Knowledge-that and Knowledge-how: The Politics of Tackling Health Inequalities in South Korea

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Outline

• Health and Health Care of South Korea
• Problems Left Unsolved, New Challenges and Threats
• Health Inequalities and Social Determinants of Health: How Can Policy and Politics Be Changed?
• Barriers and Opportunities
• How to Do ‘Turns’
The Korean Health and Health Care

• Achieved high life expectancy and health indices in a relatively short period
  • Estimated to have the highest life expectancy in 2030 (Kontis, 2017)
• Near-universal health coverage with the National Health Insurance (NHI) led to accelerated utilisation of high-quality health care
  • Health care resources investment driven by the NHI and the private sector
  • Lowest levels of health expenditure regulated by the government and NHI
• All happened within less than 30 years
Problems Left Unsolved

• Are we really healthy?

*Figure 1* Subjective health levels and life expectancy

*Figure 3* Self-reported health in OECD countries

Source: OECD Health Data 2015
• Highest suicide rate

Global suicide rates
Suicide rates and rank out of 171, selected countries, 2012

- Guyana (1st)
- South Korea (2nd)
- Indigenous (12th)
- Russia (15th)
- Japan (18th)
- Finland (34th)
- US (51st)
- Australia (64th)
- Canada (71st)
- New Zealand (73rd)
- Germany (78th)
- UK (106th)
- Brazil (113th)
- Spain (123rd)
- South Africa (149th)
- Syria (171st)

Rate per 100,000
Graph: Inga Ting | Source: WHO 2014, FC 2014

• Incidence and mortality of tuberculosis

Incidence of OECD countries, 2015
Mortality of OECD countries, 2015

Source: Global Tuberculosis Control WHO Report 2016, WHO
Unequal Health and Health Care

- Not narrowing health gap
- Income level and unmet needs

Mortality rate gap for middle school versus university graduates

Data: Report on health inequalities in South Korea, published by the Korean Society for Equity in Health

- Men
  - 1995: 8.05
  - 2000: 8.44
  - 2005: 9.66
  - 2010: 8.41

- Women
  - 1995: 3.24
  - 2000: 4.61
  - 2005: 7.31
  - 2010: 8.06

Bar graphs for years 2013 to 2015 showing health care expenditure.
"Inverse Priority Law" in Policy (and Politics)

- Not sufficient attention is paid to the higher-priority needs and demands
- Most health programmes include only supplementary health services targeting 'vulnerable' groups (mostly selectivist approach)
- Medicalisation of and NHI 'imperialism' in health and health-related practices (including policy and politics)
- Social and political determinants of health has not been 'socialised' and 'politicised', only concerned within the health sector
National Health Plan 2020 in Korea

The Goal of HP2020

1. Extension of healthy life expectancy
   - 71 year to 75 year

2. Improvement on health equity
   - Minimized the health level between regions in the income level

Implement System

Vision
- Healthy world where all people enjoy together

Goal
- Extension of healthy life expectancy & Improvement on health equity

Field of Business
- The spread of Healthy living practices
  - Non-smoking
  - Moderation in drink
  - Physical activity
  - Nutrition

- The management of Chronic degenerative disease and risk factors
  - Cancer
  - Physical examination
  - Arthritis
  - Cardiovascular disease
  - Obesity
  - Mental Health
  - Oral Health

Business Systems Management
- Infrastructure, Evaluation, Information and Statistics, Resources
A Series of New Challenges

• Conventional paradigm of health and health policy, pathos of ‘nation-building’
  • Focusing on quantity and access
  • Efficient coverage
  • Basic and essential
  • Mobilising, collectivistic and mostly utilitarian

• Challenges with the phasing-in of ‘post-nation building’
  • Changes in socio-economic determinants of health, including income, work, geographical space, the governments, market, family, culture and welfare system
  • Ageing
  • Politics and political economy in health and of policy actors
Additional (but Fundamental) Threats

- Delayed and ‘emerging’ welfare state
  - Slow progress of the public and social protection
  - Current mismatch between production and welfare regimes, e.g. ageing and retirement vs. income protection for old age
- Strengthened neoliberal govermentality
  - Combined with pre-existing ‘economism’ and ‘developmentalism’
  - Marketisation, commercialisation and privatisation
  - Ideology of the New Public Management and ‘small government’
  - Weakening social ties and individualisation (“There is no such thing as society”)
  - Neoliberal self as an individual enterprise with entrepreneurship
Baseline Knowledge: How Can Policy and Politics Be Changed?

- Higher-priority needs and demands should be met
- ‘Main-streaming’ of health equity and SDH
- ‘Socialisation’ and ‘politicisation’ of policy and programme
- Whole-of-system approach
  - Up-stream and mid-stream approaches
  - Inter-sectoral, multi-sectoral and trans-sectoral
  - Evidence-based
From Knowledge to Action/Policy

- Measurement
  - Recognition
    - Awareness raising
      - Concern
        - Mental block
      - Denial/indifference
        - Will to take action
          - Isolated initiatives
            - More structured developments
              - Comprehensive co-ordinated policy

Is Knowledge Enough?

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Better Knowledge Translation?

Source: Straus, Tetroe & Graham, 2013
Barriers in Translation of Knowledge

- **Knowledge creation & synthesis**
  (a) Rare demand
  (b) Poor awareness among the public and policy-makers
  (c) Political factors
  (d) Not well developed resources and poor working system
  \[\rightarrow \text{Weakness in knowledge supply & governance}\]

- **Knowledge tools**
  (a) Huge unmet knowledge need, from diverse aspects
  (b) Poor understanding on causality, mechanism, and pathway
  (c) Few good interventional options and policy alternatives
  \[\rightarrow \text{Weakness in intervention/policy formulation and decision-making}\]

- **Action cycle**
  (a) Poor accessibility to relevant information
  (b) Weakness in multi-sectoral coordination
  (c) Limited competencies of policy-makers and health workers
  \[\rightarrow \text{‘Vicious’ cycle}\]
Policy as Power and Process

Source: Walt & Gilson. 1994
Politics?

Kingdon’s three stream model of agenda setting
(Kingdon, 1984; adapted by Buse et al., 2005)

Problem → Policy → Politics

No change → No change → No change

Action
Figure 1. Five policy process “streams” (based on Howlett et al., 2015).
FIGURE 6.1 Flow Diagram of the Advocacy Coalition Framework

SOURCE: Adapted from Sabatier and Weible (2007).

Political Barriers (1)

- **One-Dimensional View of Power**
  (a) Behaviour
  (b) Decision-making
  (c) (Key) issues
  (d) Observable (overt) conflict
  (e) (Subjective) interests, seen as policy preferences revealed by political participation

- **Two-Dimensional View of Power: (Qualified) critique of behavioral focus**
  (a) Decision-making and non-decision making
  (b) Issues and potential issues
  (c) Observable (overt or covert) conflict
  (d) (Subjective) interests, seen as policy preferences or grievances

Source: Lukes, 2005
Political Barriers (2)

- Three-Dimensional View of Power: Critique of behavioral focus
  (a) Decision-making and control over political agenda (not necessarily through decisions)
  (b) Issues and potential issues
  (c) Observable (overt or covert), and latent conflict
  (d) Subjective and real interests

Source: Lukes, 2005
Political Barriers as ‘Root Causes’ of Policy Barriers

- **One-Dimensional View of Power**
  (a) Bureaucratic incrementalism
  (b) Non-democratic decision-making
  (c) ‘Silence’ of worse-off & worst-off
  (d) Low priority of health

- **Two-Dimensional View of Power**
  (a) Non-decision making (in terms of agenda-setting)
  (b) Prioritisation of health policy on ‘universal’ health care coverage
  (c) Reduced visibility of inequality
  (d) Not investing in R&D

- **Three-Dimensional View of Power**
  (a) ‘Economisation’ – health & inequality (Çalışkan & Callon, 2009)
  (b) Neoliberal ‘governornalibility’ (Michel Foucault, Wendy Brown)
  (c) Hegemonic ideology of pro-growth
Example 1: Politics of Knowledge and Discourses

- Truths (including scientific knowledge) are historically and socially constructed (Foucault)
  - "Regimes of truth"

- Discourses
  - Are knowledge-based
  - Are the outcome of power relationships, historically and socially
  - Have created subjects
  - Discipline (‘normalise’) subjects

- Health, inequalities and/or social determinant of health (Kim et al., 2016)
  - ‘Meritocratisation’ of health: individual value and responsibility
  - ‘De-socialisation’ of health: medicalisation, maketisation and privatisation
  - ‘Naturalising’ inequalities
  - ‘Othering’ the health inequalities and SDoH ("not my/our business")
Example 2: Class Differences in Attitude towards Governmental Responsibilities in Pro-welfare Policies

Source: Kim YS & Yeo E, 2011
How to Cope with the New Challenges? – A perspective

- Enhancing ‘literacy’ on the changing socio-economic regimes
- Making it a political agenda
- Consolidation of knowledge-base
- Promoting knowledge translation: from desk to policy to community
- Strengthening participatory health governance (bottom-up approach)
Favourable Signs (or Symptoms), Political Perspective

- Increasing concerns on equality, in general
- Accumulation of knowledge
  (a) Epidemiological
  (b) Policy
  (c) Political
- Political environment
  (a) Socioeconomic change and shifting paradigm of growth and development
  (b) Pro-welfare politics, in relation to low fertility and ageing
  (c) Strengthening of ‘representativeness’ for socioeconomic interests
- Bottom-up concerns and approaches
  (a) CSOs & NGOs more interested
  (b) Advocacy of ‘social movement’ including labour
  (c) Voices from younger generation and women
A Political Window: Rapid Ageing and Old-age Poverty

Figure 2.10. Safety-net benefits and poverty levels among the over-65s


StatLink: http://dx.doi.org/10.1787/88893330388

Source: OECD, 2015
Basic Pension recipients’ priority spending, by income level

Data: Ministry of Health and Welfare  (Unit: % by month)

- Food
- Housing
- Medical care
- Other

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<th>Housing</th>
<th>Medical Care</th>
<th>Other</th>
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<td>74.1</td>
<td>3.7</td>
<td>26.6</td>
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<td></td>
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<tr>
<td>Less than 75000 won</td>
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<td>Less than 1 million</td>
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Three ‘Turns’ for Politicisation

- Knowledge turn
- Cultural turn
- Political turn
How To Do ‘Turns’ (For Politicisation)

- **Knowledge turn**
  - From (individual) experiences to (collective) knowledge
    - From ‘suffering’ to inequity/rights/justice
  - From bench to field to policy, and back
    - From knowledge to discourse and norm
  - Knowledge on policy and politics: power, process and actor
How To Do ‘Turns’ (For Politicisation)

- Cultural turn
    - ‘Moral shock’
    - Coalescing with others
    - Ascribing responsibility
    - Mobilising rights
    - Emotional effects of mobilisation
  - How to make it happen? Another (cultural) politics
    - Capacity building for development, such as in human rights education
    - Mobilising inequalities
How To Do ‘Turns’ (For Politicisation)

- Political turn
  - Well-planned and organised cooperation with political powers
  - Empowering and mobilising grassroots
  - ‘Health Social Movement’
  - Participation in local politics
"New Constitution Movement"
Thank you

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