A Comprehensive Study of the Health Needs and of Health Care in Seoul

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During the last fifteen years since the liberation in 1945, Korea has unfortunately had insufficient political and social stability to study her own nation wide health needs and problems. Most of the administrative and educational measures taken in the field of public health and medical care have been temporary and emergency ones. Or because of traditional inertia, imported foreign systems have been followed blindly. In order to attain our ultimate goal of providing the best quality of comprehensive medical care for all people who need it and to do it at minimum cost, we need an adequate, proper plan set up on the basis of understanding the health needs at both local and national levels.

The principal purpose of this study, therefore, was to obtain information concerning the following aspects of health and health care through a study of the citizens of Seoul:

1. A measure of health needs in general.
2. The extent of unmet need for medical attention
3. The cost of medical care.
4. The attitudes of the people toward illness, toward doctors and other healers, and toward available health facilities.
5. An analysis of the socio-economic and cultural anthropologic factors involved.

METHODS

The source of information for this study consisted of a two-stage systematic sampling of 933 households consisting of 5,159 persons, a representative cross-section which is about one three hundredth of all the households (281, 601) in Seoul, a city of 1,575,000 people (Bureau of Statistics, Ministry of Intr., 1955). For the first stage, the sampling unit was the "Pan", which is the smallest cluster of households, and the sampling rate was 1/100; for the second stage, the sampling unit was the household, and the sampling rate 1/3.

In this sample, the loss rate was only 0.5%, which is extremely low compared to other countries. Also, we were able to see a relatively constant sampling ratio between the various characteristic variables, too. Therefore, the data obtained from this sample can be assumed to represent the native population reasonably well (Dept. of Survey, Bank of Korea, 1957).

In order to exclude every possible bias, well-trained, non-medical senior women college students were used as interviewers. The form used consisted of the open end questionnaire, which was revised after a pilot study. For the determination of health needs, the method of symptom-approach using 40 kinds of symptoms was used. The questionnaire inquired into the experiences of the preceding 6 months. As the survey was carried out over a one-month period from August 1, 1956, the data obtained from this study covers the experiences of Seoul citizens from February 1, to July 31, 1956; 86.3% of those questioned were female heads of households.

RESULTS AND DISCUSSION

The findings of the survey are as follows:
1. It was found that 63.6% of Seoul citizens had no symptoms; 36.4% of Seoul citizens had one or more symptoms during the six month period, averaging 1.9 symptoms during the half year. Therefore, the morbidity incidence rate was 74 symptoms per 100 citizens. The most prevalent symptoms were related to diseases of the digestive system, of nutrition and of parasitic infestation. For of 479 cases diagnosed by medical practitioners according to the classification of the WHO manual (WHO, 1948) diseases of the digestive system constituted 32.8%, followed by diseases of the respiratory system 18.0%, infectious and parasitic diseases 12.1%, and diseases of the nervous system and sense organs 11.3%. The morbidity rate of females was more than two times that of males in the age group of 15-44. In the male, the morbidity incidence was lowest in the age group of 15-24 highest in the age group of 65 and over; in the female, the incidence was lowest in the age group of 5-14, and highest in the 45-64 age group. There were significant differences in the morbidity rate among the different socio-economic family group, those low in income and in educational standards having a higher rate; the more overcrowded the living accommodations, the higher was the rate. Farmer, unemployed, and daily worker groups had higher morbidity rates than other occupational groups.

2. Only 42.8% of their symptoms did Seoul citizens regard as indicating an illness; for 57.2% of their symptoms, medical care was not sought. Particularly, where repeated or frequent bleeding of the gums, poor vision, unexplained loss of weight, repeated epistaxis, continued loss of appetite, unexplained tiredness (chronic), persistent constipation or persistent pains in the joints was the eminent symptom, less than 30% of these were regarded by the people as being abnormal conditions demanding medical care. This shows that increasing the number of medical personnel or increasing the facilities for medical care will do little to improve the general health and the medical care of the people unless there is adequate health education for the people. If we make a similar survey at the rural level and compare the results with this data, we can easily confirm the assumption that the demand rate for medical care in rural communities will be much lower than that in Seoul, though the people in rural areas might have higher morbidity rates than those in Seoul.

3. The loss of work or of the other regular activity due to illness during the 6-month period was 138 days per 100 persons and was incurred by 5.4% of the entire citizenry. This loss was 124 days per 100 males and 152 days per 100 females. Among the various age groups, the lowest rate was in the 5-14 age group for both sexes, and the highest rate was in the 45-64 age group for males and in the over 65 age group for females.

4. Only 44% of the demand for medical care was met; 15% of the demand was unmet, while the rest (41%) is uncertain. Consequently, it could be said that only one-fifth of the health needs was cared for by medical personnel and related facilities.

(Whole symptoms × 42.8/100 × 44.2/100=18.9)

Among those whose symptoms were not cared for, 78% claimed economic difficulty as their reason, such as "No Money" or "Too Expensive". This shows that the second important things to do for the improvement of the health and medical care is to provide some provision for the cost for medical care, so that every patient can get what he or she needs at any time and without delay or postponement. This might well be done by reorganizing the existing medical personnel, facilities, and medical care expenses.

5. The total cost of medical care during the 6 months was Hw 10,700* per family (including well families), and Hw 2,000 per person. Twice this 6-month cost of medical care is 7.2% of the average annual family income (Hw 300,000) of Seoul City. In general, many factors, such as low income, high morbidity in the community, a higher demand for medical care account for the

* Hw 700 was approximately $ 1.90 (U.S.)
high ratio of medical cost to income. Therefore, it is presumed that in our rural communities, the cost of medical care would surpass 7.2% of the average annual family income. Only 1/1,000 of the citizens incurred as much as a half of the entire medical costs; 1 out of 40 citizens incurred 87% of the total charges, while upon 39 out of 40 of the citizens fell 13% of the total charges. Low-income families spent a greater proportion of their income on the cost of sickness than did the well-to-do and the wealthy. The mean costs and the median costs per illness paid to medical doctors was Hw 10,300 and Hw 1,500 respectively, while those paid to the herb doctors were Hw 16,000 and Hw 1,700 respectively. The high mean costs of Hw 23,450 paid to hospitals, while its median is only Hw 1,100, is due presumably to the serious cases coming to the hospitals. But it is rather ridiculous that mean costs paid to specialists should be less than half that paid to general practitioners. It is also surprising that they paid to general medical practitioners a mean of Hw 9,400 and a median of Hw 1,500, whereas they paid to moxa and acupuncture practitioners Hw 9,800 and Hw 2,500 respectively. These phenomena show that there is much waste in the medical expenditures of the people. An analysis of medical costs according to payment to doctors, hospitals, and for drugs, etc., was rather difficult to make, since the current accounting system in this country does not clearly differentiate these categories.

6). The responses given to interviewers as to what was believed to be the cause of their illness — whether due to demons, curse, witchcraft, sin, fear or fright — were frank and revealing. In general, those born in the southern provinces of Korea gave more superstitious answers than those born in the northern provinces of Korea. Among the different religious groups, Christian gave the least superstitious answers.

7). Regarding the preferred choice of healer, 83.4% of those questioned preferred medical doctors; of these, 71.9% were general practitioners, 5.9% were specialists, 0.9% were foreign doctors, 4.7% denoted hospitals. Only 12.7% preferred herb doctors; the rest chose other healers or patent drugs. However, only 71.5% of the patients actually visited medical doctors, and as many as 14.5% of them visited herb doctors, so that the number who actually visited drugstores or superstitious healers was up to two and a half times of the number of those who preferred these. Such a phenomenon might be thought to be due to the belief that herb doctors charge less than medical doctors, in general. But actual figures reveal the opposite, for 73.0%, 22.3% and 4.7% of the costs paid to practitioners were to medical doctors, herb doctors, and other healers respectively, and facts already mentioned reveal that herb doctors charge more per illness than medical doctors, on an average. The higher the educational level of the head of the household, whether male or female and the more north the place of birth, the stronger the choice for medical doctors. Administrative workers, specialists and technical workers and sales business groups had a stronger choice for medical doctors than did other occupational groups; Christian families had a stronger choice for medical doctors than did other religious groups.

8). Inquiring into what kind of treatment was given at clinic of the various healers visited, it is surprising to find that consultations, injections, dressings, prescribing and even surgery were frequently done at drugstores, and injections were done by herb doctors. The mean duration and the median duration of care given per illness were 13.1 days and 2.9 days, respectively; however, the duration of care given by herb doctor was the longest, being 17.0 days and 4.4 days, respectively. About a half of the patients had treatment lasting three days or less, and 14% of the patients spent one month or longer for the care of their illness.

9). Very few people seem to have their own family doctors. The most prevalent reason for their choosing a healer is his nearness and convenience of access, and their hearing a favorable rumor concerning him. More than 30% of the patients
changed their doctors or healers during treatment. The primary reason given for their change was the “ineffectiveness of the treatment”; other reasons such as “expensive charges”, “unkindness” or “recommendation by family doctor” had little role in causing them to change healers. The only one exception was seen in the case of hospital where the complaint of unkindness was decisive. The unrestraint advertising of healers and drugs and the unrestraint sale of any drug without a doctor’s prescription should be controlled; and the competition for patients between general hospitals and general practitioners should be minimized.

10) Relatively few interviewees could indicate why they like or dislike a doctor or herb doctor. It seems to be the herb medicine, but not the herb doctor that they liked. Some claimed that an herb doctor or herb medicine was preferable for such vague conditions as a “cold”; and “women’s diseases”, “internal diseases”, “general malaise”, etc. About 59% of the interviewees commented favorably on “tonics”; and actually, more than 5% of sampled families used “tonics” costing an average of Hw 15,400 during the period, which is 7.7% of the entire expenditure for medical care. The family groups with higher incomes used “tonics” more frequently than did lower income groups.

11). Only 54.4% of those interviewed recognized the distinction between a general hospital and a doctor’s clinic. Those living in Songpuk-ku, and Chung-ku knew this distinction relatively well, whereas those living in Yong-san-Ku and Yongdongpo-Ku had a relatively poor understanding of what a general hospital is. The higher the educational standards of the interviewees, the better their understanding of the general hospital. The main favorable comments on general hospitals were “excellent medical doctors”, “good facilities”, “cheap cost”, and “clean”, etc. On the other hand, the main unfavorable comments were “unkindness” and “keep us waiting”. Only 22.4% of interviewees had ever heard the term “health center”. Most people generally had a poor understanding of the location, function, financing and administration of a health center. The higher the educational standards of the female heads of households, the better their knowledge concerning health center. Only 5.7% of families interviewed ever visited a health center; the higher the income and the educational standards, the higher the rate of visits was.

12) Regarding medical insurance, 45.5% of the interviewees gave favorable opinion, 24.2% had no opinion, and 30.3% had adverse opinions. Regarding national health service, 40.9% responded favorably, 36.9% were indifferent, and 22.2% responded adversely. The group lowest in educational standards and in income responded favorably to having a national health service system.

In August, 1969, a similar survey with exactly the same methods was carried out by me in Cheju Do, and the results are comparable. The rate of 36.4% for Seoul citizens who had one or more symptoms during the six-month period is lower than the 45.5% for Cheju Do, even if we account for the differences of sex ratio and age distribution between the two areas. However, they are almost twice as high as those found in the Michigan study (Hoffer, 1960)—18.7% in urban communities, 26.6% in rural communities.

Considering that Cheju Do people regarded only 12% of their symptoms as signifying illness, the 43% for Seoul City could be regarded as being much more favorable. Such a discrepancy in the demand for medical care explains partly why so many medical practitioners prefer urban communities for their practice rather than rural areas. Although rural people have more illness, they seek comparatively less medical care.

Since only 44% of the demand of Seoul citizens for medical care was met, the conclusion is made that whereas only one-fifth of the health needs were being cared for by medical personnel and related facilities in Seoul, in Cheju Do the ratio was only one-tenth.

The prevalence of the phenomenon of uneven distribution of medical costs has been well illus-
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Health needs and health care in Seoul are met by many studies made in the United States. But the width of the variations in family bills for sickness in Seoul seems much lower than that in the United States (Building America's Health, 1951).

It is paradoxical that there are many patients who seem to believe that herbs doctors would charge less than medical doctors, whereas in general the opposite is true.

The attitude toward choosing healers is not different from that of ordinary shopping, and the reason why very few have their own family doctors should be explained further.

SUMMARY

Assuming that Seoul citizens have the highest living standards of any communities in Korea, the 36.4% morbidity rate seen during the six-month period, and the 74 symptoms per 100 citizens of Seoul during the half-year period is amazingly high. The most prevalent symptoms were related to poor nutrition and poor sanitation. The variation in morbidity rate, analyzed by various biological and socio-economic factors, revealed trends similar to the results obtained in comparable studies made in the United States (Britten, 1940; Altenderfer, 1947, Downes, 1948).

The extremely low rate of demand for medical care—42.8% of their symptoms (see Section 4)—suggests that the primary need in Korea is adequate health education. Since only one-fifth of the total symptoms are being cared for by medical personnel and related facilities, due mainly (78%) to the economic situation, some provision for indigent medical care seems to be the second most important step toward improving health and medical care. Judged by present demands for medical care, there is little evidence of a shortage of hospitals or doctors in Seoul.

In general, about 7.2% of the average annual family earnings was spent for family sickness; however, the distribution of these costs is extremely uneven, and there was a great amount of unwise expenditure for improper or inadequate medical care.

Those born in the northern provinces of Korea and those of higher socio-economic living standards had generally a better cultural response to illness, doctors, medical care and public health facilities. About one-fifth of the citizens still favor herb drugs, particularly tonics, and herb doctors, even though their fees are higher.

The prevalent malpractice of various healers and pharmacists suggests a need for control. The relative scarceness of the family doctor system, the poor quality generally and the poor attitude of medical practitioners, the unregulated advertising of healers and drugs, the unregulated sale of any drug without a doctor's prescription, and the competition for patients between the general hospitals and the general practitioners, should be drastically changed.

The people's previous attitude toward the idea of medical insurance and of national health service, which a few years ago was one of scepticism and of opposition, is a bit more favorable at the present time.

In conclusion, the health needs of Korea are great, and the demands have not been met. Health education, the general improvement of living standards and some provision for the payment of sickness costs, improvement in the quality of medical personnel and facilities, adequate control of malpractice, reorganization of medical care administration—these are recommended for the improvement of medical care for the citizens of Seoul and of all Korea.

REFERENCES


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