF Korea. But those who have moved residences post-IMF have generally relocated to less desirable areas. The number of homeowners has decreased from 25.8 to 18.9 percent, living space per family from 19.2 to 18.3 square feet, while one room family occupants have increased from 10.8 percent to 12.9 percent (Cho 1998).

In relation to living conditions, an emerging problem that has been identified is an increase in the number of homeless. According to past western studies on the relation between the living environment and health, compared to an average person, a homeless individual is 2.5 times more likely to make hospital visits and is 3 times more prone to illnesses such as chronic respiratory disease. Also, the prevalence of asthma among homeless children is twice that of average children. These health indicators suggest that a poor living environment has a direct negative effect on health (Breakey et al. 1989; Wright 1990; Goldblatt 1990).

In light of the studies mentioned above, the fact that the type of housing in Korea is undergoing a shift from ownership to renting, monthly renting, and homelessness, suggests the possibility of future increase not only in respiratory and infectious diseases in the future, but negative health consequences in general. The number of homeless in Korea has increased from 1,000 in February 1998 to 6,000 later that same year. Of this six thousand, 71 percent are so-called "IMF homeless." Approximately 70 percent of the IMF homeless had daily employment, confirming again that the biggest victim of the economic crisis is the low income class (D. Kim 1998).

Disintegration of Families

Most studies that examine the relationship between economic crisis and health on an individual level have shown that social networks play a very important role in the relationship as a mediating variable. Particularly in a country where the government lacks experience managing social problems deriving from economic downturn, and where institutional safety nets remain undeveloped, the social network of family and friends can become a vital source of alleviation. Western studies show a correlation between unemployment and divorce rates, and suggest that unemployment has a negative influence on the husband-wife and parent-child relationship, giving rise to various forms of stress, conflict, and tension (McLoyd 1990; Molnar et al. 1990; South 1985). Therefore, unemployment does not merely lead to financial difficulties, but it also increases the possibility of a change in family dynamic. On the other hand, some studies on the Great Depression suggest that in times of crisis, families form a tighter bond, becoming a major facilitator in overcoming hardship. Such contrasting outcomes in the studies indicate that depending on different variables, the results vary considerably (Moen 1979, 1983).

The available data tend to support the former hypothesis. According to one such

study, unemployment of the head of the family (or the breadwinner) negatively influences a child's emotional condition. The sample size for this research consisted of 336 students including 112 children of unemployed families. The ratio of the level of emotional instability of children from unemployed families to employed was greater. The study shows in detail that parental attitude strongly correlates with the child's emotional state. If both parents are seen to demonstrate negative attitudes such as disinterest, defensiveness, and aggression, the children showed a high level of emotional instability, while children of those parents whose attitude remained relatively unchanged experienced relatively less instability. This pertains not only to parent-child relationships, but to husband-wife and other family relations as well (Lee et al. 1998).

Nineteen ninety eight reports from the Korea Legal Aid Center for Family Relations show that families have been disintegrating at an increasing pace. Of the total number of cases consulted in 1998, 60.7 percent was divorce-related, an increase from 51.1 percent the previous year. Among the reasons for divorce, 23.6 percent of the cases were related to financial conflict, 14.5 percent to debt, 11 percent to gambling, and 8.8 percent to economic incompetency, all of which are closely linked to financial instability (Lee 1998). This suggests that in Korea, the family unit cannot fulfill its positive role as mediator in the face of economic crisis. This leads to the conclusion that without strong social safety nets, Koreans will experience greater health risks.

The discussions and data provided above are by no means extensive, but it does sufficiently indicate to what extent and in what ways people's daily lives are being threatened by the economic crisis. We can then probe deeper and examine how these social changes affect the health of an individual and his family. The section below illustrates that there has been an increase in demand for, but a decrease in the supply of health care since the economic downturn.

III. DEMAND DIMENSION OF HEALTH CARE

Physical Health Problems

Previous macro-level studies on the relationship between economic crisis and health have reported that an increase in unemployment due to economic crisis leads to an increase in mortality risk as a result of increases in cardiovascular and renal diseases, liver cirrhosis, as well as an increase in the infant mortality rate. Such studies examine the relation of economic recession to health by using a longitudinal approach in order to analyze the changes in people's state of health after experiencing an economic recession. According to such studies, the time lag for negative effects to appear is on average six years. In the initial phase of financial difficulty, the death rate among the poor and the suicide rate increase, but there is a time lag of five to six years for such an effect to emerge for the general population. Also, the relationship between the rate of unemployment and death showed a curve that reached its peak at two to three years and shows a time lag of an average of six years (Brenner 1987a, b, c).

The necessity of a time lag to determine the effects of an economic crisis on health indicates that it is premature to draw a definite conclusion on the negative effects of the Korean economic crisis on the health of its citizens. Also, due to the scarcity of systematic research on the relationship between economic crisis and health, it is difficult to determine whether hypotheses of existing Western research can also be applied to the Korean experience. The following studies thus far conducted on Korea, nevertheless, imply that economic crisis does threaten the well-being of its population.

First, the death rate due to a stroke or heart attack in the first half of 1998 has risen 16 percent from the year before, and the rate of increase has been faster than before (Ministry of Health and Welfare 1998). According to figures provided by a university hospital, the 21 patients were admitted to emergency rooms for acute myocardial infarction between January and March 1998, twice that of last year. There has also been an increase in the number of patients under the age of 45, from one to ten patients, in a year (D. Kim 1998).

It appears the use of medical services by the middle-age population, between 30 to 55 years of age, and the elderly has relatively increased since the economic crisis. This is attributed to an increase in various diseases related to blood pressure and the heart, illnesses triggered by stress. Figure 3 illustrates the changes in the ratio of age groups making use of medical insurance in 1990, 1994 and 1998. The figures demonstrate that while youth make increasingly less use of medical services, the trend is opposite for the older population. What is significant, however, is drastic increase in the use of medical facilities by the middle-age population in 1998 compared to both pre-crisis years of 1990 and 1994.

FIGURE 3. CHANGES IN THE RATIO OF AGE GROUPS MAKING
USE OF MEDICAL INSURANCE

Source: Shin et al., 1999.

There has also been a report of a noticeable increase in patients with hepatitis type A as a result of deteriorating sanitary conditions in their living surroundings, which is again related to economic difficulties. According to research conducted by the Korean Liver Association on patients with hepatitis type A in 85 major hospitals throughout Korea from July 1996 to June 1998, the number of hepatitis patients increased from an average of 14 in November 1997 to 64 patients in December 1997, an increase of 4.5 times. This trend steadily rose in 1998 with 98 patients in January, 136 patients in February, 155 patients in March, 217 patients in April and 332 patients in May (Choi 1998). Since hepatitis A is prevalent in less developed countries where unsanitary living conditions make it possible for hepatitis A to spread and thrive, we can derive that deteriorating living conditions is a serious concern as the economy worsens.

At the same time in the district of Seoul, occurrences of tuberculosis that previously showed a decrease from 2,178 cases in 1995 to 1,816 cases in 1997, exhibited a reverse effect with an increase of 2,071 cases in November 1998, actually exceeding the number three years before (MOHW 1998). According to a study conducted by the Korean Association of Tuberculosis in May 1998, of the 2,432 homeless 9.5 percent, or 231 people, were diagnosed with tuberculosis (Cho 1998). Although the statistics cited above were from research conducted within a short-term time framework, it illustrates the fact that the economic crisis has begun to seriously affect the health of Korean people.

One of the most critical health problems produced by economic crisis has been the sale of bodily organs. The process involved in organ transplantation in Korea has generally been through informal channels, and has yet to be institutionalized into a legal procedure or systematic management. There are only a handful of hospitals with centers for organ transplant, where contacts between the donors and receivers are arranged and operations take place. With the recent economic crisis, the number of organ donors has suddenly increased. The number of organ consultations at a major hospital increased to three to five cases from half to one case. A majority of those consulted were predominantly male and in their forties during the pre-economic crisis. Recently, however, the demographics have broadened to include those in their thirties and forties and an increase in the number of females (Cho 1998). This indicates that there are an increasing number of desperate people who must resort to selling their bodily organs for survival. Without proper legal procedures and management guiding the organ transplantation process, the situation becomes more alarming. In light of this new problem, the special committee of Health and Welfare in Congress has just recently drafted a bill that acknowledges brain death and permits organ transplantation of a person over 16 years of age. If passed in the Parliament, it will be implemented in January 2000.

Mental Health Problems

It is too early to come to a definite conclusion on the effects of economic crisis on a population's mental and physical well-being using macro-level data. The effects on the social psychological well-being of an individual, however, can be determined with greater accuracy by examining the available survey responses. In this section, we will

review the findings of such studies in an attempt to understand the depth of negative effects of the economic crisis on the physical and mental health of the Korean population.

According to a survey study on the physical and mental health of 447 unemployed, 24.1 percent responded as having had to make a visit to the hospital for a new ailment after losing work (Lee and Lee 1998). The findings report that the rate of new ailment increased for groups that experienced unemployment for a prolonged period of over a year. Although the question of whether their newfound illness is a direct cause of loss of work does not go unchallenged, most illnesses were found to be related to stress resulting from unemployment, proving indirect correlation. Most of the respondents were suffering from at least one physical malady since the loss of work, and among them, severe headaches and insomnia were the most common complaints with 74.3 percent and 56.8 percent, respectively. Asthenia and changes in weight have also been cited with 21 percent and 20.6 percent, respectively. They also found that approximately 34.1 percent of the unemployed considered suicide, 51.3 percent among those unemployed less than a year. The statistics reveal that in a country where job security has been relatively stable throughout its economic growth, loss of work becomes a reason for tremendous shock. These figures give support to western findings that state that negative psychological conditions, such as suicide contemplation, are highest immediately after an economic recession sets in. Also, from examining the responses of 76.1 percent of the unemployed who said they felt a strong urge to blame someone for their financial difficulties, we can speculate that for Koreans, unemployment is considered to be an unexpected and very stressful life event. It has long been acknowledged that major changes in life, such as unemployment or the death of a spouse, act as a "stressor," thereby affecting the immune system and hormone secretion, which ultimately harms an individual's physical well-being.

One of the most frequent ways in which people cope with stress aggravated by economic crisis, and in the process abuse their health, is through drinking-related activities. There are two contrasting arguments in prior studies on economic crisis and drinking habits. One is that unemployment due to an economic crisis decreases the potential to consume alcohol (Seeman 1992; Hammer 1991). The other argument is that consumption of alcohol increases due to stress and with it, breeds various social problems (Brenner 1975; Catalano et al. 1993). Hence, the former study suggests that there is no significant relationship between unemployment and alcohol consumption. The latter detects a positive relationship between the rise of unemployment and rises in alcohol sales, medical facility use due to alcohol abuse, alcohol related crimes and finally, death due to liver disease. In Korea's case there is insufficient data, as of yet, to draw the conclusion that economic crisis leads to alcohol abuse. There are, however, isolated instances that give support to the former study. For example, the main cause of the rise in family disintegration since the economic crisis was attributed to drinking habits and physical abuse by the unemployed member of the family, in most cases the father (Lee 1998). Also, according to the Prosecutors Investigation Office, the number of those prosecuted from drinking-and-driving cases approximately quadrupled in 1998 (ChosunIlbo 1999). Since Korea's economic recession and restructuring efforts are

expected to cause a continual rise in unemployment, we can expect to face various problems in people's health in the foreseeable future.

However, many studies show that rather than having a direct effect on the physical and psychological well-being of an individual, the negative impact of economic crisis appears through mediating variables. Taking into account the report by Rabkin and Streuning (1976) which states that a direct correlation of independent variables to stress-i.e., economic hardships-and health is less than ten percent, there is a fair chance that the relationship between economic crisis and health results from an interaction between several variables.

In Korea, it has been suggested that individual attributes such as sex and personality, as well as social attributes such as social support and access to welfare systems, are variables that alleviate or accentuate the harmful effects of stress caused by an economic crisis. The two studies by Kim and Noh (1998) and Whang et al. (1998) highlight that social relationships such as family and friends work as influential variables to economic stress. Although on many occasions, one can seek understanding and assistance in social relationships, an individual subject to an increasingly high level of economic stress was seen to feel constantly judged and criticized by the very same relationships. This finding suggests that as an economic crisis continues, it diminishes the mediating role of social networks and reduces social sympathy. In Korea, where family takes on the role of a social safety net, conflicts in such relations cause an individual to lose the resources needed to overcome the economic crisis, ultimately making himself more vulnerable to it.

IV. SUPPLY DIMENSION OF HEALTH CARE

The negative implications an economic crisis has on the well-being of the population as explained in the previous section suggests the need for public and private institutions to provide necessary assistance to secure people's quality of life. One thing that must be examined is whether or not social resources for assistance are being adequately and sufficiently provided for. In this section, problems in social and medical resource distribution will be pointed out and some of the social changes that have a negative influence on people's health will be discussed in the next section.

Health Care Spending

The crisis becomes dire when we examine how much individuals and the government are spending to cope with the aforementioned health problems. Since the economic crisis, the average household expenditure on health has decreased by 17 percent while government expenditure on health care declined approximately 7.1 percent (NSO 1998b). While this decline in health spending is relatively low compared to the decline in overall government expenditure, the demand for medical care has increased at a rapid rate, signaling grave consequences. According to the National Health Insurance Corporation

(NHIC) and as can be seen in Figure 4, the rate of increase in medical consultation fees and the number of consultations was at its peak in 1995, but drastically fell, along with the decline in GDP, post-crisis.

FIGURE 4. CHANGES OF GDP, MEDICAL COST AND CONSULTATION

Source: Shin et al., 1999.

Spending on drugs and medicine on an individual level, including traditional oriental medicine like herbs, showed the largest decline with 19.7 percent, and medical services also declined by approximately 3.1 percent. Also, as illustrated in table 6, whereas general hospitals experienced a decline in the rate of patient visits after the crisis, that of government health centers showed a dramatic increase. This fact indicates that since the crisis, due to the average decline in income for low- and middle-income households, there has been a trend in seeking medical services from relatively low-cost medical centers.

TABLE 6. CHANGES IN THE RATES OF PATIENT VISITS BY TYPE OF FACILITIES

(unit: percent)

Types of Health Facilities	Before IMF (1996-1997)	After IMF (1998)
General Hospitals	11.3	2.0
Hospitals	7.9	2.6
Clinics	8.7	1.6
Health Centers	13.3	73.3
Drug Stores	15.0	11.5

Source: National Federation of Medical Insurance, 1999.

When examining household expenditure by income level, low-income families have

shown an increase in their medical spending while high-income families showed a decline by a greater ratio, as presented in Table 7. In other words, low-income families are faced with a situation where greater spending on medical goods and services is necessary because of the negative health effects of the economic crisis. On the other hand, the middle and high-income families have managed to cut their spending on so-called luxury medicinal goods and services like herbs and medical check ups, creating a general decline in medical expenditure.

TABLE 7. CHANGES IN URBAN HOUSEHOLD HEALTH EXPENDITURES
(THE FIRST HALF OF 1997 VS THE FIRST HALF OF 1998)

		(unit: percent)
Households	Income Quintile	Health Expenditure
1 st	quintile	8.7
2 nd	quintile	12.2
3 rd	quintile	-13.6
4 th	quintile	-5.0
5 th	quintile	-19.4

Source: National Statistical Office, 1998b.

Data from the National Federation of Medical Insurance (NEMI) support the above hypothesis. There were 3,857,000 cases for a request for health insurance payment submitted in December 1997, reaching its peak in March 1998 with 5,851,000 cases but declining slightly in September. The number of people visiting drug stores for prescription drugs also reached its highest point in March while reaching its lowest level in September (NEMI 1998). It can be speculated that those who felt burdened by medical expenses due to unstable financial conditions settled for visits to drug stores, but since the decline in income in March, people are now even reducing their spending on medication.

Whether the decline in medical spending has had direct negative consequences is difficult to answer at this point in time because there are known cases in other countries where the decline in medical spending actually resulted in the decline of unnecessary medical spending. On the other hand, it would also be difficult to conclude that less spending on medical care since the crisis has had positive effects on the health behavior of the Korean people, since most of Korea's health care system lies in the private sector and that despite health insurance provision for its citizens, individuals remain responsible for the bulk of their medical bill. It will be more likely to cause greater risk to people's health, ultimately resulting in greater expenses, if people are forced to choose low quality care or not seek help at all.

Lack of Medical Resources

The economic crisis of 1997 first affected the exchange rates, leading to an import

constraint due to the devaluation of the Korean Won. The greatest constraint of all, in relation to health, was on medical resources. As soon as the economic crisis broke out, the Ministry of Health and Welfare (MOHW) released a report titled "IMF-Related Supply Changes in the Medical and Welfare Sector and Possible Policy Suggestions (translated)," dealing with the supply of medical resources and food supplies. This report mainly deals with the problem of medical supplies made unavailable since the crisis due to the rise in the import prices of medical goods and medical supplies. There have also been numerous bankruptcies of medical centers and pharmaceutical companies from financial difficulties (This point will be further discussed in detail later in the paper). One issue mentioned in the report, for example, concerns antibiotics and diagnostic reagents. In the case of antibiotics, although domestic production is possible, because of an increasing number of pharmaceutical companies filing for bankruptcy, production and sales have been put on hold. But more problematic for Koreans is the use of diagnostic reagents, 85 percent (annual worth of \$75 million) of which is foreign import dependent. There is an insufficient amount stored because diagnostic reagents have in the past been traded only in small quantities due to certain characteristics of the product. Compared to the level prior to the IMF bailout, importation of diagnostic reagents was reported to have decreased 46.2 percent in January 1998. This trend implicates that if continued, diagnostic reagents may very well run out within a month in medical institutions.

The seriousness of dwindling medical resources applies to other medical goods as well. Materials for sanitary goods like bandages, gauze, and cotton balls are imported from countries like Pakistan and China, but in February 1998, it was reported that hospitals only have available what is stored. A serious supply deficiency was also experienced in supplies like x-ray film, surgical gloves, sutures, and disposable syringes. For example, Korea depended annually on 850 square meters of x-ray film but at the time of this study, had only enough stored to last until January; surgical gloves for approximately three months; sutures and disposable syringes for one month. Such concerns expressed by MOHW soon became a reality and the quality of medical services offered decreased in many medical facilities.

Another social change related to health was the string of bankruptcies in the medical sector as a result of organizational mismanagement. As reported by MOHW, small- and medium-sized hospitals, medical clinics, and pharmaceutical companies with financial problems have gone bankrupt, and brought on a chain reaction of bankruptcies in the medical sector. According to statistics released in December 1998, among 771 hospitals nationwide, 76 hospitals, which amounts to 9.9 percent, have filed for bankruptcy in the period between April 1997 and March 1998. And among the 76 hospitals, 19 (25 percent) have closed down, 26 (34 percent) have undergone a change in ownership, and 21 (28 percent) have restructured and cut the salaries of its medical staff. Seven are still operating and three have merged with other hospitals (MOHW 1998).

Most bankrupt institutions were small hospitals with less than 30 beds in the private sector, medical clinics that people usually first contact when experiencing health problems. These have an average of 70 percent dependency on outside capital and thus are more

vulnerable to bankruptcy. Since the Korean health care system heavily depends on the private sector, this means that accessibility to medical institutions for the population has been dramatically reduced. General hospitals, which have greater financial burdens from the rising cost of medical instrument rentals, show a decrease in the number of facilities, patients and doctors alike as shown in Table 8. Major general hospitals also face serious problems in financial management. They are managing their budget deficits by actually decreasing the supply of services offered, for example, closing down certain wings and sections in the hospital. Even hospitals that are not on the brink of bankruptcy are experiencing a tight budget squeeze and as a way of cutting back spending, some have laid off its workers or hired less qualified staff. For instance, many aid nurses are asked to work three shifts, overworking them rather than hiring new people. And when hired, they tend to be unqualified and untrained high school graduates. There have even been cases where administrative staff were illegally trained and put to work in the ward alongside the nurses.

TABLE 8. CHANGES IN NUMBERS AND RATES OF GENERAL HOSPITAL FACILITIES, HOSPITAL BEDS, AND DOCTORS (1994-1998)

General Hospitals	(unit: percent)				
	1994	1995	1996	1997	1998
General Hospital Facilities	252 (4.13)	266 (5.56)	271 (1.88)	262 (-3.32)	225 (-14.12)
Hospital Beds	91,172 (11.31)	96,865 (6.24)	100,828 (4.09)	101,615 (0.78)	101,137 (-0.47)
Doctors	21,391 (6.84)	22,683 (6.04)	25,379 (11.89)	26,561 (4.66)	25,797 (-2.88)

Source: Shin et al., 1999.

If medical restructuring is appropriately implemented, such as eliminating the common practice of providing high quality service only for those who can afford it to eliminating the small private clinics providing low quality care, it could improve the quality of services offered to everybody. However, without a coherent policy to address the financial mismanagement of hospitals or a plan to improve the availability of the health care system, the harm is inflicted on those in dire need of service.

V. POLICY IMPLICATIONS

This paper has thus far examined the negative influences of an economic crisis on people's health. Korea has traditionally pursued accelerated economic development, putting aside distribution issues. In the process, neither the state nor its citizens have been able to accumulate resources to fix social problems derived from the economic crisis. The situation currently faced by Korea is a situation where the IMF-guided policies

of economic contraction have led to massive layoffs without sufficient safety nets in place. Under the circumstances, the social and welfare policies should be oriented toward cutting the vicious link between economic crisis, poverty, and its harmful effects on health. At least until the basic social welfare system is set up in Korea, the government should carry out direct economic intervention measures in employment policy and the labor market, social policies to ensure minimum health coverage, and on an individual level, social welfare programs to ease the population's adjustment process. Enhancement in the scope of a national pension scheme, normalization in the price of medical insurance, a clear division of medical and pharmaceutical sectors, integration of a medical insurance scheme, and a general improvement in the medical system are some of the issues that need to be addressed for a long-term effective social safety net to emerge.

The social problem of unemployment due to the economic crisis remains the most serious problem in Korean society today. However, most of the immediate government policies have not effectively addressed this particular issue. Policies initiated by the government have been pension schemes for the unemployed, minimization of unemployment, creation of new jobs, provision of education and retraining, and enforcement of employer and employee networks for the unemployed.

In efforts to maintain the health and quality of life of the unemployed, the provision of a certain level of financial security is a minimal requirement. The government took the most direct form of intervention by increasing unemployment insurance benefits for those working at a workplace of five or more workers. The scope of unemployment benefits has increased 50 percent and the time frame of support has also been extended. However, workers working at a workplace with more than five workers only amount to 32.3 percent of the whole labor force. Also, the unemployment benefits for receivers like farmers and street vendors are eligible from October 1998, but in practice since one has to be insured for at least six months to enjoy the benefits, it was not to be made available until March 1999. Those most affected by the economic crisis, temporary workers with low wages, are not even eligible for unemployment insurance benefits for some time (Pascha and Kwon 1998). Social safety nets must be designed to encompass such vulnerable groups of people and provide immediate assistance. Prolonged unemployment will not only breed negative economic consequences, but also social instability ranging from an increase in crime to an increase in family disintegration. Hence, policies that provide a minimal assistance of survival to those in need must become a priority in minimizing the social impact of the economic crisis.

As for government health policy, a direct approach was taken to alleviate the problem of the lack of medical supplies. In order to relieve some of the financial burdens faced by the health sector, MOHW initiated short-term measures by temporarily widening the range of Medicaid recipients, allowing more time for payments, making loans available for payments, and so forth. However, such measures are limited to a small number of people, failing to provide benefits for the population at large. Hence, in a situation of mass unemployment, the scope of eligibility for medical insurance must be temporarily extended at large, which will help mediate the shock of unemployment for families

and individuals affected.

In addition, taking into account the fact that family networks have historically played the role of a social safety net in Korea, policies should take an inclusive group approach, where whole families with unemployed members are provided assistance, not just the individuals. One suggestion would be for various social or religious organizations to provide professional consultation services to families in need, as well as welfare education lectures where people can learn to deal with stress without resorting to self-abuse.

However, although such services work as temporary relief, for health and quality of life to be enhanced, a systematic social safety net is required. For a long-term social protection system to be established, drastic reform in the current health care system is needed.

The current national health insurance system only covers 25 percent of the total medical bill such as Medicaid. In other words, the low-income strata and unemployed are left to take responsibility for their medical bills, making it difficult to seek medical resources when necessary. Although the government implemented another policy to extend the eligibility for Medicaid to the unemployed and their families, the situation is worse for the homeless, with only 20 percent of the homeless population medically insured. Even prior to the crisis, there were many instances where the medically insured were charged a similar rate with others. Hence, not only were the uninsured homeless inadequately looked after, but those in the low-income strata were no better off. In times of economic crisis, the Medicaid system is clearly failing to meet the true needs of the people (H. Kim 1998). It is urgent that a substantial portion of government reserves should be dedicated to broadening the scope of medical insurance service to encompass both low-income families and the homeless.

This assessment can be applied to the general health insurance system, which covers all Korean citizens. In reality, the individual share is large and since some of the most common services are not applicable for insurance coverage, the current health insurance system is considered to be inadequate and pegged with many problems. The confusion and conflict illustrated by recent debates over the divisive roles between doctors and pharmacists, as well as the integration of health insurance societies and health insurance corporations, are largely due to the government's unwillingness to share the financial burden, leaving it to the health service providers and their consumers. Hence, in order to overcome the shortcomings of the health insurance system, the government must work towards acquiring a sufficient budget to lower individual burden and find a means by which the central or regional government can fully support their health expenses.

Reforms in social services, such as unemployment policy, family welfare, and health insurance, may not appear to be directly related to the current economic crisis and thus they are not given a high priority in the overall reform policy. However, the importance of these social welfare policies must not be underestimated, for they concern the cost-effectiveness of social services, which is in turn directly related to the efficiency of the public sector. For Korea to resume its path of economic growth, social stability must be attained by avoiding band-aid solutions and designing appropriate

social policies to adequately meet the needs of the overall population on a long-term basis. The current economic restructuring may pull the economy out of the crisis, but it is these long-term social reforms that will allow the economy to resume and sustain its development path after the initial recovery. Like the long-term, inclusive social welfare system designed by the United States at the time of the Great Depression and England's Beverage Report after World War II, Korea should take this opportunity to create a framework for a social welfare system that will promote its development in the most substantive sense.

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