An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

For information regarding reproduction and distribution of the contents contact the editor and research leader:
Jean-Pierre Girard
LPS Productions
205 Chemin de la Côte Sainte-Catherine, #902
Montréal, Québec H2V 2A9
Canada
info@productionslps.com
URL http://www.productionslps.com

REPUBLIC OF KOREA[1]

2014

HEALTH SYSTEM

Population (in thousands): 49,003

Population median age (years): 38.85

Population under 15 (%): 15.25

Population over 60 (%): 16.58

Total expenditure on health as a % of Gross Domestic Product: 7.5

General government expenditure on health as a % of total government expenditure: 13.6

Private expenditure on health as a % of total expenditure: 45.6

Universal health care coverage was successfully established in the Republic of Korea (RK) in 1989. Despite the increase in public expenditure on health care and social welfare, individual households still play a major role in tackling social risks. At present, health care delivery relies heavily on the private sector. Given the trend of population aging, there are some tremendous challenges in the health care sector. Social problems remain in the delivery of high quality health care to citizens at affordable costs, and in the reduction of health disparities between the rich and the poor. However, RK's strong social movement and the original and innovative approaches introduced to its local health care system all warrant attention.

In the Republic of Korea, universal health insurance was realized in 12 years. The process started in 1977, when mandatory social health insurance was first introduced to large corporations with more than 500 workers. It then was extended to employees in firms with more than 300 workers in 1979, then to firms with more than 100 workers two years later, and finally to those with more than 16 workers in 1983.[2] Meanwhile, starting in 1981, the government implemented a series of pilot programmes in order to extend health insurance to the self-employed. Once rural self-employed and urban self-employed were covered by health insurance schemes in 1988 and 1989 respectively, universal coverage of health care had been established across the country. Even at that time, employees and the self-employed were covered separately by various insurance societies. Since 2000, in a major change to the structure of the health insurance schemes, all societies have been merged into a single national health insurer, the National Health Insurance Corporation (NHIC).[3] By 2012, 99% of the RK population were covered by a health insurance program.[4]

From 1991 to 2011, the ratio of total health expenditure to GDP rose 3.7% to 7.4%. During the same period, the public share of total health spending increased from 36.9% to 55.3%.[5] Nevertheless, due to the high co-payment rate and limited benefits offered by the national health insurance programme, the private share of health spending (including insurance contributions and out-of-pocket payments) remains among the highest in the OECD, at 36%.[6]

In RK, health care services are highly market-driven. Health care delivery has relied heavily on the private sector, which provides about 90% of the hospitals and medical services.[7] By comparison, the public health sector has relatively poor infrastructure. In particular, primary care in medical services is reported to be less accessible in RK than in the other OECD countries.[8]

Like other advanced economies, the RK population is undergoing a process of aging. In 2013, the proportion of older persons (60+ years) and that of the very old (80+ years) accounted for 17.1% and 2.4% of the total Korean population, respectively. Population aging poses tremendous challenges to the country's health and social services. To address the elderly, in 2008 RK introduced the Long-term Care Insurance programme as a social insurance scheme separate from national health insurance. While the aforementioned challenges have led to a broad consensus on the need to reform national health and social care policies,[9] the Korean government has not carried out "progressive health policies" and "has not promoted the participation of citizens in medical and public health areas."[10]

In light of government's unsatisfactory record, RK's civil society has played a driving role, not only in addressing social care problems and promoting diversity in health care service delivery, but in the policy-making process. As pointed out by J.-C. Lee,[11] "given the strong interest group influence, NGOs remain the only sector that can empower the public to demand a financially stable national health program in Korea," and "many Korean NGOs [...] aggressively called for government intervention in health care reform in response to the failure to regulate the supply side of the market." Such an influence "represented a new conception and a new scope for national solidarity."[12]

HEALTH COOPERATIVES[13]

The cooperative movement in RK represents an innovative model in public health delivery. The **Korea Health Co-operative Federation** (KHCF) is a national network which began with seven member health cooperatives in 2003. Currently the network has 16 member organizations and another 10 prospective members. Since health cooperatives used to be designated "consumer cooperatives," KHCF was formally incorporated in 2011 under the Consumer Co-operative Act.

KHCF's main activities are staff training, health promotion in the community, providing support for new cooperatives, and international exchanges. In response to the aforementioned health care delivery problems, KHCF, on behalf of the Korean health cooperative movement, "is always asking the RK government to expand the public health care system."[14]

According to the KHCF, the South Korean health cooperative movement began in 1994, when the first health cooperative was set up in Anseong at the initiative of Farmer's Association and Association of Christian Students. Since then, 16 more health cooperatives have been established: Incheon, Ansan, Daejeon, Wonju, Seoul, Walking-together, Jeonju, Seongnam, Suwon, Youngin, Cheongju, Siheung, Allbarun, Sallim, Mapo, and Happy-village health cooperatives. The number of KHCF family members reached 30,000 in 2012 and is rapidly increasing. Of them, four major cooperatives (Anseong, Daejeon, Ansan, and Incheon) represent 75% of the movement's total output. (They also have 75% of the total membership.) It is noteworthy that the establishment of all these organizations relied upon the involvement of civil society groups, such as consumer cooperatives, credit union affiliated groups, community and local residents groups, religious groups, associations advocating citizen's rights to health or serving the disabled, etc.[15]

Table 1: Health Cooperative Data

Number of cooperatives	17
Types of cooperative	N/A
Number of members	＞30,000 (2012)
Number of employees	N/A
Users	N/A
Facilities	N/A
Services offered	Primary care (western medicine, oriental medicine), dental care, health promotion Illness/accident prevention Wellness and health promotion
Annual turnover	approx. $88,391,280 USD (90 billion KRW 2010[16])

OTHER COOPERATIVES[17]

RK is a pioneer in the development of social cooperatives in Asia. The development of cooperative provision of social care services got a further boost from the Korean Co-operatives Fundamental Law which came into effect in December 2012. This law recognizes two types of cooperative: general and social. Social cooperatives are non-profit organizations with at least 40% of the business designated for the "public good." That means they need to observe much stricter criteria than general cooperatives. The new law is intended to facilitate community development and social welfare and to activate cooperative development in the public interest sector, such as health cooperatives.

Prior to the enactment of the new law, cooperatives providing social care services were registered under the legal framework of consumer cooperatives and administrated by the Fair Trade Commission (FTC).[18] According to FTC statistics, the number of consumer cooperatives active in the health domain has been steadily increasing, from 108 in 2009 to 225 in 2011, a pace comparable to that of consumer cooperatives active in such domains as local retail and university education.[19] With the new law, many health cooperatives are changing their legal status to that of social cooperatives. In the meantime, consumer cooperatives remain active in fostering health care delivery in local communities. For example, the **Seed Foundation of iCOOP** (a consumer co-operative federation) has organized activities to deliver free medical services to the public, with the collaboration of three local health cooperatives.[20]

Among the 3,944 co-operatives registered under the new law (3,816 as general cooperatives, 128 as social cooperatives), 43 are currently providers of care services for patients, the elderly, and postnatal mothers and children (40 as general cooperatives, 3 as social co-operatives; see Table 2). Of these, 12 are multistakeholder cooperatives (9 general cooperatives, 3 social cooperatives), 24 are producer-owned and 7 user-owned. One is a consumer cooperative and 6 are worker cooperatives. (See Table 3, next page.)

Table 2: Co-ops registered under the 2012 Co-operative Law[21]

	Number of co-ops	Number of social co-ops
All	3,816	128
In "human health and social work activities"	164	21
Co-ops providing care services	40	3

Table 3: Types & Numbers of Other Cooperatives

		# of co-ops	# of founding members[22]
Social cooperatives[23]		3	188
General Cooperatives	Multistakeholder	9	87
	Independent producer	24	208
	Consumer cooperative	1	26
	Worker cooperative	6	94

SOURCES

[1] This is the official name of the country also called "South Korea."
[2] Lee, J.-C. 2003. "Health care reform in South Korea: Success or failure?" *American Journal of Public Health* 93(1):48-51; and Kwon, S. 2009. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." *Health Policy and Planning* 24(1):63-71.
[3] Major driving forces behind this structural change were deemed to be inequity in health care financing and the financial distress of many insurance societies for the self-employed (Kwon, 2009: 67).
[4] Ministry of Health and Welfare. 2013. *Ministry of Health and Welfare Statistical Year Book 2013*.
[5] Ministry of Health and Welfare 2013:415.
[6] Organisation for Economic Co-operative and Development (OECD). 2009. *OECD Health Data 2009*. Paris: OECD; quoted from Peng, I. 2011. "The Good, the Bad and the Confusing: The Political Economy of Social Care Expansion in South Korea." *Development and Change* 42(4):905–923.
[7] Kwon 2009:66.
[8] Korean Health Co-operative Federation (KHCF). 2014. "Brief Introduction of Korean Health Co-operatives." Internal document supplied via email.
[9] For example, Lee 2003; KHCF 2014.
[10] KHCF 2014.
[11] Lee 2003:51.
[12] The role played by civic movements has "led to the extension of the different social insurance schemes and above all the introduction in 2000 of the National Basic Livelihood Security System." Bidet, E. 2010. "Social economy and health care in South Korea: The emergence of new actors." Retrieved August 13, 2014 (http://www.inhcc.org/english/data/2010-Health-coops-in-SK.pdf). P. 5.
[13] We express our deep appreciation to the Korea Health Co-operative Federation for supplying a brief introduction to the development of health cooperatives in this sector.
[14] KHCF 2014.
[15] Bidet 2010:6.
[16] Bidet 2010:6.
[17] We would like to express our sincere thanks to Hyungsik EUM (Centre d'Economie Sociale - Université de Liège, Belgium) for providing information on Korean cooperatives which offer social care services.
[18] Regarding the development of general cooperatives in South Korea, the Ministry of Strategy and Finance is in charge of planning frameworks and policies for such cooperatives and oversees their performance.
[19] ICA Committee on Consumer Cooperation for Asia and the Pacific. 2012. "Korea: Highlights of Consumer Co-ops." Retrieved August 14, 2014 (http://jccu.coop/eng/public/pdf/asia_2012_07.pdf).
[20] iCOOP Korea. 2012. *Ethical Consumerism: A most beautiful practice - iCOOP KOREA 2012 Annual Report*. Retrieved August 14, 2014 (http://www.icoopkorea.coop/en/report.html). P. 5.
[21] As of February 2014. We used two selection processes to analyze the data provided by Hyungsik EUM regarding total registered cooperatives. The first selection, based on industrial classification, identified 185 cooperatives as active in "human health and social work activities." The second selection was made by checking the actual, declared activities of these 185 cooperatives through the portal site for Korean cooperatives (http://www.co-operatives.or.kr). That process identified 42 cooperatives to be providers of social care services.
[22] Only the number of founding members is available in the registration data.
[23] According to the law, "social cooperatives" should be classified as "multistakeholder cooperatives."