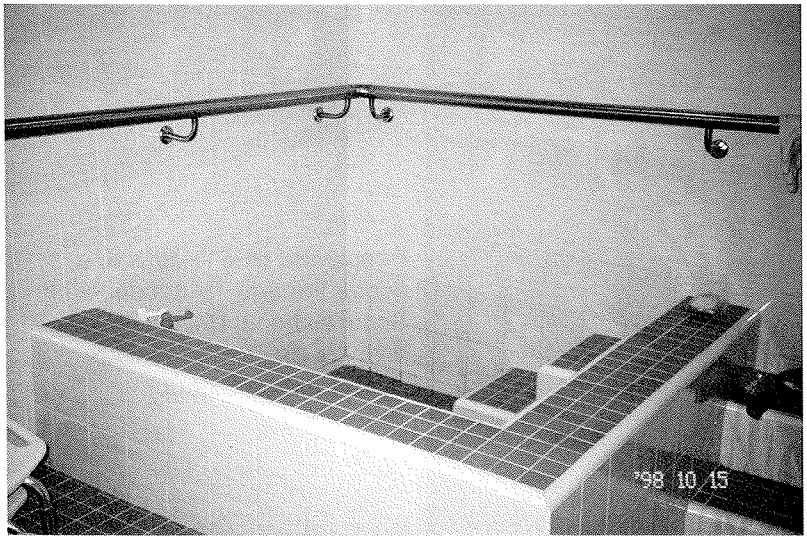
Report on the Survey of Aging and Health in Asian Countries

—— The Republic of Korea ——

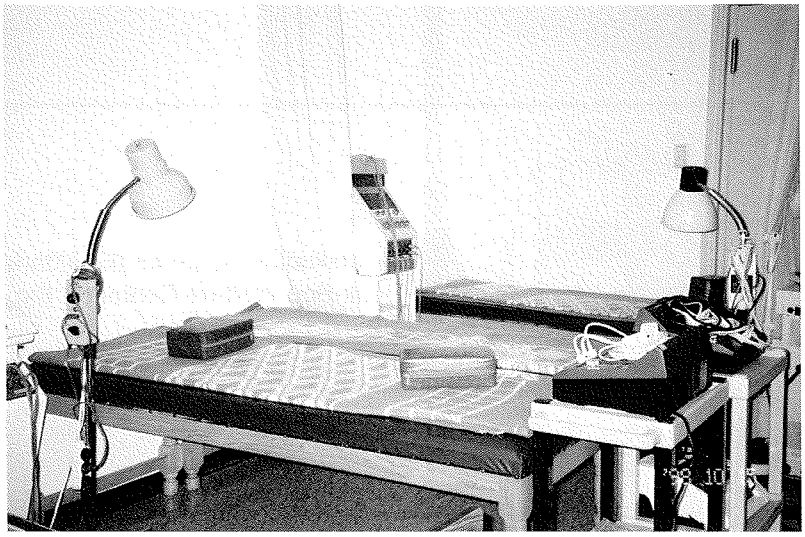
MARCH 1999

The Asian Population and Development Association

Courtesy call to Embassy of Japan in the Republic of Korea. Mr. Takahiro Matsuse, Second Secretary (right), Dr. Masato Niitsuya (middle) and Ms. Chiharu Hoshiai, Field Survey Team Members.



Bathroom of Chung Woon Nursing Home. The bath is equipped with steps to ease movement of the elderly.



Medical Check Room of Chung Woon Nursing Home

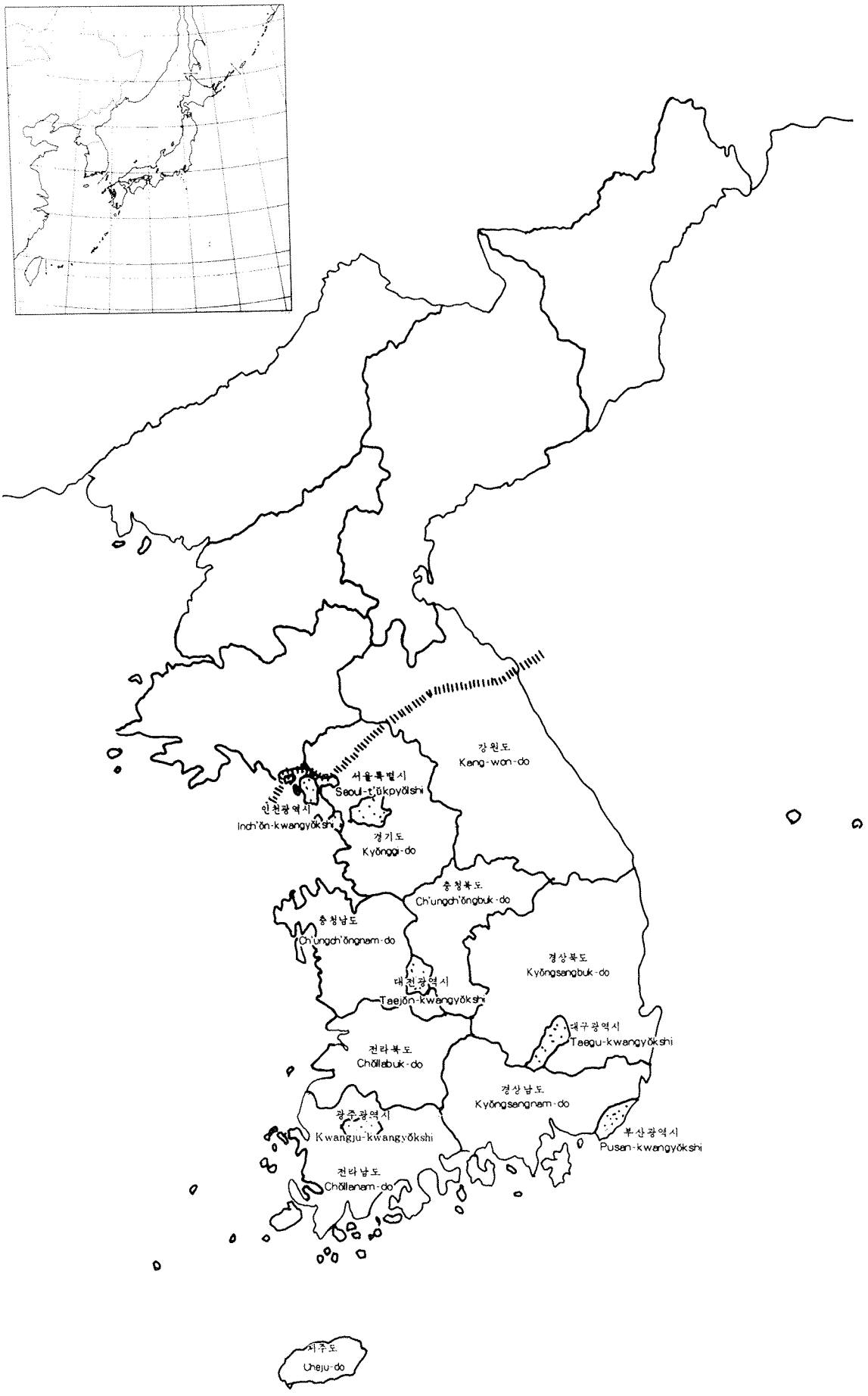
This room is open to the homeless at night (Book-Boo Welfare Center for the Elderly)

People are able to consult a doctor through TV connected to Seoul National University hospital (Book-Boo Welfare Center for the Elderly)

Rehabilitation Room for the elderly (Book-Boo Welfare Center for the Elderly)

행 정 구 역

Administrative Districts of Korea



Foreword

This report comprises a compilation of results from a survey entitled "the Survey of Aging and Health in Asian Countries" which was conducted in the Republic of Korea in fiscal 1998 by the Asian Population and Development Association (APDA) under the consignment from the Ministry of Health and Welfare and the Japan International Cooperation of Welfare Services (JICWELS). The survey and compilation were conducted by the survey committee (Chairperson: Dr. Toshio Kuroda, Professor Emeritus, Nihon University Population Research Institute) which was created within APDA.

Population of Asian countries has shifted drastically towards aging in the recent years. Aging in the Asian region, which is larger in scale and more rapid compared to the Western countries, has exerted enormous influence on the health and social security system of each country. This survey aims to analyze in detail the present situation and issues related to population, health/health care and social security system (including social insurance) of each country in the context of aging and seeks to contribute to the solution of aging population in the Asian countries and problems that are associated with such phenomenon.

In Korea, guidance and cooperation for the overall planning of this survey were offered by Mr. Takahiro Matsuse, Second Secretary of the Japanese Embassy in the Republic of Korea, Ms. Amy Kim, General Director of Korean Parliamentary League on Children, Population and Environment, and Dr. Jae-Kwan Byeon, Research Fellow of Korea Institute for Health and Social Affairs.

In Japan, special guidance and assistance were offered by those concerned at the International Affairs Division of Minister's Secretariat, Ministry of Health and Welfare and at Northeast Asia Division of the Asian Affairs Bureau, Ministry of Foreign Affairs. I would like to take this opportunity to express my sincere gratitude. I shall be happy if this report proves useful to the programs for coping with the aging issue that will be worked out by the Asian countries, including the Republic of Korea, and contributes to effective international cooperation by the Japanese government.

In conclusion, I would like to add that this report has been prepared under the responsibility of APDA based on interviews with ministry officers, experts and private organization staffs, and that it does not reflect the views and policies of the Ministry of Health and Welfare nor the Japanese government in any way.

March 1999
Dr. Taro Nakayama
Chairman
The Asian Population and Development Association

Contents

Introduction

The 6th Asia/Oceania Regional Congress of Gerontology will be held for 4 days from June 8 to 11, 1999 in Seoul. It symbolizes the deep interest about aging issues of the Korean government and the academic community.

Korea has won international acclaim as a country that has achieved a demographic transition stages over a short period of time. Total fertility rate, which is a proper indicator of fertility, reached 2.1 in 1983 and has been remaining at a low level below the replacement level thereafter. It dropped to 1.6 by the latter half of the 1980s, recovered to 1.7 in the early 1990s and then dropped again to 1.5 in the recent years.

Meanwhile, remarkable improvements have also been made in the area of mortality. Crude death rate is as low as 6 per thousand population. In particular, infant mortality rate—which is an indicator reflecting the impact of advancements in areas of social development such as public health, welfare and education in a comprehensive manner—has dropped to a low level below 10 per thousand live births. Korea has also become a country with one of the lowest fertility levels even by the standard of developed countries and is approaching the level of developed countries in mortality rate and infant mortality rate. With population increase rate below 1%, Korea has reached the final phase of demographic transition along with the developed countries.

Population control policy in Korea—particularly the fertility control achieved through family planning—attained outstanding results and contributed to remarkable advancements of the economic and social development in Korea. On the other hand, however, it would bring about a rapid aging of population in the near future. To look at the proportion of those aged 65 years and above in the entire population as an indicator of aging population, the level is still very low at 5.9% in 1995 (5.6% according to the UN estimate). The percentage of population aged 65 years and above in the Japanese population for the same year was 14.5%. However, this age group will reach 7.1% in 2000, 10% in 2010, 13.2% in 2020 and 19.2% in 2030 in Korea (population estimate by the Korean Statistics Bureau, December 1996). Let us compare Japan and Korea in terms of the length of time required for the percentage of population aged 65 years and above to increase from 7% to 19%. In Japan, it would take 34 years as it was 7.1% in 1970 and is expected to reach 19.1% in 2004. In Korea, the same process will occur over a 30-year period as it is estimated to reach 7.1% in 2000 and 19.2% in 2030. It would mean that aging will take place in Korea at an even faster speed than Japan

whose aging process was said to be unusually rapid. (According to the UN estimate revised in 1996, it will increase from 7.9% in 2005 to 19% in 2035.)

As indicated above, it goes without saying that the concern of the government in the accelerating advancement of aging in Korea grew rapidly and gave rise to measures against a wide range of problems related to aging of population. Such measures included income guarantee for the elderly, substantial enlargement of medical facilities and their staff, and programs for offering nursing and assistance to the elderly to compensate for drastic changes of the family system. The present situation of these wide-ranging measures implemented by the government is described in detail in each chapter.

A matter of particular importance concerning the issue of aging population is the fact that quantitative aspects of aging are easily understood while the same is not true when it comes to the magnitude of impact such change will have on the society as a whole and on the administration. In addition, any serious anxiety about population aging seems to be lacking in Korea because the current level of aging is low and the serious problem of aging will not occur until distant future even if it does occur at all. In reality, the country also is facing many other important economic and social issues that must be solved as early as possible.

A vital point in addressing the aging issue is the fact that aging process is not simple and that it consists of different phases that are socially and economically favorable or unfavorable for the government and household. It is extremely important for the government, business sector and households to make and implement appropriate time allotment of their plans and programs so that they can make maximum utilization of the favorable phase and adapt fully to the unfavorable phase.

The change that occurs in age structure of population through aging is preceded by a phase in which the proportion of child population drops markedly and increase of senior population is slow. During this period, dependency ratio drops sharply and is regarded as the first period of aging. However, decline in child population eventually slows down and senior population starts increasing rapidly at the same time. This stage can be regarded as the second period of aging in which dependency ratio becomes to be very high. The point of shift from the first period to the second period indicates that senior population exceeds child population. In the case of Korean population, this point will be reached around 2030. While dependency ratio remained at a considerably high level around 80 until the 19970s, it will go down and stay at very low 40 mark for 40 years from 1990 to 2030. Meanwhile, Japan has entered the second phase characterized by high dependency ratio in 1997.

In contrast, Korea entered the "Golden Age" characterized by very low dependency ratio in 1990 and will maintain such a low level until 2030. Dependency ratio will start to increase rapidly from 2030 onward, leading the country into the second phase of aging in which senior population exceeds child population. The point where senior population

exceeds child population can be referred to as the "critical point." It is necessary to strongly recognize the need to take all possible measures against aging population in Korea before entering this critical point.

Chapter One

Population Aging in the Republic of Korea

1. Profile of Korean Population: Remarkable Achievement of Demographic Transition

Korea is one of the most overpopulated countries in the world. Having a population of 44.6 million in 1995, her population density reached 449 persons per square kilometer. This is a level far greater than that of Japan for the same year, which was 337 persons. The country is scarce in natural resources and suffered from serious population pressure historically.

Population increase rate in Korea—with the exception of the sharp decline after the Korean War—showed an extraordinary increase rate of 2 to 3% a year from the 1960s to the first half of the 1970s. Recognizing the serious impact of population explosion on socioeconomic development, the Korean government carried out measures for strong population control. By 1995, population increase rate dropped to 0.5%.

In terms of fertility, crude birth rate dropped by nearly half in less than 20 years from 29.5 in 1970 to 15.1 in 1987. Total fertility rate also went down by half over a 20-year period from 3.4 per woman in 1975 to 1.7 (1.65) per woman in 1995. Remarkable improvement was attained in the field of mortality as well.

Crude death rate dropped from 13.1 in 1960 to 5.3 in 1996. In addition, infant mortality rate declined sharply from 61.6 (per 1000 live births) in 1966 to 8.5 in 1996 (above values are

from the Korean Statistics Bureau and "Demographic Transition and Policy in Korea" by Professor Lim). Therefore, average life expectancy at birth for male and female combined has been extended by more than 10 years over a 25-year period from 63.15 years in 1970 to 73.54 years in 1995. The value increased by 6.72 years from 59.77 years to 66.49 years for male and by 10.66 years from 66.70 years to 77.36 years for female. Striking increase in average life expectancy of females compared to males is worthy of note (Korean Statistics Bureau).

The experience of Korea in which demographic transition from high fertility/high mortality stage to low fertility/low mortality stage was realized can be characterized as a remarkable achievement that is rarely seen among developing countries. It is necessary to note that aging of population is a natural outcome when fertility transition is realized over a short period and fertility continues to decline.

2. A New Challenge for Asia: Complex Structure of Aging Process of Population

Aging of population is a serious demographic challenge confronting Asia in the 21st Century. However, the process of this aging differs considerably from country to country. In other words, a complex structure in which multiple patterns with different level and speed of aging exist at the same time is observed. For instance, as shown in Table 1, Asia can be divided into 4 regions, each comprised of many countries. The share of population aged 65 years and above for East Asia was high at 6.8% in 1995, while the same share for South/Central Asia, Southeast Asia and West Asia was at similar low levels of 4.3%, 4.3% and 4.4%, respectively. However, the process of aging in the coming century differs considerably among these regions. The share of senior population in 2050 is markedly high at 20.1% in East Asia, followed by 15.4% in Southeast Asia, 12.3% in West Asia and as low as 8.1% in South/Central Asia. Thus a very complex and multiple structure can be observed with regard to aging pattern in terms of broad classification based on regions.

Table 1 Comparison of share of old population in 4 Asian regions: 1995 and 2050

(%)

Year	East Asia	South/Central Asia	Southeast Asia	West Asia
1995	6.8	4.3	4.3	4.4
2050	20.1	8.1	15.4	12.3

Source: United Nations: *World Population Prospects: The 1996 Revision Annex II & III*, 1996

Needless to say, far more significant difference exists in level of aging when it is observed on a country basis instead of regional basis. For instance, aging in Japan is

projected to reach 30.41% in 2050—this is almost 3 times higher than that projected for Pakistan, which is 10.27%.

The main factor behind such striking difference in aging level among regions and nations is the level and speed of fertility decline. As will be mentioned later, Korea demonstrated remarkable decline in fertility and has realized total fertility rate lower than the replacement level. Lowering and improvement of mortality rate is a sensitive factor affecting age structure of population. Attention must be given to the fact that lower infant mortality raises the survival rate of infants. This, in turn, increases the share of child population and will bring about a phenomenon moving in the opposite direction of aging of population as a result (rejuvenation). On the other hand, lowering and improvement of mortality rate occurring among elderly population will raise their survival rate and contribute to aging of population. In Japan, marked improvement in mortality rate among senior population of ages 65 and above has been demonstrating greater contribution to extension of average life expectancy than improvement of infant mortality rate since around 1970. Therefore, attention must be given to the fact that, in the case of Japan, the majority of longer average life expectancy resulting from improvement in mortality is attributable to the improvement in senior population mortality rate and that aging of population will be accelerated by double factors comprised of lower fertility and lower mortality.

3. Population Aging in East Asia: Comparison of 3 Countries (Korea, China, and Japan)

A study of aging in Korea can be made more meaningfully by comparing Korea with China and Japan, the two major countries of East Asia. Geographical proximity, long history of exchange and cultural affinities among these countries make such comparison very significant in deepening our understanding about the demographic change of aging population.

Let us look at the trends and characteristics of structural changes of age composition of population in these countries after the Second World War.

First of all, age composition in these 3 countries are compared, based on the 3 major categories of ages 0 through 14, ages 15 through 64 and ages 65 and above from1950 through 1990 and projections for 2000 through 2050 in Table 2.

A study of trend observed in population of ages 65 and above up to now (1990) indicates that the population of this age group is increasing at almost steady level in Korea and China while this age group is increasing at a much faster rate in Japan compared to the other two countries.

Table 2 Changes in age composition of 3 East Asian Countries: Korea, China and Japan (1950-2050)

Year	Korea (%)			China (%)			Japan (%)		
	0~14	15~64	65+	0~14	15~64	65+	0~14	15~64	65+
1950	41.7	55.3	3.0	33.6	61.9	4.5	35.4	59.7	4.9
1960	41.9	54.8	3.3	38.9	56.3	4.8	30.0	64.2	5.7
1970	42.0	54.7	3.3	39.7	56.0	4.3	23.9	69.0	7.1
1980	34.0	62.2	3.8	35.5	59.8	4.7	23.5	67.4	9.1
1990	25.9	69.1	5.0	27.5	66.9	5.6	18.2	69.7	12.1
2000	21.3	72.0	6.7	24.9	68.4	6.7	14.7	68.1	17.2
2010	19.7	71.3	9.0	20.3	72.0	7.7	14.4	63.6	22.0
2020	17.6	70.6	11.8	19.6	69.6	10.8	13.7	59.5	26.9
2030	17.0	65.6	17.4	18.9	66.7	14.4	12.7	59.3	28.0
2040	17.5	60.9	21.6	18.2	62.7	19.1	12.9	56.1	31.0
2050	17.5	59.4	23.1	18.7	62.1	19.2	13.1	54.6	32.3

Source: United Nations: *World Population Prospects: The 1996 Revision, Annex II & III*, 1996; except the values for Japan which were obtained from the population census results and "*Nihon no Shorai Suikei Jinko* (Estimated Future Population of Japan)" estimated in January, 1997 (National Institute of Population and Social Security Research)

Remarks: Underlined values indicate "critical point" years in which senior population begins to exceed young population.

Table 3 Changes in Dependency Ratio of 3 East Asian Countries: Korea, China and Japan (1950-2050)

Year	Korea			China			Japan		
	Total	Young population	Old population	Total	Young population	Old population	Total	Young population	Old population
1950	80.8	75.3	5.5	61.3	54.1	7.2	67.5	59.3	8.3
1960	82.7	76.6	6.1	77.7	69.1	8.6	55.7	46.8	8.9
1970	83.0	77.0	6.0	78.7	71.0	7.7	44.9	34.7	10.2
1980	60.8	54.7	6.1	67.4	59.4	7.9	48.4	34.9	13.5
1990	44.6	37.4	7.2	49.4	41.0	8.4	43.5	26.2	17.3
2000	38.9	29.7	9.2	46.2	36.4	9.9	46.8	21.5	25.3
2010	40.3	27.6	12.7	39.0	28.3	10.7	57.2	22.6	34.6
2020	41.6	24.9	16.7	43.8	28.3	15.5	68.2	23.0	45.2
2030	52.5	25.9	26.6	49.8	28.3	21.5	68.6	21.4	47.1
2040	64.3	28.8	35.5	59.5	29.0	30.5	78.1	23.0	55.1
2050	68.1	29.3	38.7	61.1	30.1	31.0	83.0	23.9	59.1

Source: United Nations: *World Population Prospects: The 1996 Revision Annex I: Demographic indicators*, 1996, except Japan which were obtained from the same source as the above table.

Remarks: The original statistics were taken over 5 year intervals but the values in this table are shown in 10 year intervals.

The dependency ratio was calculated as follows:

$$\text{Dependency ratio total} = \frac{(\text{Population } 0 \sim 14) + (65 \text{ and over})}{\text{Population } 15 \sim 64} \times 100$$

$$\text{Dependency ratio young} = \frac{\text{Population } 0 \sim 14}{\text{Population } 15 \sim 64} \times 100$$

$$\text{Dependency ratio old} = \frac{\text{Population } 65 \text{ and over}}{\text{Population } 15 \sim 64} \times 100$$

In Japan, the share of population aged 65 and above increased by 2.5 times from 4.9% in 1950 to 12.1% in 1990. Meanwhile, the same share increased by only 24% from 4.5% to 5.6% in China during the same period. In Korea, it went up from 3.0% to 5.0%, reaching a level similar to that of China but increasing at a higher rate of 67%. As for trends predicted between 1990 and 2050, Korea is expected to experience higher aging process compared to China with population aged 65 and above accounting for 23.1% of the entire population in 2050 as opposed to 19.2% in China. What is worthy of note, however, is the comparison with Japan. The share of elderly population in Japan will reach 32.3% in 2050—this is probably the highest level in the world as it accounts for one third of the nation's population.

Figure 1 shows the trend of aging in the 3 countries. It shows that the level of Japan is extremely high and that the level of Korea is slightly lower than China in the second half of the 20th century but accelerates to a level higher than China after the year 2000. While some difference in the share of elderly population can be observed between Korea (23.1%) and China (19.2%) in 2050, they are roughly comparable to the level Japan expected around 2010 (2010). This means that the process of aging in these two countries is about 40 years behind Japan.

The share of young population aged 0 ~ 14 years is moving in the opposite direction compared to that of elderly population (Figure 2). In contrast to the curve representing the share of elderly population, the curve representing that of young population in Japan remains at the lowest level. The figure also shows that the share that of youth population in Korea has been lower than China from 1975 onward.

Figure 1 Changes in percentage of old population in the 3 countries, 1950-2050

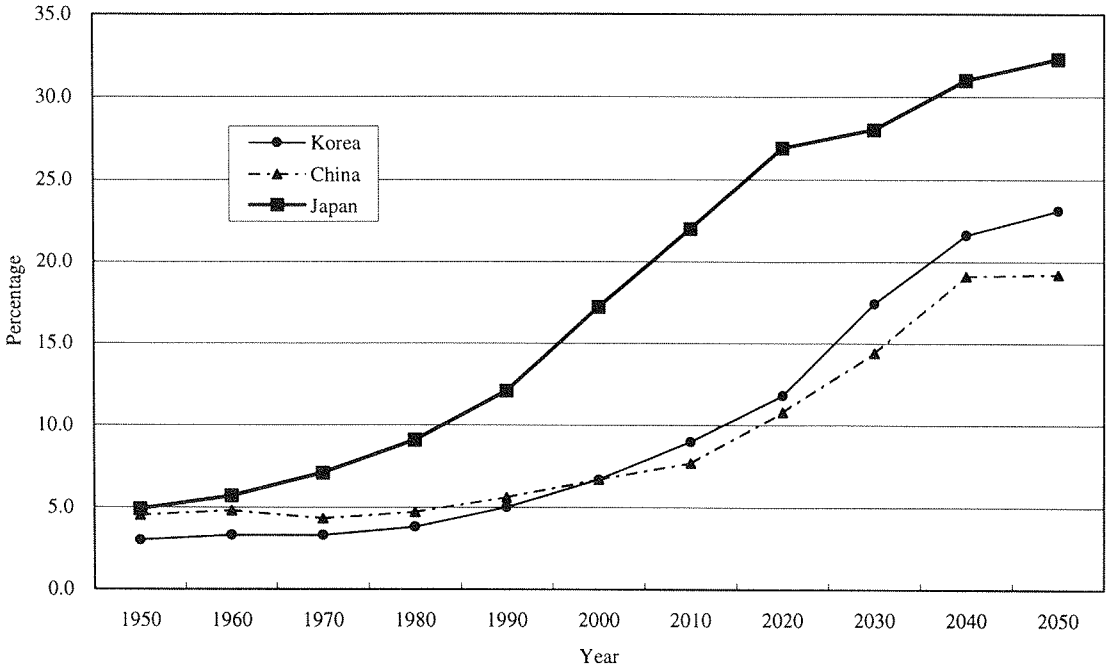
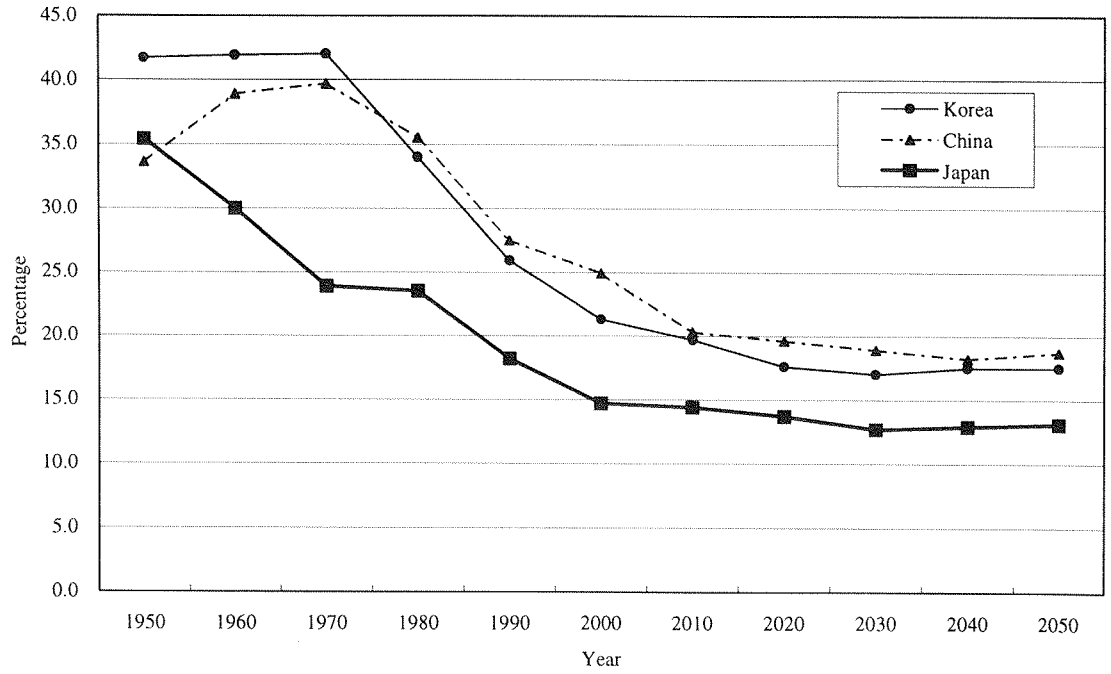


Figure 2 Changes in percentage of young population in the 3 countries, 1950-2050



Such decline in the share of young population (aged 0 ~ 14) will be affected directly by the level and speed of decline in fertility. When lowering fertility is seen in terms of total fertility rate, Japan already reached the replacement level in the latter half of the 1950s. Korea did not reach the replacement level until around 1985. Korea and China are about 25 to 30 years behind Japan in attaining replacement level. Meanwhile, the difference between Korea and in China in the percentage of young population is the result of total fertility rate level being lower and declining faster in Korea compared to China.

The aforementioned changes in age composition indicate differences in the aging process of population. An important point here is the dependency ratio. This is obtained as the sum of young population and elderly population against every 100 persons of productive age population.

Based on the assumption that children and senior citizens are supported by the population in working age, the above formula represents the number of children and senior citizens that are supported by every 100 persons of productive age population. In reality, productive age population includes those who do not work while senior population includes those who do work since not all senior citizens are dependent. Policymakers must pay attention to the dependency ratio because remarkable difference in age composition—such as high share of young population or old population in a society—is seriously related with economic and social development.

Changes in dependency ratio in the 3 countries mentioned above are shown in Table 3 and Figure 3. Attention must be given first to the point that a 3-phase process comprised of a high-level phase, a low-level phase and a recovery to high-level phase is observed in all of these countries. However, a difference exists between Japan and Korea/China in the manner of transition from one phase to another. Low-level dependency ratio period lasted for 30 years from 1970 to 2000 in Japan while it will continue for about 40 years from 1990 to 2030 in Korea and China.

When dependency ratio is at high levels of 70 or 80, it is mainly the outcome of having small old population and very large young population. This is a situation characterized by heavy social and economic burden it places on both national and family finances. On the other hand, dependency ratio at low level in the neighborhood of 40 signifies an age composition in which the burden of raising children decreases with marked decline in fertility while old population increases but has not reached an excessively high level. Let us take a look at the example of Korea.

According to Table 3, dependency ratio in 1970 was 83, of which 77 were children and 6 were elderly. It means that 100 persons belonging to productive age population will have to support 77 children and 6 senior citizens. In 1990, however, dependent population decreased considerably to 44.6. Compared to 1970, the population that must be supported by 100 persons in productive age has been reduced from 83 to 45. This reduction of 38 persons or reduction rate of

46% creates a very favorable age composition for national finances, economic development and family budget. Fewer children are born on the one hand, and at the same time children born during early high fertility period reach the young productive age of 15 to 24 to provide the source of labor needed for economic development on the other. Such favorable age composition certainly made enormous contribution to the high growth of the Japanese economy and higher quality of life. We referred to this period of very low dependency ratio as the "Golden Age." United Nations 'The State of World Population 1998' report referred to this as "demographic bonus."

Nevertheless, such favorable age composition does not last forever. Aging of population accelerates due to continued decline of fertility and improvement of mortality rate among senior citizens and raises the dependency ratio from low level to high level. However, the high level in the new phase is fundamentally different from that in the earlier phase in that it is predominantly senior population instead of young population.

Golden Age will come to an end in Korea and China around 2030 and the dependency ratio will start to rapidly increase thereafter. By 2050, Korea and China's dependency ratio are predicted to reach high levels of 70 and 61, respectively. These countries will be entering the critical second period of aging population.

The point that requires particular attention of policymakers in the process of increasing senior population—not to mention the need to take early measures against aging since it is an inevitable result of fertility control—is the fact that special consideration must be given to the existence of the period in which the number of senior population exceeds the number of young population in the process of aging population. In Japan, for instance, there were 5 senior citizens for every 35 children in 1950, i.e. the ratio between senior citizens and children was 1 to 7. However, there were 15 senior citizens for every 15 children in 1997 (meaning that the ratio between senior citizens and children was now 1 to 1), indicating that the aging issue has reached an extremely serious stage. The author refers to this point in time as "critical point in aging."

Korea and China are expected to reach this critical point, which was already reached by Japan in 1997, in 2030 and 2040, respectively. Measures against aging population must be completed before reaching this critical point. Dependency ratio in terms of young dependency ratio and old dependency ratio, and changes in their values are shown in Figure 4. It is shown that the ratio of young dependency ratio and old dependency ratio will be reversed after 2030.

Figure 3 Changes in dependent population index of the 3 countries, 1950-2050

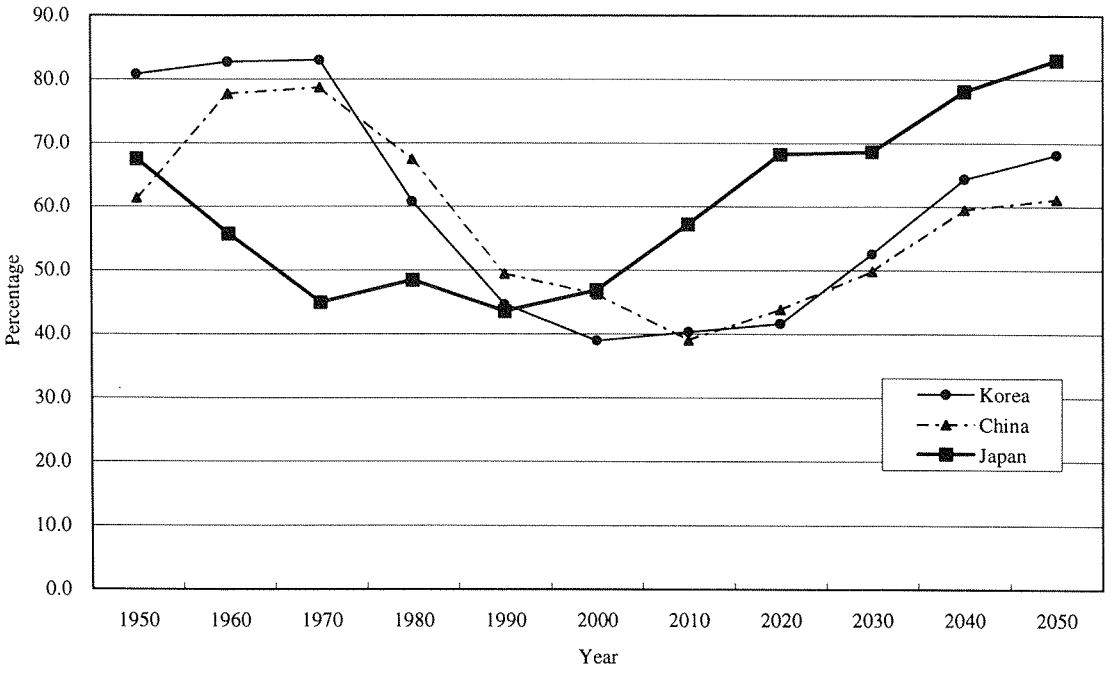
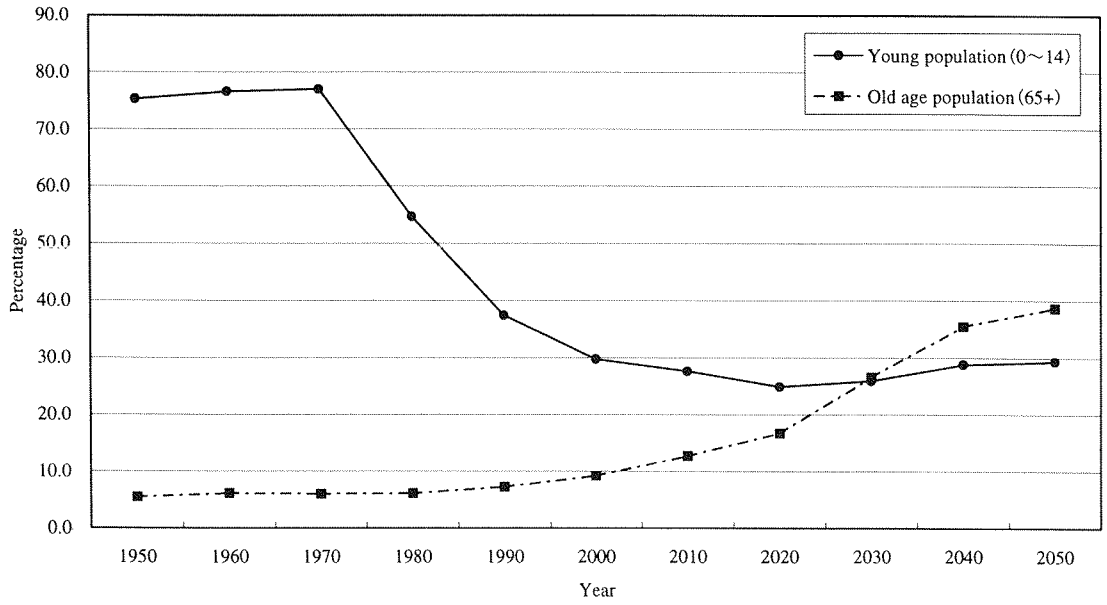


Figure 4. Changes of young dependency ratio and old age dependency ratio of Korea, 1950-2050



4. Transition of Population Policy: Towards A New Population Policy

Population control is comprised of policies that constrain or promote population growth or laissez-faire policy involving no intervention. Generally speaking, policies that moderate population growth, namely family planning policy and program are of utmost importance. Having strongly realized the hindering effect of rapid population growth on economic and social growth, the Korean government launched an active family planning policy for fertility control. Family planning policy was adopted as a part of five-year economic development program in 1962 when population growth rate was 3% and total fertility rate fluctuated at a high level between 5 and 6. However, total fertility rate dropped all the way to 3 by 1975.

Family planning policy and program adopted in 1962 were rapidly strengthened. An aspect of such strengthening was clearly reflected in the government's family planning slogan. Slogan from the early period was "Have few children and bring them up well." In 1971, the year in which Korean Institute for Family Planning was founded, two-child policy was announced by a slogan "Stop at two regardless of sex." It is worth noting that attention was already paid to the tendency of people to avoid giving birth to girls because of the strong preference for boys in Korea. Having noticed this trend of sex discrimination at birth, the government introduced the slogan "A well bred girl surpasses ten boys" in 1978. Strong preference for boys in Korea may well give rise to remarkably unbalanced sex ratio at birth under increasingly low fertility trend. This is because there will be a desire to give birth to 1 or 2 boys additionally when a baby girl is born and also because parents may wish to resort to abortion when they find out that a fetus is female.

Sex ratio at birth rose sharply in the first half of the 1980s from 105 to 109, and surpassed 110 in the latter half of the 1980s. Sex ratio increases greatly with increase in parity, and unusual cases of the ratio exceeding 200 are observed for third and fourth child (Lim paper, p.18).

Korea's family planning policy and its programs won international acclaim and produced remarkable results as total fertility rate declined rapidly and reached the replacement level in 1984. Such extraordinary low level of fertility brought about by fertility control gave rise to new interest and concern about this issue in the government and intellectual circles, as it made them strongly aware of the serious challenges that are expected to be posed by aging of Korean population, absolute decline of population and decline of working population. It is expressed as a transition to the New Population Policy.

The government's family planning budget reached its peak of 30 billion "won"[i] in 1985 and 1986. This is nearly 40 times greater than the 800 million "won" that was set aside 10

[i] 100 won = ¥9.78 (as of 19 January 1999)

years earlier in 1975. However, this was followed by a sharp budget cut, down to 10 billion won (a third of the peak period) in 1990 and to a mere 2.4 billion won in 1996. On the other hand, the budget for health sector rose sharply from 100 billion won in the early 1980s to 265 billion won in 1996 (N. Cho, p.95). This clearly suggests a shift in government's population policy. In other words, it was a shift from the conventional concept of family planning that had been carried out by exploring every avenue for fertility control. It represented a transition from the quantitative aspect of family planning by way of fertility control to the qualitative aspect of improving the people's quality of life.

The content of this New Population Policy can be summarized as follows (N. Cho, 1996, p.36)

1) Maintenance of fertility at replacement level and reduction of diseases as part of achieving sustainable socioeconomic development plan
2) Achievement of balanced distribution of population among regions
3) Implementation of regional population planning and creation of organization for collection of statistical data
4) Improvement of family health and welfare
5) Prevention of unbalanced sex ratio at birth and restraint of induced abortion
6) Approach towards sex-related problems among youth
7) Empowerment of women through increased employment opportunities and welfare service for women
8) Improvement of job opportunities for elderly and offering of proper health and welfare services
9) Strengthening of the system in terms of facility and capacity at all levels in accordance with the reconstitution of program management (including organizational and functional reconstruction needed for effective execution of the New Population Policy).

The foregoing objectives and targets of the New Population Policy represent a fundamental shift in the very system of population policy following the successful results of the family planning policy for fertility control that was implemented in Korea. It can be summarized as a declaration of completion of mission for fertility control and family planning policy as well as shift to social development orientation with emphasis on improving the quality of population. It also involves a wide range of population-related issues such as aging policies, strengthening of women's status and redressing of imbalances in regional distribution of population.

All assistance from the government for promoting lower fertility was discontinued based on the view that fertility has been lowered to the extent that assistance is no longer necessary. Instead, policies related to health, diseases and improvement of human quality are now strengthened.

The point that must be noted here is the government's view regarding the fertility with below replacement level since it is directly related to the fundamental theme of this chapter, namely population aging. The speed of population aging will be accelerated if further decline in fertility continues. In contrast, aging will be slowed down in the event that measures for recovering or increasing fertility are taken effectively based on the view that further decline in fertility is not desirable.

For instance, total fertility rate in Singapore continued to drop until it reached 1.4 in 1986. The government turned around its policy to increase the nation's population out of consideration for the effect of such low fertility rate on aging of population and population decrease. A series of incentive measures were taken under the slogan "Have three, and more if you can afford it." However, the Singapore government emphasizes the fact that such pronatalist policy is simply an effort to recover fertility to replacement level and that its ultimate goal lies in maintaining the fertility at replacement level (Population Policies in Asia, APDA, 1998, pp.55-56).

Singapore refers to this shift in population policy as "New Population Policy," which is same as the name given by Korea to her new population policy. While Singapore clearly offered a number of privileges for promoting "3 children" in the family, Korea did not express any intention to recover fertility as she merely abolished the privileges for promoting family planning. Korea's New Population Policy declared that replacement level fertility would be maintained. In addition, Korean experts predicted that total fertility rate will settle in the neighborhood of 1.8 and expressed a view that abolishing all incentives and disincentives for promoting two-child family would have very little impact (N. Cho, 1996, p36 and 70). Furthermore, views regarding fertility recovery or pronatalist policy to counteract fertility decline and population decrease are not found among politicians or mass media in Korea.

The point that still requires attention in connection with aging population is the regional disparity that exists in the aging process, particularly between urban and rural areas. Korea achieved rapid economic growth accompanied by large migration of rural population into cities over the past 30 years. The fact that percentage of urban population has soared from a mere 36.6% in 1966 to 57.3% in 1980 and to 74.4% in 1990 clearly indicates a rapid concentration of population in cities. What is important about this phenomenon is that migration from rural areas is mainly that of young population. Large-scale migration of such population from rural to urban areas causes increase of old population in rural areas and

increase of productive age population in urban areas. In other words, population becomes older in the former and younger in the latter.

Migration such as this gives rise to a new aging population issue—an aging phenomenon completely different in nature from aging of national population caused by lowering of fertility. Aging of rural population is referred to in Japan as "depopulation." This process has created rural areas with exceptionally high percentage of senior population. There are a few towns and villages where people aged 65 years and above account for more than 40% of the population.

Regional aging in Korea also took place mainly in rural areas until around 1980. However, the focus of aging policies is being shifted to cities once urban population exceeds 50% of the national population and the population that migrated from rural areas into cities will be expected to live there and reach old age. Although governments are considering redistribution of population concentrated in cities to rural areas, no successful precedent of counter-urbanization policy exists in developed or developing countries. At any rate, it is necessary to note the striking difference that exists between regions in the process of aging population.

Lastly, let us touch on the importance of the phases of aging of population and the time focus of policies that are taken against such changes. It is a strategy on a timeframe basis as seen from the viewpoint of dependency ratio. Dependency ratio goes down to very low level during the period in which young population is rapidly declining and elderly population is increasing but slowly. Dependency ratio in Korea was 80 until the 1970s. This index will drop rapidly to 40 during the 25-year period from 1995 to 2020, which means that the number of children and elderly for every 100 persons in productive age population will plummet from 80 to 40. It is the most favorable period from the viewpoint of government finance and household economy. At the same time, it is a period that can be used to prepare for the difficulties posed by rapidly increasing burden of dependent population expected to increase greatly from 2020 onward. In Japan, such period of low dependency ratio was called the Golden Age. It lasted from 1965 to 1995, and Japan has now entered a new stage of heavy burden. On the other hand, this "demographic golden age" is just starting in Korea. Measures against aging population in Korea that are examined in this study are expected to bring about an affluent and stable aging society provided that they are implemented by the government, private sectors and individuals as their top priority task in the upcoming golden age (referred to as "demographic bonus" by United Nations).

[References]

United Nations: *World Population Prospects: The 1996 Revision Annex I: Demographic indicators;* and *Annex II & III: Demographic indicators by major area, region and country.*

United Nations Population Fund (UNFPA): *The State of World Population 1998*

APDA Resource Series 6, 1998: *Population Policies in Asia*, the Asian Population and Development Association (APDA).

Symposium Report 98-01 1998: *Proceedings of International Symposium on Population and Development Policies in Low Fertility Countries*, Korea Institute for Health and Social Affairs, United Nations Population Fund (UNFPA).

Cho, Namhoon: *Achievements and Challenges of the Population Policy Development in Korea*, Korea Institute for Health and Social Affairs

Lim, Jung Duk: *Demographic Transition and Policy in Korea* (no official paper, without date of writing).

Chapter Two

Health and Health Care in the Republic of Korea

1. Changes in Composition of Diseases

(1) Present condition in Korea

Communicable diseases have been reduced enormously thanks to improvements made in overall living environment and hygiene standard as well as development of medical technology. On the other hand, chronic/retrogressive diseases such as various types of cancers, diabetes, cerebrovascular diseases and chronic liver diseases are on the increase. In addition, the problem of chronic/retrogressive diseases and increase in deaths caused by these diseases are predicted to become even more serious due to aging of population that will result from extension of average life expectancy.

(2) Statistics on death (fiscal 1996)

1) Number of reported deaths

Number of reported deaths is shown in Table 1. There were a total of 237,726 cases, comprised of 56.6% males and 43.4% females. Causes of deaths were classified for 236,254 cases, which corresponds to 99.4% of total cases.

2) Number of reports by person that has diagnosed death

Number of reports by person that has diagnosed death is shown in Table 2. Doctors and herb doctors accounted for 65.5% of total, suggesting that deaths were diagnosed by non-doctors in the remaining 34.5% of the cases.

3) Number of deaths by place of death

Number of deaths by place of death is shown in Table 3. Percentage of those who died at home was highest at 63.2%, followed by those who died at hospitals (25.2%) and at other places (11.6%).

4) Number of deaths by age group

Number of deaths by age group is shown in Table 4. People in the 75-79 age group had the highest number of deaths, followed by those between ages 70 and 74, those older than 85, and those between ages 80 and 84, in that order.

Number of deaths by age group for males is shown in Table 5, and number of deaths by age group for females is shown in Table 6. Number of female deaths was larger than male deaths in age groups of 75 years and above. This is believed to be the result of average female life expectancy being 8 years longer than average male life expectancy (69.6 years for males and 77.4 years for females in 1995).

5) Most common causes of death by age group

Most common causes of death by age group are shown in Table 7. On the whole, cerebrovascular disease is the most common cause of death, followed by traffic accident, heart disease, liver disease and stomach cancer, in that order. (Unlike in the Japanese statistics, cancer is not classified as malignant neoplasm.)

In terms of disease group, diseases of the circulatory system (hypertensive disease, cerebrovascular disease, ischemic heart disease, arteriosclerotic disease) account for the highest percentage of 24.5%, followed by malignant neoplasm (21.7%) and accidental death (14.5%).

Most common causes of death for males are shown in Table 8, and most common causes of death for females are shown in Table 9.

6) Comparison of most common causes of death between Japan and Korea

A comparison with the statistics of Japan for fiscal 1996 is shown in Table 10. In addition to the difficulty in evaluating malignant neoplasm, a notable difference between Japan and Korea exists in high rate of traffic accident-related deaths in Korea.

7) Changes in morbidity of various diseases in the last 10 years

Changes in morbidity of various diseases in the last 10 years are shown in Table 11. A close look at malignant neoplasm shows that cases of brain tumor, intestinal, rectal and anal cancer, pancreatic cancer, lung cancer and bladder cancer have shown clear increase over the 10 year period while cases of stomach cancer, uterine cancer and breast cancer are decreasing. As some are showing trends that are similar to Japan while others are not, epidemiological study of difference in lifestyle and working environment for identifying the causes for decrease in breast cancer cases and increase in brain tumor and bladder cancer cases in particular may contribute to prevention of these diseases.

Based on Table 11, diseases that demonstrated significant changes in morbidity over the 10-year period are shown in Table 12 and Table 13. Diseases that increased by highest margin were psychiatric disease and behavioral changes, followed by musculoskeletal and connective tissue disease, diabetes, malignant neoplasm on the brain, ischemic heart disease (Table 12). Disease that decreased by highest margin was poisoning by toxic substances, followed by hypertensive heart disease, arteriosclerotic disease, respiratory disease/ tuberculosis and pneumonia (Table 13).

(3) Measures taken by the Korean government

Under these circumstances, the Korean government is taking the following measures in an effort to build a national management system for these major diseases towards the 21th Century.

1) Strengthening of control and public relations for chronic/retrogressive diseases
   - Implementation of public relations through various media
   - Preparation and distribution of a wide variety of publications
   - Expansion and strengthening of visiting health service
   - Offering of free courses and public relations through affiliated organizations

2) Strengthening of neoplasm control
   - Construction of a hospital specializing in cancer with the goal of opening the hospital in the year 2000
   - Offering of medical examination service for early discovery and early treatment of cancer
   - Implementation in larger scale of registration service for analyzing cancer-related causes such as incidence, prevalence and morbidity of cancer

2. Activities for Improvement of Health

(1) Status of medical checkup implementation

Implementation of medical checkup for those insured by medical insurance and their dependents is required by Article 39.2 of the Medical Insurance Law and Article 29 of the National Medical Insurance Law. Classification of insurance and types of medical examination are shown in Table 14.

(2) Percentage of people that have received medical examination

Percentage of people that have received medical examination is shown on Table 15 and 16. The percentage is relatively high for general medical examination but low for adult disease examination.

(3) Results of regular medical examination implementation

Results of regular medical examination implementation and percentage of observation by disease in fiscal 1996 are shown in Table 17. Most common ailment was liver disease, followed by hypertension, diabetes and lipemia in that order.

(4) Measures for oral health

1) Activation of oral health improvement project

Addition of Oral Health Section to the Health and Welfare Department in November 1997 has created an environment for active implementation of studies and researches as well as development of programs in connection with oral health projects. Since introduction of fluorine to tap water is said to have significant anticavity effect, cost of fluorine injector installation is currently supported at 25 purification plants and the support is scheduled to be expanded on a yearly basis. In regions where fluorine is not introduced to tap water, health center dentists, dental hygienists and school caregivers are working together to actively promote toothbrushing using fluorine solution among elementary school students and are preparing and distributing publications about the causes and prevention of oral diseases.

2) Goals of national oral health policy

i) Lower decayed permanent teeth index of 12-year old child to 3.0 or less

ii) Lower decayed teeth/permanent teeth ratio of 12-year old child to 10% or less

iii) Lower the percentage of 15-year old child requiring teeth surface polishing to 25% or less

3) Oral health projects in progress

i) Project for addition of fluorine to tap water

ii) Project for toothbrushing with fluorine solution

iii) Project for continuing oral health management at schools

iv) Project for teeth filling

v) Project for oral health education

vi) Project for visiting oral health education for the poor

vii) Project for oral health of expectant mothers and infants

(5) Enactment of the National Health Promotion Act

Chronic/retrogressive diseases not only lower the standard of welfare for the people but brings about increase in medical expenses borne by the people. Preventive efforts are important considering the fact that majority of these diseases are caused by unbalanced diet and lack of exercise on an individual level. For this reason, a shift must be made from a health program that places emphasis on ex post infectious disease measures and various disease control to a preventive health program that seeks continuation of healthy lifestyle and improvement of health. Korea enacted the National Health Promotion Act in 1996 to raise the awareness of the people regarding their values and sense of responsibility about their health, to create an environment in which they can lead healthy lives and to legally provide that the state, not to mention individuals, must exert effort and take responsibility for improvement of health.

(6) Programs that are currently implemented

1) Activation of health improvement projects at health centers

There is a plan to select 1 health center from each city and state and implement a health improvement project comprised of disease prevention, practice of healthy life, nutritional improvement, oral health and health education/public relations on a trial basis for 2 to 3 years starting from 1998. Then a program for health improvement project will be developed by evaluating and analyzing the operating results of the project for implementation on a national level.

2) National Health Improvement Fund

National Health Improvement Fund was established in 1997 for smooth advancement of national health improvement project. The funding was secured by collecting 2 won for every 20 cigarettes sold by tobacco companies and 5% of preventive insurance operating expenses from medical insurance.

3) Creating an environment for leading healthy life including abstinence from smoking and moderation in drinking

Display of warning statement about hazards of smoking on cigarette package is mandatory. In addition, large-scale public facilities that are accessible to general public are instructed to divide their premises into non-smoking area and smoking area and permit smoking only in designated areas. Furthermore, support is offered to public antismoking campaigns to restrain smoking among youths. Meanwhile, display of warning statement is also required on liquor containers for the purpose of establishing healthy drinking culture. Liquor companies are also under restriction with regard to advertisement and offering of gifts through mass media.

4) Conducting a national nutrition survey

National nutrition survey covering the entire population is conducted every 3 years. This year, the content of survey was expanded and improved from the previous surveys that had been centered around food and nutrition intake to include studies on health conditions, food intake and diet of the people. This survey of national health and nutrition was conducted in November 1998. In addition, guidance on ideal nutritional intake is provided in connection with nutrition projects carried out by health centers. This is achieved by expanding the foundation of nutrition project through reeducation of nutritionists working at health centers and offering of financial support, and by preparing model menus for each region and holding exhibitions of such menus.

3. The Role of Health Centers

(1) Characteristic differences with Japanese health centers

National Health Insurance System was started in 1977 in Korea. As public medical facilities were not firmly established at the time, health centers offered medical consultation service and contributed to its buildup

(2) Functional expansion accompanying enactment of the Regional Health Act

Activities of health centers had been based on the Health Center Act until 1995 when the Regional Health Act was enacted. Following this legal reform, projects dealing with health of senior citizens, emergency medical service, mental health and rehabilitation were newly included in the work performed by health centers.

The most significant change that accompanied this legal reform was the requirement on the part of each health center to prepare an action plan referred to as Regional Health and

Healthcare Plan for the next 4 years. Although a guideline for preparing this plan was offered by the Health and Welfare Department, it opened the way for planning unique activities to suit the characteristics of each region instead of following the activities that are led by the government.

(3) Consideration of work consignment to private sector

It was amidst such reform that the IMF Crisis was brought to light last year. The budgets for fiscal 1998 and 1999 were cut by 17% and 13%, respectively, reducing the amount of funds available to 70% of that initially planned. For this reason, consignment of work to private sector is being considered, making it the top priority subject at present.

4. Main Tasks for the Future

The following subjects have been listed as main tasks that are related to health, welfare and healthcare.

i) Health education and nutrition: Preparation of health education materials, personnel training, activities against smoking, prevention of parasite-related diseases, nutrition and oral health.
ii) Prevention of communicable diseases
iii) Mental health
iv) Prevention of chronic diseases: Early detection and early treatment, establishment of national cancer center and launching of cancer registration service.
v) Maternal and child health
vi) Family planning
vii) Healthcare for senior citizens

1) The issue of senile dementia

Percentage of those suffering from senile dementia is estimated at 4% of population aged 65 years and above, reaching more than 100,000 people in real number. For this reason, the government prepared "The 10 Year Plan Against Senile Dementia" and initiated the efforts for substantiation of facilities such as nursing facilities and hospitals, establishment of research body on senile dementia and introduction of remote treatment on a trial basis. In particular, the government started working towards establishment of senility center for carrying out comprehensive control in 1993 and has already built 4 facilities by 1997. Construction of 12 additional centers is being planned for the future.

2) Medical checkup for preventing diseases that are unique to the elderly

The government has been subsidizing medical checkup for low-income senior citizens since 1983 to improve their health through early detection of geriatric diseases and health education for prevention of such diseases. Those suspected of having some kind of disease in the initial screening examination are recommended to take the secondary examination.

5. Concentration of Healthcare in Major Cities

(1) Medical institution statistics

Changes in number of medical institutions are shown in Table 18. Their total number nearly doubled between 1985 and 1996. To compare the percentage held by respective medical institutions, there was marked increase of dental hospitals and dental clinics in contrast to slight decrease of university and general hospitals.

Changes in number of hospital beds are shown in Table 19. Total number nearly doubled between 1985 and 1996 while the ratio of population against number of beds dropped from 447 to 245.

Changes in number of health professionals are shown in Table 20. Number of dentists almost tripled while that of doctors, herb doctors and nurses nearly doubled between 1985 and 1996.

(2) Concentration of healthcare in major cities

Much of Korean population is concentrated in major cities. Similarly, the majority (80%) of doctors are concentrated in urban areas such as Seoul.

(3) Public Health Doctor Program and Financing Program

One of the solutions for this problem of unbalanced healthcare is the Public Health Doctor Program. Under this program, those engaging in medical activities in rural areas for 3 years are released from the conscription system in Korea. Participants can choose from either going to rural areas immediately after graduating from medical school or waiting until they become specialists to do so.

The government also started offering low-interest loans in 1995 for the purpose of decentralizing hospitals. Although loans were actually offered in some regions, they resulted in oversupply of beds.

6. National Medical Expenses

(1) Present condition of medical expenses

As shown in Tables 21 and 22, medical expenses and medical expenses for the elderly are both showing signs of increase. However, one cannot conclude that medical expenses for the elderly are raising the level of medical expenses altogether as they still account for small percentage of the entire medical bill. The number of latest medical facilities such as MRI and CT is third largest in the world after Japan and the U.S.

(2) Self-pay rate among senior citizens for medical examination at hospitals

Self-pay rate among senior citizens for medical examination at hospitals is shown in Table 24. The percentage has been revised many times after the National Health Insurance System was launched in 1977.

(3) Programs for controlling medical expenses and their problems

1) Strict screening of fraudulent billing

Warnings are issued to organizations that have often engaged in fraudulent billing. Those that have failed to make improvements are excluded from insurance coverage.

2) Consideration of medical insurance

Switching the premium for examination using CT and other equipment to examination cost proportional to price fluctuation is being considered.

3) High self-pay rate

While self-pay rate at the time of hospitalization is 20%, expenses during hospitalization include both those that are covered by insurance and those that are to be paid in full by the patient. This is one of the factors that are raising the level of self-pay.

4) Examinations not covered by insurance

CT is covered by insurance but MRI is not. This is effective for cutting down on source of revenue for insurance but increases the burden on those who really require examination (MRI examination costs 400,000 to 500,000 won, whereas monthly income of an average urban family consisting of 4 people is 1.5 million won.)

5) Number of days covered by insurance

Number of days covered by insurance was increased from 180 days to 300 days. A target has been set to increase this further to 365 days by the year 2000.

7. Medical Insurance System

(1) Medical insurance system in Korea

The system is largely influenced by the system in Germany and Japan, although it is simple compared to the system in Japan.

(2) Number of people covered by medical insurance

The percentage of those covered by medical insurance is 96.5%. The remaining 3.5% are welfare recipients who are unable to pay their premium.

The Medical Insurance Federation is coordinating all medical insurance associations. These associations are comprised of three major categories (Figure 1).

A. Wage laborers (145 associations with aggregate membership of about 16 million)
B. Public servants and private school teachers (1 association with membership of about 5 million)
C. Self-employed persons (227 associations with aggregate membership of about 21 million)

Among these categories, it was difficult to collect premium from self-employed persons because of the difficulty in grasping their accurate income. For this reason, the system suffered a deficit of 200 billion won in 1998 alone. With total deficit over the last 5 years reaching 500 billion won, the government has been spending 1 trillion won every year to subsidize the system.

(3) Reform of the medical insurance system

A reform bill for improving this situation was approved in December 1997. As a result, the association for public servants/private school teachers and the associations for self-employed persons were integrated as of October 1, 1998 (Figure 2).

(4) Problems that have arisen from the reform

1) A large number of people have not received their insurance certificate

2) Premiums are collected independently in the same way as before

3) An issue has come up over whether or not to cover the deficit from the associations for self-employed persons with premium from the association for public servants/private school teachers. In addition, there is an issue over how to cover any deficit that may occur in the association for public servants/private school teachers.

(5) Future reform

1) The reform is moving in the direction of creating one large system by including the 145 associations of wage laborers and such unification is supported by the incumbent president. The National Health Insurance Bill (part of the campaign pledge) is scheduled to be submitted on October 16, 1998.

2) However, many opposing opinions, including the following, have been expressed by the associations.

- Opposition against using 2 trillion won in wage laborers' reserve to cover other deficits
- Opposition against increased interference from the government as a result of associations merging into a single organization
- Opposition against more time required for decision-making as a result of larger scale.

(6) Changes in premium and their problems

1) Percentage of the amount paid and its changes
   i) Wage laborers were paying an average of 3.2% of their wages as premium (50% paid by the worker and 50% paid by the employee). Since last year, this percentage has increased to 3.4-3.5%.
   ii) The same percentage for public servants was 3.8% (50% paid by the worker and 50% paid by the employee) but has gone up to 4.6% since the beginning of this year.
   iii) The percentage of income paid by private school teachers was 3.8% (50% paid by the worker, 20% paid by the government and 30% paid by the foundation).
   iv) The premium for self-employed persons had been determined based on 5 factors, i.e. 1) income, 2) asset, 3) number of persons in the household, 4) household, and 5) ownership of automobiles and vessels. Factors 1) through 4) are also used as criteria in Japan but 5) is unique to Korea. Since only 68% of the required amount

could be collected under this system, 3) and 4), which were dependent family factors, were eliminated. The figures related to income in 1) were changed so that premium paid by people with annual income of 5 million won or less would be determined according to their assessed income, age, sex, automobile and asset while that paid by people with annual income exceeding 5 million won would be proportionate to their income.

2) Problems related to above changes

The amount of premium became lower for 62 persons (65%) and self-pay rate increased for 38 persons (35%). In some cases, the premium doubled to 280,000 won (110,000 won was the highest amount up to that point).

Table 1 Number of reported deaths

(%)

	Total	Number of classifiable cases	Number of unclassifiable cases
Total	237,726 (100.0)	236,234 (99.4)	1,492 (0.8)
Male	134,577 (56.6)	133,759 (56.3)	818 (0.3)
Female	103,149 (43.4)	102,475 (43.1)	674 (0.3)

Table 2 Number of deaths by person that has performed diagnosis

(%)

	Total	Doctors	Herbal doctors	Others
Number of reported cases	237,726 (100.0)	151,149 (63.5)	4,485 (1.9)	82,092 (34.5)
Number of cases with classifiable causes of death	236,234 (99.4)	150,628 (63.4)	4,353 (1.8)	81,253 (34.2)

Table 3 Number of deaths by place of death

(%)

	Total	Male	Female
Total	237,726 (100.0)	134,577 (56.6)	103,149 (43.4)
Home	150,291 (63.2)	79,525 (33.5)	70,766 (29.8)
Hospital	59,921 (25.2)	37,180 (15.6)	32,761 (9.6)
Others	27,514 (11.6)	17,892 (7.5)	9,622 (4.0)

Table 4 Number of deaths by sex and age group of the reported deceased (overall)

	Total number of reported deaths	Number of classifiable cases (%)	Number of unclassifiable cases (%)
Total	237,726	326,234 (99.4)	1,501 (0.6)
0	1,971	1,960 (99.4)	11 (0.6)
1~4	1,761	1,747 (99.2)	14 (0.6)
5~9	1,096	1,088 (99.3)	8 (0.7)
10~14	1,080	1,072 (99.3)	8 (0.7)
15~19	3,108	3,093 (99.5)	15 (0.5)
20~24	3,971	3,953 (99.5)	18 (0.5)
25~29	4,733	4,706 (99.4)	27 (0.6)
30~34	5,639	5,609 (99.5)	30 (0.5)
35~39	8,483	8,450 (99.6)	33 (0.4)
40~44	9,466	9,412(99.4)	54 (0.6)
45~49	10,756	10,708 (99.6)	48 (0.4)
50~54	13,679	13,598 (99.4)	81 (0.6)
55~59	18,655	18,524 (99.3)	131 (0.7)
60~64	21,284	21,045 (99.9)	239 (1.1)
65~69	23,222	23,064 (99.3)	158 (0.7)
70~74	28,288	28,155 (99.5)	133 (0.5)
75~79	28,482	28,338 (99.5)	144 (0.5)
80~84	25,485	25,332 (99.4)	153 (0.6)
85+	26,567	26,380 (99.3)	196 (0.7)

Table 5 Number of deaths by sex and age group of the reported deceased (male)

	Total number of reported deaths	Number of classifiable cases (%)	Number of unclassifiable cases (%)
Total	134,577	133,759 (99.4)	818 (0.6)
0	1,061	1,055 (99.4)	6 (0.6)
1~4	1,017	1,006 (98.9)	11 (1.1)
5~9	682	678 (99.4)	4 (0.6)
10~14	664	659 (99.2)	5 (0.8)
15~19	2,172	2,164 (99.6)	8 (0.4)
20~24	2,851	2,841 (99.6)	10 (0.4)
25~29	3,419	3,406 (99.6)	13 (0.4)
30~34	4,155	4,138 (99.6)	17 (0.4)
35~39	6,278	6,255 (99.6)	23 (0.4)
40~44	7,102	7,071 (99.6)	31 (0.4)
45~49	8,093	8,060 (99.6)	33 (0.4)
50~54	10,051	9,993 (99.4)	53 (0.6)
55~59	13,584	13,490 (99.3)	94 (0.7)
60~64	14,277	14,109 (98.8)	168 (1.2)
65~69	13,740	13,637 (99.3)	103 (0.7)
70~74	15,448	15,375 (99.5)	73 (0.5)
75~79	13,449	13,383 (99.5)	66 (0.5)
80~84	9,623	9,570 (99.4)	53 (0.6)
85+	6,911	6,869 (99.4)	42 (0.6)

Table 6 Number of deaths by sex and age group of the reported deceased (female)

	Total number of reported deaths	Number of classifiable cases (%)	Number of unclassifiable cases (%)
Total	103,149	102,475 (99.3)	674 (0.7)
0	910	905 (99.6)	5 (0.5)
1~4	744	741 (99.6)	3 (0.4)
5~9	414	410 (99.0)	34 (1.0)
10~14	416	413 (99.3)	3 (0.7)
15~19	936	929 (99.3)	7 (0.7)
20~24	1,120	1,112 (99.3)	8 (0.7)
25~29	1,314	1,300 (98.9)	14 (1.1)
30~34	1,484	1,471 (99.1)	13 (0.9)
35~39	2,205	2,195 (99.5)	10 (0.5)
40~44	2,364	2,341 (99.0)	23 (1.0)
45~49	2,663	2,648 (99.4)	15 (0.6)
50~54	3,628	3,605 (99.4)	23 (0.6)
55~59	5,071	5,034 (99.3)	37 (0.7)
60~64	7,007	6,936 (99.0)	71 (1.0)
65~69	9,482	9,427 (99.4)	55 (0.6)
70~74	12,840	12,780 (99.5)	60 (0.5)
75~79	15,033	14,955 (99.5)	78 (0.5)
80~84	15,862	15,762 (99.4)	100 (0.6)
85+	19,656	19,511 (99.3)	145 (0.7)

Table 7 Most common causes of death by age group (overall)

	First	Second	Third	Fourth	Fifth
Overall	Cerebrovas-cular disease	Traffic accident	Heart disease	Liver disease	Stomach cancer
0	Congenital abnormality	Perinatal death	Sudden infant death syndrome	Heart disease	Traffic accident
1~9	Traffic accident	Drowning	Congenital abnormality	Falling	Leukemia
10~19	Traffic accident	Suicide	Drowning	Leukemia	Heart disease
20~29	Traffic accident	Suicide	Drowning	Leukemia	Falling
30~39	Traffic accident	Suicide	Liver disease	Heart disease	Cerebrovas-cular disease
40~49	Liver disease	Traffic accident	Cerebrovas-cular disease	Liver cancer/intrahep-atic bile duct cancer	Heart disease
50~59	Cerebrovas-cular disease	Liver disease	Liver cancer/intrahep-atic bile duct cancer	Traffic accident	Heart disease
60~69	Cerebrovas-cular disease	Stomach cancer	Heart disease	Tracheobron-chial/lung cancer	Liver cancer/ intrahepatic bile duct cancer
70~	Cerebrovas-cular disease	Heart disease	Chronic lower respiratory duct disease	Stomach cancer	Hypertensive heart disease

Table 8 Most common causes of death by age group (male)

	First	Second	Third	Fourth	Fifth
Overall	Cerebrovas-cular disease	Traffic accident	Liver disease	Heart disease	Liver cancer/ intrahepatic bile duct cancer
0	Congenital abnormality	Perinatal death	Sudden infant death syndrome	Heart disease	Pneumonia
1~9	Traffic accident	Drowning	Congenital abnormality	Heart disease	Leukemia
10~19	Traffic accident	Drowning	Suicide	Falling	Leukemia
20~29	Traffic accident	Suicide	Drowning	Heart disease	Falling
30~39	Traffic accident	Liver disease	Suicide	Heart disease	Cerebrovas-cular disease
40~49	Liver disease	Traffic accident	Liver cancer/intrahep-atic bile duct cancer	Heart disease	Cerebrovas-cular disease
50~59	Liver disease	Cerebrovas-cular disease	Liver cancer/intrahep-atic bile duct cancer	Cerebrovas-cular disease	Heart disease
60~69	Cerebrovas-cular disease	Tracheobron-chial/lung cancer	Stomach cancer	Heart disease	Liver cancer/ intrahepatic bile duct cancer
70~	Cerebrovas-cular disease	Heart disease	Stomach cancer	Chronic lower respiratory duct disease	Tracheobron-chial/lung cancer

Table 9 Most common causes of death by age group (female)

	First	Second	Third	Fourth	Fifth
Overall	Cerebrovas-cular disease	Heart disease	Traffic accident	Stomach cancer	Diabetes
0	Congenital abnormality	Perinatal death	Sudden infant death syndrome	Traffic accident	Heart disease
1~9	Traffic accident	Congenital abnormality	Drowning	Falling	Heart disease
10~19	Traffic accident	Suicide	Leukemia	Heart disease	Drowning
20~29	Traffic accident	Suicide	Heart disease	Stomach cancer	Leukemia
30~39	Traffic accident	Suicide	Stomach cancer	Cerebrovas-cular disease	Heart disease
40~49	Cerebrovas-cular disease	Traffic accident	Stomach cancer	Heart disease	Liver disease
50~59	Cerebrovas-cular disease	Stomach cancer	Traffic cancer	Heart disease	Liver disease
60~69	Cerebrovas-cular disease	Heart disease	Diabetes	Stomach cancer	Traffic accident
70~	Cerebrovas-cular disease	Heart disease	Hypertensive heart disease	Chronic lower respiratory duct disease	Diabetes

Table 10 Comparison of common causes of death in Korea and Japan (1996)

		First	Second	Third	Fourth	Fifth
Overall	Korea	Cerebrovas-cular disease	Traffic accident	Heart disease	Liver disease	Stomach cancer
	Japan	Malignant neoplasm	Heart disease	Cerebrovas-cular disease	Pneumonia/ bronchitis	Contingency
Male	Korea	Cerebrovas-cular disease	Traffic accident	Liver disease	Heart disease	Liver cancer
	Japan	Malignant neoplasm	Heart disease	Cerebrovas-cular disease	Pneumonia/ bronchitis	Contingency
Female	Korea	Cerebrovas-cular disease	Heart disease	Traffic accident	Stomach cancer	Diabetes
	Japan	Malignant neoplasm	Heart disease	Cerebrovas-cular disease	Pneumonia/ bronchitis	Caducity

Table 11 Changes in causes of death over the 10-year period

Causes of death	1987			1988			1989			1990			1991		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1. Infectious and parasitic diseases	19.9	26.3	13.3	17.4	23.9	10.7	16.0	21.2	10.6	15.7	21.1	10.0	14.4	19.3	9.1
1) Respiratory disease and tuberculosis	14.9	21.0	8.5	13.4	19.4	7.2	12.0	17.1	6.6	11.0	16.0	5.7	10.4	15.0	5.5
2) Septicemia	1.7	2.0	1.4	1.2	1.4	1.0	1.4	1.5	1.2	1.4	1.5	1.3	1.3	1.4	1.2
2. Neoplasm	96.9	121.1	71.9	99.4	124.4	73.7	105.0	130.8	78.3	110.6	136.9	83.2	108.2	133.2	81.7
1) Malignant	94.5	118.1	69.9	99.5	124.3	73.8	105.2	130.8	78.5	110.4	136.7	83.0	105.3	129.8	79.2
(1) Lip, oral cavity and nasal cancer	0.8	1.1	0.4	0.7	1.0	0.4	0.8	1.3	0.4	0.9	1.3	0.5	0.9	1.3	0.5
(2) Esophageal cancer	2.8	4.5	0.9	2.7	4.6	0.7	2.9	4.9	0.8	3.3	5.7	0.8	3.1	5.3	0.7
(3) Stomach cancer	32.8	40.5	24.8	31.5	38.8	23.9	31.7	39.1	24.1	31.5	39.1	23.6	29.5	36.2	22.5
(4) Intestinal, rectal and anal cancer	3.1	3.3	2.9	3.1	3.1	3.0	3.9	4.2	3.7	4.5	4.5	4.5	4.4	4.2	4.7
(5) Liver and intrahepatic bile duct cancer	21.6	32.0	10.6	22.4	33.4	10.9	23.8	35.3	11.6	24.1	35.4	12.0	23.7	34.7	11.7
(6) Pancreatic cancer	2.2	2.6	1.8	2.7	3.3	2.0	3.0	3.7	2.3	3.3	3.8	2.8	3.4	3.8	2.9
(7) Pharyngeal cancer	1.5	2.4	0.5	1.6	2.5	0.7	1.6	2.5	0.7	1.6	2.6	0.5	1.5	2.4	0.6
(8) Tracheobronchial/ lung cancer	10.5	15.3	5.3	11.8	17.1	6.2	13.2	19.3	6.7	14.5	20.8	7.7	15.2	22.1	7.7
(9) Breast cancer	1.9	-	3.9	1.2	-	2.4	1.6	-	3.4	1.7	-	3.5	1.7	-	3.6
(10) Uterine cancer	7.6	-	7.6	7.5	-	7.5	7.8	-	7.8	7.9	-	7.9	7.3	-	7.3
(11) Bladder cancer	0.7	1.1	0.3	0.8	1.2	0.4	0.8	1.3	0.3	0.9	1.4	0.5	0.9	1.3	0.5
(12) Brain	0.8	0.9	0.5	2.5	2.9	2.2	2.7	3.0	2.3	1.3	1.4	1.2	1.5	1.6	1.4
(13) Leukemia	3.0	3.2	2.7	3.0	3.2	2.7	3.2	3.4	3.1	3.2	3.5	3.0	3.3	3.5	3.1
3. Nutritional, endocrine and metabolic abnormalities	9.2	10.0	8.5	8.4	9.0	7.9	10.7	11.5	10.0	13.7	14.5	13.1	14.0	14.3	13.8
1) Diabetes	7.8	8.7	6.9	7.4	8.0	6.8	9.4	10.1	8.6	11.8	12.9	10.8	12.4	12.9	12.1
4. Psychiatric diseases and behavioral changes	3.5	4.9	2.0	1.7	1.7	1.6	1.7	1.8	1.6	3.1	3.5	2.6	5.1	6.7	3.2
5. Nervous diseases	5.9	6.5	5.3	5.5	6.3	4.8	5.6	6.2	4.9	6.0	6.2	5.8	6.5	6.7	6.5
6. Circulatory diseases	171.6	182.9	162.0	163.8	173.4	154.8	161.5	167.3	156.9	164.0	165.8	163.9	157.2	161.2	153.1
1) Hypertensive heart disease	45.2	50.0	40.4	39.9	43.4	36.3	37.3	39.7	35.1	35.6	36.8	34.7	29.9	30.1	30.2
2) Ischemic heart disease	6.2	7.3	5.0	6.8	8.0	5.5	9.0	9.9	8.2	10.4	11.3	9.6	11.6	13.2	10.0
3) Cerebrovascular disorder	73.5	75.4	72.1	73.3	74.9	72.2	74.1	74.7	74.2	75.7	75.0	77.3	72.6	69.7	77.1
4) Arteriosclerosis	2.1	2.0	2.2	1.9	1.8	2.0	1.9	1.8	2.0	2.3	2.1	2.5	2.5	2.3	2.9
7. Respiratory diseases	22.9	25.0	20.8	22.6	25.2	20.0	23.7	26.3	21.0	21.9	23.7	20.1	21.4	23.4	19.5
1) Pneumonia	8.0	8.6	7.5	8.5	9.3	7.8	7.8	8.8	6.8	6.2	6.5	5.9	5.1	5.3	4.8
2) Chronic lower respiratory duct disease	10.2	10.9	9.6	8.9	9.7	8.2	10.8	11.2	10.4	10.5	10.9	10.3	11.6	12.1	11.1
8. Digestive organ diseases	48.8	70.7	26.0	45.7	66.6	24.0	47.1	68.5	24.4	44.5	65.1	22.4	42.6	61.5	21.9
1) Stomach and duodenal ulcer	2.5	3.1	1.8	1.9	2.4	1.4	1.8	2.3	1.3	2.0	2.5	1.4	1.9	2.3	1.4
2) Liver disease	35.1	54.5	14.5	33.5	52.6	13.4	34.6	54.5	13.5	33.7	53.2	13.0	32.3	50.1	12.7
9. Musculoskeletal and connective tissue diseases	1.8	1.5	2.2	1.7	1.6	1.9	2.1	1.7	2.5	2.4	1.9	3.1	2.5	1.8	3.5
10. Urinary and genital diseases	4.9	4.9	4.8	4.2	3.3	5.0	3.6	3.8	3.4	4.5	4.7	4.3	4.7	4.8	4.7
11. Congenital abnormality, deformity and chromosomal aberration	2.0	2.1	2.0	3.0	2.9	3.1	3.3	3.4	3.3	3.4	3.6	3.2	3.5	3.5	3.5
12. External causes	74.6	107.3	40.3	75.2	109.8	39.0	80.7	117.0	42.3	84.8	121.3	45.7	85.8	122.1	46.3
1) Traffic	23.7	35.0	11.8	23.5	34.7	11.7	31.8	47.1	15.7	39.8	58.1	20.4	38.3	55.7	19.1
2) Falling	8.4	12.7	3.8	8.8	13.7	3.8	4.7	7.2	2.2	3.6	5.5	1.6	3.0	4.6	1.2
3) Drowning	7.3	11.2	3.2	6.2	9.8	2.5	5.5	8.7	2.0	4.2	6.6	1.6	4.9	7.6	2.0
4) Fire and smoke (fire)	1.6	2.1	1.1	1.9	2.5	1.4	2.1	2.7	1.4	1.7	2.2	1.1	1.5	2.0	1.0
5) Poisoning by toxic substances	9.1	10.4	7.8	7.3	8.5	6.2	6.3	7.3	5.3	5.2	6.0	4.4	4.6	5.4	3.8
6) Suicide	9.6	13.6	5.5	8.5	11.9	4.9	8.7	11.8	5.4	9.1	12.1	5.8	8.4	11.2	5.5
7) Homicide	1.3	1.7	0.9	1.2	1.8	0.6	1.7	2.2	1.2	1.9	2.4	1.3	1.7	2.2	1.1

(100,000 population)

1992			1993			1994			1995			1996			Comparison of '87 and '96		
Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
13.8	18.7	8.7	13.2	17.7	8.6	13.1	17.7	8.4	11.6	16.3	6.9	10.7	14.7	6.7	-46.2	-43.9	-49.5
9.9	14.3	5.3	9.6	13.7	5.3	9.0	13.2	4.8	8.3	12.5	4.0	7.3	10.7	3.8	-50.3	-49.0	-55.3
1.4	1.6	1.2	1.4	1.6	1.2	1.7	1.9	1.4	1.5	1.7	1.3	1.7	2.0	1.5	2.0	-0.4	5.4
112.0	138.3	84.6	111.0	138.9	82.3	113.8	145.2	82.0	112.1	142.7	81.2	111.9	142.4	81.0	15.5	17.6	12.7
110.9	137.0	83.6	110.6	138.4	82.0	112.7	144.0	81.0	110.7	141.3	79.9	110.1	140.4	79.5	16.5	18.9	13.7
1.0	1.4	0.5	0.9	1.3	0.5	1.2	1.7	0.6	1.1	1.7	0.5	1.2	1.8	0.6	48.8	65.6	38.3
3.0	5.1	0.8	3.0	5.3	0.8	3.1	5.4	0.8	3.2	5.6	0.8	3.0	5.3	0.7	7.8	18.1	-22.4
30.6	37.2	23.8	29.4	36.1	22.5	28.8	36.5	21.1	26.5	33.2	19.8	25.5	32.0	18.9	-22.2	-20.9	-23.7
4.6	4.7	4.5	5.3	5.4	5.1	5.6	5.7	5.6	5.8	6.1	5.6	6.3	6.5	6.1	102.9	97.2	109.3
23.9	35.2	11.8	23.1	34.5	11.2	23.0	34.9	11.0	22.0	33.6	10.4	21.4	32.6	10.0	-0.9	2.0	-5.2
3.8	4.4	3.1	4.0	4.5	3.4	4.4	5.1	3.6	4.3	4.9	3.7	4.4	5.1	3.6	98.3	95.8	101.5
1.6	2.5	0.6	1.8	2.9	0.6	1.9	3.2	0.6	1.9	3.3	0.6	1.7	3.0	0.5	15.2	23.4	-3.4
17.0	24.5	9.0	17.4	25.4	9.1	18.8	28.0	9.5	18.9	28.1	9.6	19.4	28.7	10.0	85.0	87.9	88.8
1.9	-	3.9	2.0	-	4.1	1.9	-	3.8	2.0	-	4.0	2.2	-	4.3	-15.8	-	10.7
7.5	-	7.5	6.8	-	6.8	7.0	-	7.0	6.2	-	6.2	6.1	-	6.1	-19.7	-	-19.7
1.1	1.6	0.5	1.1	1.5	0.6	1.1	1.6	0.6	1.1	1.8	0.5	1.2	1.9	0.6	71.4	70.7	106.4
2.3	2.5	2.1	2.8	3.1	2.5	2.2	2.4	2.0	2.0	2.1	1.9	1.7	1.9	1.5	111.1	107.2	202.2
3.4	3.6	3.2	3.3	3.7	3.0	3.2	3.7	2.6	2.9	3.1	2.7	2.9	3.3	2.6	-2.3	3.1	-5.2
14.8	15.0	14.6	17.7	18.1	17.3	18.3	18.6	17.9	18.7	18.7	18.7	18.7	18.5	18.8	103.1	85.5	121.5
13.5	13.9	13.2	16.3	17.0	15.7	17.0	17.6	16.4	17.2	17.4	17.0	17.4	17.4	17.3	122.9	100.4	151.2
6.4	7.2	5.5	7.1	8.5	5.6	10.5	11.4	9.6	11.4	10.4	12.4	13.0	11.3	14.7	272.5	131.6	637.2
6.1	6.5	5.7	7.0	6.9	7.1	5.4	5.9	4.9	4.9	5.6	4.3	4.6	5.1	4.1	-21.2	-20.8	-21.9
156.4	149.2	165.7	156.0	149.2	163.9	158.3	152.3	164.6	138.6	134.5	142.8	127.0	124.4	129.6	-26.0	-32.0	-20.0
27.5	26.1	29.2	26.9	24.9	29.1	25.8	23.8	27.8	18.3	16.4	20.2	13.8	12.0	15.7	-69.3	-75.9	-61.6
12.5	14.3	10.7	13.3	15.8	10.8	12.6	15.3	9.8	13.1	15.7	10.4	13.0	15.4	10.5	109.1	111.4	109.5
80.4	75.4	86.7	82.5	78.0	87.7	84.4	80.4	88.5	79.7	75.6	83.9	74.7	71.0	78.4	1.6	-5.8	8.8
2.6	2.4	2.9	2.3	2.1	2.5	2.0	1.8	2.1	1.6	1.6	1.6	1.0	1.0	1.0	-52.5	-49.1	-55.5
22.8	24.8	20.8	25.1	27.4	22.9	25.7	28.8	22.5	24.3	27.6	21.0	23.2	26.8	19.5	1.3	7.4	-6.3
4.5	4.9	4.2	4.7	5.2	4.2	4.6	5.1	4.0	4.2	4.6	3.8	4.1	4.8	3.5	-48.1	-44.6	-52.9
12.9	13.2	12.8	15.5	15.9	15.1	15.7	16.7	14.6	14.9	16.1	13.7	14.0	15.4	12.0	36.9	41.2	31.5
42.7	61.6	22.6	42.3	61.0	23.1	40.7	58.5	22.0	39.2	58.3	19.9	36.1	53.3	18.6	-26.1	-24.6	-28.3
2.2	2.7	1.6	2.1	2.6	1.6	2.3	2.7	1.8	1.8	2.2	1.4	1.7	2.0	1.3	-33.0	-35.6	-24.9
31.7	50.0	12.2	31.4	49.4	12.7	29.2	46.7	11.4	29.4	47.8	10.9	27.3	44.0	10.5	-22.1	-19.2	-27.6
3.6	2.3	5.0	4.8	3.4	6.3	5.2	3.5	7.0	4.5	2.9	6.2	4.4	2.8	6.0	145.7	89.3	173.7
4.8	5.0	4.8	5.0	5.2	4.7	5.2	5.5	4.9	4.9	5.2	4.5	4.8	5.1	4.5	-2.0	3.5	-5.5
3.2	3.4	3.0	3.0	3.3	2.8	2.7	2.9	2.4	2.2	2.4	2.0	2.1	2.2	2.0	4.4	5.4	-1.8
81.5	116.9	43.9	76.5	110.1	41.7	73.6	107.9	38.8	75.4	108.9	41.7	75.1	109.6	40.2	0.6	2.2	-0.2
34.5	50.0	18.1	33.0	48.0	17.5	35.3	52.0	18.3	38.7	57.1	20.0	38.3	56.6	19.9	61.7	61.7	68.4
3.6	5.3	1.7	4.1	6.3	1.9	5.1	7.7	2.6	5.3	7.5	3.0	5.1	7.5	2.7	-39.1	-40.6	-30.0
5.2	8.2	1.9	4.6	7.3	1.7	5.4	8.7	2.1	3.9	6.3	1.5	4.0	6.5	1.4	-45.6	-42.3	-54.7
1.9	2.6	1.2	2.1	2.8	1.3	1.8	2.4	1.3	1.9	2.5	1.2	1.8	2.4	1.1	10.1	13.0	3.8
4.5	5.3	3.7	4.1	5.0	3.1	3.4	4.3	2.5	2.9	3.8	2.0	2.4	3.1	1.7	-73.4	-69.7	-78.4
9.0	12.1	5.7	10.8	14.6	6.8	10.6	14.4	6.8	11.8	16.2	7.4	14.1	19.4	8.7	46.9	42.6	58.2
1.4	1.7	1.1	1.7	2.1	1.2	1.6	2.2	1.1	1.8	2.3	1.3	1.9	2.3	1.5	48.2	38.6	65.9

Table 12 Diseases whose morbidity increased over the 10 year period

Psychiatric disease and behavioral changes	+272.5%
Musculoskeletal and connective tissue diseases	+145.7%
Diabetes	+122.9%
Malignant neoplasm of the brain	+111.1%
Ischemic heart disease	+109.1%

Table 13 Diseases whose morbidity increased over the 10 year period

Poisoning by toxic substances	-73.4%
Hypertensive heart disease	-69.3%
Arteriosclerotic disease	-52.5%
Respiratory diseases and tuberculosis	-50.3%
Pneumonia	-48.1%

Table 14 Classification of medical checkup

	General medical checkup	Adult disease examination
Medical insurance association at workplace	Insured	Dependent
Medical insurance association for civil servants and school teachers	Insured	Dependent
Regional health and medical insurance association		Insured

Table 15 Percentage of persons that have received general medical checkup

	Intended number of testees	Actual number of testees	Percentage of persons that have received general medical checkup
Persons insured at workplace	3,755	3,008	80.1%
Insured public servants and teachers	1,318	1,229	93.2%

(Unit: 1,000 persons)

Table 16 Percentage of persons that have received adult disease examination

	Intended number of testees	Actual number of testees	Percentage of persons that have received adult medical checkup
Persons insured at workplace	1,363	289	21.2%
Insured public servants and teachers	959	336	35.0%
Persons insured by regional association	3,580	761	21.3%

(Unit: 1,000 persons)

Table 17 Results of regular medical checkup, number of persons diagnosed by disease and percentage of disease observation

Classification	Number of testees	Tuberculosis	Other respiratory (or lung) diseases	Hypertension	Lipemia	Liver disease	Diabetes	Renal or Kidney disease	Anemia
Total	4,105,933	10,540 (0.26)	4,979 (0.12)	56,229 (1.37)	29,622 (0.72)	96,123 (2.34)	41,215 (1.00)	12,155 (0.30)	7,060 (0.17)
Persons insured at workplace	2,877,116	8,451 (0.29)	3,996 (0.29)	39,763 (1.38)	22,003 (0.76)	71,178 (2.47)	27,698 (0.96)	8,346 (0.29)	5,094 (0.18)
Insured public servants and teachers	1,228,817	2,089 (0.17)	983 (0.08)	16,466 (1.34)	7,619 (0.62)	24,945 (2.03)	13,517 (1.10)	3,809 (0.31)	1,966 (0.16)

Value inside parentheses are percentages

Table 18 Number of medical institutions

	1985	1990	1995	1996
Total number of medical institutions	14,358	21,077	29,308	30,722
University hospitals	1.3	1.1	0.9	0.9
General hospitals	2.2	1.6	1.4	1.4
Clinics	56.2	51.9	48.9	48.8
Dentists*	20.9	25.1	28.3	28.6
Herb doctors*	19.4	20.4	20.5	20.4

* Total of hospitals and clinics

Table 19 Number of beds

	1985	1990	1995	1996
Total	91,220	119,061	174,900	185,713
Population per bed	447	360	258	245

* Total of hospitals and clinics

Table 20 Number of persons engaged in medicine

	1985	1990	1995	1996
Doctors	29,596	42,554	57,188	59,399
Dentists	5,436	9,619	13,681	14,371
Herb doctors	3,789	5,792	8,714	9,299
Pharmacists	29,866	37,118	43,269	44,577
Nurses	165,444	224,746	309,129	324,933

Table 21 National medical expenses-related indices: 1985-1995

Fiscal year	National medical expenses (billion won)	Increase rate (%)	Ratio against GNP (%)	Ratio against GDP (%)	Per person (thousand won)	Medical expenses ($)
1985	3,814.5	—	4.81	4.65	93.5	201
1986	4,257.4	11.6	4.58	4.45	103.3	218
1987	4,811.8	13.0	4.39	4.29	115.6	239
1988	5,939.1	23.4	4.52	4.46	141.3	285
1989	7,353.1	23.8	4.97	4.93	173.2	346
1990	9,099.0	23.7	5.10	5.07	212.3	402
1991	10,652.6	17.1	4.97	4.94	246.2	438
1992	12,792.0	20.1	5.36	5.32	293.0	518
1993	14,346.6	12.2	5.40	5.37	325.6	559
1994	16,383.0	14.2	5.39	5.35	368.5	612
1995	18,838.5	15.0	5.41	5.36	420.0	678

Table 22 Changes in increase of medical expenses for senior citizens covered by medical insurance by fiscal year

(unit: million won)

Fiscal year	Overall medical expenses	Increase index	Medical expenses for senior citizens	Increase index	Percentage occupied by medical expenses for senior citizens
1985	583,278	(100)	27,515	(100)	4.7
1990	2,219,773	(381)	239,173	(869)	8.2
1996	7,423,716	(1,273)	976,184	(3,548)	13.1

(%)

Table 23 Contribution of factors related to increase of national medical expenses: 1985-1995

(unit: %)

Fiscal year	Increase rate of national medical expenses [1]	Relative price of insured medicine [2]	General material standard [3]	Population	Use and strength (remaining)
1986	11.5(100.0)	1.1 (9.6)	2.7(23.5)	1.00(8.7)	6.7(58.2)
1987	15.9(100.0)	0.4 (2.5)	3.0(18.9)	0.99(6.2)	11.5(72.2)
1988	23.8(100.0)	-0.5 (-2.1)	7.1(29.8)	0.98(4.1)	16.3(68.2)
1989	27.4(100.0)	-2.8(-10.2)	5.7(20.8)	0.99(3.6)	23.5(85.8)
1990	22.5(100.0)	-1.3 (-5.9)	8.6(38.2)	0.99(4.4)	14.2(63.1)
1991	18.9(100.0)	-2.5(-13.2)	9.3(49.2)	0.93(4.9)	11.2(59.3)
1992	18.3(100.0)	-1.9(-10.5)	6.2(33.9)	0.91(5.0)	13.1(71.6)
1993	12.8(100.0)	-1.9(-14.8)	4.8(37.5)	0.90(7.0)	9.0(70.3)
1994	10.9(100.0)	-3.0(-23.4)	6.2(48.4)	0.90(8.3)	8.7(68.0)
1995	16.3(100.0)	1.8(11.0)	4.5(27.6)	0.90(5.5)	9.1(55.8)
1988-1995	219.1(100.0)	-11.1 (-5.1)	55.3(25.2)	6.70(3.0)	168.2(76.8)

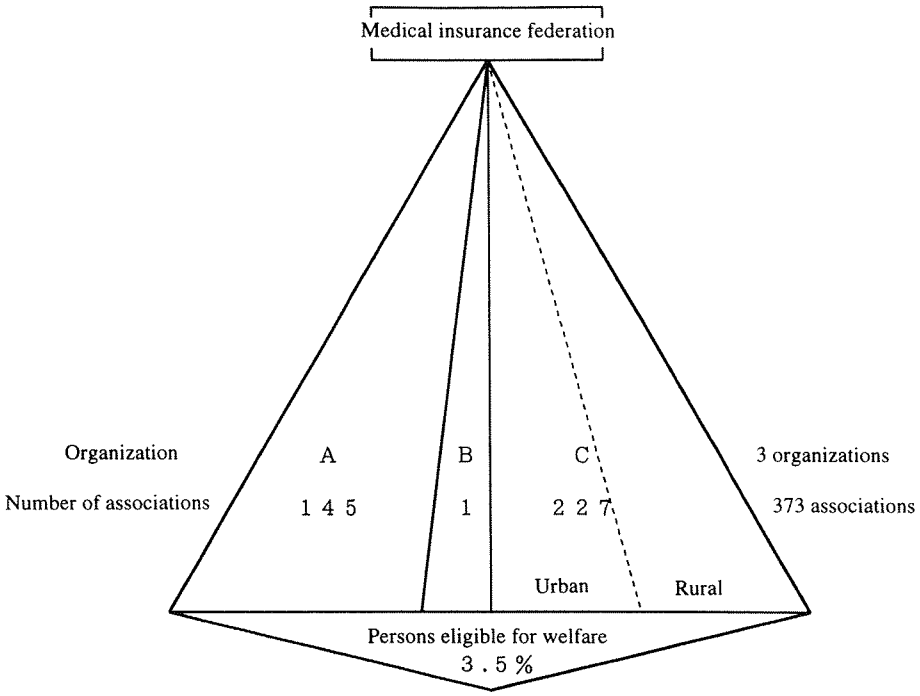
1) Increase rate of expenditures for personal health medicine excluding public health and investment expenditure]
2) Value obtained by dividing Medical Consumer Price Index (MCPI) by overall Consumer Price Index (CPI)
3) Increase rate of Consumer Price Index (CPI)

Table 24 Self-pay rate among senior citizens for medical examination at hospitals

Hospitalization	20%
Outpatients University hospitals (max)	55%
General hospitals	40%
Clinics (fixed rate)	3200 won
Dentists (fixed rate)	4000 won

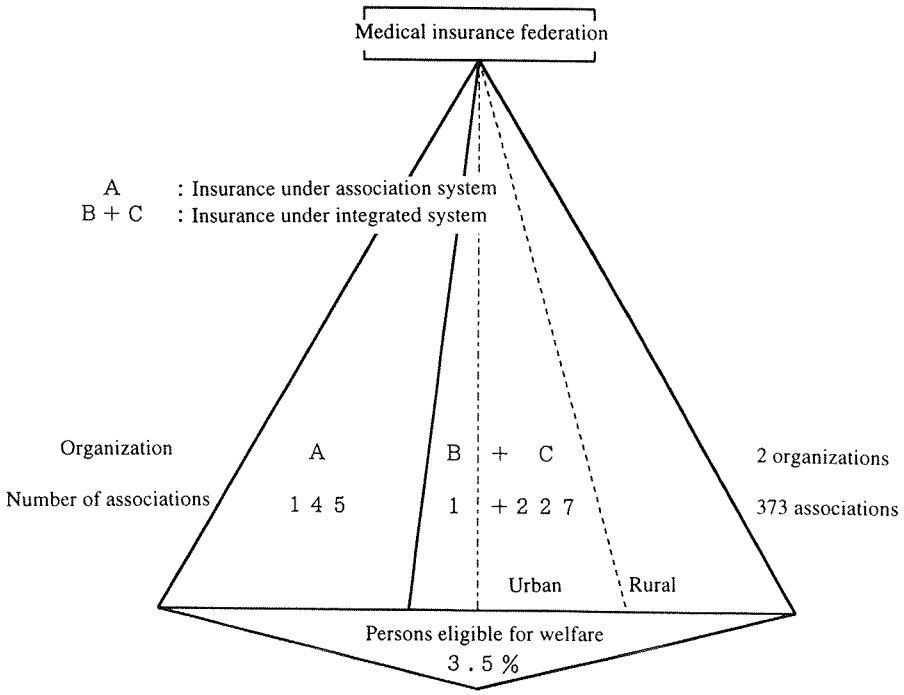
* Difference is charged as premium

Figure 1 Composition of medical insurance association



A: Wage laborers, B: Public servants and private school teachers,
C: Self-employed workers

Figure 2 Composition of medical insurance association after the reform



A: Wage laborers, B: Public servants and private school teachers,
C: Self-employed workers

Chapter Three

Examination of Health and Welfare Policy for Senior Citizens in the Republic of Korea

1. Introduction

(1) Trend of aging in Korea

Korea's life expectancy improved from 69.0 years in 1985 to 71.3 years in 1990 and is expected to reach 74 years by the year 2000, thanks to economic growth that has been continuing up to present, and improvement of living standard and advancement of medicine. At the same time, old age population (those aged 65 years and above) increased and came to account for 6.6% of the entire population as of 1998. Their percentage will increase to 7.1% or 3,371,000 persons by 2000, which means that Korea will join the ranks of aging society. By 2022, Korea is expected to turn into an aged society as this percentage goes up to 14.3%. Dependent population index, which is the ratio of old age population against productive age population (those between 15 and 64 years of age), is predicted to jump from 9.2% as of 1998 to 20.8% in 2022. This means that while every 10.9 persons in productive age are currently supporting one elderly person, every 4.8 persons in productive age will have to support one elderly person by 2022.

Table 1 Trend of old age population aged 65 years and above

Classification	1990	1998	2000	2003	2022
Senior population	2.20 million (5.1%)	3.05 million (6.6%)	3.37 million (7.1%)	3.90 million (8.0%)	7.52 million (14.3%)
Total population	42.69 million	46.43 million	47.27 million	48.43 million	52.56 million
Dependent population index	7.4	9.2	10.0	11.4	20.8

Reference: National Statistical Office, December 1996, Population Projection

Such speed of increase in old age population, which is seen nowhere else in the world, is expected to turn an aging society (defined as a society in which old age population accounts for 7% of entire population) into an aged society (defined as a society in which old age population accounts for 14% of entire population) in a period of only 22 years. As shown in Table 2, in countries like France and Sweden where aging was experienced at early stage, the transition from aging to aged society occurred over a period of 115 years and 85 years, respectively. Meanwhile, in Japan, the same process occurred over a period of 25 years. In contrast, problems in areas such as support for the elderly, health/medical care and welfare will naturally manifest at an early stage in Korea as the transition is predicted to take place over an even shorter time than Japan of only 22 years. Therefore, the preparation for the upcoming aging society is a matter of urgency.

Table 2 Number of years needed for making the transition from aging society to aged society

Ratio of senior population	Japan	US	UK	France	West Germany	Sweden	Korea
7%	1970	1945	1930	1865	1930	1890	2000
14%	1996	2020	1975	1980	1975	1975	2022
Number of years	26	75	45	115	45	85	22

Note: JARC, Aging in Japan, 1996

(2) Health and welfare demand of senior population

While 2.1% of the entire population received public assistance as of 1997, the percentage more than quadruples to 8.6% for senior population to indicate relative inferiority of income standard for the elderly.

Table 3 Scale of population receiving public assistance

	Entire population	Senior citizens
Total population	46,429,817	2,908,283
Population receiving public assistance	988,812	251,085
Component ratio	2.1%	8.6%

Reference: Ministry of Health and Welfare, "Analysis of Present Status of People Receiving Public Assistance in 1997", November 1997

Moreover, the percentage of those suffering from chronic diseases is obviously higher among those aged 65 years and above compared to the entire population. In 1995, the percentage of those suffering from chronic diseases was 105.2 for every 1,000 population among those aged 65 years and above, as opposed to 43.1 for every 1,000 population among the entire population. In addition, while some 150,000 senior citizens (which account for 5.6% of those aged 65 years and above) were bedridden elderly who were not capable of even minimal movements required for their daily life in 1994, not even basic health and medical services could be provided to these people in Korea.

Table 4 Prevalence of acute and chronic diseases among senior population

(unit: number of cases)

Prevalence	Nationwide		Urban areas		Rural areas	
	65 years and above	Entire population	65 years and above	Entire population	65 years and above	Entire population
Acute diseases (Note 1)	925	477	931	462	914	531
Chronic diseases (Note 2)	1052	431	1081	403	1012	531

Note 1: (Number of disease cases that lasted for 2 weeks/total population included in the survey) X 1,000
Note 2: (Number of chronic disease cases that lasted for 1 year/total population included in the survey) X 1,000
Reference: Korea Institute for Health and Social Affairs, 1995, "Realities of the Health of Korean People and Their Use of Medical Care"

Table 5 Health condition and degree of functional disorder among elder persons aged 65 years and above

<table>
<tr><td rowspan="4">Elder persons that are healthy and capable of independent life (13.3%)</td><td colspan="3">Elder persons suffering from chronic diseases but are capable of independent life (86.7%)</td></tr>
<tr><td rowspan="3">Elder persons suffering from chronic diseases but are capable of independent life (43.4%)</td><td colspan="2">Elder persons limited in terms of IADL only (43.4%)</td></tr>
<tr><td rowspan="2">Elder persons limited in terms of IADL only (18.4%)</td><td colspan="2">Elder persons limited in terms of ADL (31.9%)</td></tr>
<tr><td>Those having 1 to 5 ADL limitations (28.4%)</td><td>Those having 6 ADL limitations (3.5%)</td></tr>
</table>

Note 1: N=2,221 persons
Note 2: ADL: Activities of Daily Living
Note 3: IADL: Instrumental Activities Daily Living
Reference: Chung Kyung-Hee et al., 1998, National Survey on the Livelihood Realities of Elderly Persons and Their Demand for Welfare for Fiscal 1998

Meanwhile, number of elderly persons living by themselves has increased rapidly after the function of families in supporting the elderly was reduced due to increase of nuclear families and declining fertility. The percentage of households comprised only of elder persons in all households has more than doubled from 2.7% in 1985 to 5.8% in 1995.

Moreover, the current percentage of elderly persons that do not live with their children (independent senior households) is 42.3%, an increase of 19.1% from 10 years ago.

There is a need for a new policy to cope with such absolute and relative increase in senior population and resulting diversification of health and welfare needs among them, as well as with the concurrent decline in the function of families in supporting the elderly.

Table 6 Form of residence among senior population

(unit: %)

Form of resident	1985	1990	1995
(Senior single households + senior couple households)/Total households	2.7%	3.7%	5.8%
(Number of elderly persons living in senior single households and senior couple households)	23.2	30.0	42.3

Reference: Chung Kyung-Hee, 1997, "Changes in Family as Seen from Social Index and Policy Issues"; Health and Social Study, vol. 17, issue 1

2. Basic Direction of Welfare Policy for Senior Citizens

A more productive, peaceful and fulfilling senior life must be guaranteed by meeting diverse welfare needs that will grow rapidly with the arrival of aging society in an efficient manner. The matter of utmost importance is the need for shared recognition among all people of Korea about the basic goal of the elderly health and welfare policy, which is "support for self-reliance through social solidarity." The basic direction that must be followed for this purpose includes:

① Expanding the group of people that are eligible for elder welfare by stepping up projects that are mainly intended for senior citizens receiving public assistance and by gradually developing welfare policies for the elderly to improve the social productivity of all senior citizens. For this purpose, low-income senior citizens without means of self-sustenance shall have their minimum requirements such as income, medical care and housing guaranteed through government support. Meanwhile, private resources shall be utilized for the elderly that have access to economic resources.

② Making a shift from subject-oriented projects to needs-oriented projects while seeking development from facility-oriented projects to community/household-oriented projects. In addition, welfare system that places more priority on community resources than facility capacity shall be established by making maximum use of traditional family system unique to Korea that offers protection to the elderly to compensate for weakening of the function for supporting the elderly in the industrialized society. At the same time, a project

base centered on the user shall be established to enable elderly persons to utilize welfare services according to their own needs. Effort must also be made to improve the convenience of such project base so that elderly persons can utilize such welfare service at an appropriate time.

③ Strengthening the support for self-reliance through social solidarity. For this purpose, conditions that will enable elderly persons to spend their remaining years by participating in worthwhile social activities through lifelong education, reemployment and volunteer activities must be made available. In addition, an image of respected and energetic senior citizens shall be established by creating an atmosphere of respect and courtesy for the elderly through measures including support for families with elderly dependents by making maximum use of Korea's unique traditional family system.

3. Policies Related to Welfare for the Elderly

(1) Income guarantee policy

1) Economic condition of the elderly

As of 1998, 29% of senior citizens are working and earning income. Income from their work accounts for 33.7% of their total income.[1] Meanwhile, 66.3% of senior citizens receive assistance from their children living in a separate household while 23.4% of senior citizens receive assistance from their children living in the same household. When senior citizens that are receiving assistance from their children living in a separate household are taken into consideration, one can conclude that the majority of senior citizens are receiving assistance form their children.

Under these circumstances, senior citizens that responded as having income from real estate and rent accounted for 12% and those that responded as having income from public assistance and old-age allowance accounted for 8.5% of all senior citizens. Considerably small percentage of senior citizens were receiving income related to their lifelong labor such as public pension, retirement allowance and personal pension; the percentage was 2.9%, 0.9% and 0.2%, respectively. This indicates the fact that only a small portion of senior citizens is receiving income from the public income guarantee system and that today's senior citizens have no choice but to depend on their children.

[1] Since this figure comes from a study of labor income accruing from spouse's labor as well as the person in question, the aforementioned percentage of senior citizens engaged in paid labor was slightly higher.

Table 7 Employment of senior citizens

(unit: %)

Ability to work	Sex		Age			Overall
	Male	Female	65~69	70~74	75+	
Working	39.8	22.6	40.2	28.5	16.3	29.0
Not working	60.2	77.4	59.8	71.5	83.7	71.0
Total (number of persons)	100.0 (874)	100.0 (1,497)	100.0 (901)	100.0 (693)	100.0 (776)	100.0 (2371)

Note: 1 person has been excluded for not responding

Reference: Chung Kyung-Hee, 1998, National Survey on the Livelihood Realities of Elderly Persons and Their Demand for Welfare for Fiscal 1998

2) Income guarantee system

① Pension

National pension system is the key system of social security that guarantees stable livelihood of the people against social risks such as old age, disability and death. Korea enacted the National Welfare and Pension Act in 1973 and was to introduce the pension system in 1974, although its introduction was postponed indefinitely due to deterioration of economic condition at the time partly due to the oil crisis. However, the need for introduction of the national pension system for guaranteeing income at old age was brought up repeatedly as a result of subsequent economic growth and improvement of living standard for all the people. The government enacted the National Pension Act after thoroughly revising the National Welfare and Pension Act in 1986 and decided to implement a national pension system for workers of businesses having 10 or more employees as of January 1988. In 1992, priority was given to workers of small businesses by expanding the system to workers of businesses having 5 or more employees. Furthermore, application of national pension was expanded to include farmers and military-affiliated private undertakings in 1995 in an effort to develop the national pension system that had been limited to workers of businesses having 5 or more employees into a more universal public pension system. The fact that all of this took place in only 7 years after the introduction of national pension suggests that it was an epoch-making measure aimed at recovering the delay in introduction of national pension system compared other developed countries. In addition, the preparation for expanding the system to cover self-employed persons in urban areas is under way.

Table 8 Income source of senior citizens

(unit: %)

Source of income	Area		Age		Overall	
	Urban	Farming and fisheries villages	65~69	70~74	75+	
Job, occupation	23.1	52.0	46.5	32.3	18.0	33.7
Real estate, rent	13.2	9.8	12.8	13.4	9.4	12.0
Savings and stock dividend	6.8	3.7	6.7	4.3	5.8	5.7
Pension	4.0	0.9	3.8	4.2	0.2	2.8
Retirement allowance	1.0	0.7	1.6	0.5	0.3	0.9
Private pension	0.3	0.2	0.3	0.4	0.0	0.2
Assistance from children in separate house	64.0	70.3	62.5	68.3	69.2	66.3
Assistance from children in same house	24.8	20.9	20.2	22.8	28.3	23.4
Assistance from other relatives	1.8	0.2	1.1	0.9	1.6	1.2
Public assistance and assistance from	8.6	8.3	6.5	10.0	9.7	8.5
Old-age assistance organizations	0.8	0.3	0.4	1.0	0.5	0.6

Note 1: Results of overlapped response.
Note 2: N = 2,224 persons (148 substitute responses are omitted).
Note 3: Includes savings and securities.
Note 4: Includes retirement allowance and personal pension.
Note 5: Eldest son (5.8%), other sons (40.2%), daughters (38.0%), unmarried children (5.8%), Grandchildren (4.7%), other relatives (2.4%)
Reference: Chung Kyung-Hee, 1998, National Survey on the Livelihood Realities of Elderly Persons and Their Demand for Welfare for Fiscal 1998

Table 9 Present condition of national pension annuitants

(unit: thousand persons)

Fiscal year	Total number of annuitants	Annuitants from workplace	Annuitants from farming and fisheries areas	Regional annuitants	annuitants continuing on optional basis
1993	5,160	5,109	-	40	11
1994	5,445	5,383	-	48	14
1995	7,496	5,542	1,890	49	16
1996	7,829	5,678	2,085	50	16
1997	7,871	5,693	2,046	52	80

Reference: National Pension Management Corporation, "Annual National Pension Report" from respective years

Total number of annuitants increased sharply from 5.45 million in 1997 to 7.87 million in 1997 after 1.89 million farmers and fishermen were added by expansion of regional pension for farming and fisheries villages. This fact can also be rated highly in the sense that it offered the basis for income guarantee measures in farming and fisheries villages in the future. Although social security system did not exist for farmers and fishermen with regard to disability and death due to their ineligibility for health system, application of national pension

has provided the foundation for a comprehensive social security system by providing disability pension and survivor's pension in addition to old age pension.

Meanwhile, "filial piety pension program," the purpose of which was to improve the premium collection rate by inviting the children living in urban areas to pay the premium for their parents and enhance their sense of filial piety, was actively carried out as a social movement. A target of enrolling 100,000 persons (aimed at the children of 671,000 farmer and fishermen annuitants aged 50 years and above) as filial piety pension participants was set through joint participation of Korean Senior Citizen Association, Agriculture, Fisheries and Stock Farming Association and field administrative bodies. The program has been successful, achieving participation of 97,803 persons as of the end of July 1997.

Moreover, improvement of national pension system is under way for long-term stabilization of national pension by establishing National Pension Fund System Improvement Planning Group to correct the unbalanced structure of "low charge and high payment" which had been pointed out as a problem and to improve the profitability, transparency and specialization of national pension fund employment.

② Filial piety pension system

The old age allowance system introduced in 1991 did not reach a satisfactory level as it only paid 10,000 won per month to 76,000 householders aged 70 years and above that are receiving public assistance. Nevertheless, the system gradually increased its amount and expanded its recipients. As of 1997, 35,000 won is paid to senior citizens between ages 65 and 79 that are receiving public assistance (228,477 persons) and 50,000 won is paid to senior citizens aged 80 years and above that are receiving public assistance (36,642 persons) every month. However, the old age allowance system was abolished by the extensive amendment of the Senior Welfare Act in July 1997 and was replaced by the newly introduced filial piety pension system.

While the national pension system is the key system of income guarantee for senior citizens in Korea that was introduced in 1988, the national pension system was established as a system for guaranteeing the income of worker households when they reach old age at the time of its introduction, and those that had already become senior citizens at the time were excluded from the system. These senior citizens were people that did not have savings for their old age as they had to pay the premium for the filial piety program in addition to educational expenses for their children when they were working. They are the generation of the transition period from private support by families to public support. However, the senior citizen income guarantee policy during this period was limited to restrictive and indirect support, consisting of public assistance and old age allowance for weak low-income senior

citizens and provision of transportation expenses for ordinary senior citizens aged 65 years and above.

In this respect, introduction of old age pension system tends to be regarded as an epoch-making system of public income guarantee for the existing senior population that do not qualify for national pension. However, one can conclude that the old age pension system provided in the present Senior Welfare Act is still incomplete.

The filial pension currently being implemented is functioning as an senior income guarantee system for public assistance recipients and low income senior citizens among the existing class of senior citizens that have been excluded from the national pension program. Therefore, it is being run as a filial pension system by absorbing and integrating the existing old age allowance provided to public assistance recipients

In addition, as the allowance is paid only to low income senior citizens instead of all senior citizens that are ineligible for the national pension program due to limitations of the budget, the criteria for selection are provided separately in the enforcement order for the Senior Welfare Act. The income criteria have been set to monthly average income (obtained by dividing the total monthly income of the senior citizen, his or her spouse and dependent by the number of persons in the household) corresponding to 60/100 of the monthly average income of urban laborer households in the previous year. Meanwhile, the asset criteria have been set to the sum of assets of the senior citizen, his or her spouse and dependent being 140% or less compared to the asset criteria used for selecting the self-support allowance recipients under the Public Assistance Act (Article 15 of the Senior Welfare Act).

As of August 1998, old age pension is paid to 623,479 persons including 248,764 senior citizens receiving public assistance (39.9%) and 374,715 ordinary low-income senior citizens (60.1%). This coverage corresponds to 20.4% of all senior citizens aged 65 years and above. The amount of payment is 50,000 won for senior citizens receiving public assistance, 40,000 won for senior citizens aged between 65 and 79, and 20,000 won for ordinary low-income senior citizens. Married couples receive 15,000 won after reducing 25% of the amount paid to each spouse. The budget required for this program is 105.4 billion won; 72.2 billion won (68.5%) of which comes from the general account budget and 33.2 billion won (31.5%) comes from the municipal budget.

Table 10 Payment of filial piety pension (1988)

Classification	Senior citizens receiving public assistance		Low-income senior citizens		Total
	Below 80 years of age	80 years of age and above	Full amount recipients	Reduced amount recipients	
Number of recipients	195,345 persons (31.3%)	53,419 persons (86%)	291,296 persons (46.7%)	83,419 persons (13.4%)	623,479 persons (100.0%)
Amount received (per person)	40,000 won	50,000 won	20,000 won	15,000 won	—
Required budget [1)]	46.8 billion won (44.5%)	16.0 billion won (15.2%)	35.0 billion won (33.2)	7.5 billion won (7.1)	105.4 billion won (100.0%)

Note 1: 72.2 billion won from the general account budget and 33.2 billion won from the municipal budget

Reference: Internal data from Older Persons Welfare Division of Ministry of Health and Welfare, 1998

3) Employment-related policies

① Assistance of employment for senior citizens

Korean Senior Citizen Corporation has been running senior ability banks since 1981 to provide senior citizens with good use of their spare time and income earning opportunities through consultation and assistance for their employment. Meanwhile, the government offered 500,000 won per month to each of 70 such locations in 1997 (formerly 300,0000 million won) as subsidy for their operating expenses. At the same time, senior employment agencies affiliated with the Labor Department have been established at 25 locations since July 1993, and Seoul Municipality has created and is running an employment assistance center for senior citizens.

Table 11 Results of employment assistance results by fiscal year

Classification	Total	1992	1993	1994	1995	1996	1997
Total	1,069,400	88,009	76,868	107,879	97,728	91,488	70,594
Long-term employment	186,643	25,438	21,000	27,579	25,593	27,726	17,215
Short-term employment	791,269	62,571	55,868	80,300	72,135	63,762	53,379

Reference: Health and Society White Paper for respective years, Ministry of Health and Welfare

② Collective workshop

The government is recommending creation of workshops at senior welfare facilities including Day care center for the aged. These facilities not only make good use of their spare time but offer increased income by enabling the elderly to work according to their aptitude. The government is subsidizing the basic construction cost for building collective workshops at such facilities. (This subsidy, which is funded 50% by the national treasury and 50% by

municipal budget, has been increased from 3 million won per facility to 5 million won per facility in 1997.) The number of facilities receiving this subsidy has increased considerably from about 200 in 1992 to 481 in 1998.

Meanwhile, 60 occupational categories have been designated as conforming occupational categories pursuant to the Law for Promotion of Employment for Senior Citizens in 1991 to expand the employment opportunities of senior citizens. The number of such occupational categories is scheduled to be increased to 80 by 2002.

Table 12 Creation of collective workshops for the elderly by year

Classification	1990	1991	1992	1993	1994	1995	1996	1997	1998
Number of workshops built	152	212	266	311	356	401	441	461	481
Number of workshops supported	50	66	54	45	45	45	40	20	20

Reference: Health and Society White Paper for respective years, Ministry of Health and Welfare

(2) Welfare and Health/Medical Care Programs

1) Health/medical care

Health is a very important issue for senior citizens because most of them suffer from chronic geriatric diseases that accompany physical and psychological aging. The majority of Koreans are currently covered by medical insurance, and medical protection is offered to public assistance recipients. As of 1995, 96.7% of senior citizens are covered by medical insurance and the rest are under medical protection. Meanwhile, there was a problem of medical insurance payment to senior citizens being limited 270 days a year that prevented senior citizens suffering from chronic retrogressive diseases to receive long-term medical consultation and treatment until 1995. However, medical expenses incurred by senior citizens were reduced after the removal of time limit in the insurance system for senior citizens and disabled persons in 1996.

Nevertheless, the current medical insurance system is centered around treatment of acute diseases and therefore does not fully reflect the characteristics of senile diseases which require nursing and recuperation in addition to incurring excessively large burden in terms of support in the event of long-term treatment. Since various examinations (e.g. MRI, CT), preventive health examination, physical therapy, herbal medicine expenses, provision of food/drug containing iron, geriatric medical equipment, medical apparatuses and articles, assisting device expenses are not covered by medical insurance, efforts must be made to gradually include them in the insurance coverage. In addition, it is necessary to lower the age limit for discount on medical expenses paid by insured outpatients from 70 to 65.

Meanwhile, the expenses that are linked to home-care nursing programs, home-care helper programs, nursing home facilities and hospice programs must be covered by insurance payment by qualifying home-care and nursing home facilities for medical insurance. At the same time, a method for developing and applying other treatment service expenses in lieu of conventional treatment expenses must be actively reviewed. Moreover, it is necessary to introduce a new "nursing system" through other insurance systems such as the long-term treatment insurance available in the U.S. and the public nursing insurance system implemented in Japan and Germany.

On the other hand, the number of senile dementia patients is estimated at 250,000; this corresponds to 8.3% of senior population aged 65 years and above and the percentage is predicted to reach 9.0% by 2020. Therefore, the government is planning to launch a community-based dementia management program by setting up senile dementia consultation centers at public health centers across the country. Further, treatment facilities for patients suffering from severe senile dementia that cannot be treated at home or general treatment facilities are in operation or under construction through government support at a total of 24 locations as of the end of 1998. The number of such facilities will be increased to 50 locations by 2003. Concurrently, dementia treatment hospitals (existing at 6 locations as of the end of 1998) will be built at every city and county by the year 2001.

At the same time, a research team of retrogressive diseases will be created at the Center of Brain Medicine and Pharmacology in the National Health Institute in an effort to establish a comprehensive research system for causes, prevention, treatment and diagnosis of dementia while training experts in dementia research.

2) Free medical checkup

The government has been offering free medical examination for low-income senior citizens since 1983 with the aim of discovering senile diseases at an early point in time so that health guidance and health education can be implemented to improve the health of senior citizens. A more complete health checkup is sought by including senile diseases such as diabetes and cataract among the health checkup items in 1992 and offering examination for special senile diseases including cancer examination at routine blood examination and X-ray examination in 1996.

Medical checkup for senior citizens is conducted in first and second phases. Second phase examination is performed on those suspected of having some disease in the first phase examination. The results of examination are notified to senior citizens and their family, and are utilized for prevention and treatment of senile diseases.

A budget of 342 million won has been set aside for this medical checkup in fiscal 1997 (233 million won supplied by national treasury and 190 million supplied by from municipal

budget) and the checkup will be offered free of charge to approximately 30,000 low-income senior citizens.

3) Senior welfare facilities

In addition to expansion of senior welfare facilities that have been offering free help to needy senior citizens with no relatives, new paid facilities such as nursing homes, geriatric treatment centers, senior welfare houses and geriatric hospitals as well as dementia treatment facilities have been built. Moreover, the National Pension Fund is planning to finance 100 billion won every year from 1995 to 2000 to activate supply of various paid senior welfare facilities and invite active participation of private sector. As of the end of 1997, 9,539 senior citizens, which account for only 0.3% of the entire senior population, are living in facilities at 173 locations nationwide.

Furthermore, low-interest loan of 5 to 6 billion won and tax incentives are offered to businesses that build facilities such as paid nursing homes, treatment facilities and geriatric hospitals to encourage participation of private sector in meeting the demand for high-quality housing among senior citizens.

Table 13 Present condition of senior welfare facility operation (as of the end of 1997)

(unit: locations, persons)

Type of facility	Number of facilities	Number of persons
Free nursing homes	85	4,526
Free treatment centers	53	3,243
Dementia treatment centers	4	659
Discount nursing homes	3	88
Discount treatment centers	12	562
Paid nursing homes	13	411
Paid treatment centers	3	50
Total	173	9,539

4) Home-care welfare service

The government is implementing home-care welfare programs for mid- and low-income senior households and for senior citizens with mental and physical disorder with the aim of enabling them to lead fulfilling life at their homes. Home-care welfare service of this sort is being stepped up by clarifying the program's criteria and allowing participation of individuals and private companies after the legal basis for the program was laid down along with the amendment of the Senior Welfare Act in 1993.

Interest in home-care welfare grew in the mid-1980s and the number of home-care welfare facilities started to increase after home-helper dispatch program was implemented on a trial basis at 2 locations in 1987. As of 1998, there are a total of 98 facilities consisting of 52 home-helper dispatch offices, 31 weekly care facilities and 15 short-term care facilities. In

addition to these home-care services for the elderly that are offered pursuant to the Senior Welfare Act, 243 home-care welfare service centers have been attached to 276 social welfare centers by the Social Welfare Program Act as of 1996. There are also a visiting nurse service offered by nursing associations and public health centers pursuant to the Medical Care Act and a visiting nurse service, which is currently operated by hospitals as a model project and is scheduled to be implemented on a nationwide basis starting in July 1999. The current home-care welfare service for the elderly is not limited to senior citizens receiving public assistance but has been expanded to include low-income senior citizens and ordinary senior citizens. The service is offered free of charge to the recipients of public assistance, at discounted rate to senior citizens aged 65 years and above that belong to households with income below the monthly average income of a standard urban worker 4-person household (2.15 million won), and at full rate to ordinary senior citizens aged 60 years and above. However, there is shortage of current home-care welfare service in an absolute sense considering the scale of such service.

Home-helper dispatch centers, which offer various types of daily-life convenience services such as cooking, shower assistance and advice regarding hospitals to senior citizens that are having difficulty taking care of themselves with regard to daily matters due to mental and physical reasons, are currently established at 52 locations as of 1998 and are scheduled to be opened at least 1 location in cities, counties and districts throughout the country by 2000.

On the other hand, weekly care facilities and short-term care facilities that accept senior citizens during the day or for several days (2 to 3 days and 10 to 15 days, respectively) when their family cannot look after them due to inevitable reasons (e.g. illness or business trip of the caretaker) and offer necessary services are available at 31 and 15 locations, respectively, as of 1998. The number of both of these facilities is scheduled to be increased to 238.

As of 1998, annual subsidy of 75 million won and 60 million won are offered every year as operating expenses to home-helper dispatch programs and short-term care facilities, respectively. While this subsidization of operating expenses had been provided without regard for the scale of service offered by each facility, it has become possible after the revision of the Senior Welfare Act to adjust the amount of subsidy according to the scale of facility according to the results of facility evaluation pursuant to provisions in Article 43 of the Social Welfare Program Act (Paragraph 4, Article 27, Senior Welfare Act). Efforts must be made to offer subsidy for operating expenses in a fair manner and to increase the number of senior citizens that can benefit from the services offered by these facilities.

The main problems that will have to be solved by home-care senior welfare service include absolute shortage of facilities, uneven distribution of facilities between regions and offering of services that cannot meet the demands of the elderly. The need for regional

balance and expansion of home-care senior welfare service through cooperation among existing facilities has been pointed out as solutions to these problems.

5) Leisure facilities

Leisure facilities have been built and operated throughout the country to meet the needs of senior citizens to participate in social activities and spend their leisure time in a fulfilling way.

Day care center for the aged is a typical community leisure facility for senior citizens living at their homes with the largest number of facilities. It has 30,401 facilities as of 1996 and is receiving 44,000 won per month in operating expenses and 240,000 won a year in heating expenses per location from the national treasury as of 1998. At the same time, Day care center for the aged is developing and providing a wide variety of wholesome leisure programs to activate its programs and is making efforts to actively offer information on topics such as health and welfare consultation, employment guidance, health/medical care and pension. There are also senior classes offered at 444 locations that are not very active. Senior welfare centers have rapidly increased their number from 43 locations at the end of 1996 to 80 locations as of May 1998.

Table 14 Present condition of senior welfare facilities

(unit: locations, persons)

Fiscal year	Day care center for the aged	Senior classes	Senior welfare centers
Number of facilities	30,410	444	43
Number of senior citizens using the facility	1,326,473	43,713	—

The government has also introduced senior resting stations in addition to Day care center for the aged and senior classes that have been legislated by the Senior Welfare Act to diversify the leisure facilities and made arrangements to manage and operate these resting stations by registering them at cities, counties and districts. In addition, "Comprehensive Welfare Town for the Elderly" for offering various types of welfare service including health, culture, entertainment and culture to senior citizens in general will be operated at 5 locations in the country by 2000 as model cases and will be expanded to other areas of the country thereafter.

6) Expanded opportunities for volunteer and social participation

While some senior citizens are participating in volunteer activities such as nature conservation and traffic guidance, the rate of participation is low due to lack of understanding about these activities among senior citizens and insufficiency of social conditions. As

volunteer activities contributes significantly to life after retirement by promoting their mental and physical health and by enabling them to lead productive and fulfilling life, the government has a plan to foster the activities of private organizations to activate such activities by subsidizing transportation expenses that are required for these activities.

(3) Promotion of Social Atmosphere to Respect the Elderly

1) The government has designated the week including the Parents' Day on May 8 of each year as the Respect for the Aged Week pursuant to the Senior Welfare Act in an effort to create an atmosphere for expressing gratitude to parents and paying respect the elderly. Also to develop the though of respect for the aged and filial piety which is a traditional good custom and public moral of Korea, events for expressing respect for the elderly are held not only on an administrative unit basis (e.g. cities, counties and districts) but on a workplace basis. At the same time, dutiful persons that respect the elderly and set good example to others are picked out from various parts of the country for commendation. A total of 4,918 persons have been commended as of 1997. Starting in 1997, numerous activities including commendation of model senior citizens as well as athletic events and academic seminars for the elderly are also held on Seniors' Day (October 2) for the purpose of increasing the social roles of senior citizens and social interest in them.

Table 15 Commendation of dutiful children

Year	Total	Dutiful children	Splendid father	Contributors to senior welfare	Model traditional family
Total	4,918	3,720	294	645	259
1982~96	4,669	3,575	278	572	244
1997	249	145	16	73	15

2) Rooting and expansion of respect and courtesy for the elderly

The system of respect and courtesy for the elderly started on the Parents' Day, May 8, 1980 by introducing a courtesy system in 8 areas of service including railroad and public bath for senior citizens aged 70 years and above. In 1982, the age qualification for this system was lowered to 65 and the applicable services were increased to 13 by adding 5 services including city bus and theater.

However, problems such as refusal of bus boarding and unkindness occurred as the system was operated solely by private companies without any government support during this period. To solve them, the government took charge of the finance in 1990 and started supplying a senior pass in 1994 from the local budget. In 1996, the system was further

improved by supplying cash. In addition, transportation discount system was expanded for a part of railroad named limited express *T'ong-il-ho* (50%) and subways. Starting in June and July 1996, the discount was expanded to airplane and vessel tickets (10% and 20%), respectively.

On the other hand, there is room for improvement in the discount system operated by private sector as it is limited to services such as public bath and barber and their range of services is small.

Authors: Dr. Byeon Jae-Kwan, Research Fellow of Korea Institute for Health and Social Affairs
Dr. Chung Kyung-Hee, Research Fellow of Korea Institute for Health and Social Affairs

[Bibliography]

National Pension Management Corporation, "Annual National Pension Statistics Report" from respective years

Ministry of Labor, 1998, Labor White Paper

Byeon Jae-Kwan, 1998, "Present Condition of Senior Health and Welfare Policy and Policy Legislation in Korea," Health and Welfare Forum, vol. 25, pp.6-13

Byeon Jae-Kwan, "Crisis of Welfare State and Reorganization Towards New Conservatism," Mother and Child Study 17, Shinsei-kai Social Welfare Institute, April 1996

Byeon Yong-Chan, 1997, "Development and Research on Dementia Management Mapping", Korea Institute for Health and Social Affairs.

Ministry of Health and Welfare, 1997, Analysis of Present Condition of Public Assistance Recipients in 1997

Ministry of Health and Welfare, Social Welfare White Paper from respective years

Seo Mi-Kyung, "Present Condition of Senior Health and Medical Care and Direction of Policy," Health and Welfare Forum, vol. 25, pp.27-35

Seok Sae-Eun, "Present Condition of Filial Piety Pension and Direction of Its Development," Health and Welfare Forum, vol. 25, pp.36-48

Chung Kyung-Hee et al., 1998, National Survey on the Livelihood Realities of Elderly Persons and Their Demand for Welfare for Fiscal 1998, Korea Institute for Health and Social Affairs.

Chung Kyung-Hee, 1998, "Present Condition of Senior Welfare Service and Policy Tasks," Health and Welfare Forum, vol. 25, pp.14-26

Chung Kyung-Hee, 1997, "Changes in Family as Seen from Social Index and Policy Tasks," Health and Social Study, vol. 17, issue 1

National Statistical Office, 1996, Future Population Estimation

National Statistical Office, 1996, Social Index of Korea

National Statistical Office, Report on General Survey of Population and Housing from respective years

Korea Institute for Health and Social Affairs, 1995, Realities of People's Health and Medical Care in Korea

Japan Aging Research Center, Aging in Japan, 1996

Chapter Four

Employment of Senior Citizens in the Republic of Korea

1. Employment of Senior Citizens

(1) Employment rate of senior citizens

According to the Labor Fact-Finding Survey of Concerns conducted every year by the Labor Department on all firms employing 5 or more people, employment rate of senior citizens as of 1997 is 6.65% (Table 1). The Senior Citizen Employment Promotion Act requires entrepreneurs to hire at least 3% senior citizens among their employees---the goal of this law has already been achieved.

(2) The need for promoting employment of senior citizens

In Japan, decline in number of young laborers is expected to occur by 2005 and will give rise to the need to utilize senior citizens as workforce. Meanwhile, in Korea, fewer children being born will not offer a reason for promoting employment of senior citizens. Therefore, securing income for senior citizens and stabilizing their livelihood has become the purpose for promoting their employment. When the Senior Citizen Employment Promotion Act was enacted in 1991, the Korean economy was strong and there was shortage of labor. While foreign labor was initially utilized to make up for this shortage, eyes were later turned to senior citizens for "utilization of idle labor" and "promotion of labor welfare."

(3) Senior citizen employment promotion subsidy system

Three kinds of senior citizen employment promotion subsidy system are available in addition to the pension system for promoting employment of senior citizens.

1) Bonus for employing large number of senior citizens

Firms having 6% or more senior citizens among their employees will receive 90,000 won per quarter (360,000 won per year) for every senior citizen in the form of bonus for employing large number of senior citizens.

2) Bonus for newly employing senior citizens

Entrepreneurs that have newly employed at least 10 senior citizens or a number of senior citizens corresponding to 5% of firm's workforce during a 6 month period will receive 20 to 25% of the salaries paid to newly employed senior citizens in the form of bonus for newly employing senior citizens.

3) Bonus for reemployment

Entrepreneurs that have reemployed retired middle- and old-age persons (45 years of age or older) within 2 years from their retirement will receive 400,000 to 800,000 won in reemployment bonus for each such person reemployed.

(4) Future direction

In 2010, the percentage of senior laborers in Korea is expected to reach the level of Japan in 1998. From a short-term viewpoint, however, promotion of employment for senior citizens must be pursued carefully because of the high rate of unemployment among college and high school graduates. In addition, long-term programs have not been laid out as of present. Meanwhile, "Analysis of Senior Citizen Market" conducted by the Korean Labor Institute in 1997 has identified problems concerning a part of future demographic predictions and characteristics of senior citizen labor market determined through comparison of Japan and Korea.

2. Age-Limit System

(1) Laws related to age limit

Age limit for employees is set at the discretion of firms as no general provision exists with regard to the establishment of retirement system in the laws concerning labor. However, Article 19 of the Senior Citizen Employment Promotion Act (Law No. 4487, 91.12.31)

provides that "An entrepreneur must make an effort to set the age limit to 60 years or higher when deciding the age limit of his or her employees." In addition, Article 21 of the same law provides that an entrepreneur reemploying a senior citizen who has left his or her job on reaching retirement age can exclude the previous period of service in the consecutive working hours calculation for determining the retirement allowance and number of paid vacation days provided in the Labor Standards Act through an agreement with the person concerned.

(2) Present situation of age limit

A worker's age limit is usually 55 and the average age limit under the uniform retirement system was 55.2 years in 1988. The average went up slightly to 56.5 years in 1995, although extension of age limit is difficult considering the present condition of the industry. In fact, 86.8% of establishments having 5 or more employees have age limit below 60 years (Table 2). Incidentally, those aged 55 years and above are referred to as senior citizens while those aged between 50 and 54 years are referred to as quasi senior citizens.

(3) Pension system for retirement and unemployment

While Health and Welfare Department has a national pension plan in place as the pension system for retirement and unemployment, Labor Department does not have any special system of this sort. In employment insurance, however, there is a system comparable to unemployment insurance in Japan that offers unemployment insurance coverage to those who have lost their jobs.

(4) Reemployment after reaching the retirement age

In Japan, some workers are seconded to an affiliate company after reaching retirement age. In Korea, many people start working in low-skill or simple jobs. For this reason, guidance is given so that workers can return to their former workplace as much a possible upon reemployment. However, number of people leaving their company irrespective of age limit is increasing considerably due to restructuring which is being carried out on a large scale.

Table 1 Percentage of firms that are employing senior citizens

Year	Scale of business	Number of businesses	Total number of workers	Number of workers aged 55 years and above	Senior citizen employment rate
1993	5 or more employees	153,554	5,733,837	276,418	4.82
	More than 300 employees	2,052	1,679,176	43,402	2.58
1994	5 or more employees	167,403	6,085,354	315,546	5.19
		(+9.0%)	(+6.1%)	(+14.2%)	
	More than 300 employees	2,086	1,785,779	50,937	2.85
		(+1.7%)	(+6.3%)	(+17.4%)	
1995	5 or more employees	178,051	6,617,596	352,762	5.72
		(+6.4%)	(+1.4%)	(+11.8%)	
	More than 300 employees	2,113	1,719,201	52,176	3.03
		(+1.3%)	(-3.7%)	(+2.4%)	
1996	5 or more employees	186,903	6,236,261	389,695	6.24
		(+4.5%)	(+1.1%)	(+10.5%)	
	More than 300 employees	2,113	1,694,295	54,488	3.21
		(+0%)	(-1.4%)	(+4.4%)	
1997	5 or more employees	202,095	6,342,071	422,344	6.65
		(+8.1%)	(+1.7%)	(+8.4%)	
	More than 300 employees	2,048	1,611,679	55,837	3.46
		(-3.1%)	(-4.8%)	(+2.4%)	

Source: Report from Labor Fact-Finding Survey of Concerns

Table 2 Distribution of retirement age under the uniform retirement system

Year	~ 49	50	55	56~57	58~59	60	61 ~	Average retirement age
88	—	3.8	88.3	0.7	2.7	4.1	0.3	55.2
95	0.2	1.0	54.8	11.2	19.6	11.7	1.5	56.5

(unit: %)

Chapter Five

Tasks of International Cooperation

1. Basic Viewpoint

When attempting to understand international cooperation in the area of social welfare and social security, one cannot neglect the sociopolitical climate of the country in question. Therefore, let us take a brief look at the sociopolitical situation of Korea before examining the issues related to Korea and international cooperation.

Many countries are aiming to improve the quality of life for their people and are looking to welfare states for the ideal situation. Korea is one of the countries that are trying to follow this path of welfare state. This is manifested in the fact that the name of the Fourth Economic Development Plan which was changed from "Economic Development" to "Socioeconomic Development" when it was laid down in 1977, as well as in the fact that building of welfare state was mentioned in the plan from 1981 onward.

Incidentally, it is often said, "development of economy will lead to development of welfare." This is called the "trickle down effect" of economic development. However, this is not necessarily true. Clear examples of this can be seen in Southeast Asian countries, for instance. Although they are currently hit by economic crisis, Southeast Asia attained rapid economic growth. However, a study of Gini coefficient—which is an indicator of equal distribution of wealth—for these countries reveals that wealth is distributed unevenly and that certain social groups monopolize vast majority of wealth. While it is difficult to explain in a

few words how such situation came about, one of the possible factors is the political situation of these countries. As pointed out by W. A. Robson, existence of democratic political climate in which the government can be elected by the people through peaceful means is crucial when realizing a welfare state (W. A. Robson, "Welfare State and Welfare Society," Tokyo University Press, 1980, p.10). There are countries in Southeast Asia that still have laws for maintenance of public order. In these countries, democracy exists only to a limited degree even if the head of state is elected by election. In other words, democracy is an indispensable political element in substantiating and developing social welfare and social security of a nation.

Let us examine the development of social welfare in Korea in time series by considering these political factors. As for the legislative trend of laws concerning social security and social welfare and the trend of sociopolitical situation, various laws related to livelihood protection and child welfare came into existence in the 1960s including the Livelihood Protection Act and the Child Welfare Act which were both enacted in 1961. However, as seen in the Report on the Realities of Worker Wages from 1968, average wage of workers was not even sufficient to meet 50% of minimum living expenses and the country did not have the ability to operate a social security/social welfare system of this magnitude. Therefore, one may safely say that these legal frameworks were quite nominal.

However, various efforts were made to realize true democracy and the tone of military dictatorship faded in the 1980s. This was followed by the birth of the first civilian president Kim Young Sam in 1993 and the election of the opposition party leader Kim Dae Jung as president in 1997. As for developments in social welfare and social security, interest in local welfare increased in the 1980s when democratization started to move forward. After entering the 1990s, the Fundamentals of Social Security Act was enacted and national insurance coverage was achieved. In other words, the system of actual social welfare and social security was formed when the nation started moving towards democracy.

It can therefore be said that social welfare and social security in Korea did not start solidifying in form and essence until recently. This, in turn, has prepared Korea for seeking substantiation of her social welfare/social security system in the future.

2. Ideal International Cooperation between Korea and Japan

There are two areas of international cooperation that are connected to social welfare and social security; one is cooperation between governments (intergovernmental cooperation) and the other is cooperation in the private sector (private cooperation). Private cooperation in Korea has been active since the Korean War days. For instance, the Holt Foundation Fund,

which was started in 1955 when Mr. and Mrs. Holt of Oregon, U.S.A. adopted 8 Korean and American children, has expanded its scale and is currently running a children's home and an international adoption service (Bertha Holt, "The Seed from the East," Holt International Children Service, 1992 (3rd edition)).

Such international cooperation in the field of social welfare and social security by foreign private organizations became very active in Korea. However, foreign private cooperation slowed down somewhat in the 1960s after the system of social welfare and social security was put in place at least in form. Foreign international cooperation organizations turned their eyes to other developing countries after Korea attained certain degree of success in the field of economy and legal system related to social welfare and social security. Criticism against international adoption that arose among the public just before the Seoul Olympic Games was another reason that made the Holt Foundation Fund shift its emphasis from international adoption to operation of children's homes.

Hence social welfare activities based on foreign assistance are gradually Koreanized on one hand and regional social welfare activities are becoming active on the other, giving rise to the gradual recovery of entities for receiving private cooperation. Welfare activities by religious organizations are also active due to the fact that 30% of Korean population are Christians. Once such activities by these religious organizations lead to participation of the citizens, implementation of a more democratic social welfare will become possible. The only problem is shortage of talents in the field of social welfare. Partly due to the fact that university-level education and research are inclined towards policy, training of field professionals in the private sector is not sufficient.

Let us now examine the possibility of intergovernmental cooperation. As mentioned earlier, the system of social welfare and social security in Korea has made remarkable progress in form and in substance compared to those that existed in the past. However, the problem that arises here again is the training of talents. Social welfare research in Korea mainly consists of policy studies at the Seoul National University, Pusan National University and Yonse University that are performed by researchers that have studied theory in the U.S. Many of the talents that these institutions turn out are employed by the government and receive training as policy administrators. Training of experts will be necessary in the field of assistance skills from now on.

3. Korean Culture and International Cooperation

Korea is pursuing Korean-style welfare society, a unique form of welfare society based on Korean culture. According to the 1997 Health and Welfare White Paper, Korean-style

welfare society is a society aiming for: 1) building of a social safety net for protecting all people from the risks of old age, disease, unemployment and industrial disaster; 2) integration of marginal classes and harmonization of social classes; 3) harmonization of family/community mutual aid and social welfare based on the philosophy of respect and filial piety for the elderly; 4) mutual cooperation among public aid, social insurance and social service; and 5) harmonization of economic development and welfare. While this applies to international cooperation with any country, it is necessary to fully understand the Korean culture manifested in this Korean-style welfare society when considering international cooperation with Korea in the field of social welfare and social security.

Chapter Six

Survey Members and Itinerary

1. Survey Members

Committee in Japan

Toshio KURODA	Director Emeritus, Nihon University Population Research Institute
Hidesuke SHIMIZU	Professor and Chairman, Dept. of Public Health and Environmental Medicine, Jikei University School of Medicine
Yasuo HAGIWARA	Professor, Social Work Research Institute, Japan College of Social Work
Masato NIITSUYA	Assistant Professor, Dept. of Preventive Medicine, Kitasato University, School of Medicine (member of the field survey team)
Tsuguo HIROSE	Executive Director and Secretary General, the Asian Population and Development Association (APDA)
Osamu KUSUMOTO	Senior Researcher, APDA
Haruyo KITABATA	Manager of International Affairs, APDA
Chiharu HOSHIAI	Chief of International Affairs, APDA (member of the field survey team)

2. Cooperators (Survey in Republic of Korea: 12 – 17 October 1998)

Embassy of Japan

Mr. Takahiro Matsuse	Second Secretary

Korean Parliamentary League on Children, Population & Environment (CPE)

Ms. Amy Kim	General Director

Ministry of Health and Welfare

Mr. Do-Seok Jeon	Director-General, Bureau of Family Welfare
Mr. Kyong-Ho Park	Director, Older Persons' Welfare Division
Mr. Weonjong Kim	Manager for Program Planning and Evaluation, Policy Coordination Division, Health Policy Bureau

Ministry of Labour

Mr. Dong-Nam Kim	Director, Division for the Employment of the Disabled
Mr. Jong-Seok Choi	Deputy Director, Division for the Employment of the Disabled

National Statistical Office

Mr. Bong Ho Choi	Director, International Cooperation Division
Mr. Jong-Joon Ryu	Deputy Director, International Cooperation Division
Mr. Jae-Ho Seo	Statistical Cooperation Division, Statistical Planning Bureau
Dr. Ahn Jae-Hack	Deputy Director, Population Census Division, Population and Social Statistics Bureau
Dr. Kyung-Ae Park	Deputy Director, Vital Statistics Division
Mr. Dong-Hoy Kim	Deputy Director, Vital Statistics Division
Dr. Saim Woo	Deputy Director, Social Statistics Division
Mr. Ha Bong Chae	Deputy Director, Social Statistics Division

Korea Institute for Health and Social Affairs

Dr. Kyung-Bae Jung	President
Dr. Nam-Hoon Cho	Vice President
Dr. Jae-Kwan Byeon	Research Fellow
Dr. Eun-Jin Choi	Research Fellow
Dr. Kyung-Hee Chung	Research Fellow
Dr. Mee-Kyung Suh	Fellow

Seoul National University

Dr. Seonja Rhee	Associate Dean, Graduate School of Public Health
Dr. Lee Si Baek	Professor, Graduate School of Public Health Vice President, The Korean Federation of Family Planning
Dr. Sung-Jae Choi	Professor, Dept. of Social Welfare, College of Social Sciences
Dr. Ok Ryun Moon	Professor of Health Policy and Administration, Division of Health Policy, Graduate School of Public Health
Dr. Chang-Yup Kim	Assistant Professor, Dept. of Health Policy and Management, College of Medicine

Chung Woon Nursing Home

Mr. Lee Jong-Hoo	Director

Book-Boo Welfare Center for the Elderly

Mr. Kong Dong-Won	Director
Mr. Bae Suk-Kyung	Head of Welfare Department
Mr. Moo-Young Lim	Social Worker, A Planning Education Department

Itinerary

Period: 12 October - 17 October, 1998

Date	Activities
12 October (Mon.)	• 11:20 Departure from Narita (JD251) • 13:40 Arrival at Seoul. • Reconfirmation of arrangement of a survey with local counterparts.
13 October (Tue.)	• Visit to Embassy of Japan to Republic of Korea. Briefing on outline of Korean social security and welfare systems from Mr. Takahiro Matsuse, Second Secretary. • Visit to Ministry of Health and Welfare. Briefing on outline of policies of welfare for the elderly and social security from Mr. Do-Seok Jeon, Director - General of Bureau of Family Welfare. • Briefing on ageing policies, family planning projects, and social security policies from Mr. Kyong-Ho Park, Director of Older Persons' Welfare Division. • Briefing on organisation of Ministry of Health and Welfare, and outline of health policies from Mr. Weonjong Kim, Manager for Program Planning & Evaluation of Policy Coordination Division
14 October (Wed.)	• Visit to Ministry of Labour. Briefing on employment policies of the elderly and health examination system from Mr. Dong-Nam Kim, Director of Division for the Employment of the Disabled, Mr. Jong-Seok Choi, Deputy Director of Division for the Employment of the Disabled and Mr. Bong-ho Choi, Deputy Director of International Cooperation Division. • Visit to National Statistical Office in Taejeon city. Briefing on population composition and changes of family function from Dr. Ahn Jae-Hack, Deputy Director of Population Census Division, Population & Social Statistics Bureau; on vital statistics and population projection from Mr. Dong-Hoy Kim, and Dr. Kung-Ae Park, Deputy Directors of Vital Statistics Division; and on economically active population and household survey from Dr.

	Saim Woo and Mr. Ha Bong-Chae, Deputy Directors of Social Statistics Division.
15 October (Thu.)	• Visit to Korea Institute for Health and Social Affairs. Briefing on the current situation of Korean population ageing from Dr. Nam-Hoo Cho, Vice President and on health, medicine, population and social security from Dr. Jae-Kwan Byeon, Dr. Eun- Jin Choi, Dr. Kyung-Hee Chung, Research Fellows, and Dr. Mee-Kyung Suh, Fellow. • Visit to Chung Woon Nursing Home. Prior to observation, briefing on activities of the Home from Mr. Jong-Hoo Lee, Director. • Visit to Book-Boo Welfare Center for the Elderly. Briefing on activities of the Center from Mr. Kong Dong-Won, Director, Mr. Bae Suk-Kyung, Head of Welfare Department, and Mr. Moo-Young Lim, Social Worker prior to observation.
16 December (Fri.)	• Visit to the tenth President of the Korean Gerontological Society, Dr. Seonja Rhee, Associate Dean of Graduate School of Public Health, Seoul National University and briefing on the activities of Korean Gerontological Society. • Briefing from population policies and situation of population ageing from Dr. Si-Baek Lee, Professor of Graduate School of Public Health, Seoul National University, and Vice President of the Korean Federation of Family Planning. • Briefing on health and medical policies and system of public health center from Dr. Chang-Yup Kim, Assistant Professor, Dept. of Health Policy and Management, Seoul National University College of Medicine. • Briefing on prospects of Korean population ageing and its countermeasures, and rural-urban ageing issues from Dr. Sung-Jae Choi, Professor, Dept. of Social Welfare, College of Social Sciences of Seoul National University.
17 December (Sat.)	• 11:45 Departure from Seoul (UA882) • 13:55 Arrival at Narita.

Appendix

— List of Collected Publications —

Ministry of Health and Welfare

1. The Republic of Korea. Ministry of Health and Welfare. 1997 Major Programs for Health and Welfare

National Statistical Office

2. The Republic of Korea. National Statistical Office. 1997 Annual Report on The Economically Active Population Survey, May 1998.

3. The Republic of Korea. National Statistical Office. An Official Guide to National Statistical Office, 1997.

4. The Republic of Korea. National Statistical Office. 1996 Annual Report on the Cause of Death Statistics (Based on Vital Registration), December 1997.

5. The Republic of Korea. National Statistical Office. 1995 Life Tables for Korea, May 1997.

6. The Republic of Korea. National Statistical Office. Korea~Figures in Short 1998, May 1998.

7. The Republic of Korea. National Statistical Office. Statistical Handbook of Korea, 1997.

8. The Republic of Korea. National Statistical Office. 1995 Population and Housing Census Report Volume I Whole Country (1), 1995.

9. The Republic of Korea. National Statistical Office. 1995 Population and Housing Census Report Volume I Whole Country (2), 1995.

10. The Republic of Korea. National Statistical Office. 1995 Life Table for Korea, May 1997.

11. The Republic of Korea. National Statistical Office. 将来推計人口 (Population Projection), December 1996 (in Korean).

12. The Republic of Korea. National Statistical Office. Report on the Social Statistics Survey, 1997.

13. The Republic of Korea. National Statistical Office. Social Indicators in Korea, December 1997.

14. The Republic of Korea. National Statistical Office. Monthly Report on the Economically Active Population Survey, August 1998.

15. The Republic of Korea. National Statistical Office. Annual Report on the Family Income and Expenditure Survey, June 1998.

16. The Republic of Korea. National Statistical Office. An Official Guide to National Statistical Office, 1997.

17. The Republic of Korea. National Statistical Office. 1996 Annual Report on the Vital Statistics (Based on Vital Registration), December 1997.

18. The Republic of Korea. National Statistical Office. Statistical Handbook of Korea, 1997.

19. The Republic of Korea. National Statistical Office. Invitation to hold the 53rd Session of the International Statistical Institute in Seoul, Republic of Korea in 2001, August 1997.

Korea Institute for Health and Social Affairs

20. Cho, Namhoon. Achievements and Challenges of the Population Policy Development in Korea, Korea Institute for Health and Social Affairs, November 1998.

21. Symposium Report 98-01 1998: Proceedings of International Symposium on Population and Development Policies in Low Fertility Countries, Korea Institute for Health and Social Affairs, United Nations Population Fund (UNFPA), May 1998.

22. Korea Institute for Health and Social Affairs, Development of Comprehensive National Policies on Aging: Life-Long Preparatory Measures Including Social Security, August 1994.

23. Chung, Kyunghee and Jungja Nam. Women's Health Status and Policy Issues in Korea, Korea Institute for Health and Social Affairs, November 1996.

24. Chung, Kyunghee and Meekyung Suh. The Changing Structure of the Korean Family and Policy Issues, Korea Institute for Health and Social Affairs, January 1997.

25. Hwang, Nami. Overview of Reproductive Health Indicators in Korea, Korea Institute for Health and Social Affairs, November 1996.

26. Han, Youngja and Eunjin Choi. Health Profile of Korean Women ~Exploring the Socio-Cultural Dimensions of Women's Health, Korea Institute for Health and Social Affairs, November 1996.

27. Han, Youngja., et al. Infant Mortality Rate and Causes of Death of 1993 Birth Cohort in Korea, Korea Institute for Health and Social Affairs, May 1998.