Universal but Precarious: A Case Study of the South Korean Health Care System

Green Bae*, Minah Kang**

Abstract

Since its inception in 1977, the development of the National Health Insurance system in South Korea took the world by surprise. In 2001, South Korea introduced a single-payment system. However, in spite of the advancements made in medical technology and services and the fact that the National Health Insurance system covers the whole population, its citizens are seemingly still insecure and often experience precariousness with regard to their health coverage. It is ironic that despite the nearly 100% population coverage, many South Koreans also purchase private health insurance because of their anxiety about the limited coverage of the National Health Insurance benefit package. Even though the health care system in South Korea displays symptoms of precariousness, there is still no academic research that analyzes this concept as an approach to understanding the challenges that face the system. In this study, we examine the suitability of applying three attributes of precariousness, namely uncertainty, disempowerment, and insecurity (both financial and institutional), previously researched in the employment sector, to the health system to analyze how South Koreans experienced them and to explain the precariousness of the health care system at both the individual and institutional levels.

Keywords: Precarity, Precariousness, Health Care Coverage, Fictional Stability

I. Introduction

Universal health coverage (UHC), which is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring

* Special Appointment Professor, College of Pharmacy, Ewha Womans University
** Corresponding author, Professor, Department of Public Administration, Ewha Womans University

This work was supported by the Ministry of Education of the Republic of Korea and the National Research Foundation of Korea (NRF-2015S1A3A2046566). This study has developed as part of a doctoral dissertation.
access to the health care services they need, is a major endeavor to strengthen health care systems by improving the distribution of health and health care services. Margaret Chan, the Director-General of the World Health Organization (WHO) wrote that UHC is “the single most powerful concept that public health has to offer.” In addition, in the context of the right to health, UHC matters because “health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

While the UHC concept is blossoming as a global health agenda, South Korea has often been cited as an exemplary case, for nearly full population coverage was achieved but not in the sense of the “cube model of UHC.” According to the model, not only population coverage but also benefit and cost coverage should be achieved when a system claims to have universal coverage. Despite the nearly 100% population coverage, many South Koreans also carry private health insurance because of their anxiety with regard to the limited coverage of the public National Health Insurance (NHI) benefit package. According to health data collected by the Organisation for Economic Co-operation and Development (OECD) in 2013, 61% of the total Korean population was covered by private health insurance. In addition, the advancement of which, between 2005 and 2013, was higher than that of the United States as well as other advanced countries. Private health insurance coverage rates of other advanced countries in 2013 have decreased since 2005, while South Korea has recorded the biggest increase. Indeed, it is ironic that in South Korea, where the NHI is considered

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to have resulted in the achievement of UHC, people find it necessary to purchase private health insurance to feel secure in case they get sick.

Since its inception in 1977, NHI in South Korea developed rapidly and in a manner that has stunned the world. South Korea also achieved a single-payment system in 2001 through the unification of multiple unions, while many other countries including Japan have still not reached it. However, even though South Korea does have NHI with nearly 100% population coverage and a single-payment system, why do people continue to keep purchasing private insurance in addition to public insurance, which also intends to protect them when they get sick? If the current system in Korea cannot cover adequate health care, it can only be described as fictionally stable. Despite the fact that the system covers the whole population by law and its medical technology and services are surprisingly advanced, it seems that the people do not feel secure about such institutional and technological development.

In this paper, we suppose that this paradox is the manifestation of the precariousness experienced by the Korean people about their health care system. On the basis of this notion, we tried to identify the multidimensional aspect of the concept, especially the attributes that ensure health security for the Korean people.

Previous precariousness research emerged from Europe, mostly in studies of the employment sector.8,9,10 Brett Neilson and Ned Rossiter said that, in Judith Butler’s *Precarious Life*, “Precariousness is an ontological and existential category that describes the common, but unevenly distributed, the fragility of human corporeal existence.”11 In fact, we are faced with precariousness in all spheres of life, especially in maintaining our health, as it plays an important role in our daily lives. While health care in South Korea shows symptoms of precariousness, there is still no academic research that makes use of this concept to study the health system. In this study, we examine the suitability

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10 Leah F. Vosko, Martha MacDonald, and Iain Campbell. *Gender and the Contours of Precarious Employment* (Routledge, 2009).
of applying three attributes of precariousness, namely uncertainty, disempowerment, and insecurity (both financial and institutional), previously researched in the employment sector, to the health system to analyze how South Koreans experienced them and to explain the precariousness of the health care system at both the individual and institutional levels.

II. The History of the Development of the NHI System in South Korea

The South Korean government enacted the Medical Insurance Act in 1963 and started a mandatory social health insurance program targeting large corporations (i.e., those that hire more than 500 employees) in 1977; the program was expanded incrementally until it included the self-employed. Through this step-by-step enlargement, the NHI was extended further to include the entire population in 1989. Before the single-payer system, there were 370 trusts in South Korea. Each provided different services and cost coverage, according to their financial capabilities. Because of the fiscal gaps between trusts, expanding services and cost coverage were not an easy matter, both politically and practically. Subsequently, the NHI program was integrated into a single-payment system in 2001. Financial integration of trusts was achieved in 2003.

The NHI in South Korea began as a modest service provision system with low cost coverage, because the government’s highest priority was on achieving complete population coverage. The goal at the time was to first achieve full coverage of the whole population and then expand services and cost coverage as the system grew. As a result, South Korea built a single-payment NHI system in a cost-effectiveness framework to provide service coverage for pharmaceuticals and health care technologies. Preventative services are not included in benefit packages except for biannual health checkups and vaccinations. Co-payment rates are, generally, 20% for inpatient care and 35-50% for outpatient care. In practice, however, there are several different co-payment rates depending on the age, types of diseases, hospitals being visited, etc.\footnote{Soonman Kwon. “Thirty Years of National Health Insurance in South Korea: Lessons for Achieving Universal Health Care Coverage,” \textit{Health Policy and Planning} 24, no. 1 (2009): 63-71.}
In 2004, when the NHI recorded a budget surplus, requests for health coverage enhancements blossomed into a movement embraced by civic groups and politicians. The government announced “The First Plan for Benefit Extension (2005–2008)” in 2005, and “The Second Plan for Benefit Extension (2009–2013)” in 2009. These plans included reducing caps on out-of-pocket (OOP) expenses and ancillary burdens of such expenses and enlargement of the services included in benefit coverage. At that time, the policy aimed at reduction of out-of-pocket costs from catastrophic diseases such as cancer. In 2013, the government again announced a benefit enhancement plan for four major conditions that included: 1) expanding coverage to almost all previously non-covered, essential, and elective medical services, except for decidedly non-essential services such as cosmetic surgery; 2) improving benefit coverage in light of current scientific knowledge; 3) reducing high out-of-pocket payments through tiered fees based on income level; and 4) reducing the financial burdens from three major non-covered services including physician surcharges, private room charges, and private charges for custodial care.

Table 1. Chronology of the UHC policy in South Korea

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>Enacted and promulgated the National Medical Insurance Act</td>
</tr>
<tr>
<td>1977</td>
<td>Companies with more than 500 workers began subscribing to health insurance as an obligation (486 health insurance unions established)</td>
</tr>
<tr>
<td>1978</td>
<td>Legislation and enforcement of the National Medical Insurance Act</td>
</tr>
<tr>
<td>1979</td>
<td>Expansion of population coverage of health insurance to include civil servants and private school teachers</td>
</tr>
<tr>
<td>1980</td>
<td>Choen MG, a minister from the Ministry of Health (MoH), suggested a single payment system</td>
</tr>
</tbody>
</table>

15 *Id.*
1981 Companies with more than 100 workers began subscribing to health insurance as an obligation  
Local Health Insurance operations were first tested

1983 The person who was pursuing integration was ousted from the MoH

1986 The flat rate for co-payment began

1988 Nationwide expansion of rural health insurance.  
Companies with more than 5 workers began subscribing to health insurance as an obligation

1989 Rules-for-dependent beneficiaries reformed  
Local Health Insurance in urban areas began  
Pharmacy coverage began

**Phase II: Achievements of the Single-Payer System**

1994 Health care coverage reform committee established  
Extended maximum health care coverage period to 210 days per year  
Expanded the range of dependents

1996 Extended maximum health care coverage period to 240 days per year  
Applied no limit on the period for health care coverage of the elderly and disabled

1997 Enacted the National Medical Insurance Act: the first integration of organizations

1999 Enacted and promulgated the National Health Insurance Act: integration with 140 company unions and the National Health Care Management Corporation  
Enacted National Medical Insurance Act reform: temporary finance separation

2000 National Health Insurance Act enforcement

2001 Unification of NHI management

2002 Enactment and enforcement of special fiscal consolidation of National Health Insurance Act  
(state was the government-funding support)

2003 Financial integration of company unions and local unions

**Phase III: Expansion of Benefit Coverage**

2004 Conversion of non-reimbursement services to reimbursement services (e.g., gamma knife surgery)  
High-level coverage of ambulatory-care copayment in cancer and rare disease  
Initiated the co-payment cap (ceiling) for medical cost  
The Health Insurance Policy Review Committee decided on a $1.5 trillion (Korean Won) coverage expansion to begin in 2005

2005 Conversion of non-reimbursed services to reimbursed services (e.g., MRI and cochlear implant)  
Exceptions for (excused from) co-payment introduced (e.g., natural childbirth and premature baby support)  
Reduced co-payment (psychiatric outpatients)  
Coverage enhancement for severe and high cost-of-treatment diseases such as cancer (reduction in copayment $20 \rightarrow 10\%$ and conversion of non-reimbursed services to reimbursed services)
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<table>
<thead>
<tr>
<th>Year</th>
<th>Changes</th>
</tr>
</thead>
</table>
| 2006 | Exceptions for (excused from) co-payment for inpatients under 6 years of age  
Conversion of non-reimbursed services for severe disease to reimbursed services (e.g., PET scan, organ transplant surgery, chronic obstructive pulmonary disease (COPD) patients with oxygen therapy at home)  
Reduction in co-payment for certain types of cancers  
Health care coverage for prisoners began |
| 2007 | Reduction in co-payment for patients with severe diseases (patient support for rare and incurable diseases)  
Adjustment of fees for health care services (professional rehabilitation and disability and maternal care)  
Co-payment ceiling cuts (₩300 → ₩200 million)  
Reduction in co-payment for outpatients under 6 years of age (70% of adult copayment) |
| 2008 | Adjustment of co-payment for inpatients under 6-years of age (0 → 10%, excluding newborns)  
Adjustment of co-payment of inpatient meals (20% → 50%)  
Prenatal care voucher system implemented |
| 2009 | Implementation of co-payment cap (ceiling) by income level  
Reduction in co-payment for patients with incurable diseases (20% → 10%)  
Reduction in co-payment for rare and incurable diseases in inpatients and outpatients (20% → 10%)  
Reduction in copayment for cancer inpatients and outpatients (10% → 5%)  
Conversion of non-reimbursed services to reimbursed services (sealants for preventing childhood cavities and oriental physical therapy) |
| 2010 | Reduction in copayment for cardiac and cerebrovascular diseases (10% → 5%) |
| 2014 | Announcement of four major disease coverage enhancements (coverage range expansion, selective coverage by severity)  
Reduction in financial burden for three major non-reimbursed services (expense of selecting doctors, the cost of high-level hospital rooms, care-giver costs)  
Co-pay ceiling cuts adjusted by income level |
| 2015 | Establishment of the coverage enhancement plan by life cycle  
Plan for enhancement of tooth implants and dentures in the elderly  
Enhancement support for high-risk pregnant women  
Prosthetic and orthotic support for the disabled  
Health care coverage expansion to include essential treatment at home |

### III. Precarity and Precariousness

#### A. The Dawn of the Concepts

The concept of precarity became prominent as an influential descriptor of social
struggles that spread across Europe beginning in 2003; a precarity movement appeared four years later.17 Within the context of social movements by autonomous political groups, and new forms of labor organization, the term precarity was coined by English speakers as a translation of the French précarité.18 Milanese activist Alex Foti described precarity as “being unable to plan one’s time, being a worker on call where your life and time is determined by external forces.”19 The term comprises a variety of social insecurities, including the exploitation of labor and a lack of reasonable guarantees.20 Neilson & Rossiter refer to other attributes of precarity, including uncertainty, inflexibility, and transformation in the workplace.21 As they note, “[precarity] also extends beyond the world of work to encompass other aspects of intersubjective life, including housing, debt, and the ability to build affective social relations.”22

In a similar context, Martha Fineman23,24 used the terms “vulnerability” and “dependency” describing the states of precarity or precariousness, and maintains that public institutions and relationships can mitigate vulnerabilities.25 Fineman also argued that individual choice can play a role in revealing and defining collective responsibilities among stakeholders. Like Fineman, Judith Butler, in Precarious Life26 and Frames of War,27 describes her perception of precariousness. Butler also suggested that, in such an environment, the human capacity to live with a sense of autonomy and self-agency can thus be easily damaged or harmed. She writes, “Precariousness implies living socially, that is, the fact that one’s life is always in some sense in the hands of the other. It implies exposure both to those we know and to those we do not know;
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a dependency on people we know or know not at all.”

Although “precarity” and “precariousness” are often used interchangeably, they are not synonyms. For example, Neilson and Rossiter distinguished the concepts of precarity and precariousness in their article, “From Precarity to Precariousness.” According to them, precarity is the condition of living a precarious economic existence. It occurs when a certain population has a greater risk of death and suffering than another. In comparison, precariousness is more or less a situation where one’s life is dependent on the lives of others. It is a concomitant ethics of precarity. Lastly, the term, “precariat” is used to describe the group of the workers in precarious situations. All of these concepts have common properties, which are uncertainty, lack of control, and insecurity.

B. Attributes of Precariousness

There is no universal definition of precariousness, neither in terms of “precarious employment” nor à propos to the general concept of “precariousness.” According to Barbier’s article, Agnès Pitrou argued that the concept of precariousness has the following attributes: 1) absence of labor market skills, resulting in difficult working conditions and low wages, as well as the absence of any career prospects, and 2) scarce as well as irregular financial resources; unstable or unsatisfactory housing conditions; health problems; uncertainty about the future number of children; relative lack of social contact.

Laparra emphasized a time-related facet (duration/continuity of employment prospects), a social facet (social rights and protection), an economic facet (security of income), and an element of working conditions as characteristics of the concept of precariousness.

According to Rodgers, “Precariousness involves instability, lack of protection,

28 Id.
29 Neilson and Rossiter, “From Precarity to Precariousness and Back Again,” 2005.
30 Id.
insecurity, and social or economic vulnerability.” Similarly but in more specific terms, Vosko defined the attributes of precariousness as limited social benefits and statutory entitlements, job insecurity and uncertainty, low wages, high risks of ill-health, and lack of certainty. In addition, Vosko argued that the attributes of precariousness should be considered in the context of legal, economic, political, psychosocial, sociological, and statistical insights. She focused on contingent work, flexible work, vulnerable workers, casualization, and segmentation. However, as she pointed out, the most important aspects of the concept of precariousness are quality of work and flexibility.

Throughout various attempts of conceptualizing precariousness, uncertainty is one of the most frequently cited characteristics that usually describe a status where there are no legislative or institutional protections. For example, the employment-strain model referred to uncertainty as its main characteristic. Other aspects such as insecurity or instability, powerlessness or disempowerment, vulnerability, low or insufficient wages, limited rights, and an incapacity to exercise rights are often cited as integral attributes of precariousness.

IV. Attributes of the Precariousness in the Korea Health Care System

Based on the previous literature on precariousness in the employment sector, we applied three attributes of precariousness, uncertainty, disempowerment, and insecurity (both financial and institutional) to explain the precariousness of the health care system that Koreans experience at both individual and institutional levels. Table 2 summarizes

38 Vosko, MacDonald, and Campbell, Gender and the Contours of Precarious Employment, 2009.  
the three attributes of the precariousness concept and mapping results of those attributes to the Korean health care system at both micro and macro levels. The micro level corresponds to the individual dimension and the macro level corresponds to the institutional dimension. The first attribute is uncertainty, which includes the sub-components of instability, lack of certainty, and high risks. The second attribute is disempowerment, which includes various components such as a lack of control, vulnerability, powerlessness, disempowerment, and incapacity. The last attribute is insecurity, which implies a lack of protection as well as insufficient, unsatisfactory, and limited rights.

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Sub-components</th>
<th>Micro-level Experiences</th>
<th>Macro-level Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty</td>
<td>Instability</td>
<td>Aging, genetic and environmental factors for personal health outcomes</td>
<td>Unpredictable policy change processes for population health</td>
</tr>
<tr>
<td></td>
<td>Uncertainty</td>
<td>• A high percentage of people with low self-rated health status and worries about their health</td>
<td>• Policy decision without social consensus, trust, and transparency</td>
</tr>
<tr>
<td></td>
<td>High risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disempowerment</td>
<td>Lack of control</td>
<td>Insufficient resources for using necessary services</td>
<td>Unaccountable decision-making process</td>
</tr>
<tr>
<td></td>
<td>Vulnerability</td>
<td>• Unmet health needs</td>
<td>• Decision-making without opportunities for public participation</td>
</tr>
<tr>
<td></td>
<td>Powerlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powerlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disempowerment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incapacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insecurity</td>
<td>Lack of financial protection</td>
<td>Individual experiences of deficiencies in financial protection</td>
<td>National and institutional level insecurity</td>
</tr>
<tr>
<td></td>
<td>Insufficient, unsatisfactory,</td>
<td>• Catastrophic medical expenditure</td>
<td>• Health services and benefits not covered by the NHI plan</td>
</tr>
<tr>
<td></td>
<td>and limited rights</td>
<td></td>
<td>• Deficient epidemic control system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Purchasing private health insurance in addition to the NHI</td>
<td></td>
</tr>
</tbody>
</table>

**A. Uncertainty**

Health is an intrinsically uncertain issue for human beings. While aging, genetic, and environmental factors certainly are known determinants of diseases, most diseases
often appear without a warning. The causes of many diseases are still unknown to us. It is natural for any human being to be uncertain about when and how they become sick.

It is notable that, at the micro-level, Koreans seem to be more worried and uncertain about their own health status now and for the future than people of other countries. Perceived health status among adults in South Korea is the worst among OECD countries, according to OECD health data. The low level of the perceived health status of a country may result from many factors, including its societal attitude or cultural trait toward health maintenance, as the indicator captures the subjective aspect of one’s health status. Nevertheless, the indicator is mostly widely used, owing to its high correlation with one’s objective health status indicators. In addition, the indicator reflects mental health status, which is also an important component of one’s overall health status.

People’s uncertainties about health security for themselves and their family members may also come from macro-level institutional factors, namely the unpredictable policy making process in South Korea. Currently, there are several governmental committees that make major decisions on the NHI benefit package. The most critical one of these health policy decision-making groups is the Health Insurance Policy Review Committee, which makes most of the critical decisions on adding to or deleting health care services and benefits from the NHI plan. However, it is reported that most Korean people do not know of its existence but assumes that the transparency of the committee is very poor.

Also, at the macro-level, the criteria for policy decision-making on the NHI benefit package are not clearly defined, which makes Koreans uncertain about future changes in their NHI plans. For example, in South Korea, health care coverage enhancement policy has been focused on four major conditions: 1) digestive system diseases, 2)

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45 Bae, A Study on the Precariousness, 2016.
musculoskeletal system and connective tissue diseases, 3) circulatory system diseases, and 4) neoplasms. The health care coverage costs for these conditions account for almost half of the total cost of health care in Korea. Furthermore, coverage rates for these conditions have increased even as total coverage rates have decreased. According to data from the “14-18 Midterm Plan for Health Care Coverage” of 2015, which shows the distribution ratio of catastrophic medical expenditure per family by disease, in South Korea, digestive system diseases make up the largest portion of health care costs, and musculoskeletal system and connective tissue diseases come second. Circulatory system diseases and neoplasm are third and fourth, respectively. There are, of course, several other diseases that entail catastrophic medical expenditure besides these four major conditions. However, despite the significant expenditure for these disease groups, no clear evidence was presented on why these conditions, and instead of other diseases, were chosen for better coverage. Without clearly defined criteria and principles of decision-making, Koreans experience persistent uncertainties about the national health insurance protection in the future when they get sick.

In addition, at the institutional level, no social consensus, trust, or transparency are present in the health care policy decision-making process; rather, this process seems to be often used for a moment of political will-power, credit-claiming, and blame avoidance. In other words, South Koreans cannot be sure of the future prospect for their health and health care coverage. This uncertainty, endemic in this kind of unpredictable policy making process, results in degrees of instability, for example, in the case of coverage expansion policy, which is dependent on the president, or the ruling party, currently in power.

B. Disempowerment

Disempowerment is another main attribute of precariousness in health care. It has been recorded that 17.64% of South Koreans experienced unmet health care needs in 2013, a value that is 2.75% higher than in 2011. The low-income group, older group, and irregular worker group often experienced unmet health care needs due

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to the lack of economic, social, and political resources to access necessary health care services.\textsuperscript{48} According to Huh and Lee (2016), people experience unmet health care needs because of financial or time constraints, the proportions of which have increased steadily from 2011 to 2013.\textsuperscript{49} Indeed, at a personal level, many Koreans experience a lack of control over their health care utilization and health maintenance.

In addition, Koreans experience disempowerment at the macro level, as the policy decisions on the NHI plans are not transparent, and, furthermore, do not provide opportunities for them to voice their opinions. For example, the most recent NHI plan for insurance benefit package was established in 2013 by the Park administration, most of the content is based on President Park’s presidential election pledge. Despite the continuous generation of national insurance coverage expansion policies in presidential election pledges, the health care coverage enhancement policy in Korea has often been skewed toward gaining political benefits for politicians rather than promoting health security for its citizens. Health care policies matter not only for people’s health outcomes but also for their economic status and quality of life. However, Korean citizens do not have knowledge on nor have appropriate access channels to such decision-making. This important procedure never properly included the public in its investigations, nor was public opinion elicited. Despite the NHI being financed by people’s contributions and health care also being funded by taxes from the people, South Koreans still feel that they were not able to affect any policy related to health care.

In sum, at the micro level, people experience disempowerment when they do not have enough resources to access necessary health care services. At the macro level, disempowerment is caused by the lack of programs for citizen participation in decision-making process, which, if appropriately managed, could contribute to the empowerment of the citizenry. A decision-making body, with health care coverage as its priority, should reflect the social values and opinions of the citizens. For this reason, the decision-making body should be representative and inclusive. Furthermore, it should consider collaborating with the citizen participation program, if it is created. When experts and citizens work together and are effective in influencing government

\textsuperscript{48} Id.
\textsuperscript{49} Id.
policy, more reasonable, and lasting, decisions will be achieved.

C. Insecurity

According to the National Health Insurance Corporation’s (NHIC) yearly report on benefit coverage rates since 2004, the rate never exceeded 65%.50 After achieving a single-payer system, the South Korean government continuously attempted to expand benefit coverage. However, the total benefit coverage rate has remained stagnant owing to an increase in the use of non-covered services. In 2013, when the South Korean government implemented a benefit enhancement plan for the four major conditions, the expected reduction in OOP costs was 64% for medical services, 33% for private room charges, and 64% for physician surcharges.51

Table 3. Benefit coverage rate of four major conditions in 2011-201252

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHI coverage rate</td>
<td>77.8%</td>
<td>77.3%</td>
</tr>
<tr>
<td>OOP53 for covered services</td>
<td>6.2%</td>
<td>7.6%</td>
</tr>
<tr>
<td>OOP for non-covered services</td>
<td>16.0%</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

However, benefit coverage rates for the four major conditions were already higher than those for most other conditions and services (Table 3), as the previous benefit enhancement plan focused on three major conditions, including cancer.54 So, there is some controversy about horizontal equity issues, as households that experienced catastrophic financial difficulties within these four major conditions are less than one-third out of the total number of households.55 According to Seo’s study of household

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50 NHIC. The Survey of Medical Expenses (Seoul: National Health Insurance Corporation, 2014).
52 NHIC. Survey on the Benefit Coverage Rate of the National Health Insurance Corporation 2015 (Seoul: NHIC, 2015).
53 OOP indicates out-of-pocket costs of patients for health care services that are not covered by the NHI benefit basket and co-payment for certain services.
catastrophic health expenditure (CHE), 3.69% and 4.26% of the households were found to be facing CHE in 2010 and 2011, respectively. Unfortunately, utilization of non-reimbursement health care services has continued to increase, increasing the burden on patients and their family members.

As a result, out-of-pocket medical spending as a share of total household consumption in South Korea is the highest among OECD countries. In 2014 WHO health data report, the out-of-pocket expenditure, as a percentage of total expenditure on health care in South Korea, was 36.09%. This rate was similar to that of Senegal, Iraq, and Mongolia, countries with substantially lower levels of health spending. Those of Japan and China was 13.91% and 31.99% and Germany, Canada, New Zealand, Denmark was from 11% to 14%. According to WHO health financing data, the government expenditure on health per capita (at average exchange rate) of South Korea was $1,113.59 USD (PPP $2,530.57) and that of Japan was $3,095.25 (PPP $3,726.68) in 2014. The UK’s government expenditure on health per capita was $3,271.52 USD (PPP $3,376.87) and that of the U.S. was $4,254.49 (PPP $9,402.54). In addition, in 2013, according to the Ministry of Health and Welfare, the out-of-pocket expenditure, as a percentage of total individual expenditure on health care, was 42.1%. It has further increased since 2010. In this situation, many Koreans tend to experience the feeling of insecurity, especially in financial terms, both at the personal level as well as at the macro level. Household catastrophic health expenditure can lead to other related problems owing to treatment costs and loss of income or employment. Hence, patients may experience a doubling of the torment. The health security system becomes important in the context of the right to live.

In sum, at the micro level, sick people may experience insecurity due to a low level of accessibility even though, nationwide, there exists an accessibility protection.

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58 Id.
59 Purchasing Power Parity
61 Id.
system and nearly 100% coverage by the NHI. In fact, the seemingly protective system does not yet provide enough coverage for a range of diseases and services, so when people get sick they may end up facing catastrophic medical expenditure.

Last but not least, it is also possible that Korean people do not feel secure and are anxious about health maintenance after the collective experiences of the deficient response system of the government in dealing with calamities, including several chemical safety events and episodes of infectious disease epidemics. For example, humidifier disinfectants and associated interstitial lung disease have caused several deaths. This tragedy expressed the vulnerability of public safety against toxic chemicals. Also, South Korea experienced the largest hospital outbreak of the Middle East respiratory syndrome coronavirus (MERS-CoV) in 2012. Additionally, more than 1,200 humans were infected with approximately 40% of fatal diseases.

V. Conclusion

Drawing from previously reviewed literature, we have selected three attributes of uncertainty, disempowerment, and insecurity (both financial and institutional) to explain precariousness in health care coverage. We identified them at both personal and institutional levels and mapped them onto the South Korean health care system.

Our findings are as follows: first, it seems that the micro level of uncertainty is induced by the unpredictable risks of getting sick. As most sicknesses come without a warning, people naturally feel anxious about maintaining their health status. However, they also experience a macro-level of uncertainty due to the unpredictable health policy decision-making process in Korea. Indeed, in South Korea, the process of health policy decision making seems to depend on political factors rather than scientific evidence.

64 Adnan Khan, Amber Farooqui, Yi Guan, and David J Kelvin. “Lessons to Learn from MERS-CoV Outbreak in South Korea,” The Journal of Infection in Developing Countries 9, no. 6 (2015): 543-546.
or logical reasoning. Without a predictable health policy making process that is evidence-based, people cannot predict how the current health insurance system will change. This makes them feel unconfident about health security.

Secondly, the lack of social and economic resources to access necessary health care services and benefits and resulting unmet health care needs experiences are the micro-level causes of disempowerment. When people are in uncontrollable situations, they feel frustrated and anxious. Also, the macro level factor of disempowerment is the lack of information and opportunities to participate in the decision-making process for the NHI plans in Korea. In the framework of a representative democracy in which a parliament performs the central role of governing, demands for comprehensive citizen participation in policy making processes have increased.\(^{65}\) Traditionally, health care policy making was regarded as an area that required high-level knowledge of its complexity; thus, it was left to the experts who is seemed were the only ones who could understand and make judgment. However, the decision-making process needs to be more democratized to incorporate opinions of the lay people.\(^{66}\) These lay people are the taxpayers and the beneficiaries of the policies. However, since citizens cannot participate in all decisions regarding health care owing to practical reasons, a reliable representative decision-making body is needed. Then, at least, the health care decision-making body would be transparent and accountable to the public. Without them, people will remain disempowered with regard to maintaining health security for themselves and their family members. Thirdly, a relatively high probability of catastrophic medical expenditure in Korea is a micro-level case of insecurity. People feel insecure as they could fall into poverty when they or their family members get sick. Koreans also experience macro-level cases of insecurity owing to incomplete coverage of non-covered services, and the deficient epidemic control system.

Despite universal population coverage by NHI in Korea and the stunning development of medical technologies and top-notch services, both the micro- and macro-level experiences of uncertainty, disempowerment, and insecurity reveal the fictional stability


of the South Korean health care system. While population coverage is universal, the service and financial coverage packages of the Korean NHI do not provide full protection. In addition, the policy mechanism that is supposed to protect people from unpredictable accidents and epidemics were found to have significant loopholes.

In sum, in order to eliminate fictional stability and reduce the instability of the Korean health care system, it is necessary to consider these three dimensions of precariousness at the two levels. Through this classification of concepts related to health care precariousness, we will be better able to map out a strategy for achieving universal coverage in the context of true stability.

Received: February 28, 2017
Revised: March 27, 2017
Accepted: March 29, 2017