Privatization of Health Care

STRUGGLE AGAINST PRIVATIZATION:
A CASE HISTORY IN THE USE OF COMPARATIVE PERFORMANCE EVALUATION OF PUBLIC HOSPITALS

Juhwan Oh, Jin-Seok Lee, Yong-Jun Choi, Hyeong-Keun Park, Young Kyung Do, and Sang-Jun Eun

After the 1997 economic crisis, the South Korean government implemented neoliberal policies in many sectors. In health care, the government attempted to privatize nine public hospitals, framing the initiative as “better management.” In this discourse, public hospital workers were stereotyped as lazy and incompetent, while public hospitals were portrayed as poorly managed and of low quality. However, the government did not present any relevant evidence of improvement in already privatized hospitals, even though three hospitals had been semi-privatized at that time. In this study, the authors evaluated the effects of the semi-privatization, comparing the performance of the semi-privatized hospitals with that of the nine other hospitals targeted for privatization. They found adverse effects on performance, unlike the claims made by the government. Semi-privatization intensified the workloads of hospital workers and the instability of employment, froze or decreased real wages, and drastically increased hospital revenue per patient stay. The changes may have resulted from redefining profit as the goal of the hospitals, as opposed to the previous focus on decision-making on public health. These research findings played a decisive role in the struggle to keep the targeted public hospitals free of privatization, especially in two of the nine hospitals targeted for privatization in 2001.

Neoliberalism has driven the reduction of state interventions and the deregulation of markets, leading to various social impacts such as a growing number of unemployed, increases in casual jobs, wage freezes, worsening working conditions, erosion of social welfare, and social polarization in many parts of the
world (1, 2). Since the 1997 economic crisis, South Korea has also followed a neoliberal trajectory under the auspices of the International Monetary Fund and its bailout program. President Kim Daejung’s government began to implement neoliberal policies in various sectors, including the financial sector, the labor market, and the public sector (3–5). One of the major neoliberal policies related to the public sector, including public health care, was a privatization program similar to programs elsewhere in the world (6, 7). In early 2001, the government eventually extended this policy orientation to the public health care sector, announcing its plans to privatize or semi-privatize public provincial hospitals.

This planned privatization seemed worrisome, given that among the OECD countries, Korea had the lowest percentage (9%) of public hospital beds as proportion of total domestic hospital beds (21,383 public beds; 215,000 private beds) (8, 9), that the hospital reimbursement system was based on fee-for-service rather than a global budget, and that most hospitals were only not-for-profit in name (10, 11). Nine provincial hospitals were targeted for privatization at the time, more than a quarter of Korea’s 34 public provincial hospitals. Even though these hospitals in many ways already reflected privatized operations, the government stigmatized the public sector as lacking in responsible ownership, mismanaged, and fraught with unnecessary regulations, to legitimize the need for privatization. In addition, the public hospitals were branded as old-fashioned, inefficient, and of low quality, while public hospital workers were stereotyped as lazy and incompetent (8).

The discourse alleging these problems also equated profitability with both proper management and proof of appropriate performance for the hospitals’ communities, speaking as if all members of society had agreed that profitability should be the goal of public hospitals (6, 8). Based on these alleged problems, the government suggested several basic remedies, including privatization (12, 13). The government exposed its willingness to sell public institutions to private buyers and to restructure the remaining public institutions as profit-seeking entities with mechanisms of competition for the next round of privatization. According to this discourse, to avoid privatization, public hospitals had to make enough profit for independent management without any government subsidies. At the same time, because of their profitability, private hospitals were cast as instructive models for public hospitals.

The allegations of the government, however, did not hinge on any obvious evidence. The government also did not mention the conflict between profitability and the mission of public hospitals, nor did it present evidence of improvement from the prior privatizations that might have legitimized this new policy discourse. If the government had tried to explain the impact of the profit motive within the operation of public hospitals, or how profitability affects the management of public hospitals, citizens could have made an informed decision regarding the privatization policies from the beginning. Likewise, had the government openly presented data indicating desirable changes in performance resulting from the
previous semi-privatization of health services provision, the public might have accepted the logic of this new policy. Yet the government offered neither logical explanation nor proof; rather, it merely repeated the alleged problems of public hospitals. Similarly, the government showed no evidence to support its stereotyping of public hospitals and their workers. Then, the government targeted nine hospitals for full privatization. We therefore conducted our own investigation to produce evidence on the impact of privatization policies on hospital performance.

We collected data from three previously semi-privatized hospitals to approximate the impact that full privatization might have on the nine newly targeted hospitals. Previous semi-privatization of the hospitals differed from full privatization in terms of hospital ownership; in the three semi-privatized hospitals, management functions were outsourced to private managerial groups, while formal public ownership was maintained, unlike in full privatization. We regarded semi-privatization as a preliminary stage for full-scale privatization, because full privatization is a complete change to private ownership. In fact, the semi-privatization contracts between provincial governments and private managerial groups contained clear statements mandating that provincial governments should give purchasing priority to those agencies that had managed the hospitals through the semi-privatization, in the event that the semi-privatized hospitals ought to be fully privatized. The three semi-privatized hospitals operated in Masan (MS), Icheon (IC), and Kunsan (KS). The MS provincial hospital was semi-privatized in November 1996 (closed in February 1996, then reopened in April 1997). IC was semi-privatized in April 1998, and KS in November 1998. Examining these three semi-privatized hospitals, we could explicitly confirm whether hospital performance had improved under semi-privatization.

Our investigation aimed to evaluate the effects of semi-privatization on two hospital outcomes: hospital revenue per hospital stay, and hospital working conditions such as job insecurity, workloads, and real wages. We compared the hospitals’ performance in the period before semi-privatization with the performance in the period after. First, we evaluated hospital revenue per hospital stay because the semi-privatized hospitals might be effective in maximizing revenue through profit-seeking behavior, even though they were not totally privatized, thus presenting an attenuated form of full privatization. Second, we investigated changes in working conditions because semi-privatization might maximize profit by reducing labor-related costs. Using these indicators across the eight-year period from 1993 to 2000, we compared the performance of these three semi-privatized hospitals with the performance of nine public hospitals that were, at that time, targeted by the provincial governments for full privatization. In other words, this investigation made two comparisons: change in performance between the period before semi-privatization and the period after; and difference in performance between the semi-privatized and the still fully public hospitals.

We found that in the semi-privatized hospitals, there had been large increases in hospital revenue and a worsening of working conditions. These results played
a decisive role in the struggle to keep the targeted public hospitals free of privatization, especially in the case of two impending privatizations of the nine hospitals targeted for privatization in 2001. In the discussion section we provide a brief account of our success in the struggle against neoliberalism.

METHODS

To develop expectations for the results of the proposed full-scale privatization, we investigated the performance of the three semi-privatized hospitals. Using quantitative performance data, we examined whether private management had substantially improved performance or not. In addition, as a supplementary qualitative study, we used a structured questionnaire to interview a number of workers in the semi-privatized hospitals who had worked there both before and after the semi-privatization. Tables 1 and 2 present the descriptive characteristics of the hospitals and the interviewees.

Quantitative Methodology

Annual performance reports from the internal audits of each hospital were collected to evaluate the performance of the 12 hospitals: the 3 semi-privatized (MS, IC, and KS) and the 9 targeted for privatization: Kangreung (KR), Wonju (WJ), Suwon (SW), Jinju (JJ), Kimcheon (KC), Pusan (PS), Kangjin (KJ), Suncheon (SC), and Seosan (SS). From these reports, we extracted variables to use as proxies for the effects of privatization on patients and workers for each year. We used the following variables.

Hospital Revenue for Hospital Stay. The average total revenue per inpatient per day was chosen as a proxy to demonstrate the changes in hospital revenue for hospital stay after semi-privatization. The average total revenue per inpatient per day was defined as the total annual sum of all inpatients’ medical fees (measured in Korean won) divided by the annual number of inpatients in person-days. Eight consecutive years’ values were compared after being adjusted to fiscal year 1993 revenue as a reference value (set at 100). Then, each of the three semi-privatized hospitals’ revenues from before semi-privatization were compared with those after, and this change in performance was compared with the performance of the nine public hospitals that were currently being targeted for privatization. In addition, for the purpose of investigating the burden on socially disadvantaged groups in the community, the same indicator (average total revenue per inpatient per day) was applied to citizens receiving Korean Medicaid. They also had to pay the full price of uninsured services as well as a co-payment, even though they were exempted from the social insurance premium.

To summarize the money flow relevant to hospital revenue, revenue came from two sources: out-of-pocket payments by patients and reimbursement from
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<td>148 (89)</td>
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<td>153 (76)</td>
<td>154 (71)</td>
<td>146 (71)</td>
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<td>197 (110)</td>
<td>215 (115)</td>
<td>218 (114)</td>
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<td>377 (160)</td>
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<td>366 (220)</td>
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**Public hospitals targeted for privatization**

**Semi-privatized hospitals**

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<td>292 (150)</td>
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<td>MS</td>
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<td>79 (71)</td>
<td>68 (71)</td>
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<td>81 (45)</td>
<td>80 (44)</td>
<td>95 (47)</td>
<td>95 (57)</td>
<td>112 (67)</td>
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**Sources:** Each hospital’s annual report for internal audit (1993–2000) and Korean Healthcare and Medical Workers’ Union (KHMWU).

**Note:** See text for locations of the 12 hospitals.

*a* Semi-privatized in November 1998.

*b* Closed in February 1996, semi-privatized in November, then reopened in April 1997; 113 union member in 2001.

*c* Semi-privatized in April 1998.

*d* Hospital closed during 1996. These two numbers originated from different times in 1996 and from different sources: one from management documents, the other from union documents.
social health insurance funds. The hospitals’ profits were the sum of flows from these two sources of money minus real costs. Total payments for uninsured services and co-payments among fee-for-insured services flowed from each patient’s pocket to each hospital account at the point of discharge. The other part of fee-for-insured services was reimbursed from the insurer by the hospitals’ claim through a utilization review process after the patient’s discharge (10).

Workers’ Job Stability. The rate of temporary contract workers was examined as a proxy for the job security of hospital workers and was calculated as the proportion of temporary workers in the total number of workers.

Work Intensity. The number of inpatients per hospital worker per year and the number of outpatients per worker per year were used as proxies for hospital workers’ work intensity.

Workers’ Salary. Each hospital’s average nominal wages for hospital workers were analyzed, excluding those of doctors. The annual report data did not distinguish between salaries of higher-level managerial group and lower-level hospital workers. Therefore, these data probably overestimate the actual wages for hospital workers. Although there was no method to separate the higher salaries of the managerial group, the doctors’ salaries were discernible and thus excluded from calculation of employees’ wages.

Qualitative Methodology

To complement the quantitative findings, we interviewed hospital workers using questionnaires designed to capture the working experience before and

### Table 2

Characteristics of interviewees at the three semi-privatized hospitals

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<th>KS</th>
<th>MS</th>
<th>IC</th>
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<tr>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
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<tr>
<td>Number of interviewees</td>
<td>38</td>
<td>82</td>
<td>4</td>
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<tr>
<td>Mean age, years</td>
<td>40.2</td>
<td>36.9</td>
<td>34.0</td>
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<tr>
<td>Mean period of employment, years</td>
<td>10.8</td>
<td>9.16</td>
<td>10.0</td>
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*Note:* All interviewees were selected from union members. See text for locations of the three hospitals.
after semi-privatization. These interviews supplemented our understanding of the quantitative results and enriched the interpretation.

Because acquiring complete documentation on the duration of each individual’s employment was impossible and there were no other formal data relevant to our inclusion criteria for this interview, we selected the interviewees by snowball sampling. Thus, meeting the eligibility criteria—working at the hospital both before and after semi-privatization—was determined from interviewees’ statements. Although the exact number of workers who worked both before and after the semi-privatization was unknown, each interviewee’s eligibility criteria were confirmed by the questionnaires. The number of interviewed workers varied across the three hospitals: 120 interviews were carried out at KS, 23 at MS, and 20 at IC. Overall, 163 interviews by questionnaire were collected in the three semi-privatized hospitals (Table 2). Thus, these interviews allowed us to compare personal experiences and feelings between the periods before and after semi-privatization. The questionnaire inquired about four major aspects: wages, working conditions, the social role of the provincial hospitals and public health in general, and the union’s activities and responses to semi-privatization. In addition, an open request was made: “Please write anything you would like to tell your colleagues in other public hospitals being considered for privatization.”

RESULTS

Using our quantitative and qualitative investigations, we found that semi-privatization had increased hospital revenue per hospital stay and aggravated job stability, work intensity, and real wages of hospital workers in the semi-privatized hospitals.

Quantitative Results

Hospital Revenue for Hospital Stay. Immediately after semi-privatization, the revenues for hospital stays at the three semi-privatized hospitals increased dramatically compared with revenues just prior to semi-privatization: 2.8 times in terms of present value of fiscal year 1993 at the MS provincial hospital, 2.0 times at IC, and 1.5 times at KS. On the other hand, the nine public hospitals did not show any significant changes (Figure 1). The increases at the semi-privatized hospitals imply that the economic burden for health care increased abruptly among the populations of those three areas. Before semi-privatization, these three hospitals had lower revenues than the average for other similar-sized private hospitals, and lower revenues than the average for the nine public hospitals. However, after semi-privatization, revenues rose higher than previous figures.

We also investigated the average total revenue per inpatient per day for the low-income group, the beneficiaries of Korean Medicaid. The results were similar to those for the whole population: revenues increased 3.1 times for MS, 2.1 times
Figure 1. Average total revenue per inpatient per day at 12 hospitals, South Korea, 1993 to 2000, adjusted to fiscal year 1993 revenue set at 100. Arrow indicates semi-privatization. KS, MS, and IC are semi-privatized hospitals (see text).
for IC, and 1.2 times for KS, compared with the period before semi-privatization (results not shown). However, the same indicators for the nine publicly administered hospitals showed either no increase in revenues or a slight decrease during the same period.

**Workers’ Job Stability.** The proportion of temporary contract workers in the three semi-privatized hospitals increased at different rates (Figure 2). The greatest rate increase was shown by KS hospital, with a 110 percent increase within the first year of semi-privatization (from 20 to 42 workers) and 57.1 percent per year after that (from 42 to 66). MS had 3 temporary contract workers just before semi-privatization, and 14 immediately after. IC, however, had minimal changes. Meanwhile, the number of temporary workers in the nine public hospitals decreased. In terms of the proportion of temporary contract workers to total numbers of workers, the public hospitals maintained a consistent proportion at around 8 percent in the late 1990s and 2000. However, the three semi-privatized hospitals showed an abrupt increase just after privatization: KS, 18.8 percent (1999) and 26.7 percent (2000); MS, 17.4 percent (1998), 19.5 percent (1999), and 24.2 percent (2000); and IC, 10.7 percent (2000) (Figure 2).

**Work Intensity.** The number of inpatients per hospital worker per year and the number of outpatients per worker per year were examined as proxies for work intensity. The nine public hospitals showed consistent numbers, between 654 and 718. However, the three semi-privatized hospitals showed increasing trends. The outpatient ratio around the fiscal year of semi-privatization at IC was 1.35 (1,084 in 1999; 804 in 1997); at MS, 2.33 (502 in 1998; 215 in 1995); and at KS, 1.35 (604 in 1999; 448 in 1997). Meanwhile, the annual average ratio for the nine public hospitals around a similar period was 0.99 (692 in 1999; 697 in 1997). The picture for the inpatient ratio was different. The ratio of inpatients around the fiscal year of semi-privatization at IC was 1.44 (256 in 1999; 178 in 1997); at MS, 0.89 (326 in 1998; 365 in 1995); and at KS, 0.83 (343 in 1999; 415 in 1997). These values were inconsistent among the semi-privatized hospitals. The nine public hospitals revealed similar inpatient patterns: an average of 0.97 (359 in 1999; 369 in 1997).

**Workers’ Salary.** Each hospital’s average nominal wages of hospital workers, excluding those of doctors, had increased over the eight-year period, while real wages stagnated in the three semi-privatized hospitals. The nine public hospitals had had increasing trends in real wages except for 1998, just after the economic crisis (Figure 3). For doctors’ wages, the pattern was distinctly different from that of workers, especially after semi-privatization in the three hospitals. Doctors’ real wages, the treatment of which we assumed was probably similar to that of those in the managerial group in two of the three hospitals, increased after semi-privatization, even in the economic crisis, while workers’ wages stagnated.
Figure 2. Work stability: proportion of casual workers at 12 hospitals, South Korea, 1993 to 2000. KS, MS, and IC are semi-privatized hospitals (see text).
Figure 3. Hospital workers' average wage per annum, excluding doctors, at 12 hospitals, South Korea, 1993 to 2000, adjusted for inflation set at fiscal year 1995 market prices. Arrow indicates semi-privatization. KS, MS, and IC are semi-privatized hospitals (see text).
Wage disparities between the semi-privatized and public hospitals increased after semi-privatization. Ranking the real-wage rate of increase by group (doctors and other workers) and period (before and after semi-privatization) revealed markedly unequal rates. The highest increase in rate was for doctors in the semi-privatized hospitals after semi-privatization. The second highest was for doctors in the nine public hospitals, followed by workers in the nine public hospitals. The group with the lowest increases, if any, was workers in the semi-privatized hospitals (results not shown).

Qualitative Results

We interviewed 163 hospital workers who were rehired after semi-privatization, using the questionnaire. The qualitative survey results were consistent with the results from quantitative analyses.

Wages. The majority of respondents felt dissatisfied with their salary after semi-privatization: 46 percent answered “dissatisfied,” and 20.3 percent answered “satisfied.” The reasons for dissatisfaction reported were “real wage was decreased” (44.3%); “not much increase compared with increased workloads” (43.3%); and “not much increase compared with managerial group’s and doctors’ salary increase” (11.3%).

Working Conditions. The majority of interviewees (86.0%) answered “more difficult and harder to work after semi-privatization,” while none (0.0%) responded “easier to work than before semi-privatization.” Possible reasons were listed as follows: “more requested work per patient than before” (35.7%); “increased control and intervention by management” (24.2%); “increasing number of patients” (21.9%); and “increasing amount of extra work” (16.6%). An overwhelming majority (92.5%) thought that “it would become more difficult to work thereafter.” In their view, interpersonal relationships among workers were aggravated after semi-privatization: 68 percent of the respondents answered “aggravated,” and 10.5 percent responded “better.” Regarding job security, “feeling insecure after semi-privatization” (79%) was the most common answer; only 2.5 percent of respondents felt “secure.”

Social Role of the Public Provincial Hospital. We found that 58.5 percent of the respondents thought semi-privatization was “bad,” and 14.4 percent responded that semi-privatization was “good.” The majority (70.0%) of them answered “yes” to the question: “Do you feel that the profiteering practice of management has made doctors provide more costly services or unreasonable services to the patients after semi-privatization?” Only 12.3 percent answered “no.” We asked about the reason for the possible decrease of utilization by the low-income stratum: 66.3 percent of interviewees responded that the primary cause of this
change was “increased hospital fees under the new managerial policy in semi-
privatized hospitals to prioritize profits”; 18.3 percent responded that semi-
privatization had caused care providers to “change in their treatment efforts
and attitudes toward the poor.”

Union Response and Activities. Regarding the union response to restructuring
and privatization offensives, interviewees replied that the union’s response was
“poor” (65.9%) or “sufficient” (14.9%). From their perspective, the weakest
points in the union response were “no strategic vision or insufficient commit-
tment to social role of provincial public hospital” (69.5%); “not enough education
programs about privatization” (17.1%); and “no concrete plans for struggle
against privatization” (11.4%).

Advice to Colleagues at Other Target Hospitals. Most respondents opposed
privatization. Some examples:

- “Opposition to the privatization. The goal of provincial public hospitals
should be for improvement of public health care, not profitability. You have
to think whether public health care is alive in Korea or not” (nurse).
- “Privatization is a very disastrous word. We feel like slaves to our new
employers. I cannot express my sadness enough about this, just about to
shed tears of rage writing these short words” (worker).
- “No semi-privatization, if possible. The workplace becomes unstable and
the majority of workers will feel a sense of incongruity immediately after the
semi-privatization” (41-year-old male worker).
- “You should keep independence, if possible. Semi-privatization is the worst
condition” (31-year-old female worker).
- “New managerial institution (capital) does not make a definite investment but
abandons the responsibility to support the poor” (worker in operating room).
- “Semi-privatization can be compared to living under the harsh rule of
Japanese imperialism” (laboratory worker).
- “100 percent governmental budget is necessary for activation of public health
services” (nurse).
- “Not profit, but public interest we should pursue, even in budget deficit
status” (facility department worker).
- “As a public hospital, it needs financial support from the local government and
it should pursue public interest, not profitability” (50-year-old male worker).

A minority of respondents were in support of semi-privatization:

- “I agree with semi-privatization. Big corporations are being privatized, now.
If it is a dominant trend, we cannot swim against the stream. Do not develop
such negative thinking” (34-year-old female worker).
We have to watch over the detailed content of the contract through the semi-privatization. We can make no trouble between the workers and the managements if the contract is analyzed properly” (38-year-old female worker).

DISCUSSION

Our study found that semi-privatization of public hospitals in South Korea in the late 1990s was associated with immediate increases in hospital revenues, along with aggravated working conditions for hospital workers. These results suggest that semi-privatization of public hospitals had negative consequences for both the community and hospital workers. Rather than improving management efficiency, the semi-privatized hospitals in our study seem to have achieved their goals of profit maximization through increased financial burdens on patients (hospital revenues) and reduced compensation to hospital workers (operating costs). In other words, from an individual hospital entrepreneur’s standpoint, the new profit-maximizing strategies proved successful, even though they were implemented at the cost of increasing the burden on hospital workers and the community. Our study revealed critical adverse consequences missing from claims about the alleged benefits of semi-privatization propagated by the government. This contributed to the struggle against the government’s further attempts to privatize public hospitals.

In this section, we discuss our results and comment on additional concerns about the quality of care. We then describe how our study had real impacts on the struggle against the proposed privatization of public hospitals in South Korea in the early 2000s. We also briefly discuss implications for current policy debates on for-profit hospitals, as well as a generalizable lesson for struggles against neoliberal influences in the health care sector.

Regarding hospital revenue for hospital stay, our quantitative analyses reveal immediate increases. These results are similar to patterns of rising medical revenues following for-profit conversions in the United States (14, 15). The first point of discussion here is how did semi-privatization of public hospitals lead to these immediate increases in hospital revenues? Our qualitative results suggest a plausible answer. Seventy percent of the interviewees reported that they thought semi-privatization led to more intensified profiteering practice patterns, such as ordering more costly services and unreasonable or inappropriate services for patients. Such volume-expanding practices are facilitated by a flawed fee-for-service reimbursement system. Under the managerial group’s discretion, hospitals have a large capacity for extra-billing, using increased prices for uninsured services and volume expansion for insured services.

Our study also finds that semi-privatization was associated with aggravated working conditions for hospital workers, through dramatic rises in the proportion of temporarily contracted workers, increases in work intensity, and stagnated or decreased real wages for hospital workers. The shift toward temporary, contracted
work has been observed in other countries, including the South African government’s strategy to facilitate casual short-term contracts (16) and the casualization of ancillary labor such as laundry, cleaning, and food preparation in the privatization of the Canadian health care industry (17). The increased work intensity found in our study was mainly mediated by a markedly increased number of both inpatients and outpatients (not shown in the results section), while the number of hospital workers increased only slightly in all three semi-privatized hospitals, which again occurred mainly through increased temporary work contracts (see Table 1 and Figure 2). Despite increases in workloads, hospital workers’ real wages stagnated or decreased in the semi-privatized hospitals. These several pathways may have jointly contributed to reduced operating costs in the semi-privatized hospitals, as has been reported for other countries (10, 14–17).

One might also suspect that semi-privatized hospitals’ entrepreneurial behavior has affected the quality of care (14, 18). However, we could not directly evaluate the possible change in quality of care, given a lack of data, so further study is needed. Nonetheless, our qualitative survey results do suggest that the quality-of-care effect of semi-privatization might be negative rather than positive. The majority of the survey respondents at the three semi-privatized hospitals agreed that profiteering practices of the new semi-privatized management have made doctors provide more costly services or unreasonable services to patients. It is unlikely that the immediate increases in hospital revenues after semi-privatization led to sudden increases in effective medical care. In addition, uncompensated care as a proportion of total care in for-profit hospitals might be lowered (19, 20). Lacking relevant data, however, we cannot evaluate the possibility of decreases in charity care. Furthermore, increased hospital fees in the semi-privatized hospitals seemed to reduce accessibility for low-income patients, thus undermining the first precondition of quality care at the community level. It is also possible that semi-privatization adversely affected the quality of services provided by hospital workers, who probably experienced lowered job satisfaction resulting from increased work intensity, job instability, and reduced real wages (21, 22).

The results of our study had policy impacts in conjunction with the public’s struggle against the neoliberal policies to semi-privatize more public hospitals. In November 2001, the KR provincial government announced the formal recruitment process for a new private buyer of the KR provincial hospital. Based on our research findings, the Korean Healthcare and Medical Workers’ Union (KHMWU) was able to provide evidence that the privatization plan would not work in the way the government promised. When another privatization plan was announced for the PS hospital, in the second largest city in South Korea, it became one of the hottest issues both locally and nationally. A citywide broadcasting station (PBS) carried detailed coverage on the issue, citing our research findings. The representatives of semi-privatized hospitals, such as the MS hospital (near PS) could not defend the privatization plans by publicly justifying their own performance. Hospital workers also regained confidence in
their struggles against what had seemed an indomitable influence of neoliberal policy. Joining in their struggle were other local workers, such as taxi drivers, metal workers, and school teachers, with the movement evolving into a united campaign to save public hospitals from privatization. The united workers’ struggle contributed to public awareness among citizens and communities about public hospitals. The more powerful and influential the struggle of the united workers became, the greater was the public awareness of the horrendous impacts of privatization of public hospitals on local communities. In the face of growing opposition, both KR and PS local governments withdrew their attempts, and even the central government no longer insists on the alleged need for privatization of public hospitals. The KR provincial government declared its decision to withdraw its privatization plan on November 20, 2001. The PS city government followed suit on December 3, 2001. During the entire period of this struggle, the organization undertaking the current study not only conducted the research project but also worked closely with the KHMWU and hospital workers to disseminate the study results among the public.

Our study has implications for current policy debates in South Korea as well as lessons for struggles against neoliberal policy in other countries. Unfortunately, once again the Korean people are faced with the return of a developmental pragmatist-conservatism newly launched under the Lee Myung-bak administration. In 2008, the new government tried to implement another massive privatization campaign targeting health care, only to face strong public protests. However, the threat of privatization of health care is growing. Our current study reaffirms that a principled struggle of the public based on sound research can stop an overwhelming drive for privatization. Our experience provides lessons for societies that have been under threat of neoliberal policies. In hearing our story, others might benefit and be victorious in their own struggles. Many intellectuals are struggling to combat the dominance of neoliberal discourse by providing tangible alternatives, such as through welfare state discourse and social democratic and socialist policies (23). However, the predominance of the neoliberal discourse is not just an immutable trend with impersonal force, but rather a strategic decision made by transnational oligarchic classes and their ideologues (24). A combination of scientific research and a principled struggle is needed to dispel the myth of neoliberal inevitability (25).

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