Health Reconstruction in North Korea

by

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Prepared for the conference "The Korea Project"

August 20-21, 2010

Held at the Korean Studies Institute

University of Southern California, Los Angeles, California

Sponsored by the

Korean Studies Institute, University of Southern California

Center for Strategic and International Studies

The Korea Foundation

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“... North Korea is not an undeveloped country; it is a country that has fallen out of the developed world...” Barbara Demick, Nothing to Envy: Ordinary Lives in North Korea, NY: Spiegel and Grau, 2009, pp. 4.

“...until recent years international agencies found that life expectancy rates, child welfare, inoculation rates and general public health conditions were all quite good in North Korea, comparatively speaking. Unlike other places afflicted by humanitarian disasters, this is not a peripheral, penetrated state with a weak government.”

“...the suffering of the North Korean populations is truly inexcusable, because something could be done about famine conditions and malnutrition if there was really a will to do so among the central authorities. Instead, they seem morbidly insecure and determined therefore to give the armed forces what they need to the detriment of every other institution in society...” Bruce Cumings, Korea’s Place in the Sun: a Modern History, NY: Norton and Co, 2005, pp.445-446.

The mid-90s famine has morphed into a chronic food emergency in which “large portions of North Korea’s highly urbanized society suffer from unreliable access to food” and the consequent “ravages of malnutrition.” Stephen Haggard and Marcus Noland, Famine in North Korea: Markets, AID and Reform, NY: Columbia University Press, 2007.

Introduction

The organizers of this USC/CSIS gathering have requested brief observations on “lessons from the reconstitution of failed health care systems for North Korea” with a special focus on the “longer-term and indispensible tasks associated with the integration of the peninsula.” (italics added)

Before I attempt an answer, a few caveats.

First, I come to this exercise as no expert on the Koreas. In preparation, I’ve tried to become passably familiar with the issues before North Korea, especially as they pertain to health and reunification, but I remain a neophyte.

I am a political scientist whose career has been predominantly centered on Africa. I have written and taught over the years on ending wars and the process of implementing peace accords, and in the past decade, have been increasingly focused on a wide span of global health challenges, including the interface between health and security. In recent years that has included health-related issues in fragile states with degraded health systems: e.g. Zimbabwe, southern Sudan, and Burma. It has also included work on HIV/AIDS and related issues in
China, India, Viet Nam and Russia, and post-war reconstruction and the role of health in Ethiopia, Uganda, Rwanda and DRC, and most recently, the dramatic turnaround in health approaches in South Africa. While some of what has transpired in these cases undoubtedly has some relevance to the discussion of health reconstruction, North Korea and unification, I believe the value is more often marginal, given North Korea’s exceptionalism.

Second, the analytic literature is woefully thin on the reconstruction of health systems that have been weakened or radically degraded by violent conflict or protracted misrule. There is much written about organizing emergency humanitarian responses, including urgent health interventions in the midst of roiling crises driven by war, natural disasters and malgovernance and repression. Far more difficult, and far more relevant to this session’s deliberations, is locating useful comparative studies that track the reconstruction of health sectors from the delicate transition out of conflict to a subsequent phase where the objectives are stability and sustainability. Unfortunately, in most peace accords there is at best passing mention of health, and in most later retrospective studies there is typically very little commentary on health reconstruction.

Third, luckily there is a valuable exception in the 2006 Rand study Securing Health: Lessons from Nation-Building Missions. It offers a comparative analysis of the health component in seven nation-building cases emerging from major combat: Germany and Japan (post-WWII); Somalia, Haiti and Kosovo (1990s); and Afghanistan and Iraq (post 9/11). Admittedly, six decades have passed since North Korea emerged from armed combat, and one hopes that whatever future transition to an integrated Korean peninsula is free of a return to violent armed conflict. Nonetheless, the RAND study’s core conclusions remain germane and useful to the discussion here, and provide the foundation for my remarks below.

Fourth, there is very little analysis that offers insights as to how health can advance national “integration” or “unification” and/or how the reform of health in a weak, fragile state can be best achieved as that state is unified with another

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more coherent, financially viable and stable state. German reunification and the role of health during that process have drawn some study.\(^2\) Comparative studies do not exist, which should not be surprising, given how rare unifications are. It has been far more common in the past two decades for states to separate, fragment or secede following protracted conflict and misrule: e.g. East Timor, Eritrea, the Czech and Slovak republics, the Balkans, and the former Soviet states. In 2011, we are likely to see a newly independent southern Sudan, a fragile, unsteady entity with formidable health and other challenges and minimal internal capacities.

**Guideposts for health reconstruction in North Korea**

The following guideposts derive from the RAND study, with added commentary specific to the Koreas.

1. **Establish health reform as a strategic priority.**

   Health reconstruction will not succeed unless high-level political leaders designate health as a strategic priority. At an early point, it is essential for leaders to state very clearly that through the transition phase, a reformed and more effective health system will be fundamental to stability, economic recovery, and political legitimacy.

   At first glance, it does not appear difficult to make this case in the Korean context.

   The food and famine crisis in North Korean that became suddenly visible in the early to mid-1990s and led into the ‘Arduous March’ of the late 1990s persists unresolved to this day, fifteen years later, compounded by continued immobilism at North Korea’s center, collapse of the PDS entitlement system, a worsening budgetary crisis, donor fatigue at filling the roughly 2 million ton annual gap in food supplies, a “military-first” socialism, and recurrent natural disasters.

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Chronic food insecurity has become a conspicuous threat to both stability and health: fully a third of North Koreans are today malnourished, increasingly reliant on weeds and grasses, and unable to access scarce commercial food, priced out of reach by runaway inflation and marginal markets. The country faces dire health outcomes -- almost 20 percent stunting and 5 percent wasting among under-5 children, and depressed immune defenses that have advanced the spread of MDR TB and other infectious diseases. Previously reliable water and sanitation systems, neglected for almost two decades, are deteriorating steadily and contributing to rising diarrheal diseases.

Any serious consideration of unification will by definition have to contend with chronic food shortfalls. There would also appear to be little choice but to confront the gross and increasing dichotomies in health status and health expenditures between the north and the south. While the South Korean government expends approximately $45 billion per year on health, over 12 percent of its budget, North Korea has seen its health expenditures plummet to less than $1 per capita per year.  

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3 The $45 billion figure is the product of two WHO Global Health Observatory statistics from 2007: first, that the ROK spends $927 per capita per year on health, and second, that the South Korean population was 48,152,000. The WHO also reports that this expenditure constituted 12.1% of South Korea’s budget. The South Korean Ministry of Strategy and Finance projects expenditures for “Health, Welfare and Labor” of $63.4 billion in 2010 (26.2% of total government expenditure) and $364.2 billion over the 5-year period 2009-2012 (27.8% of total government expenditure over that period).
But making the case effectively to a wary South Korean tax payer, a North Korean popular audience, the Chinese government and others will be challenging. It will be necessary to build the argument that there is no alternative to smart health reconstruction if worst-case outcomes -- a spiraling internal humanitarian disaster, including a mass exodus of refugees -- are to be averted. It will require convincing proof that that such an ambitious complex enterprise is indeed affordable, and achievable, and has a reasonable chance of attracting external technical and financial support from international organizations, donors and non-governmental groups. And it will benefit substantially from the argument that reconstruction can build systematically upon North Korean’s enduring health assets -- its large numbers of doctors, nurses and mid-wives still serving in communities, the continued high rates of immunization and antenatal visits: health reconstruction can be an effective means of empowering and revitalizing local communities while lifting the lives of North Korean citizens.
2. Success depends operationally on strong coordination & planning.

Coordination and planning need to be led by either a state entity or an international organization with adequate assured authority.

The goal should be generating consensus early around a single unified health sector development plan, which incorporates appropriate ministries, international organizations, donors, and non-governmental organizations (NGOs.) Typically, five years is the planning window needed to achieve a health system that can sustain itself.

More often than not, efforts to bring about a unified coordination effort fail, owing to competing, fragmentary interests, insufficient early attention to the health priority, and lack of sustained high-level political will. Since the mid-1990s, that has frequently been the pattern with respect to North Korea: coordination among donors in the international response to famine and chronic food insecurity has been very problematic. This legacy will not likely disappear in a future unification scenario. Indeed, a concentrated diplomatic effort will be needed to minimize division and ensure a workable level of concerted international effort.

Realistically, the South Korean government is the only entity capable of leading a health reconstruction effort, assuming it is the political and financial fulcrum of unification. That will involve enlisting the active cooperation of the United States, China, Japan, WFP, WHO, UNICEF, GAVI and others. There might also be a role for the World Bank in systems planning and cost estimations. The UN Secretary General and the WHO Director General can potentially be highly valuable in helping expedite the planning and coordination process. The RAND study offers the following model for a planning process:

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### Sample Planning Process

<table>
<thead>
<tr>
<th>Steps</th>
<th>Summary</th>
<th>Description</th>
<th>Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preparatory phase</td>
<td>Take a variety of steps, such as launching a donor conference, and do an initial needs assessment.</td>
<td>Memorandum of understanding Initial needs assessment report</td>
</tr>
<tr>
<td>2</td>
<td>Political consensus on health objectives and scope</td>
<td>Produce a health recovery strategy that is owned by national stakeholders and international community, making sure to involve key donors.</td>
<td>Memorandum of understanding</td>
</tr>
<tr>
<td>3</td>
<td>Coordination unit, including lead actor</td>
<td>Key donors, international institutions, and NGOs establish an institutional arrangement for coordinating assistance, including appointment of a lead actor, in order to support and manage the technical aspects of health reconstruction.</td>
<td>Coordinating body and lead actor</td>
</tr>
<tr>
<td>4</td>
<td>Long-term vision for health</td>
<td>Establish an overall vision for post-conflict health recovery by focusing on a small number of key objectives. This should be negotiated among the national authorities and the international community and should take local realities into account.</td>
<td>Briefing paper</td>
</tr>
<tr>
<td>5</td>
<td>Priority sectors and cross-cutting issues</td>
<td>Prioritize key health sectors in line with initial needs assessment. This should include identification of key multidimensional issues that cut across health and other areas (such as gender, environmental, and HIV/AIDS issues).</td>
<td>Briefing paper</td>
</tr>
<tr>
<td>6</td>
<td>Overall nation-building analysis</td>
<td>Conduct an analysis of security, political, economic, and other sectors that may impact health.</td>
<td>Briefing paper</td>
</tr>
<tr>
<td>7</td>
<td>Time requirements</td>
<td>Establish deadlines for completion of key health activities, taking into consideration that the time required may vary depending on the data, materials available, assessments already done, and initial conditions. This should include immediate recovery, medium-term, and long-term needs; and the resulting timeline should be revisited, modified, and updated as new information becomes available (step 11).</td>
<td>Timeline</td>
</tr>
<tr>
<td>8</td>
<td>Costing</td>
<td>Develop realistic and comprehensive cost estimates.</td>
<td>Sectoral cost estimates</td>
</tr>
<tr>
<td>9</td>
<td>Planning document</td>
<td>Establish a coherent planning document, detailing what should be achieved in each health sector and how this can be done. Such a planning framework is best derived by using an outcome-based approach and should provide a comprehensive definition of the principal objectives, vision, and scope of the health effort, as well as the priority sectors, timing, costs, and cross-cutting issues.</td>
<td>Plan for health</td>
</tr>
<tr>
<td>10</td>
<td>Team composition</td>
<td>Form primary group of experts who will collect data and analyze the actual health needs of the country, and who will be responsible for elaboration of sectoral analyses, planning frameworks, and technical reports.</td>
<td>Health team</td>
</tr>
<tr>
<td>11</td>
<td>Implementation and assessments</td>
<td>Implement plans and programs, monitor performance, and make necessary corrections.</td>
<td>Regular performance assessments tied to outcomes</td>
</tr>
<tr>
<td>12</td>
<td>Lessons learned</td>
<td>Compile major insights and lessons learned.</td>
<td>Lessons learned report</td>
</tr>
</tbody>
</table>
3. Success depends operationally upon sufficient infrastructure and ample long-term financing.

Sufficient infrastructure will be a combination of targeted revitalization of North Korean hospitals and clinics, strategic upgrading of North Korean health personnel skills, and augmentation from South Korean and other external sources. This will require a detailed survey of existing North Korean assets, a costing exercise for revitalization of the health sector, and careful multi-year planning that includes concrete targets for training; introduction of information and communications technology; financial management, including integration into the South Korean insurance scheme; national supply chains; and integration into a national data system. Rehabilitation of water and sanitation systems will need to proceed in parallel.

Forward long-term budget commitments will be essential, as will a financing plan that includes a target goal for self-sustainability that builds confidence that some ‘normal’ or acceptable level of subsidization will be realized after a minimum five year major investment. The South Korean President’s recent proposal of a tax to finance reunification signals the opening of debate over financing, and an implicit admission that any unification will carry a heavy interim price tag.²

The RAND chart below plots the comparative performance of different post-conflict states in reconstructing their health sectors, along two axes: coordination/planning, and infrastructure/resources. That study does not include the German unification experience, which if included would rank in this chart as a success. There was a unified vision for incorporating East Germany expeditiously into national health structures, sustained political leadership, careful planning and a substantial upfront financial commitment. Integration proceeded swiftly, popular support was leveraged among West German citizens behind the urgency and necessity of taking this step, moribund East German health structures were soon visibly revitalized, and major public health gains were apparent in a matter

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of a few years. While health reconstruction in the context of Korean unification promises to be even more problematic and challenging than the German experience, success does not appear inconceivable.

4. Health reform is a powerful ‘soft power’ tool to win ‘hearts and minds,’ bring quick tangible gains, and consciously help legitimize a new order.

Early, quick action should be carefully sequenced and prioritized.

Attention in the first instance should be paid to the most vulnerable victims of the current failed system. In the North Korean context, that means targeted attention to children; pregnant and lactating mothers; the elderly; orphans; and populations newly pauperized, in urban settings as well as marginalized regions such as the northeast.

A closely related second priority should be enhanced controls over infectious disease outbreaks: tuberculosis, pneumonia, malaria, and diarrhea.
A closely-related third priority should be a focus on health basics: the renewal of preventive and palliative services and care.

Across all three of these areas, there needs to be a deliberate strategy to empower local authorities and ensure that they see these gains as one which they own, versus largesse engineered from without.

There also needs to be special care to avoid mishandling responses to acute health challenges: overpromising to deliver, and/or simply failing to recognize the gravity of deteriorating local circumstances. These mistakes can severely damage broader public confidence.

5. Improved, credible data needs to be a strategic priority.

Health outcome measures are the most fundamental and important: life expectancy; birth rate; death rate; infant mortality rate; infectious disease rate; and malnutrition. These measure the actual health impacts within the population.

A competent measurement system takes time to develop, and in order to acquire credibility and confidence requires a sustained political commitment to building a culture of assessment, transparency and accountability, ensuring uniform national access, and welcoming outside technical support.

In the North Korean context, there have been ongoing controversies over health and economic data since the early 1990s, exacerbated by regime secrecy, political manipulation of data, and suspicion of substantial diversions by the military and political elites. Many surveys, by necessity, have relied on refugee sources, outside North Korea. It will be vital to establish, early, on a plan to generate a trusted data baseline and put into operation monitoring instruments that are grounded internally within North Korea.6

Inputs will also need to be tracked: e.g. financial flows, external personnel.

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Outputs, the immediate results of expanded programs, will also be important short-term measures of progress: e.g. numbers of trained personnel, functioning hospitals, vaccination rates, percentages of births with skilled attendants.

Measurement efforts will need to be linked with those organizations on the ground with established networks. The NGO sector in North Korea remains small and vulnerable. WFP has for a decade and a half struggled to put in place a monitoring system, and made some progress. UNICEF has in recent years been able to produce important surveys.

Example of Performance Matrix

<table>
<thead>
<tr>
<th>Key Health Goals</th>
<th>Baseline Conditions</th>
<th>Inputs</th>
<th>Outputs, First 6 Mos.</th>
<th>Outcomes</th>
<th>Broader Development Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address immediate health needs</td>
<td></td>
<td>Amount of financial assistance</td>
<td>Number and quality of doctors, nurses, and other personnel trained</td>
<td>Life expectancy rate</td>
<td>Level of security</td>
</tr>
<tr>
<td>Develop a cost-effective and sustainable health system</td>
<td>Quantitative and qualitative description of initial conditions</td>
<td>Number of international advisors</td>
<td>Number and quality of health facilities built or refurbished</td>
<td>Birth rate</td>
<td>Quality of governance</td>
</tr>
<tr>
<td>Improve overall health conditions</td>
<td></td>
<td>Amount and type of health equipment, drugs, and other consumables delivered</td>
<td>Number and quality of health facilities built or refurbished</td>
<td>Infant mortality rate</td>
<td>Economic conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infection disease rate</td>
<td>Education levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Malnutrition rate</td>
<td>Provision of key services, such as power and water</td>
</tr>
</tbody>
</table>

6. Success requires ensuring that other sectors reinforce – versus constrain or undermine – progress in health reconstruction.

In North Korea, a top priority in enhancing human security will be to stabilize the food security situation, remove the specter of recurrent famine, and put in place agricultural policies that ensure adequate, reliable and affordable food. Over a
transition period, that is likely to be a mixture of improved inputs, pricing and other market-based incentives, including private investment, and a mix of commercial external purchases and interim donor contributions. Similarly, parallel rehabilitation of water and sanitation systems will be essential.

Other key sectors which will require special attention, as they relate to health, include: electric power, fuel and transport systems, and aging or lack of technology.

**Conclusion**

The chasm in health conditions and health infrastructure between North and South Korea has widened steadily over the past two decades, has its root cause in failed governance in North Korea, but also has over time become profoundly multi-dimensional. The chasm may be bridgeable, but that will only become possible if the governing crisis is resolved, and if that is followed by a major, sustained effort over several years that mobilizes political will, adequate finances, the support of both South and North Korean citizens, and the help of outside partners.