POVERTY AND SOCIO-ECONOMIC CHANGES IN KOREA

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Contents

I. Poverty Measurement

1. Introduction

Korea had been hailed as one of the most successful cases to achieve poverty reduction in short period. However, the economic crisis in 1997 exposed the inability of Korean anti-poverty system to deal with external shocks. After Korea was hit by an economic crisis, the gap between the income of the rich and the poor widened and the social equity of the nation has deteriorated. The social cost of the crisis was dramatic, and the shortcomings of the existing anti-poverty system were obvious.

The Korean government, and those ministries concerned with anti-poverty policies, made an effort to formulate new policies tailored to the circumstances of Korea. Subsequently, a new model for welfare evolved. It was called “Productive Welfare” and this new welfare philosophy was articulated as a mature welfare philosophy in accord with the sophistication of the Korean economy and changing social needs. The changes made to the social protection system reflect the desire to extend benefits to all of society and to update the system.

Presently, the need is to give serious consideration to the shift in welfare philosophy, the expansion of existing benefits and addition of new policies. Among these reforms of anti-poverty system, introduction of the National Basic Livelihood Security Act (NBLSA) is considered as a major change. Enacted in October 2000 as a replacement of the Livelihood Protection Act, the NBLSA guarantees

minimum living standards to all low-income families with an income below the official poverty line, regardless of their ability to work. So, unlike the previous system, all low-income earners with the ability to work also are eligible for benefits under the new system. As the NBLSA puts emphasis on the nation's responsibility for protecting the life of low-income people, its introduction has tripled the number of livelihood payment beneficiaries from 540,000 in 1999 to 1.51 million in 2001.[1]

Livelihood payment of the NBLSA is designed to provide supplementary payment to households with an income under the official poverty line, and the amount of support is equal to the difference between the household income and the official poverty line. Also, civil rights were enhanced through acknowledging the NBLSA as a social duty. The NBLSA fostered a condition in which the number of the Self Reliance Aid Center increased from 6 in 1997 to 161 in 2001 and the number of social workers also increased from 3,000 persons in 1997 to 5,500 in 2001. Also, the importance of the Survey of Minimum Cost of Living in protecting the poor has been more emphasized.

2. Review of Official Poverty Line Measurement in Korea

Estimating poverty level requires poverty line, and determining poverty line cannot be achieved without data on household income and expenditure. In Korea, the official poverty line is estimated on the

[1] Legislated in September 7, 1999 and enacted in October 1, 2000, the NBLSA, which is one of the public assistance programs, has improved the nation's welfare system greatly.

basis of results of the Survey of Minimum Cost of Living conducted by the Korea Institute for Health and Social Affairs (KIHASA). However, there are several reasons why KIHASA conducts a new survey for estimating minimum cost of living, instead of simply using existing statistical data.

In Korea, there are two representative household income and expenditure surveys, conducted by the National Statistical Office, Family Income and Expenditure Survey (hereinafter FIES) and National Survey of Family Income and Expenditure (hereinafter NSFIE). However, it is considered that the two surveys are not relevant to be used for measuring the minimum cost of living. Because first, the FIES covers only 5,200 urban households excluding one person households and rural households. It is not sufficient for analyzing the poor households' expenditure, especially the expenditures of specific poor households such as the elderly, the disabled, and the children headed households, etc. Also, the NSFIE covers 30,000 households including one person household and rural household but it has a limit to be used for the measurement of minimum cost of living since its expenditure items are composed for not low-income households but general households. By this reason, more specific survey focusing on the poor households is conducted by KIHASA.

On the basis of the minimum cost of living obtained by KIHASA, The Ministry of Health and Welfare (MOHW) estimates official poverty line. MOHW ought to carry out the Survey of the Minimum Cost of Living every 5 years as a legal obligation due to the Livelihood Protection Act revised in 1997.

Methodology Used for Establishing the Official Poverty Line

Survey of 1999 Minimum Cost of Living

The Survey of Minimum Cost of Living consists of a preliminary survey and a main survey as follows. As a preliminary survey, 15,000 households were sampled from the whole country, and surveyed on income of the household members. Among the 15,000 sample households, those with household income that was below 40% of average household income were selected.

The selected households were filtered again based on their appropriateness in measuring the minimum cost of living, then finally 1,500 households were chosen as “the standard households” which agreed to keep a record of households budget diary. The budget diary recorded by the standard households provided the essential statistical information to fix a market basket by region (metropolitan, medium-small cities, rural areas). On the basis of results of the main survey, the minimum cost of living was measured by utilizing Market Basket Method. The minimum cost of living for the non-survey year is estimated on the basis of socio-economic changes by KIHASA and took the same proceedings with the result of survey.

KIHASA had conducted the surveys in 1988, 1994 and 1999. Since then, the minimum cost of living had been updated by the CPI for the non-survey year.

Official Poverty Line

The minimum cost of living measured by KIHASA should go

through a review of the Central Minimum Living Standard Committee organized by MOHW. The Committee reviews the structure of market basket, items prices, consumption pattern, etc., and revises the minimum cost of living estimated by KIHASA if necessary. MOHW updates the revised minimum cost of living on the basis of the anticipated CPI of next year, and decides the poverty line of next year.

Institutional Aspects of the Poverty Monitoring System

The 5,500 social workers [2] in about 3,500 regional administrative offices are searching individuals or households newly impoverished to help them through public assistance programs. At the same time, the social workers are examining individuals or households whose income is now over the poverty line, that is, escaped from the poor situation. The social workers update their administrative information system for the poor when such changes occurred. The information system plays a role of the poverty monitoring system.

Survey Data on Household Income and Expenditure and National Accounts Data

It is observed also in Korea, certain level of discrepancy between household income data from the Family Income and Expenditure Survey and national accounts data. For instance, the total of labor income obtained by survey reaches at 85% - 90% of the total income in the national account. In case of the property income and transfer

[2] The number of social workers will reach to 7,000 in 2002.

income, it falls down to about 30% - 35% of those in the national account. The reason seems to stem from several factors. First, the survey data and the account data are established by different agencies, that is, the National Statistical Office (NSO) and the Bank of Korea separately. Therefore, the discrepancy arises from the way these two agencies define and classify income and expenditure. Also, a serious technical difficulty exists in surveying the income of self-employed and the workers in informal sector.

Comparability over Time and Geographic Disaggregation

The minimum cost of living and the official poverty line are shown in Table 1. The official poverty line is estimated by MOHW for the purpose of selecting the eligible persons for the NBLS program, and it consists of both income and property criteria. As shown in Table 1, the poverty line had been estimated for metropolitan, medium and small cities and rural areas separately until 1986. Then it was merged into one for whole country in 1987. However, the minimum cost of living has been always measured separately according to size of region in order to account for the gaps among regions.

Table 1 : Minimum Cost of Living(MCL) and Poverty Line(PL) of Korea

(Unit: Korean Won)

year		Region	1.person household	2- person household	3-person household	4-person household	5-person household	6-person household
2001	MCL	Metropolitan	354,571	587,225	807,690	1,015,961	1,155,148	1,303,478
		Medium & Small Cities	333,731	552,712	760,218	956,250	1,087,256	1,226,868
		Rural Areas	287,275	475,773	654,394	823,137	935,905	1,056,084
	PL	Whole Country	330,000/ 31,000,000	550,000/ 31,000,000	760,000/ 34,000,000	960,000/ 34,000,000	1,090,000/ 38,000,000	1,230,000/ 38,000,000
2000	MCL	Metropolitan	344,243	570,122	784,164	986,370	1,121,503	1,265,513

		Medium & Small Cities	324,011	536,614	738,076	928,398	1,055,588	1,191,134
		Rural Areas	278,907	461,915	635,333	799,161	908,646	1,025,324
	PL	Whole Country	320,000/ 29,000,000	540,000/ 29,000,000	740,000/ 32,000,000	930,000/ 32,000,000	1,060,000/ 36,000,000	1,200,000/ 36,000,000
1999		Metropolitan	334,217	553,516	761,325	957,641	1,088,838	1,228,653
	MCL	Medium & Small Cities	314,574	520,984	716,579	901,357	1,024,843	1,156,441
		Rural Areas	270,784	448,462	616,829	775,885	882,181	995,460
	PL	Whole Country	230,000/ 29,000,000	460,000/ 29,000,000	690,000/ 29,000,000	920,000/ 29,000,000	1,150,000/ 29,000,000	1,380,000/ 29,000,000
1998	PL	Whole Country	230,000/ 29,000,000	460,000/ 29,000,000	690,000/ 29,000,000	920,000/ 29,000,000	1,150,000/ 29,000,000	1,380,000/ 29,000,000
1997	PL	Whole Country	220,000/ 28,000,000	440,000/ 28,000,000	660,000/ 28,000,000	880,000/ 28,000,000	1,100,000/ 28,000,000	1,320,000/ 28,000,000
1996	PL	Whole Country	210,000/ 27,000,000	420,000/ 27,000,000	630,000/ 27,000,000	840,000/ 27,000,000	1,050,000/ 27,000,000	1,260,000/ 27,000,000
1995	PL	Whole Country	200,000/ 25,000,000	400,000/ 25,000,000	600,000/ 25,000,000	800,000/ 25,000,000	1,000,000/ 25,000,000	1,200,000/ 25,000,000
1994		Metropolitan	221,070	381,331	584,511	714,061	820,036	903,384
	MCL	Medium & Small Cities	206,141	355,580	545,039	665,840	764,659	842,377
		Rural Areas	179,229	309,159	473,883	578,914	664,832	732,404
	PL	Whole Country	170,000/ 20,000,000	340,000/ 20,000,000	510,000/ 20,000,000	680,000/ 20,000,000	850,000/ 20,000,000	1,020,000/ 20,000,000
1993	PL	Whole Country	140,000/ 13,000,000	280,000/ 13,000,000	420,000/ 13,000,000	560,000/ 13,000,000	700,000/ 13,000,000	840,000/ 13,000,000
1992	PL	Whole Country	100,000/ 10,000,000	200,000/ 10,000,000	300,000/ 10,000,000	400,000/ 10,000,000	500,000/ 10,000,000	600,000/ 10,000,000
1991	PL	Whole Country	65,000/ 6,000,000	130,000/ 6,000,000	195,000/ 6,000,000	260,000/ 6,000,000	325,000/ 6,000,000	390,000/ 6,000,000
1990		Metropolitan	132,487	218,536	292,487	359,717		
	MCL	Medium & Small Cities	125,576	206,648	276,614	340,221		
		Rural Areas	112,548	185,892	248,924	306,226		
	PL	Whole Country	48,000/ 3,400,000	96,000/ 3,400,000	144,000/ 3,400,000	192,000/ 3,400,000	240,000/ 3,400,000	288,000/ 3,400,000
1989		Metropolitan	124,622	205,006	274,378	337,446		
	MCL	Medium & Small Cities	117,361	193,129	258,517	317,963		
		Rural Areas	105,580	174,383	233,512	287,266		
	PL	Whole Country	46,000/ 3,400,000	92,000/ 3,400,000	138,000/ 3,400,000	184,000/ 3,400,000	230,000/ 3,400,000	176,000/ 3,400,000
1988		Metropolitan	116,361	191,416	256,189	315,076		
	MCL	Medium & Small Cities	109,581	180,326	241,380	296,885		
		Rural Areas	98,581	162,823	218,032	268,223		

	PL	Whole Country	44,000/ 3,200,000	88,000/ 3,200,000	132,000/ 3,200,000	176,000/ 3,200,000	220,000/ 3,200,000	264,000/ 3,200,000
1987	PL	Whole Country	43,000/ 3,200,000	86,000/ 3,200,000	129,000/ 3,200,000	172,000/ 3,200,000	215,000/ 3,200,000	258,000/ 3,200,000
1986	PL	Metropolitan	42,000/ 3,200,000	84,000/ 3,200,000	126,000/ 3,200,000	168,000/ 3,200,000	210,000/ 3,200,000	252,000/ 3,200,000
		Medium & Small Cities	38,000/ 2,900,000	76,000/ 2,900,000	114,000/ 2,900,000	152,000/ 2,900,000	190,000/ 2,900,000	228,000/ 2,900,000
		Rural Areas	34,000/ 2,600,000	68,000/ 2,600,000	102,000/ 2,600,000	136,000/ 2,600,000	170,000/ 2,600,000	204,000/ 2,600,000
1985	PL	Metropolitan	38,000/ 2,900,000	76,000/ 2,900,000	114,000/ 2,900,000	152,000/ 2,900,000	190,000/ 2,900,000	228,000/ 2,900,000
		Medium & Small Cities	34,000/ 2,600,000	68,000/ 2,600,000	102,000/ 2,600,000	136,000/ 2,600,000	170,000/ 2,600,000	204,000/ 2,600,000
		Rural Areas	30,000/ 2,300,000	60,000/ 2,300,000	90,000/ 2,300,000	120,000/ 2,300,000	150,000/ 2,300,000	180,000 / 2 ,300,000
1984	PL	Metropolitan	36,000/ 2,300,000	72,000/ 2,300,000	108,000/ 2,300,000	144,000/ 2,300,000	180,000/ 2,300,000	216,000/ 2,300,000
		Medium & Small Cities	32,000/ 2,000,000	64,000/ 2,000,000	96,000/ 2,000,000	128,000/ 2,000,000	160,000/ 2,000,000	192,000/ 2,000,000
		Rural Areas	28,000/ 1,800,000	56,000/ 1,800,000	84,000/ 1,800,000	112,000/ 1,800,000	140,000/ 1,800,000	168,000/ 1,800,000
1983	PL	Metropolitan	35,000/ 2,100,000	70,000/ 2,100,000	105,000/ 2,100,000	140,000/ 2,100,000	175,000/ 2,100,000	210,000/ 2,100,000
		Medium & Small Cities	31,000/ 1,850,000	62,000/ 1,850,000	93,000/ 1,850,000	124,000/ 1,850,000	155,000/ 1,850,000	186,000/ 1,850,000
		Rural Areas	27,000/ 1,600,000	54,000/ 1,600,000	81,000/ 1,600,000	108,000/ 1,600,000	135,000/ 1,600,000	162,000/ 1,600,000
1982	PL	Metropolitan	26,000/ 2,000,000	52,000/ 2,000,000	78,000/ 2,000,000	104,000/ 2,000,000	130,000/ 2,000,000	156,000/ 2,000,000
		Medium & Small Cities	23,000/ 1,750,000	46,000/ 1,750,000	69,000/ 1,750,000	92,000/ 1,750,000	115,000/ 1,750,000	138,000/ 1,750,000
		Rural Areas	20,000/ 1,500,000	40,000/ 1,500,000	60,000/ 1,500,000	80,000/ 1,500,000	100,000/ 1,500,000	120,000/ 1,500,000
1981	PL	Metropolitan	26,000/ 700,000	52,000/ 700,000	78,000/ 700,000	104,000/ 700,000	130,000/ 700,000	156,000/ 700,000
		Medium & Small Cities	23,000/ 600,000	46,000/ 600,000	69,000/ 600,000	92,000/ 600,000	115,000/ 600,000	138,000/ 600,000
		Rural Areas	20,000/ 500,000	40,000/ 500,000	60,000/ 500,000	80,000/ 500,000	100,000/ 500,000	120,000/ 500,000

1980	PL	Metropolitan	20,000 / 700,000	40,000 / 700,000	60,000 / 700,000	80,000 / 700,000	100,000 / 700,000	120,000 / 700,000
		Medium & Small Cities	18,000 / 600,000	36,000 / 600,000	54,000 / 600,000	72,000 / 600,000	90,000 / 600,000	108,000 / 600,000
		Rural Areas	16,000 / 500,000	32,000 / 500,000	48,000 / 500,000	64,000 / 500,000	80,000 / 500,000	96,000 / 500,000

Note: Poverty line in 2001 is 330,000/31,000,000. It means that \330,000 is income poverty line and \31,000,000 is property poverty line.

Other Household Income Surveys in Korea

Family Income and Expenditure Survey

The first reference year is 1963 for Family Income and Expenditure Survey and the periodicity for the survey is monthly and quarterly for the tabulation and release. The reference period is a whole month and this survey covers households residing in sixty-nine cities, in Korea. However, the following households are excluded from such survey: farmers' households, fishermen's households, one-person households, households whose income and expenditures are difficult to be calculated, for example, households which run restaurants or inns or boarding houses, and households with 2 or more business employees and foreigners' households.

The sample size is 5,200 households and items of the survey are household distinction, number of household members, number of income earners, existence spouse of household head, sex, age, educational attainment, industry, occupation of household head and wife, items concerning other household members (relationship to household head, sex, age, activity status), household type, number of generation in household, income source in no-occupation households, yearly income, items concerning residence, type of living quarters,

number of possessed private automobile, types and amount of income, items and amount of expenditures. Data has been collected by the account book method.

As a result, data is released at the end of the following quarter, then Annual Report on the Family Income and Expenditure Survey is published annually and Monthly Statistics of Korea is published quarterly.

National Survey of Family Income and Expenditure

The first reference year is 1991. Periodicity of the survey is quinquennial (years ending in 1 and 6). Reference period is as follows; receipts and disbursements are 1 October to 30 November 1996, yearly income is 1 December 1995 to 30 November 1996, durable goods, savings and liabilities are 30 November 1996.

Receipts and disbursements are surveyed for the period from 1 October to 30 November 1996, yearly income from 1 to 7 December 1996, and durable goods, savings and liabilities from 1 to 7 December 1996.

Sample size is 30,000 households. As for the survey items, “items concerning household and residence” include household type, family composition, number of household members, number of earners, types of living quarters, relationship to the household head, sex, age, educational attainment, w/o spouse, industry and occupation, type of tenure of dwelling, number of rooms, total floor space. In case of “items concerning receipts and disbursement”, in regard to the income, only salary and wage earners’ households were surveyed earnings, dealing with business and subsidiary work, returns from

assets, transfer income etc., and in regard to disbursement, kinds of items, names of items, uses, quantities of purchase and amount of disbursement were recorded in detail. “Items concerning yearly income” include each household members’ income and total household income for the period of one year. As to “items concerning durable goods”, the 33 durable goods such as beds, parlor suites, automobile and so on were investigated by these quantities that were possessed, quantities purchased by year and making nation Methods of data collection are as follows, in case of receipt and disbursement, self-enumeration (keeping account book) has been used and in case of the information about status of households, yearly income, saving and liabilities and durable goods, direct interview (questionnaire) has been used.

Data of release is on December 1997, and publications are including National survey of Family Income and Expenditure (Volume I: Income and Expenditure, Volume II: Yearly Income, Savings & Liabilities and Durable Goods, Volume III: One Person Household, Volume IV: Distribution of households by Characteristics of household).

3. Review of Non-Official Poverty Measurements

Review of Minimum Cost of Living

In Korea, the existing data on minimum cost of living had been obtained by various methods depending on their purposes, showing some inconsistency. Table 2 shows the data on the minimum cost of

living by various methods and experts.

Table 2. Already Existing Minimum Cost of Living

Person or Institute	Published Year/ Estimated year	Areas	M.C.L[1)]	Method
S.S.C.C.[2)]	1974/1973	Whole	4,348	Engel
Suh, Sangmok.	1979/1973	Urban	4,633	Engel
		Rural	3,879	
S.S.C.C.[2)]	1978/1978	Medium-small cities	83,000	Engel
S.S.C.C.[2)]	1978/1978	Metropolitan	110,000	Leyden
Yoon, Sukbum.	1980/1980	Whole	33,744	Leyden
Jang, Hyunjin	1986/1984	Urban	66,000	Rowntree
Lee, J.	1986/1985	Urban	66,000	Leyden
Bae, Mooki.	1987/1987	Urban	181,000	Rowntree
KIHASA	1989/1988	Metropolitan	116,361	Rowntree
		Medium and	109,581	
		Small cities	-	
		Rural area	98,581	
KIHASA	1994/1994	Whole	206,997	Rowntree
		Metropolitan	221,070	
		Medium-small cities	206,141	
		Rural area	179,229	

Notes: 1) Minimum Cost of Living for one-person-household, unit: won/nominal price.

2) The Social Security Consultation Committee.

The minimum cost of living estimated by the Social Security Consultation Committee in 1973 was the first official estimation. It was computed based on the Engel's Law and the National Life Condition Survey[3] of 1,162 households from September 1973 to

[3] The National Life Condition Survey was launched in 1973 covering 5,030 households of the whole country. From the sample households, 1,162 households were selected, that is, the households earning less than 24,000 at the time of July 1973, the underemployed, the unskilled workers, the rural households farming 5 Danbo, and the Livelihood Protection Recipients Households. These selected households were investigated on the items

April 1974.

In 1979, Suh, S. estimated the minimum cost of living of 1973 based on the food consumption pattern data from the National Life Condition Survey conducted by the Ministry of Health and Welfare. The Engel method was applied to measure the minimum cost of living. On the basis of the estimated minimum cost of living in 1973, its longitudinal data from 1965 through 1981 were computed with the deflator[4] of 5 items (food, housing, fuel-light, clothing-footwear, and miscellaneous).

To measure the minimum cost of living, Yoon, S. (1995) conducted a survey covering 1,600 households from both rural and urban areas in 1980, and among them, 478 households with consistent responses were selected. He then divided the households into 3 types - four-person-household, five-person-household, and six-person-household - and estimated their minimum cost of living in 1980 by using the utility function. With the estimated minimum cost of living, he longitudinally drew the minimum cost of living between the period of 1970 and 1992. As the method of longitudinal drawing, a distribution function of household income by income class and average household income of each year was applied. This method allows to include the effect of the elasticity of the minimum cost of living to income, and at the same time, the effect of disequilibrium of income distribution, which are disregarded when applying only the change rate of consumer price.

Jang, H. computed the minimum cost of living according to the lowest 10 %, 20 %, and 40 % of the urban household consumption

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concerning household income and expenditure, household member, and housing, and so on.

[4] Deflator has been annually estimated by the Korean Central Bank.

level. He used three kinds of market basket already established by Suh, S. and KIHASA. He diversified the minimum cost of living by region and household size, and differentiated it by calory consumption (2,000 kcal, 2,500 kcal, 2,900 kcal) to detect changes of the minimum cost of living according to calory consumption. His research showed that the minimum cost of living could vary by the composition of items in the market basket.

Table 3. 1988 Minimum Cost of Living by KIHASA

(Unit: Won)

Year	Region	Household Size (Persons)			
		1	2	3	4
1988	Metropolitan	116,361	191,416	256,189	315,076
	Medium-small cities	109,581	180,326	241,380	296,885
	Rural	98,581	162,823	218,032	268,223
1989[1)]	Metropolitan	124,622	205,006	274,378	337,446
	Medium-small cities	117,361	193,129	258,517	317,963
	Rural	105,580	174,383	233,512	287,266
1990[2)]	Metropolitan	132,487	218,536	292,487	359,717
	Medium-small cities	125,576	206,648	276,614	340,221
	Rural	112,548	185,892	248,924	306,226

Notes: 1) the minimum cost of living inferred by the change rate of consumption-price of 1988.

2) the minimum cost of living inferred by the expected change rate of consumption-price of 1989.

Sources: Ahn, Changsoo et al, 1989.

In 1988, KIHASA measured the minimum cost of living by utilizing Rowntree's Basic Needs Approach. Firstly, 5,000 households were sampled from the whole country, and among the sample households, those below 30% in terms of income were selected. The

selected households were filtered again based on their appropriateness in measuring the minimum cost of living, then finally 950 households were chosen as the standard households which agreed to keep a record of households budget diary. The budget diary recorded by standard households provided the essential statistical information to fix a market basket by region (metropolitan, medium-small cities, rural areas). Also, on the basis of the market basket, the minimum cost of living was measured by region. The minimum cost of living for the years of 1989 and 1990 were inferred by multiplying the change rate of consumption-price of 1988 and the expected change rate of 1989.

The minimum cost of living in 1994 was also measured by Rowntree's Basic Needs Approach. In this case, the number of sample and standard households were 5,000 and 950 respectively in 1988 and changed to 3,000 and 600 in 1994. From the downsized number of standard households, a market basket was fixed by utilizing the method of 1988, and then on its basis, the minimum cost of living was measured.

Table 4. 1994 Minimum Cost of Living by KIHASA

Household Size	Minimum Cost of Living			
	Whole country	Metro-Politan	Medium-Small Cities	Rural Areas
1	206,997	221,070	206,141	179,229
2	357,057	381,331	355,580	309,159
3	547,303	584,511	545,039	473,883
4	668,606	714,061	665,840	578,914
5	767,835	820,036	764,659	664,832
6	845,877	903,384	842,377	732,404
7	903,277	964,686	899,541	782,105

Sources: KIHASA, 1994.

Longitudinal Data on Minimum Cost of Living

As mentioned before, the minimum cost of living in Korea has not been measured consistently. So in order to make a longitudinal data on minimum cost of living, one method has been chosen as a standard among the already existing minimum cost of living. That is a minimum cost of living for one-person-household measured by KIHASA in 1994. The data was inferred for each year from 1975 to 1995, by applying two indexes. First, the consumption-price change rate and second, the household expenditure change rate.

Table 5. The Longitudinal Data on Minimum Cost of Living (Monthly Minimum Cost of Living for One-Person-Household)

Year	Minimum Cost of Living (Won)	Year	Minimum Cost of Living (Won)
1975	11,581	1986	65,218
1976	14,520	1987	75,302
1977	17,015	1988	88,404
1978	22,723	1989	110,698
1979	30,868	1990	128,087
1980	38,380	1991	152,164
1981	109,400	1992	176,293
1982	117,168	1993	189,841
1983	121,134	1994	213,678
1984	123,943	1995	239,059
1985	126,918	-	-

Notes: Minimum cost of living inferred by urban household expenditure change rate.

Source: Author's estimation.

The method of applying the consumption-price change rate is the simplest way to infer the minimum cost of living in the non survey year.[5] The method was also used by Suh, S. (1979) to draw the

[5] That is $MCL_t = MCL_0 \times (1 + p_{0,t-1})$. Here, MCL_t is the minimum cost of living in

longitudinal data on minimum cost of living.[6]

Table 5 shows the longitudinal data on minimum cost of living for one-person-household from 1975 - 1995. This data was drawn on the basis of the minimum cost of living of KIHASA (1994) according to the retrospective change rate of urban household expenditure.

Household Equivalence Scales and Household Income by Income Group

Household Equivalence Scales

In order to compare real income levels of households of different sizes, household equivalence scales are needed. Household equivalence scales are an attempt to express, in proportional terms, the presumed reduced cost of living experienced by members of households sharing resources. The household equivalence scales are used to measure the level of household income or expenditure to make the households consisting of different number of members reach the same satisfactory level.

The Korean household equivalence scales have been estimated by Jang, H. (1986), KIHASA (1989, 1994), and Kim, G. (1996). The

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concerned year (t), MCL_o is the minimum cost of living in standard year (0), and p_{0t-1} is the change rate of consumption price from the standard year (0) to the previous year (t-1) of the concerned year (t).

[6] However it has some drawbacks to over-estimate for a retrospective inference and to under-estimate for a prospective inference of the minimum cost of living, especially the over or under estimated gap should be getting larger, times goes on farer from the standard year. By the reason it is possibly eligible to be applied in case of 1 or 2 years' time lag from the standard year, but risky in case of over 3 years. It is furthermore not recommendable to be applied for the country, such as Korea, because, in which was experienced very radical changes of the quality of life and consumption pattern mainly provoked by very fast economic growth during the last 3 decades, so that the inferred minimum cost of living of Korea by the simple method may be misled by missing those effects.

household equivalence scales by KIHASA were measured based on the data from the National Life Condition Survey and those of Jang, H. and Kim, G. were computed with the data from the Family Income and Expenditure Survey. The comparison of the results are shown in Table 6.

Table 6. Household Equivalence Scales by Household Size

Researcher	year	Household Equivalence Scale by Household size						
		1	2	3	4	5	6	7
Jang, H.	1965	-	0.61	0.80	1.00	1.16	1.41	-
	1970	-	0.61	0.80	1.00	1.16	1.41	-
	1975	-	0.62	0.80	1.00	1.16	1.42	-
	1980	-	0.62	0.80	1.00	1.16	1.43	-
	1984	-	0.61	0.80	1.00	1.16	1.41	-
KIHASA	1989	1	1.65	2.20	2.71	3.18	3.63	4.05
	1994	1	1.73	2.65	3.24	3.72	4.09	4.37
Kim, G.	1996	-	1	1.18	1.36	1.63	1.77	-

Sources: Jang, Hyunjun, 1986; KIHASA, 1989, 1994; Kim, Geneuhc, 1996.

As shown in Table 6, Jang, H. and Kim, G. did not compute household equivalence scales for one-person-household because the data used is from the Family Income and Expenditure Survey which does not cover one-person-household. On the other hand, KIHASA was able to cover household equivalence scales for one-person-household because the data used was from the National Life Condition Survey, which was designed for measuring the minimum cost of living of all household sizes.

The household equivalence scales by Jang, H. were longitudinally drawn from 1965 to 1984. The results indicated that in Korea, a slight change of the value of household equivalence scales was made during the 20 years. The values of household equivalence

scales, computed by KIHASA in 1989 and in 1994, are quite different from each other, showing 1.65 in 1989 and 1.73 in 1994 for two-person-household. Such differences have also been found in other household sizes as shown in the table. It is due to the inconsistency of the sample households, namely, number and regional distribution of the sample households of the two different surveyed years, and also, due to the inconsistent use of estimating methods.

To compare the household equivalence scales on an equal base, the two-person-household's equivalence scales were set up "1" as a standard, then, other household's equivalence scales were proportionally recomputed. Table 7 shows the result: the value of household equivalence scales by Kim G. is the smallest, followed by that of Jang, H.'s, that of KIHASA's of 1989, and lastly, that of 1994.

Table 7. Equivalence Scales by Household Size

Researchers	year	Equivalence scales by household size						
		1	2	3	4	5	6	7
Jang, H.	1984	-	1	1.31	1.63	1.90	2.31	-
KIHASA	1989	-	1	1.33	1.64	1.93	2.20	-
	1994	-	1	1.53	1.87	2.15	2.36	-
Kim, G.	1996	-	1	1.18	1.36	1.63	1.77	-

Source: Author's estimation.

Among the equivalence scales in Table 7, the one computed by KIHASA in 1989 was chosen to infer the household income by income class because it's mid range position on the data. The household equivalence scales of Jang, H. were another option, however, it did not include the one-person-household. With the

selected equivalence scales, the household income by income group was inferred in the following section.

II. Review of Socio-Economic Conditions

1. Economic Changes from Early 1990s

In 1990s, the real GDP grew by over 5% every year except for 1998. In 1990 and 1991, the growth rate for the real GDP was 9.0% and 9.2% respectively, but for the following year it fell down to 5.4% and it was maintained at a similar level in 1993. The year just after the peak of 1997 economic crisis recorded the highest real GDP growth rate reaching 10.9% during the period. For the first half of 1990s, the CPI increase rate marked over 5%, then turned down to less 5% except for 1998 which was a year of the economic crisis peak. In 1999 and 2000, it recorded very low at 0.8% and 2.3% respectively.

The low unemployment rate in Korea has been regarded as an example case until the economic crisis was occurred in 1997. From 1999, it fell down again reaching below 5% and is recovering back to the level of unemployment prior to the economic crisis. In August 2000, the population over the age of 15 increased by 1.0% (374,000 persons) to 36,195,000 persons, and the economically active population increased by 1.4% (304,000 persons) to 22,071,000 persons compared to the same month last year. The number of jobless fell to 0.82 million from 1.24 million a year earlier. The unemployment rate fell to 3.7%, slightly higher than the previous

month's level.

Trade balance in 1990s was mostly negative until 1997 (except 1993). In Korea, trade balance came up as one of the most critical issues to be dealt with in overcoming the economic crisis. Under the circumstance, trade balance had been carefully dealt with during the crisis period, then as the result, Korea's chronic negative trade balance was turned over to positive from 1998. As of the end of 2000, Korea's total external liabilities amounted to US$136.31 billion, down by US$0.73 million from the previous year. This decrease was attributed to a greater number of trade credits being linked to economic recovery and the decreased borrowing of domestic branches of foreign banks.

Table 8. Korea: Overall Economic Performance

	Real GDP Growth Rate(%)	CPI Increase Rate (%)	Unemploy-ment Rate(%)	Trade Balance in Current Account (million US$)	Gross Foreign Liabilities (million US$)	Exchange Rate (Annual Average Won/US$)
1990	9.0	8.6	2.4	-2,003.3	31,699	716.4
1991	9.2	9.3	2.3	-8,317.2	39,135	760.8
1992	5.4	6.2	2.8	-3,942.9	42,819	788.4
1993	5.5	4.8	2.4	989.5	43,870	808.1
1994	8.3	6.3	2.0	-3,866.9	97,437	788.7
1995	8.9	4.5	2.0	-8,507.7	127,491	774.7
1996	6.8	4.9	2.6	-23,004.7	163,489	844.2
1997	5.0	4.5	6.8	-8,166.7	159,237	1415.2
1998	-6.7	7.5	6.3	40,364.9	148,705	1207.8
1999	10.9	0.8	4.1	24,476.7	137,069	1145.4
2000	8.8	2.3	3.7	11,043.9	136,306	1259.7

Source: Bank of Korea, National Statistical Office, Ministry of Finance and Economy, Wharton Econometric Forecasting Associates - Asia Economic Outlook.

After the onset of the financial crisis, Korea suffered a serious economic downturn. However, the Korean government, on the basis of the IMF program, implemented drastic reforms to correct the

structural weaknesses inherent in its economy. The economic restructuring was carried out in the corporate, financial and labor sectors in order to promote transparency, efficiency and flexibility.

Starting 1999, the Korean economy has shown a trend of rapid recovery. The growth rate, after dipping to -6.7% in 1998, was up 10.9% in 1999 and 8.8%.

2. Social Changes from Early 1990s[7]

Health

Health Profile

The general health status of Koreans has greatly improved in the past three decades along with the rapid economic development. The life expectancy at birth for females increased from 53.7 years in 1960 to 77.4 in 1995 which is translated as a 23.7-year extension of life expectancy in 35 years (Table 9). The life expectancy of Korean women has now reached the level of life expectancy of those in advanced countries. In contrast, the increase in male life expectancy at birth has been far less than that of females for the similar period. Life expectancy of males at birth rose by 18.4 years, from 51.1 to 69.5, during the same period. Considering that women's life expectancy is generally longer than that of men's, the difference of 7.9 years between males and females is quite large compared to the usual gender difference noted in advanced countries.

A comparison of the probability of dying among each age group

[7] Yoon, Byungsik, Hyun Song Lee, Chanyong Park, Meesook Kim, Dong-ki Min and Seung-Uh Lee (1998) *Korea Development Report UNDP 1998.*

as shown in Table 10 furnishes part of the clue to the reason for the large gender gap. Between the early and the very old ages, there is not much difference in the probability of dying.

Table 9. Life Expectancy at Birth

(Unit: Years)

Year	1960	1965	1970	1975	1980	1985	1990	1995
Male	51.1	58.1	59.8	N.A.	62.7	64.9	67.4	69.5
Female	53.7	64.7	66.7	N.A.	69.1	73.3	75.4	77.4

Source: Ministry of Health and Social Affairs, Yearbook of Health and Social Statistics, 1991.
National Statistical Office, Social Indicators in Korea, 1996, 1997.
National Statistical Office, 1995 Life Tables for Korea, 1997.

Table 10. Probability of Dying by Age in 1995

(Unit: %)

Age	Male	Female	Ratio	Age	Male	Female	Ratio
0	0.92	0.78	1.24	45	3.36	1.17	2.87
1	0.28	0.25	1.08	50	5.00	1.80	2.78
5	0.24	0.16	1.50	55	7.33	2.74	2.68
10	0.20	0.13	1.54	60	10.79	4.38	2.46
15	0.52	0.24	2.17	65	16.44	7.63	2.15
20	0.61	0.29	2.10	70	24.80	13.69	1.81
25	0.79	0.32	2.47	75	35.69	23.16	1.54
30	0.97	0.37	2.62	80	49.89	36.63	1.36
35	1.46	0.52	2.81	85+	100.00	100.00	1.00
40	2.27	0.79	2.87				

Source: National Statistical Office, 1995 Life Tables for Korea, 1997.

For example, the probability of dying before the age of 1 is 0.92% for males and 0.78% for females, and 0.28% for males and 0.26% for females aged 1. However, as they grow older, the gender

gap in the probability of dying up to 60 years old becomes relatively large in proportion. Table 10 shows that the gender gap regarding the probability of dying reaches a peak in the age groups of 40 to 45 and 45 to 50, which are also the peak ages for a person's social and economic participation. When this peak is exceeded, the gender gap for occurrence of death becomes smaller with age. One can infer from the discrepancies found in the data that the reason for the shorter life span of men in this country resides in the conditions of men's economic participation and their associated health practices. Insecure and stressful work environments and poor health habits are responsible for the high risk of death among economically active men. Death by industrial accident remains at a high level as well. Extremely long working hours (49.2 hours a week in manufacturing industries in 1995) can also be a contributing factor to high risk of death in those years. Traffic accident deaths, (35.9 per 100,000 persons in 1994), are also among the highest in the world. In this stressful work and social environment, people are more inclined to acquire bad health habits. Almost two-thirds of males are smokers, among whom 70% aged 15 and higher smoke more than a pack of cigarettes a day. More than 80% of males 15 years and older drink alcoholic beverages, while more than one-tenth of males drink almost every day. Female smoking and drinking rates remain low in comparison to other industrial countries. However, studies show that these rates have been rising in recent years (6.0% and 44.6%, respectively, in 1995).

Table 11. Trends in Infant Mortality Rate and Maternal Mortality Rate

(Unit: %)

	1960	1965	1970	1975	1980	1985	1990	1993
Infant mortality rate [1)]	69.0	61.8	53.0	41.0	17.3	13.3	12.8	9.9
Maternal mortality rate [2)]	-	88.0	83.0	56.0	42.0	34.0	30.0	-

Notes: 1) per 1,000 livebirths

2) per 100,000 livebirths

Source: Ministry of Health and Social Affairs, Yearbook of Health and Social Statistics, annual.

The infant mortality rate is an important component of the degree of life expectancy and a key determinant of the reproductive health status of women of child-bearing age. As shown in Table 11, the infant mortality rate over the past 30 years has fallen dramatically owing to improved living conditions as well as increased utilization of health-care services. From 1960 to 1992, the infant mortality rate per 1,000 livebirths decreased from 69.0 to 9.9. The major causes of infant death were congenital malformation and certain conditions that originate during the prenatal period. The maternal mortality rate per 100,000 livebirths also dropped from 88 in 1965 to 30 in 1990. Hospital studies point to toxemia as the most common cause of maternal death from 1961 to 1966, accounting for 51.8% of all maternal deaths. From 1982 to 1986, postpartum haemorrhage was the most common cause of death, accounting for 60.0% of all maternal deaths. This problem stems from a failure of the prenatal emergency care system, specifically due to a lack of transportation and inadequate referral system between primary, secondary and tertiary care facilities.

Reproductive health has greatly improved as more women give birth in hospitals. The proportion of pregnant women receiving prenatal care rose from 57.2% in 1977 to 99.2% in 1994. This situation is partly due to fact that the medical insurance system was expanded to provide universal coverage during the fifteenth year. Similarly, 98.8% of all deliveries took place at medical institutions in 1994. Among these deliveries, 96.2% occurred at hospitals and clinics, 1.9% at midwifery clinics, and 0.7% at public health care facilities.

Regarding the population control, induced abortion is also one of the most problematic issues concerning reproductive health. In principle, abortion is not allowed under the Maternal and Child Health Law in Korea. Yet, on account of the large number of pregnancies caused by faulty contraceptive practices, the abortion is being practiced at a high rate. The rate of induced abortion among married women was 49% in 1994. Table 12 shows that only 61% of pregnancy proceeded to actual birth, while 28.3% ended up as induced abortions. It also shows that abortion is more prevalent in urban than rural areas because of easy access.

Table 12. Pregnancy Outcome by Residence

(Unit: % (Number))

	Entire Country	Urban	Rural
Total pregnancies	100.0 (15,316)	100.0 (12,384)	100.0 (2,932)
Births	61.0	59.7	66.3
Still births	0.4	0.3	0.6
Abortions	8.2	8.5	6.8
Induced abortions	28.3	29.2	24.6
Pregnant	2.1	2.2	1.6

Source: Korea Institute for Health and Social Affairs, 1994 National Fertility and Family Health Survey, 1995.

The high abortion rate is partly due to unwanted pregnancies among married women caused by faulty contraceptive practices and prenatal sex selection based on the desire for male offspring. Loosened sexual standards among youngsters have been another contributing factor. According to a study conducted in 1990, abortions among unmarried women accounted for at least 33% of all abortions performed. Students and young employees receive sex education and counseling services, but family planning and contraceptive services are rarely provided for in the context of the Confucian culture. Despite legal restrictions on induced abortions, they are widely available and confidentially performed. The first institutional attempt, which made abortion illegal was placed to control the practice of induced abortion in 1953. According to the Act, medical personnel providing such services and women accepting them could be imprisoned. However, since the start of the family planning program as part of the population control policy in the early 1960s, legal regulations have not curbed the easy access to abortion so that services remain available nationwide throughout the past three decades.

Although women's life expectancy at birth is longer than men's, women are ill more frequently and for a longer period than men. According to the 1995 National Health Survey, the morbidity rate over the two weeks, from June 17-30, before the time of the survey was higher among women than among men. The highest morbidity rates were found among women in their fifties and older (Table 13).

The prevalence of chronic diseases was also higher among women than men. The differences in the prevalence of chronic conditions between women and men generally became greater with the increase of the respondents' age.

Table 13. Morbidity Rate Over the Two Weeks, from June 17-30, by Age Group

(Unit: Spell per 1,000 Persons)

	Average	0-4	5-9	10-19	20-29	30-39	40-49	50-59	60-69	70+
Total	477	483	348	217	333	435	552	749	965	867
Male	378	498	384	209	261	322	395	536	730	749
Female	570	465	304	226	396	544	712	946	1,140	924

Source: Nam, Jungja et al., 1996.

Table 15. Prevalence of Chronic Conditions by Age Group

(Unit: Spell per 1,000 Persons)

	Average	0-19	20-29	30-39	40-49	50-59	60-69	70+
Total	431	138	274	400	562	832	1,170	973
Male	335	140	234	314	432	616	876	816
Female	521	136	303	483	695	1,031	1,279	1,048

Source: Nam, Jungja et al., 1996.

Several reasons for the higher morbidity rate among women can be identified. First of all, women are exposed to more risks than men due to their frequent contact with young children and emotional distress. Because mothers have more contact with their children than do fathers, they tend to develop infectious diseases transmitted by children. Also, women experience more psychological distress, such as anxiety, depression, guilt, and conflicting demand, on a day-to-day basis and throughout their lifetime, than men. In addition, women tend to readily label their symptoms as physical illness and assess their illnesses and injuries as more severe and serious than men. The patriarchal family culture deeply rooted in Confucianism seems to aggravate the inferior health environment of women.

Health Care Systems

In providing curative care, Korea's health care system depends primarily on the private sector. In 1996, private clinics and hospitals comprised more than 91.0% of all medical facilities and 91.0% of all beds, and employed 88.8% of all physicians. Despite the increase in the proportion of health expenditures borne by health insurance, along with the expansion of coverage by the compulsory national medical insurance plan, in 1993 the private sector still bore 56.7% of national health spending while the public sector was responsible for only 20.2% (Table 15).

Table 15. Components of National Health Spending

(Unit: %)

Year	Health Insurance	Private Sector	Public Sector
1980	9.75	71.25	19.01
1985	16.21	68.63	15.17
1990	21.65	57.31	21.04
1993	23.11	56.70	20.18

Source: Hong, Joungkee, 1995.

The proportion of total national health expenditures in GDP increased from 2.1% in 1970 to 5.1% in 1985, and is estimated to have been around 4.8% in 1995.

The private sector-centered healthcare system lead to a severe disparity in the distribution of health resources between urban and rural areas. The number of doctors per 10,000 persons in urban and rural areas was respectively 13.3 and 3.2, in 1994 (Table 17).

Table 16. Ratio of National Health Spending to GDP

(Unit: %) Year

Year	Ratio to GDP	Year	Ratio to GDP	Year	Ratio to GDP
1970	2.13	1979	3.16	1988	5.08
1971	2.20	1980	3.56	1989	5.52
1972	1.65	1981	3.78	1990	5.69
1973	2.55	1982	4.36	1991	5.51
1974	2.76	1983	4.71	1992	5.52
1975	2.64	1984	4.84	1993	5.67
1976	2.49	1985	5.11	1994	5.64
1977	2.62	1986	4.85	1995	4.75
1978	2.96	1987	4.97		

Source: Hong, Joungkee, 1995.

Table 17. Health Resources by Area in 1994

(Unit: Numbers per 10,000 Persons)

	Urban	Rural	National
Beds	45.7	25.1	41.0
Hospitals	0.16	0.10	0.14
Clinics	3.6	1.5	3.1
Doctors	13.3	3.2	11.0
Traditional Medical Doctors	1.7	0.5	1.4
Pharmacists	0.68	0.11	0.55

Source: Ministry of Health and Welfare, Yearbook of Health and Welfare Statistics, annual.

There are also regional disparities in the number of hospital beds, with 45.7 beds per 10,000 persons in urban areas and only 25.1 in rural areas. The inadequacy and poor distribution of medical personnel and facilities has exacerbated the unbalanced quality of health care provision throughout the country, despite the government's efforts to establish more health care facilities in rural areas. In order to access

health care facilities, rural residents have to spend more on travel than do urban residents because of the lesser quantity of medical care facilities in rural areas.

To overcome the problem of unequal distribution of medical resources, the government has continuously tried to replenish the supply of medical manpower and facilities in rural areas. Financial incentives such as long-term and low-interest loans have been provided to those who establish medical facilities in rural areas. The government has also expanded primary health facilities and outfitted them with modern medical equipment in an effort to improve health services for people in rural areas. The government enacted a special law in 1980, allowing “Public Health Doctors” to work in medically underserved areas in lieu of compulsory military duty. As follow-up, the government established 1,303 health sub-centers in rural and fishery areas, and 2,301 public health doctors were assigned to sub-centers in 1994.

In 1981, the Special Law for Primary Health Care in Rural and Fishery Areas was enacted. As of 1995, some 2,039 Primary Health Care Posts (PHP) had been established in rural and fishery areas with a population of more than 500 (more than 300 for the islands), providing medical facilities located within a 30-minute reach by conventional transportation. Community Health Practitioners, qualified nurses or midwives who have completed 24 weeks of special job training serve at these centers, providing preventive health care and basic medical treatment. Health center or sub-center doctors in designated areas make regular visits to the PHP for supervision and consultation.

Patients are first required to visit a primary care doctor, or a

hospital, prior to being referred to a general or university hospital. This referral system was introduced in 1989 to discourage patients from going directly to expensive medical facilities for minor ailments. Under this referral system, patients visit a doctor at a clinic or hospital of their choice near their homes, and must obtain a referral letter in order to receive treatment at a general or university hospital, with no regional restrictions. This regulation, of course, does not apply to emergencies, and the referral system allows for exceptions regarding certain types of treatment. In practice, however, there are several possible ways that patients can receive the desired treatment from their preferred provider immediately, rather than through the referral process. “Preferred provider” for patients means the nearest urban medical center, rather than the local hospital. Hospitals have no reason to refuse patients, either on an inpatient or an outpatient basis, since they are paid according to the fee-for-service schedule. The fee-for-service payment system also encourages medical centers to treat patients who actually do not require treatment in a specialized department of the hospital. Thus, patients are often willing to travel to urban areas to receive what they believe to be better treatment and what the primary care sector or the rural care sector can not provide. Consequently, the demand is geared towards urban medical centers, especially large university hospitals or general hospitals, where the waiting time for some services is unnecessarily long, resulting in a deterioration of the quality of service.

In 1977, Korea initiated a compulsory health insurance scheme with limited coverage of less than 10% of the population. Until then, an individual’s medical care was his or her own responsibility, with the exception of those insured under pilot health insurance schemes

and the indigent who were cared for by government and/or private charity hospitals. In 1976, the Korean government introduced a health insurance law to provide its citizens with compulsory medical care. The compulsory medical insurance plan first covered only firms with 500 or more workers due to the government's financial limitations. At the same time, the Medicaid program for those under the poverty line was introduced under government sponsorship. Since 1977, coverage has gradually been extended to smaller firms (Table 18).

Table 18. Major Health Insurance Developments in Korea

Year	Major development	Population coverage [1] (%)	Per capita GNP (US$)
1977	-Initiated compulsory health insurance for firms with 500 workers or more -Provided medicaid program for low income earners under public assistance scheme	14.5	1,012
1979	-Compulsory insurance for government employees, teachers, and the staff of private schools -Expanded coverage to firms with more than 300 workers	26.9	1,644
1981	-Expanded to firms with at least 100 workers	29.6	1,734
1983	-Expanded to firms with 16 workers or more	39.3	2,002
1987	-Included oriental medicine under insurance coverage	79.1	3,110
1988	-Compulsory insurance for rural residents -Expanded to firms with five workers or more	-	4,127
1989	-Compulsory insurance for urban residents -Included prescription drugs at pharmacy within its coverage	99.9	4,994
1995	Extended coverage from 180 to 210 days	-	10,076
1996	Unlimited coverage for elderly and disabled	-	-
1997	Extended insurance from 240 to 270 days	-	-

Note: 1) Includes population under medicaid.

Sources: Ministry of Health and Welfare; Bank of Korea; Federation of Korean Medical Insurance Societies.

As summarized in Table 19, the National Health Insurance scheme is currently composed of three different elements: Industrial Health Insurance Funds for industrial workers (145 funds), Government Health Insurance Funds for government employees and private school teachers, and Regional Health Insurance Funds for rural and urban self-employed workers (227 regions). Most funds are legally independent in terms of both administration and finance. The National Federation of Medical Insurance plays an important role in examining and paying fees charged by medical care institutions. Premiums for industrial and government insurance funds are imposed at a proportional rate of the insured's monthly earnings, while for the regional insurance funds, several factors such as income, value of real estate and family size are taken into account when calculating the premiums. For the financing of regional funds, the government provides subsidies, most of which are supported through capitalization. A portion of the subsidies is distributed to the funds in different amounts depending on the amount of taxable income and the dependency ratio of the elderly for each fund. There is some disparity in the financing ability among funds. Some funds have accumulated a considerable amount of financial reserves, whereas others are financially weak. To lessen these disparities, a risk-sharing mechanism was adopted in 1991, based on the simple idea that the richer insurance funds can subsidize the poorer ones.

The national health insurance system initially started with a high co-payment level and limited benefits for the insured. By adopting this restricted national health insurance system, Korea had been able to establish a universal health insurance system much faster than otherwise would have been possible. However, co-payments are

actually higher than the official schedules. For example, under the current medical insurance scheme, patients are supposed to pay 20% of hospitalization fees, and certain rates regarding co-payment of outpatient fees. Patients pay the full amount for any treatment beyond the limited period per year, which now accounts for 270 days. In addition to high co-payments, patients have to pay for treatment fees that are not covered by the fee-for-service schedule. These limits have led to a financial burden for some patients, especially the poor and the elderly. Thus, low income groups can not easily access medical care because they are burdened by heavy payments. Therefore, the prevalence of patients paying out of their own pockets leads to inequities.

Physician and hospital reimbursements are largely based on the fee-for-service schedule, which is determined by the government. The fee-for-service reimbursement system is linked to the physician's over-treatment problem and the deterioration of health care quality. Primary care doctors and hospitals are paid mainly on a fee-for-service schedule covering several thousand items. They, therefore, tend to give each patient as much treatment as possible, including unnecessary practices such as the duplication of services and the prolongation of visits or stays in hospitals. This leads to a volume of services beyond those, which would be considered optimal on purely medical grounds. Furthermore, volume expansion can lead to malpractice as physicians do not spend sufficient time with their patients.

Table 19. Current Status of Health Insurance Scheme in Korea (in 1996)

Types	Universal social insurance system with 373 funds nationwide: Industrial workers (145 occupational funds) Civil servants and private school teachers (1 fund); and Self-employed (227 regional funds).
Population Coverage	Employees of firms with 5 or more workers; Civil servants, private school teachers, and dependents of military personnel; and Employees of firms with less than 5, the self-employed, and pensioners.
Financing	Contribution plus government subsidy: 3% total, 1.5% employee, 1.5% employer; no ceiling; 3.8% total, 1.65% employee, 1.65% government; no ceiling; and Premiums according to income, property, and family size, plus government subsidy (half of expenditures). Risk adjustment among 373 funds nationwide.
Benefits	Statutory benefits: (main in kind) medical examinations, drugs, surgery, nursing, ambulance and check-ups. Duration: 240 days/year (no limit for the disabled and the elderly). Patient co-payment: 20% of hospitalization fees and varying rates of co-payment for outpatient fees (30% clinic, 40% hospital, 55% general hospital). Reimbursement: fee-for-service, fees under control of government, additional fees allowed (10% clinic, 15% hospital, 23% general hospital, 30% university hospital) and special consultation fees for specialists at hospitals.
Organization	A, b, c: Ministry of Health and Welfare Affairs. c: National Federation of Medical Insurance. B: Korean Medical Insurance Corporation.

Source: Yeon, Hacheong, 1996.

The above mentioned issues have inspired a wide variety of reforms to be enacted. Reform strategies primarily address the questions of how to attain efficiency in managing the health insurance scheme, how to increase fairness among the insured and the insurance

funds; and how to improve the quality of health care.

To cope with the burdensome out-of-pocket payment problem, the government has considered expanding the number of reimbursable benefits by insurance funds and reducing the co-payment rate. A more rational use of hospital facilities could be expected if more services were included in the reimbursement schedule. For example, many people are waiting for expensive tests, such as Magnetic Resonance Imaging, ultrasonic testing and other electronic examinations, to be covered by insurance. In addition to this measure, the reimbursable treatment period per year is presently 240 days, to be extended gradually every year until it finally covers 365 days by the year 2000. This extension plan will provide more treatment opportunities for the chronically ill and the elderly who require more medical attention and longer treatment.

These measures would lead to restructuring health care financing. Financing a broader coverage of benefits will certainly result in higher premiums while also increasing government subsidies to regional funds, whereas the pressure of increasing expenditures for financially weak funds must be alleviated through a risk-sharing mechanism. For low-income earners, some adjustments in the premium schedule should be arranged.

To solve the problem of over-treatment and the deterioration of health care quality, the government is now considering reformulating the fee-for-service structure into a Resource Based Relative Value Scale and introducing the Diagnosis Related Groups system. The former price mechanism is expected to alleviate treatment distortions by physicians. The latter DRG system underwent testing to see if it can be successful, through a series of demonstration projects effective

until late 1997. Such a system would be phased in, starting perhaps with inpatient treatment which can be more readily defined and easily calculated. However, the system might eventually be extended to most services, including some outpatient treatments provided by private clinics. Another strategy to consider is screening medical bills more carefully. Particularly, it might be possible to give the insurance funds more leeway when it comes to screening, including the review of bills and treatment processes.

Another view towards making the system efficient suggests that Korea could develop a competitive health insurance system. This development could eventually move, as in several European countries, towards giving individuals a choice among insurance funds, thus introducing an element of competition among the funds.

3. Poverty Profile and Inequality

Trends of Poverty and Inequality Level

The minimum cost of living in Korea has not been measured consistently. So in order to make a longitudinal data on minimum cost of living, one method has been chosen as a standard among the already existing minimum cost of living. That is a minimum cost of living for one-person- household measured by KIHASA in 1994. The data was inferred for each year from 1975 to 1995.[8]

[8] That is $MCL_t = MCL_0 \times (1 + p_{0,t-1})$. Here, MCL_t is the minimum cost of living in concerned year (t), MCL_o is the minimum cost of living in standard year (0), and $p_{0,t-1}$ is the change rate of consumption price from the standard year (0) to the previous year (t-1) of the concerned year (t).

Table 20 shows the longitudinal data on minimum cost of living for one-person-household from 1975 - 1995. This data was drawn on the basis of the minimum cost of living of KIHASA (1994) according to the retrospective change rate of urban household expenditure.

On the basis of the longitudinal data on minimum cost of living (see Table 20), the poverty ratios were measured by using the urban households' income data only. Gini coefficients were also calculated by using the same data. As a poverty index, the poverty headcount ratio was used, which is the most popular in the related research fields. The poverty headcount ratio denotes the ratio of households that expend less than the minimum cost of living. It can be represented as follows:

$H = \sum P_i / N,$

H : poverty ratio, P_i : number of households expending certain amount less than the minimum cost of living (or poverty line), N : total number of households

The result of estimated poverty ratio and Gini coefficients are shown in Table 20. In the table, the poverty ratio and Gini were statistically inferred on the basis of the urban household income.

The Table 20 shows poverty ratio and Gini coefficients. The poverty ratio decreased annually from 1975 to 1981, and thereafter remained consistent at the level of 18% until 1985 and fluctuated within the range of 8.81% - 16.88% between 1986 and 1992. Since 1993, the ratio stabilized at the level of around 8%. The reason for its sudden augmentation in 1982 may be the due to the decrease of the 1982 average urban household income in real terms as economic difficulty arose.

Table 20. Poverty Ratio, Minimum Cost of Living and Gini Coefficients

(Unit: %)

	Poverty ratio	Minimum Cost of Living[4)]	Gini
1975	21.52[1)]	11,581	0.340[1)]
1976	19.62[1)]	14,520	0.352[1)]
1977	19.54[1)]	17,015	0.359[1)]
1978	17.49[1)]	22,723	0.356[1)]
1979	16.00[1)]	30,868	0.360[1)]
1980	15.25[1)]	38,380	0.354[1)]
1981	13.37[1)]	45,308	0.351[1)]
1982	20.42[1)]	45,617	0.386[1)]
1983	18.96[1)]	50,247	0.379[1)]
1984	18.88[1)]	54,740	0.386[1)]
1985	18.50[1)]	59,662	0.384[1)]
1986	16.51[1)]	65,218	0.374[1)]
1987	14.30[1)]	75,302	0.369[1)]
1988	15.46[1)]	88,404	0.379[1)]
1989	16.88[1)]	110,698	0.403[1)]
1990	15.74[1)]	128,087	0.395[1)]
1991	14.94[1)]	152,164	0.393[1)]
1992	8.81[1)]	176,293	0.364[1)]
1993	8.61[1)]	189,841	0.362[1)]
1994	8.15[1)]	213,678	0.363[1)]
1995	8.47[1)]	239,059	0.370[1)]
1996	7.41[2)]	-	0.377[2)]
1997	7.67[2)]	-	o.369[2)]
1998	14.28[2)]	-	0.390[2)]
1999	15.38[2)]	-	0.398[2)]
2000	8.38[3)]	-	-

Source: 1) Author's estimation.

2) Chanyong, Park and Kim, Geneuhc, 1999.

3) Nanak, Kakwani and Son, Hyun Hwa, 2001.

Also, during 1981-1982, income inequality was aggravated by the rise in Gini coefficient from 0.351 in 1981 to 0.386 in 1982. The above reasons and the aggravation of income inequality have caused the poverty ratio to escalate in 1982. After then, the poverty ratio preceded to slowly

decrease until 1991 and to drop further in 1992.

Characteristics of the Poor in Korea

To examine the characteristics of the poor in Korea, this study analyzes the traits of the recipients of Livelihood Protection, which is a form of public assistance provided to low income people. Recipients are required to meet the legal criteria. More specifically, it discusses the size of recipients, duration of protection, type of household, household composition, employment status, causes of poverty, health, education, and housing to understand the conditions of the poor in Korea. Not all of the poor people are the recipients[9] of Livelihood Protection; nonetheless, this study assumes that the recipients, who are part of the poor population, have similar or more unfavorable characteristics than the general poor population, because they are the poorest of the poor in Korea. Livelihood Protection is divided into three types: Home Care, Institutional Care, and Self-support Care.

Based on the "Analysis of Livelihood Protection Recipients", an annual report published by the Ministry of Health and Welfare, the characteristics of Livelihood Protection recipients are analyzed excluding Institutional Care Recipients. An overall analysis is made

[9] The criteria for the selection of recipients consists of both the per capita income of a family and the value of household property. In 1997, to be eligible for Home Care recipients, one's monthly family income should be ₩210,000 or less and one's household property be ₩29 million or less. Out of those who satisfy the above criteria, only those without supporters or those incapable of working due to chronic diseases are selected as Home Care recipients. To be eligible for Self-support Care recipients, one's monthly family income should be ₩220,000 or less and one's household property be ₩28 million or less. Therefore, the rate of Livelihood Protection recipients in this chapter, which is selected based on the above criteria, differ from the poverty rate computed in the previous chapter. Although Livelihood Protection recipients are the economically poor population in Korea, they are selected upon various criteria as well as family income.

for each characteristic, followed by the comparison of the traits between the two types of recipients. The comparison, then, is used to draw reasonable policy implications to improve the conditions of those recipients.

Demographic Characteristics

Size of Recipients and Length of Protection

The number of poor households and the rate of poverty between 1990 and 1996 have continuously decreased. The number of poor households was 900,000 in 1990 and 650,000 in 1993. In 1996, the number decreased even more to 520,000. The poverty rate, namely, the proportion of poor household to total household was 8% in 1990 and progressively reduced to one-half (4%) in 1996.

Table 21. Livelihood Protection Recipients in Korea, 1990-1996

(Unit: households, %)

Year	Total Household	Recipients Household	Rate of Recipients
1990	11,355,000	904,914	7.97
1991	11,510,000	750,535	6.52
1992	11,807,000	726,479	6.15
1993	12,112,000	645,087	5.33
1994	12,427,000	586,266	4.72
1995	12,961,000	600,983	4.64
1996	13,067,000	521,739	3.99

Note: The number of recipient households do not constitute those who actually receive protection, but the those who are entitled to protection.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients Analysis, 1990-1996.

In 1996, of the total Livelihood Protection recipients, the rate of Self-support Care recipients was the largest, followed by that of Home care and Institutional Care[10] (see Table 22).

Table 22. Livelihood Protection Recipients in 1996

(Unit: person (household))

Total	Recipients in 1996		
	Home Care	Institutional Care	Self-support Care
1,159,206 (464,624)	285,185 (179,484)	76,001	798,020 (285,140)

Note: Numbers in parentheses indicate actual number of persons receiving benefit.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

The examination of the length of protected period reveals how long it takes for recipients to become self-sufficient. As shown in Table 23, 38.3% of recipients has received protection for over 5 years, and 27.2% of them, between 3-5 years. A total of 65.5% has received protection for over 3 years. However, the rate of households receiving protection for less than a year was merely 10.8%. That is, while two thirds of recipients' household were in long-term protection of over three years, only one-tenth of recipients' households have become self-supportive within less than or equal to one year, subsequent to receiving protection. The recipients remain on welfare on a relatively

[10] Home Care recipients include the aged over 65, children under 18, pregnant women, the sick, the disabled, and those whose households compose of members incapable of working or with only women aged over 50. Institutional Care recipients are those who are legally qualified as recipients but do not have their own home or are unable to live in their own home. While the contents of benefit for Home Care and Institutional Care recipients are the same, the amount of benefit is different. Self-support Care recipients are households eligible for Livelihood Protection but do not belong in the category of Home Care or Institutional Care (i.e., they are capable of working).

long-term basis rather than become self-supportive.

Table 23. The Number of Recipients by the Length of Protection

(Unit: Household, %)

	Total	1 or less	1 to 3	3 to 5	Over 5
Total Recipients	100 (464,624)	10.8	23.7	27.2	38.3
Home Care	100 (179,484)	9.5	21.2	24.6	44.7
Self- support Care	100 (285,140)	11.6	25.3	28.7	34.4

Note: Numbers in parentheses indicate number of households.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Household Types of Recipients

The knowledge of household types of the poor is vital for providing proper assistance, because various households whether they are elderly households or lone parent households, need different kinds of support. The elderly household constitutes the largest proportion among various household types, as shown in Table 25. 55% of household heads and 38% of household members belong to the elderly household. The next common type of household is the disabled household, consisting of 25.4% of household heads and 32.0% of household members.

Of lone parent households, the proportion of households with mother-children is almost four times the rate of those with father-children. Since the majority of poor households consist of mother-child than father-child, it reveals that women are more economically

disadvantaged than men. This pattern is manifested in both types of recipients, which proves that poverty is mose certainly related to gender as well as age and disability.

Furthermore, while the proportion of the elderly household and households headed by boys or girls under 18 are largely Home Care recipients than Self-support Care recipients, the disabled household and lone parent households occupy less in the former than in the latter.

Table 24. Household Types of Recipients, 1996

(Unit: %)

Type		Children	Mother-Child	Father-Child	Disabled	Elderly
Total	Head	4.4	11.8	3.4	25.4	55.0
	All	5.0	19.0	5.7	32.0	38.3
Home-care	Head	6.6	5.4	1.7	22.8	63.5
	All	8.4	10.5	3.2	29.2	48.8
Self-support care	Head	1.8	18.8	5.3	28.4	45.7
	All	2.5	25.4	7.6	34.0	30.4

Notes: 1) The disabled household indicate household with at least one disabled person.

2) The elderly household consists of only the aged over 65.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Number of Household Members

The acquired data on number of recipients' household members contradict the common belief that households of the poor consist of large families. The average number of household members of recipients is 1.59 for Home Care recipients and 2.80 for Self-support

Care recipients. The average number of household members of recipients is actually smaller than that of non-recipients (3.3 in 1995).

Most recipients are single family households. 42% of recipients live alone and a majority of them receive Home Care than Self-support Care (see Table 25) followed by households with two persons. 19% of recipients are two person household and 16% are three person households. Overall, including families with more than four persons, Home Care recipients have smaller numbers of family members than Self-support Care recipients.

Table 25. Number of Household Members of Recipients

(Unit: Household, %)

	Total	Single	Two	Three	Four	5 or more
	100 (464,624)	41.8	19.2	15.5	12.9	10.6
Home Care	100 (179,484)	66.1	15.8	8.4	6.2	2.2
Self-Support care	100 (285,140)	26.5	21.4	19.9	16.7	15.5

Notes: 1) The average number of household of Home Care recipients is 1.59.
2) The average number of household of Self-Support Care recipients is 2.80.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Economic Characteristics

Economically Active Recipients

Poverty is highly related to not only people's economic activity

whether active or inactive but also the kinds of employment situation whether employed full-time or part-time, because they determine earning power and the level of earning. Regarding economic activity, about half of recipients are economically active. A little over half of the recipients, 54.5% of household heads and 57% of the household members, are economically active.

A comparison of the employment status between the two types of recipients shows a wide difference in characteristics of their economic activity. While only between 15% and 17% of the Home Care recipients are employed, between 44% and 52% of the Self-support Care recipients are employed. Moreover, the rate of the unemployed[11] is higher in the former (20%-23%) than in the latter (15-19%). This difference is due to the differential selection criteria for Livelihood Protection: to be eligible for Home Care one should be aged over 65, children under 18, pregnant women, the sick, the disabled, or those whose households compose of members incapable of working or with only women aged over 50, while to be eligible for Self-support Care one should belong to households qualified to receive Livelihood Protection but do not belong in the category of Home Care nor Institutional Care.

Among economically active recipients, the employment rate consists of 69.3% of household heads and 64.5% of household members. By comparing the two types of recipients, we can find that the employment rate of Home Care recipients (43%) are much lower than that of Self-support Care recipients (69%-78%). The

[11] Unemployed people are those who have the desire and ability to work but do not find a job, or wait for a job, or can not work due to being sick, or plan to run their own business. The economically inactive population include people under 14, homemaker, students, and the aged, disabled, and sick incapable of working.

unemployment rate among economically active recipients are 30.7% for household heads and 35.5% for household members. That is, one third of economically active recipients are unemployed. Their unemployment rate is much higher than that of the total population, which was 2% in 1995. The high unemployment rate may cause or aggravate their economic situation.

Table 26. Economically Active Recipients

(Unit: %)

		Total (A+B+C)	Economically Active		Economically Inactive (C)
			Employed (A)	Unemployed (B)	
Total	Head	100 (464,624)[1)]	37.7 (69.3)[2)]	16.8 (30.7)[2)]	45.5
	Member	100 (1,083,205)	36.8 (64.5)	20.2 (35.5)	43.0
Home	Head	100 (179,484)	14.7 (42.6)	19.9 (57.4)	65.4
Care	Member	100 (285,185)	16.8 (42.6)	22.7 (57.4)	60.5
Self-Support	Head	100 (285,140)	52.2 (78.0)	14.8 (22.0)	33.0
Care	Member	100 (798,020)	44.0 (69.4)	19.3 (30.6)	36.7

Note: 1) Number of households.

2) Numbers indicate the proportion of employed and unemployed people to the economically active population.

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Employment Type

Although recipients have jobs, they are employed under very unstable conditions or in small businesses. Only few of them hold a secure job (see Table 27). The most common type of employment among recipients is part-time employment, followed by the order of

employment in small agriculture and fishery, and temporary employment. Full-time employment[12] consists of only less than 10%; merely one out of ten recipients maintains a stable job.

Table 27. Occupation of Employed Recipients

(Unit: Households, %)

		Occupation				
		Small Business	Agriculture and Fishery	Full Time	Part Time	Daily Basis
Total	Head 175,460	9.3	30.0	8.3	14.2	38.2
	Member 398,857	8.3	30.7	10.2	15.5	35.9
Home Care	Head 26,434	10.8	27.1	4.0	13.1	44.9
	Member 48,051	10.9	27.4	4.7	14.1	42.9
Self-Support	Head 149,026	9.0	30.5	9.1	14.4	37.0
	Member 350,806	7.9	30.4	11.0	15.7	34.9

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

When comparing the two types of recipients, more Home Care recipients are part-time employees than Self-support Care recipients. As for small self-employed and temporary employment, the two types

[12] Small Business: Running one's own business such as agriculture, retailing (stores, outdoor sales, soliciting sales)
Full Time: Salaried employment by companies or individuals for more than a year.
Part Time: Salaried employment by companies or individuals between 1 month and a year.
Daily Basis: Employed on a daily basis by companies or individuals for less than a month (peddler, porter, etc.)

of recipients show similar trends. Accordingly, we can infer that the employment conditions of Home Care recipients are slightly more disadvantaged than that of Self-support Care recipients.

Social Characteristics

Health

Poor health condition is another attributing factor of poverty, because it determines one's capability to work. Survey has shown that only 51% of them are healthy, around 20% are either sick or disabled, and 29% have other types of illness, indicating that almost half of the recipients are either disabled or sick. In the case of Home Care recipients, as much as 64% of household heads are disabled or sick, and only 36% of them are in good shape, while in the case of Self-support Care recipients about 60% of household heads are disabled, sick, or short-term patients, and 40% of them are healthy. Overall, Home Care recipients are in slightly worse health conditions than that of Self-support Care recipients.

Table 28. Health Status of Recipients, 1996

(Unit: %)

		Healthy	Disabled	Sick	Other
Total	Head	38.6	13.1	15.4	32.9
	All	51.4	8.7	10.9	29.0
Home Care	Head	36.1	16.9	17.6	29.5
	All	43.5	15.0	15.7	25.8
Self-Support	Head	40.2	10.8	14.1	35.0
	All	54.2	6.6	9.2	30.5

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Education

Education as well as skills are indispensable elements in finding a job. Most recipients have less than ten years of education. 77% of household heads have an elementary school education, and most of them have less than junior-middle school education. A total of 80% of all household members have less than junior-middle school education. Lack of education is a major obstacle for them in finding a well-paid or stable job.

Table 29. Educational Level of Recipients, 1996

(Unit: Household, %)

		No Education	Elementary	Junior Middle	High School	Junior College
Total	Head	47.6	29.8	14.8	7.1	0.6
	All	35.2	29.1	19.0	14.6	1.1
Home	Head	64.1	21.8	9.1	4.6	0.5
Care	All	54.1	24.4	12.9	8.1	0.6
Self-	Head	37.3	34.9	18.5	8.7	0.6
Support	All	29.8	30.8	21.2	16.9	1.4

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Recipients with more than an high school education totalled 15.7% of which 8.7% (household heads: 5.1%) are of Home Care recipients, and 18.3% (household heads: 9.3%) of Self-support Care recipients. These figures indicate that the overall educational level of recipients is substantially low, although the educational level of the latter is slightly higher than the former.

Home Ownership

Home ownership an another indicator that reveals the characteristics of the poor. The home ownership rate in 1996 was higher than expected. About 40.3% of recipients are home owners[13] (see Table 30). In spite of the high home ownership rate of recipients, further evaluation must be made on their living standard. Without considering the size of their homes, the condition of home environment, and the price of housing in rural areas, it is hard to comprehend the overall situation.

About 25.7% of recipients rent houses, 19.6% of them live in free leasing apartments, and 13.6% of them live in leasing apartments. In six big cities[14] the home ownership rate of recipients is merely 5.2%, and the majority of them (94.8%) do not own houses, but live in rented houses, leasing or free leasing apartments.

The comparison of home ownership between the two types of recipients shows that housing situation is more unfavorable for Home Care recipients than Self-support Care recipients. The data reveals that only 33.8% of Home Care recipients own a house, compared to the 44.5% of Self-support Care recipients.[15] In six big cities, however, the home ownership rate of Home Care recipients is only 4.6%, and over 95.4% do not own their own house and that of Self-support Care

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[13] According to statistics in 1995, the home ownership rate across the nation was 53.3%, and that in Dong district or above level was 46.4%, that in Eup or above level 77.2%. Since prices of land and housing are cheaper in rural areas than in urban areas, the home ownership rate in the former was much higher than the latter. Therefore, the home ownership rate of the recipient who live in rural areas as well as urban areas was relatively high.

[14] Seoul, Pusan, Taegu, Inchon, Kwanju, Taejun

[15] The home ownership rate of the recipients in the 6 big cities is 5.5%.

recipients is also expected to be low. This indicates that recipients' economical burden on housing is considerably high.

Table 30. Home Ownership Rate, 1996

(Unit: Households, %)

	Housing					
	Total	Own	Rent	Leasing Apt	Free Leasing	Others
Total	100 (464,624)	40.3	25.7	13.6	19.6	0.1
Home Care	100 (179,484)	33.8	26.8	7.4	30.9	1.1
Self-Support Care	100 (285,140)	44.5	25.1	17.5	12.5	0.1

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Causes of Poverty and Policy Implications

Causes of Poverty

Fully comprehending the causes of poverty is essential for devising proper antipoverty policies. The most common cause of poverty in Korea has proved be the lack of working capacity due to age (either being too old or too young), illness, disability, and not having a father in the family (66%), as shown in Table 31. That is, aging, sickness, disability and fatherless families are the main factors of poverty, because under these conditions they are unable to work and to earn income.

The second cause is the lack of education, work experience and

skills, even though the recipients are capable of working (29%). To be employed, especially with secure working conditions, education, working experience and skills are required. Persons without those elements have difficulties in finding jobs and thus, their chances of becoming poor is high.

The third cause is the unemployment of recipients with same skills. Only 6% of them fall into this category. Since unemployed persons with skills can easily find jobs, their chances of emerging from poverty is higher than most other recipients without any skills.
From above findings, we can conclude that most people become poor due to poor physical condition or lack of education, working experience and skills.

The % distribution of the causes of poverty between the two types of recipients, however, reveal a little different result. Most Home Care recipients (96%) have become poor due to their age, illness, disability and being in a family without a father, whereas only about half of Self-support Care recipients (48%) have become poor due to the same reasons. The remaining 45% of Self-support Care recipients are capable of working but have become poor due to the lack of education, work-experience, and skills. In terms of capacity to work, only 4% of Home Care recipients are able to work, whereas as much as 53% of Self-support Care recipients are able to work. Therefore, to lift from poverty Home Care recipients need to receive more public assistance and medical aid, while Self-support Care recipients need more opportunities to obtain education as well as skills.

Table 31. Causes of Poverty, 1996

(Unit: Households, %)

	Total	Home Care	Self-Support Care
	100 (464,624)	100 (179,484)	100 (285,140)
Age, Disease, Disability, Fatherless (No available labor force in the household)	66.4	96.4	47.5
Lack of education, working experience, and skills (Labor force available in the household)	28.6	3.0	45.0
Possess skills but not finding a job. (Labor force available in the household)	5.9	0.5	7.5

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Policy Implications

By examining the characteristics of recipients, much efficient anti-poverty policies can be developed, and policies appropriate for each type of recipients can be made.

In the case of Home Care recipients, most households consist of a single person household or the sick. As shown in Table 32, two thirds of them (76%) are those who can never become self-supportive. Therefore, the basic orientation of the protection policies should be an extension of the existing ones, which have protected them with welfare expenditure. As pointed out previously, since most of them have no capacity to work rather than no desire to work, main policies should be geared to assisting their subsistence. In addition,

educational aid covering entrance fees and tuition must be extended to cover other school-related expenses, so that their children can receive proper education to find jobs. As a result, the younger generation will not inherit poverty from their parents. Furthermore, since many of the recipients are disabled or sick, the coverage of medical aid should be expanded to not only cure diseases but also to prevent them.

In contrast, most Self-support Care recipients (71%) can become self-supportive by finding a job or getting the proper education and skills. Thus, job training and career placement services which are offered by self-reliance aid centers should be expanded in terms of their programs and contents of services.

Table 32. Possibility and Ways to be Self-supportive, 1996

(Unit: Households, %)

	Total (464,624)	Home Care	Self-Support Care
	100	100	100
1. Impossible to be self-supportive due to aging, sickness, and disability	35.5	67.9	15.1
2. No desire to be self-supportive	11.6	7.9	14.0
Not self-supportive (1-2)	47.1	75.8	29.1
3. Possible if children grow up and find a job	18.5	15.0	20.7
4. Possible if sickness is treated and find a job	7.3	6.7	7.7
5. Possible if they get a job or job training.	13.5	1.4	21.1
6. Possible if they receive a self-reliance fund	5.7	0.5	9.0
7. Possible if they move to a country side or receive a self-reliance fund.	7.9	0.7	12.6
Self-supportive (3-7)	52.9	24.2	70.9

Source: The Ministry of Health and Welfare, Analysis of Livelihood Protection Recipients, 1996.

Finally, the effect of anti-poverty policies should be carefully reviewed after applying them to the poor. The main purposes of the policies in Korea, namely Livelihood Protection, are not only to support its recipients in guaranteeing a minimum standard of living, but also to provide them with infrastructure essential for self-supportiveness. However, until we evaluate the effectiveness of these policies, it is difficult to assure whether the policies reduce poverty and assist recipients to become self-sufficient. Therefore, evaluation of the policies should be performed regularly to examine their effect and to redress their limitations to completely satisfy the needs of the poor.

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