

# The Emergence of an Informal Health-Care Sector in North Korea

Eun Jeong Soh

## INTRODUCTION

Although health care in North Korea has remained a major area of humanitarian concern for outside observers, important aspects of the health-care system have gone unnoticed. Reports (Amnesty International 2010; Huffington Post 2013; Watts 2003) have focused on the population's nutritional status and the dire condition of health-care facilities. In assessing a nation's health status, the World Health Organization (2009) pays attention to certain indicators and the specific areas for improvement that it has targeted. In contrast, there has been little discussion of daily health-care practices in North Korea, which remain largely hidden because they take place outside of the formal system. Where do people turn first when their children fall ill?

Despite evidence of the degeneration of its health facilities since the famine of 1994-98, North Korea has continued to claim that it is maintaining its socialist health-care system. WHO, which has channeled assistance through state health-care facilities and collaborated with the Ministry of Public Health, has noted a subsequent revitalization and normalization of the health-care system, especially in the arena of preventive health (WHO 2009). At the same time, the country's health sector has been no exception to the 'bottom-up' marketization process that has continued since the economic crisis of the 1990s. Although illegal, buying medicine on the open market is now widespread in North Korea. Private pharmacies are evident on the streets of major cities. This situation elicits some important questions. How do people navigate a health system that

combines official adherence to socialist medicine with continuing market encroachment? What are the implications of this transition for North Korea's health system?

This article examines the emergence of informal health-care practices in North Korea, practices that exist alongside and are influenced by the norms and habits of the past. Based on first-hand accounts of physicians and their coping strategies, private medicine sellers, and home-practicing doctors, it describes how health workers and patients have coped with the decline of the hospital system, the strategies and relationships they have developed, and the factors that have enabled the emergence of new practices amidst the decline of the old health-care regime. It then considers the consequences of these changes for health-care, as well as their broader implications for the country's social, political, and economic systems. I argue that traditional norms and practices have in turn become the basis for the emergence of new norms and practices in the health arena.

One major finding is that the emergence of an informal health-care space does not necessarily conflict with, but rather complements, the formal sector. The resilience of North Korea's formal sector, comprising multiple levels of hospital facilities and a nation-wide medical supply system, is partly due to the expansion of informal networks which supply monetary and material resources to the formal sector. Although little is known about the current state of North Korea's health care system, the evidence suggests that the formal sector continues to function alongside invisible

networks of informal practices.

To gather material for the study, I conducted twenty-six in-depth interviews in 2013 with North Koreans who had resettled in the South. While there are valid concerns about using defector interviews as evidence for social change in North Korea (Joo 2014; Jung and Dalton 2006, 774; Lankov and Kim 2008, 53), narratives about everyday life practices are less likely to be influenced by the defection experience than respondents' views on political matters. The interviews sought to elicit accounts of practices, choices and interactions relating to health care as well as interviewees' opinions on the subject. Nineteen individuals, including two doctors and three pharmacists, described their experiences of health care in North Korea. Interviewees with particularly rich stories to offer were interviewed more than once. A number of former health workers, including two doctors, two pharmacists and one local health administrator, were particularly informative about how the formal system and informal networks functioned. The participants were diverse in terms of occupation, socioeconomic status, age, and date of departure from North Korea. The testimonies from those who left North Korea 10 to 15 years ago describe situations and practices that are now considered out of date; however, they are included here as they help provide an evolutionary picture of the process of social change. Most of the interviewees were from the northern regions of North Hamgyung Province and Ryanggang Province, reflecting the general make-up of the North Korean refugee population in South Korea. Thus the study contains an inevitable bias toward the situation in these provinces. Three informants, however, were from Hamhung, South Hamkyung Province, and their experiences and accounts corroborate those from the northern provinces. In addition to this first round of interviews, two further rounds of interviews were conducted to supplement and confirm the initial findings. In 2014, I conducted interviews with ten Diaspora

Koreans residing in Northern China who frequently travel to North Korea to support hospitals and orphanages. Another round of supplementary interviews with fifteen North Korean refugees in South Korea took place in May 2015.

I began by asking the participants to provide a brief personal oral history, which I followed with questions about their experiences of health care. The first question was: "What did you do when you were ill or when your children were ill?" The participants also played an important role in shaping the subcategories of my inquiry. In several initial interviews, selling medicine, home-practicing doctors, and informal payments were recurring themes. I then formulated more specific questions to gain further information about these activities. In particular, the interviews sought information about the networks, mechanisms, and psychology of informal health-care practices from the perspective of both providers and recipients, in an effort to understand the factors that enabled such practices to emerge in the first place.

Table 1] The First Round of Interviewees

	Age	Gender	Home province	Occupation in North Korea	Date of departure
1	29	M	N. Hamgyung	Student	2006
2	75	F	N. Hamgyung	Factory worker	1999
3	48	F	N. Hamgyung	Doctor	1998
4	28	F	N. Hamgyung	Student	1997
5	44	F	Ryanggang	Pharmacist	2008
6	78	F	Ryanggang	Housewife	1997
7	80	F	Ryanggang	Pharmacist	2008
8	47	M	S. Hamgyung	Teacher	2012
9	45	F	S. Hamgyung	Farmer/Housewife	2012
10	73	F	N. Hamgyung	Farmer/Housewife	2006
11	46	F	N. Hamgyung	Doctor	2008
12	35	M	N. Pyongan	Military	2012
13	32	F	N. Hamgyung	Farmer	2012
14	60	M	N. Hamgyung	School official	1998
15	47	M	S. Hwanghae	Police	2008
16	68	M	N. Hamgyung	Retired factory official/ trader	2006
17	47	F	Ryanggang	Housewife/ market entrepreneur	2012
18	55	M	S. Hamgyung	Pharmacist	2012
19	40	M	N. Hamgyung	Accountant for local drug- supply office	2013

## BACKGROUND

Free health care has been a major pillar of North Korean socialism from the founding of

the country in 1948. With assistance from the Soviet Union and other allies, the North Korean authorities strove to establish a free and comprehensive health-care system, even as early as the Provisional People's Committee period (1945-1948). With limited resources, much of the resources devoted to health care in this formative period focused on preventive medicine, and this is still an important emphasis today. The revolutionary rhetoric of this period emphasized the notion of health as liberation, an abrupt departure from the colonial health-care system that was seen as ineffective for the masses and only benefited the ruling elites and the colonial authorities (Hwang and Kim 2007; Hwang 2006, 7). By contrast, the health-care policies formulated immediately after liberation placed the emphasis on free and universal accessibility. To realize their ideal of universal free health care with limited resources, the leaders of the new state stressed the value of preventive medicine and mobilized mass participation in health and hygiene campaigns (Hwang and Kim 2007).

Along with this new conception of health as central to the socialist revolution, the fledgling state also regarded health care as an important part of national security (Hwang 2006; Smith, 2005). During the Korean War, death and illness caused by disease threatened national security as much as battle casualties (Hwang 2006, 45). This emphasis on health care was realized through building hospitals at all levels of administration as well as major pharmaceutical production facilities, with education, technology, and equipment provided in the 1950s by the Soviet Union, Poland, Czechoslovakia, Romania, Bulgaria, and Hungary (Hwang 2006, 60-61). Aid from socialist states was also crucial to the development of medical education. Between 1960 and 1964, the number of doctors (including physician assistants or "assistant doctors") in North Korea doubled from 11,919 to 22,706 (Park, Kim, and Hwang 2003, 8). The rapid establishment of the health-care system

was also stimulated by 'regime competition' with South Korea. The conception of health in terms of national security recurred in the 1990s when the economic crisis and the ensuing famine led to widespread epidemics and a virtual collapse of the state health-care system (Smith 2005).

If Soviet influence and aid shaped North Korea's health-care system in its formative period, a distinctively indigenous socialist health-care system emerged in the early 1960s. During this period, the state moved towards becoming a "unitary-Suryong regime" based on the supreme authority of a single leader and the promotion of *juche* ideology (self-reliance). An emphasis on the development and utilization of Korean traditional medicine was also evident during this period, being compatible with the state ideology of self-reliance.

Two schemes which demonstrate the nature of North Korea's highly mobilized socialist health-care system were the Jeongsung (dedication) movement and the doctor-designated district system, both introduced in the early 1960s and still in place today. Both policies fostered a close relationship between health workers and local people by internalizing a sense of dedication towards patients on the part of health workers and encouraging a sense of trust by patients in health workers. At the same time, both health providers and patients learned to find ways of circumventing the rules for their own convenience in everyday practice.



**Above: “Health care workers work selflessly”**

**Below: “Let us further increase the superiority of the socialist health care system”**

The Jeongsung movement, begun in June 1961, was a Stakhanovite-type campaign in which the government lauded a chosen health worker’s selfless dedication for their patients and initiated a nationwide system on this model. The movement also sought to sweep away the sense of superiority traditionally felt by health professionals over their patients and integrate them into society as equal workers and neighbors (Ch’oe, Kim, and Hwang 2006). Under this system, public recognition and career advancement were the most valued incentives for health workers.

Ms Lee was a pharmacist who graduated from the prestigious Pyongyang University Medical School. Because of her privileged family background, however, she was posted to a hospital in North Korea’s most remote province, Ryanggangdo. She was aware that the only way to make amends for her family background was to prove her dedication through diligent effort at the hospital, and by becoming a member of the Party. Armed with both a strong sense of dedication and determination for career advancement, when

she did not have enough lab rabbits to test a drug that she developed, she injected herself with the serum, causing an outbreak of jaundice.<sup>1</sup> On a number of occasions she donated skin grafts to patients with burns (Interview, J. Lee, November 20, 2013). Health workers considered such acts of dedication a personal duty that was rightly demanded of them (Hwang 2006). Ms Lee even postponed her marriage as a mark of dedication to her job and the party. She was thus able to become a Party member and receive promotion within the hospital system. Professional advancement and communal recognition, however, could function as incentives for such exemplary dedication only when the system was able to guarantee economic security. Such unconditional commitment displayed by the nation’s health workers fell away as the state could no longer guarantee a stable income.

A second policy that shaped the doctor-patient relationship was the doctor-designated district system. The scheme was introduced in all administrative units - cities, counties and districts - in 1969 and was strengthened in 1980. A single doctor was made responsible for the general health of 5-8 *inminbans* (neighbourhood units of 1200 to 1500 people) by implementing public health campaigns, education and hygiene projects. If the Jeongsung movement as a form of ideological mobilization encouraged health workers to sacrifice for their patients, the household-doctor system formed a close bond between doctors and patients through obligatory household visits, educating residents about health and hygiene, and conducting regular health checks in designated households (Ch’oe, Kim, and Hwang 2006, 29). The system resembled that in place in the Soviet Union, which emphasized the role of preventive medicine (Lee 2008, 27). Through this grassroots network, it was thought that preventive health care could be effectively implemented. Particularly given limited resources, the emphasis on preventive

medicine and traditional medicine made sense.

One outcome of the household-doctor system was that doctor-patient relations became close and often personal, allowing patients to seek assistance outside of the formal health-care system. Former doctors who had worked in the system told me that patients often came to their home after hours to avoid long queues in the hospital and see the doctor of their choice (Interview, J. Kim, October 5, 2013; Interview, S. Hahn, October 5, 2013). Patients also utilized personal networks when it came to seeking advanced health services (Interview, D. Kim, December 10, 2014), seeking out skilled doctors through word of mouth and personal connections (Interview, S. Hwang, December 10 2013). It was also possible to obtain medical notes from health workers with whom they were acquainted in return for a small token of appreciation (Interview, D. Kim, December 10, 2014).

Whether it is a remnant of traditional culture or the natural authority associated with healers, health workers in North Korea have always enjoyed the respect of their fellow citizens and have an occupation with relative security. Regardless of the state's relegation of health workers to a level equivalent to ordinary laborers, they were in general well-respected and took pride in their profession. As elsewhere, doctors in North Korea enjoyed a degree of social prestige. One interviewee told me that when she became a doctor in her early twenties, her patients occasionally brought gifts to her house, and her mother was proud that she received such respect (J. Kim, October 5, 2013). While limited in incentives compared with a political career, for North Koreans a job as a health worker was relatively secure, prestigious and intellectually challenging. For this reason, for those whose family background (*sŏngbun*)<sup>2</sup> did not allow them to pursue a prestigious political career, medicine was the primary choice of occupation. For instance, many children of Korean returnees from Japan<sup>3</sup>

chose to pursue medicine: not only did they have a preconceived perception of a medical career as an honorable path, but they also anticipated that it would be a relatively secure way of managing their lives (D. Kim, December 10, 2013).



**Pyongyang Maternity Hospital**

By the mid-1990s, a discrepancy had arisen between the health-care goals of the state socialist system and the reality of what North Korea's formal health-care institutions could provide for ordinary citizens. With the state's inability to supply basic medicine, electricity and reliable salaries for workers, hospitals became unable to treat patients adequately. The free state health-care system virtually ceased to function at all levels, with primary care especially hard hit (Linton 2010). Health workers, lacking food rations and income, were suddenly forced to find alternative ways of making a living. This situation encouraged them to negotiate a move away from the workplace to seek other economic opportunities, just as many other state-sector workers did during the period when the national food distribution system ceased to function.<sup>4</sup> As malnutrition and the spread of communicable diseases increased the demand for health care, the state authorities sought to clamp down on absenteeism by health workers. At the same time, with the limited services that hospitals and clinics could provide, patients' expectations, levels of trust and reliance on the formal health-care system deteriorated.

The degradation of the nation's health infrastructure, a lack of transportation services, and unreliable electricity and water supplies all remain obstacles to accessing good-quality health care in North Korea. This situation was graphically portrayed in an Amnesty International report published in 2010 (Amnesty International 2010). Chronic malnutrition, stunted growth in children, widespread tuberculosis and a lack of treatment for incommunicable diseases all remain serious concerns. Demand for medical services is high due to the persistently high malnutrition rate and consequent exposure to both communicable and incommunicable diseases. Paradoxically, however, according to official WHO figures, North Korea has a lower child mortality rate, higher levels of immunization and maternal care access, and a

higher number of health workers than the regional average for Southeast Asia (WHO 2009; WHO 2014).<sup>5</sup> According to WHO, this situation has come about as a result of North Koreans' high level of health awareness and the maintenance of an extensive health-care infrastructure through which WHO assistance is channeled (WHO 2009).

The North Korean government has emphasized its intention to maintain a free and socialized health sector. As a result, despite lacking the resources to provide for the country's over 700 hospitals, 6000 clinics and 300,000 health workers, privatization and decentralization in the health-care sector have apparently been minimal. While there are reports of privately owned and financed pharmacies operating in the streets of major cities and even in a number of hospitals (*Choŭnböttŭl* 2007), health workers and hospital managers are generally reluctant to seek outside resources directly and autonomously for fear of repercussions by the state authorities. Nevertheless, under North Korea's unique path of post-famine transition, informal health-care practices such as informal payments, a black market for medicines, and doctors practicing from private homes have developed.

## HEALTH WORKERS TAKE TO SELLING MEDICINES

During the period when the ration system failed, health workers generally remained at their posts, cooperating with their co-workers in an attempt to cope with the shortage of medicines. Dr Kim, who worked in a children's ward at Chongjin City People's Hospital, told me that over a period of several months in 1996, each doctor was given sufficient supplies of penicillin to treat only two patients. If a doctor had ten patients requiring treatment, she had to make a strategic decision about the allocation of the drug, much like triage logic in military hospitals during wartime. Dr Kim recalls asking herself, "Should I give it to the

patients with the most serious conditions? But if they are going to die anyway, should I not give it to others who have a greater chance of survival?" Doctors rented and borrowed medicines from each other in an effort to save their patients (Interview, J. Kim, October 5, 2013). In their daily struggles with dying patients and economic hardship, however, few questioned the source of the problem: "No one really questioned what was really wrong at the time" (Interview, J. Kim, October 5, 2013). Interviews suggest that most accepted the state's reassurances to its citizens, including physicians, that the economic sanctions applied by the US were the source of the nation's hardships.

Though Dr Kim struggled to feed her own family, she told me that she dared not sell the scarce medicines to which she had access, seeing child patients dying in front of her every day. As medicine from China became readily available in North Korea thanks to smugglers, more health workers began trading in drugs. However, some health workers had to overcome serious misgivings before becoming involved in informal activities of this kind. It took two years of persuasion by former schoolmates before Ms Lee, a pharmacist, finally decided to get involved. A sense of guilt held her back. She began the practice only when contraband secured by her husband was confiscated by the police and she became the sole breadwinner for her family (Interview, Y. Lee, October 23, 2013). Another interviewee, also a pharmacist, never became involved because she was aware that many medicines circulating around that time - the late 1990s and early 2000s - were fake (Interview, J. Lee, November 20, 2013).

Normally, informally acquired medicines were (and still are) sold quietly under the counter in marketplaces or in private homes. Through word of mouth, patients know where to find effective drugs. Over time, competition among medicine sellers and private "house doctors"

provided incentives for them to demonstrate their credibility and so gain the trust of their patients. Because many dangerous counterfeit medicines are still being imported from China, practitioners with the ability to provide safe and effective drugs are keenly sought after. Because of their expertise and credibility in this area, many retired doctors have taken to selling medicines in the marketplace.

As the informal health system developed, patients bought medicines in the local marketplace (*jangmadang*) and brought them to their doctors to confirm that their purchases were safe to ingest or be injected. As the state authorities regulated the sale of medicines and forbade doctors from seeing patients at home and selling drugs, innovative referral practices, employing existing networks of doctors and pharmacists, were developed to avoid the regulations. These networks also had the effect of mutual monitoring and enforcement of expertise and trust. The "utilization of community networks as social capital," observed in previous studies of North Korea's informal economy (Chang 2004, 342), is also evident in the formation of supply networks involving medicines based on preexisting relationships in which mutual obligations and trust in each party's expertise and competence are embedded.

## THE EMERGENCE OF DOCTORS PRACTICING FROM PRIVATE HOMES

The phenomenon of doctors practicing privately out of their own homes also emerged in response to the emergency conditions of the 1990s. While unregistered traditional healers had always existed their activities were not recognised by the state health-care system (H. Lee, October 15, 2013). During the 1990s, people increasingly sought the help of these informal healers, aware that they could not access treatment from the hospital system without money and personal connections. The practice of Korean traditional medicine by

state-sanctioned health workers, regardless of their expertise, was already widespread thanks to the official emphasis on the twin use of traditional and modern medicine. In the absence of resources in the formal sector, patients demanded these services and health workers were eager to provide them, often using personal networks and working in settings outside of the formal hospital and clinic environment. Over time, patients came to prefer private “house doctors” for reasons of both convenience and trust. Many respondents described North Korean hospitals as “empty,” adding that “nowadays, private house doctors are more popular among the people” (Interviews: S. Hwang, October 25, 2013; M. Park, November 18, 2013; G. Kim, November 10, 2013; Y. Lee, October 8, 2013).<sup>6</sup>

When a person is hospitalized in North Korea, the patient has to provide everything needed during treatment: medicines, IV, blankets, firewood, and meals, not only for themselves but also for the staff responsible for their care. As a result, only those who can afford these expenses are admitted to hospital, and it has consequently become common for patients to opt for private house doctors over hospital treatment. Private doctors are often seen as more trustworthy than hospital doctors, who have less incentive to establish a reliable reputation and trusting relationships with patients. In the earlier period of the 1990s famine, unqualified home-practicing doctors were responsible for high levels of medical misadventure. Despite attempts to conceal their incompetence, such practices could not be sustained for long, as reputation (spread by word of mouth) has always been the most important factor making for a successful practice.

House doctors generally examine a patient’s pulse, apply acupuncture treatments, and tell patients where to find medicine sellers. These are functions of a primary doctor. Patients do not visit them with empty hands. For the

average citizen, remuneration in the form of a gift could be anything from a bundle of noodles to a packet of cigarettes. In Musan, North Hamgyong Province, there was a set monetary payment for seeing a home-practicing doctor of between 30 and 40 thousand won (equivalent to about 10 kg of corn) in 2013.

House doctors provide services that the state health care system struggles to provide – resources, expertise, and immediate accessibility. Their success depends on the trust built up with patients and word-of-mouth recommendations. For instance, one interviewee who had worked as a farmer told me about a doctor attached to her local *jillyoso* (primary-level clinic at a cooperative farm) in a small town in Southern Hamkyong Province. Because her treatment (both diagnosis and prescription) is regarded as competent and effective, many residents prefer to see her over other doctors working at the clinic. *Jillyoso* doctors regularly receive patients at home after working hours, but because selling medicines from private homes is prohibited, she refers her patients to another private house where medicines are sold – incidentally illustrating the mutually beneficial relationships enjoyed by private practitioners. This particular doctor also has a mutually beneficial relationship with a police officer; she provides him with free medical assistance and he protects her from any official repercussions that her activities might incur. Although she was once sacked from the *jillyoso* and was ordered to “revolutionize herself” (by laboring on a cooperative farm for three years) for her illicit medical practices, she continued to see patients as they sought her care. As a result, the *jillyoso* lost face and were forced to readmit her to the practice, and the authorities cancelled her sentence (G. Joo, November 10, 2013; B. Cha, November 10, 2013).

The key factors that determine a house doctor’s success are possession of a practicing license, work experience, sincerity, and personal



recommendation. Many home-practicing doctors are retired medical practitioners. With a background of experience of working in the hospital system and acquiring specialist knowledge and good reputations, they are in a better position to gain their patients' trust. People tend to trust retired doctors, who are generally considered to have had a sound medical education along with a good deal of experience, at the expense of younger doctors educated during or after the period of the famine and the more general breakdown of societal systems in North Korea (Interview, S. Hwang, October 25, 2013). Qualifications gained in the past and a career begun when the formal health system was functioning also matter to North Koreans. Even though the free health-care system provided by the state is today only a shadow of its former self, its legacy is still important for the doctor-patient relationship in the 21<sup>st</sup> century.

### MAINTENANCE OF THE FORMAL SECTOR

For doctors of working age, there are many practical reasons for them and other health workers to remain in the hospital system rather than to receive patients in their private homes. Indeed, whether it is even possible for doctors of working age (up to 55 for women, 60 for men) to leave their hospital positions and see patients at home was disputed by my interviewees and varies according to region. By seeing patients at the hospital, doctors have more opportunities to visit them and receive gifts. However, while continuing to meet their obligations in the hospital system, they are generally still able to receive patients at home after working hours. Thus, informal practices do not compete with the formal sector, but rather complement it.

Female health workers are especially well placed to benefit from their hospital roles, as opposed to working as housewives, as well as engaging in informal economic activities. When Ms Lee, one pharmacist informant, got

married, she quit her job and became a full-time housewife. Before the 1990s economic crisis, it was common for a married woman to be a stay-at-home wife. Since the crisis, however, she was frequently mobilized for public works projects, ranging from road building to farming. Thus, it was much harder work being a member of her local *inminban* than working in a hospital. In the mid-2000s, Ms Lee went back to work at a hospital pharmacy. By belonging to the hospital staff, she was able to avoid the physically demanding public mobilizations required of *inminban* members and had more spare time to earn some extra income (Interview, Y. Lee, October 23, 2013). Thus, by strategically rejoining the formal institution, Ms Lee became freer to conduct informal health-care practices such as selling medicine and seeing patients privately. Ms Lee's strategic choice to maintain her affiliation with the hospital system while engaging in these informal practices demonstrates why state institutions continue to function in North Korea despite the rise of informal alternatives.

Over time, North Korean hospitals, forced to self-manage in the absence of the central state's provision of medicines and other supplies, have accepted the role of private pharmacies and informal payments. Though it may not be possible for hospitals to negotiate individually to acquire medicines from foreign donors, buying drugs and other necessary supplies from China is sometimes an option (Y. Lee, October 8, 2013). One semi-privatised hospital pharmacy is managed by a private dealer who procures medicines, sells them on site, and pays a portion of his income to the hospital. In this way, the hospital both meets its need for medicines and makes some profit that goes towards meeting its expenses (Y. Lee, October 23, 2013).<sup>7</sup> Thanks to such informal arrangements, the collapse of the state-run hospital system has been avoided. Hospitals continue to function as places where patients receive diagnoses, possibly for free, and where

doctors and patients meet and establish relationships. Some interviewees affirmed that medical care is available free of cost for emergency patients (e.g. M. Park, November 18, 2013). Interviewees recognized that, in particular, hospitals are places where patients go to receive a diagnosis, especially when there is a need for diagnostic equipment like x-ray machines. Officially, diagnoses are still provided for free, although there is an expectation that patients will offer doctors a packet of cigarettes or similar items to show their appreciation (Interview, Y. Lee, November 18, 2013).

However, the biggest obstacle to reviving the formal health sector is growing mistrust and a lack of expectation from patients. Economic power and personal networks have become essential for accessing the resources of the formal health-care system. As a result, while the formal sector continues to be maintained, it has a reduced role to play. North Korea's once free and comprehensive health-care system has had the effect of marginalizing ordinary citizens and especially the poor.

## **THE ETHICS OF INFORMAL HEALTH CARE**

The “moral economy” of a given society has been described in terms of a popular consensus on “what distinguishes legitimate from illegitimate practices” (Arnold 2001, 93). Such a consensus is rooted in a society's traditional norms and practices and is “capable of inspiring action” (Arnold 2001, 89). Is there a popular moral consensus in North Korea on health care? If so, is it rooted in values embedded in and fostered by the health-care institutions of the nation's past, or does it reflect a newly emerging set of market-based values? And does any such consensus extend to informal health-care practices?

One possible answer can be found in the surprising reaction of North Korean defectors to their experiences of South Korean hospitals.

Despite witnessing and benefiting from technological advancement and the high funding levels enjoyed by hospitals in the South, many were somewhat dissatisfied with the impersonal and capitalistic character of the health-care system in their new home. These interviewees frequently expressed their nostalgia for the socialist ideals and humanitarian attitudes that they had experienced in North Korean hospitals. In part, this phenomenon reveals the common human tendency to reflect on one's past experiences when evaluating new situations. Supporting these anecdotal observations, I suggest that the new informal practices, networks, relationships, and expectations that have emerged in North Korea since the 1990s are rooted in the norms and incentives fostered by the earlier, socialist health-care system: intimate doctor-patient relationships based on a reciprocity involving dedication and trust, and the moral economy of a free health-care regime.

Close relationships between doctors and patients were fostered under the state's moral injunction that health workers ought to be selflessly dedicated to their patients. The state's inculcation of such values in health-care workers had the effect of blurring the line between private and public spaces for treatment, with the consequence that visiting doctors at home was not perceived as a strange or new practice for patients. As mentioned above, even when the formal system was functioning well, patients sometimes visited doctors' homes when circumstances allowed, bringing a small gift as a show of appreciation, in order to avoid long waits and to see the physician of their choice. Though doctors might be irritated by such visits, the selfless devotion to patients' needs internalized by state propaganda campaigns compelled them to receive patients at home, albeit often reluctantly. The “home doctors” who emerged in the post-famine period were seen as a legitimate continuation of such interactions

beyond the spaces of hospitals and clinics, in both the minds of health workers and patients. These normalized interactions outside of formal health-care institutions acted to reinforce health workers' expertise and credibility in the public eye, even when practicing medicine outside of formal settings. Several interviewees were happy to categorize *jangmadang* medicine sellers and home-practicing doctors as health-care workers, thus ensuring that their expertise could be trusted.

Despite a clear recognition of the illegal status of such practices, my interviewees registered a quiet and reluctant approval of the informal activities of medicine sellers and home doctors. Their reasons were economic: "They have to feed their families as well" (Y. Lee, October 8, 2013). Many interviewees thought that retired doctors should be entitled to some form of income in the absence of the state provision of welfare for retirees. This practice is also justified because doctors in North Korea enjoy living standards equivalent to those of ordinary workers, notwithstanding the sense of privilege associated with the profession. This "economic subsistence" argument is used to justify the widespread existence of what are called "non-legal activities" in North Korea, activities that are legally prohibited but de facto (or customarily) permitted (Cho et al. 2008, 168). "Loyalty to the Party" or "achieving socialism" must give way to such immediate concerns.

My informants agreed that the state should provide health care and, when it cannot, it loses the moral authority to regulate "anti-socialist" activities that nonetheless ameliorate the harsh conditions of life faced by many people in North Korea. As long as they do not harm anyone, such informal activities help residents and provide comfort in times of hardship, and therefore should not be regulated. "They are doing what the country cannot do for us. So why should such practices be regulated? What they do indeed saves lives." On the other hand, interviewees expressed

moral indignation towards bogus doctors and medicine sellers who endanger trusting patients' lives (Y. Lee, October 8, 2013).

Contrary to the general approval for *jangmadang* medicine sellers and home doctors, there was a shared criticism of certain informal practices prevalent in the formal sector. Interviewees expressed contempt for health workers or hospital administrators who hoard medicines. Mrs Cha (December 20, 2013) described how doctors and hospital pharmacists make out bulk prescriptions for drugs donated by the UN, but instead of giving them to patients, they sell them to private medicine dealers. In describing this informal hoarding system, she conveyed the sense of injustice she feels about what the system has become, even though, in times of personal need, she had herself acquired drugs directly from the hospital.

How is such shared moral outrage expressed and communicated to the bureaucrats charged with enforcing the regulations? Dissatisfaction can be expressed verbally as a way of confronting local officials directly. Interviewees argued that in order to survive in North Korea, one often has to take a firm line and defend one's position logically in order to persuade officials of the merits of one's case. While this might seem surprising given the state's tight control over its citizens, the expression of complaints to local officials is facilitated by preexisting relationships between officials and complainants formed through family networks, neighborhood relations, friendships, a shared history as classmates, and so forth. Social relations in small regional cities in North Korea are close, shaped by cultural traditions, socialism, and communalism, and reinforced by the coping and survival strategies developed to weather times of hardship.

However, given the nature of a regime that does not accommodate dissent, the expression of dissatisfaction generally takes non-verbal

forms. One term that cropped up frequently was “disaffection” (*panbal*). In the narratives recorded in this study, *panbal* refers to feelings as well as expressions of disaffection against the authorities (normally local officials charged with regulating anti-socialist activities), as well as with life in general. Although the authorities are well aware of such disaffection in the populace, Ms Hahn expressed her opinion that in reality the government lacked the power to impose its own regulations: “If the authorities regulate even those activities, there would be too much disruption” (Interview, S. Hahn, October 26, 2013). According to a former police officer, “a police officer will be unpopular if he takes unnecessary enforcement action” (Interview, M. Park, November 18, 2013). If complaints against local officials accumulate, they will damage their reputation with residents. In E. P. Thompson’s words, referring to the 18<sup>th</sup>-century English crowd, “the authorities were, in some measure, the prisoners of the people” (Thompson 1971, 88).

From the point of view of local officials, the existence of these informal coping networks and strategies are to be applauded, as alternative ways of providing health care may have the effect of allaying complaints by residents. Local officials also have private incentives to turn a blind eye to such informal activities. Normally, these private practices operate with the help of local police who accept bribes from practitioners. More importantly, police officers also draw on the services and expertise of informal health-care workers for their own families’ survival and wellbeing. As a result, local officials and residents have come to share similar views on these extra-judicial activities. Thus the convergence of preferences among providers, consumers, and regulators has contributed to the emergence of an active and evolving informal health-care sector in North Korea.

## CONCLUSION

This article has presented and analyzed an evolutionary view of the emergence of an informal health-care space in North Korea. The emergence of new health-care practices in North Korea was triggered by the incapacity of the formal health-care system to supply resources during the ongoing health crisis of the 1990s and later. These practices are shaped by existing norms of fairness, interpersonal networks and habits fostered under the state-led health-care system, as well as newly introduced norms relating to trust, expertise and rewards. This space has emerged without significant changes in the formal institution, and in fact complements it. However, the role and influence of the formal sector have shrunk as the power dynamics of monetary payments and interpersonal networks have reduced its footprint. As a result, the space occupied by the formal sector has been reduced, while the informal sector continues to expand its zone of influence. The new norms of payment for services and the utilization of personal relationships in the formal sector are regarded as unjust at the same time that these practices are considered inevitable, necessary, and even efficient. The new norms adopted in the formal sector have contributed to the creation of an informal health-care space, while the role and influence of the formal sector have dwindled.

Three main conclusions are offered based on this preliminary study of the informal health care sector in North Korea. (1) The emergence of an informal sector complementing the state-controlled formal sector will not necessarily result in the collapse of the latter, as the two are interlinked by actors’ incentives to engage in both sectors, by the sharing of resources that flow in both directions, and by the division of roles between the two sectors. (2) It also implies a possible shift of social norms – the concept of fairness and justice in health care – from the formal to the informal sector, as the formal sector is affected by encroaching market influences. (3) While this study suggests that

the informal sector is accommodating existing social concepts of morality and fairness in health care, this premise needs to be further tested in more systematic studies. It is too soon to conclude that the informal sector is more accessible to ordinary citizens and the poor. It may rather be that adequate health care is equally inaccessible to the poor not only in the formal sector but also in the and informal sector, where the logic of money and privileged relationships operate.

However these questions may finally be answered, the development of informal health-care practices in North Korea since the 1990s does not mark the demise of the formal socialist health-care system. In fact, this paper suggests that the informal sector has contributed to the resilience of the formal sector. While the complete dominance of the state-provided health system is a thing of the past, the emergence of an informal health-care sector has paradoxically facilitated the survival of the socialist system. The dynamics of interaction between the two sectors helps to fill out the broader picture of “muddling through” that is such a marked characteristic of the socialist state of North Korea.

The research on which this article is based arose out of the ARC Laureate Project ‘Informal Life Politics in the Remaking of Northeast Asia,’ funded by the Australian Research Council.

The author would like to thank Simon Avenell, Gavan McCormack, and Tessa Morris-Suzuki for their valuable comments.

## References

Amnesty International. 2010. [Crumbling State of Health Care in North Korea](#).

Arnold, T. C. 2001. Rethinking Moral Economy. *The American Political Science Review* 95 (1): 85-95.

Chang, S. 2004. Pukhan Tosi Chuminŭi Sahoejök Kwan'gyemang Pyönhwa [Changes in Social Networks of City Residents in North Korea]. *Han'guksahoehak* 39 (2): 100-134.

Ch'oe, Y., S. Kim, and S. Hwang. 2006. Chöngsöngundongi Pukhan Pogönŭiryoe Mich'in Yöngyang [The Influence of the Devotion Movement on the Health Care in North Korea]. *Korean Journal of Medical History* 15 (June): 23-48.

Choŭnböttül. 2007. Pissadörado Pyöngwön Yakp'um Sönho [People Prefer Hospital Medicine Despite Having to Pay a Higher Price]. March 16.

Cho, C., C. Seo, S. Lim, P. Kim, and Y. Park. 2008. [Pukhan Chuminŭi Ilsangsaenghwal \[Everyday Life of North Korean Residents\]](#) Korean Institute of National Unification.

Huffington Post. 2013. [North Korea Health Care: Freezing Hospitals Cast Doubt on Official Narrative](#).

Hwang, S. 2006. *1950 yöndae Sahoejuŭi Könsölgŭi Pukhan Pogönŭiryö, Söultaehakkyoch'ulp'anbu* [North Korean Health Care System during the Formative Period of Socialism in the 1950s]. Seoul: Seoul National University Press.

Hwang, S. and S. Kim. 2007. Haebang Chönhubut'ö Chöngbu Suriipkkaji Pukhan Pogönŭiryö [North Korea's Health Care from Independence to Establishment of the Government]. *Korean Journal of Medical History* 16: 37-70.

Joo, H. 2014. Hidden Transcripts in Marketplaces: Politicized Discourses in the North Korean Shadow Economy. *The Pacific Review* 27 (1): 49-71.

Jung, K. and B. Dalton. 2006. Rhetoric versus Reality for the Women of North Korea: Mothers of the Revolution. *Asian Survey* 46 (5):

741-760.

Lankov, A. 2013. *The Real North Korea: Life and Politics in the Failed Stalinist Utopia*. Oxford: Oxford University Press.

Lankov, A. and S. Kim. 2008. North Korean Market Vendors: The Rise of Grassroots Capitalists in a Post-Stalinist Society. *Pacific Affairs* 81 (1): 53-72.

Lee, H. 2008. Pukan Pogönüiryochegyeüi Pahaenghwawa Pyönhwaye Tehan Yongu [A Research on the Decline and Change in North Korea's Health-care System]. Master's Thesis in North Korean Studies, Kyeongnam University.

Linton, S. 2010. [Pukhan Üiryohyönan'gwa](#)

[Haegyöl Taech'aekæ \[Problems of Healthcare in North Korea and Responses\]](#).

Smith, H. 2005. *Hungry for Peace*. Washington DC: US Institute of Peace.

Thompson, E. P. 1971. The Moral Economy of the English Crowd in the 18<sup>th</sup> Century. *Past and Present* 50: 76-136.

Watts, J. 2003. Health-care Divide Widens in North Korea. *The Lancet* 362: 2072-2073.

World Health Organization. 2009. [WHO Country Cooperation Strategy, 2009-2013](#). Geneva: WHO.

World Health Organization. 2014. [Country Statistics](#).

Eun Jeong Soh participated in Tessa Morris-Suzuki's Australian Research Council Laureate Project, [Informal Life Politics](#), as a post-doctoral fellow (June 2013 - January 2016), at the School of Culture, History and Language, College of Asia and the Pacific, the Australian National University. She currently resides in Seoul. [Eunjeong.soh@gmail.com](mailto:Eunjeong.soh@gmail.com)

## Notes

<sup>1</sup> This story also indicates that, even in the 1970s, the development of new drugs in hospitals was common in North Korea.

<sup>2</sup> *Söngbun* is a social classification system that divides the entire population into five major groups according to their families' status and deeds during the Japanese colonial period and the Korean War. One's *söngbun* is an important, if not the only, factor determining prospects for higher education opportunity and career advancement: See Fyodor Tertitskiy, ["Are you special, basic or complex? Behind North Korea's caste system,"](#) *The Guardian* (4 March 2015).

<sup>3</sup> "Returnees" are 93,340 ethnic Koreans from Japan who returned to North Korea between December 1959 and July 1984. The repatriation took place on the largest scale in 1960 when 49,000 individuals made this journey. Their children and grandchildren often seem to retain this identity. See Tessa Morris-Suzuki, ["Exodus to North Korea Revisited: Japan, North Korea, and the ICRC in the "Repatriation" of Ethnic Koreans from Japan,"](#) *The Asia-Pacific Journal* 9, Issue 22, Number 2, May 24, 2011.

<sup>4</sup> This period is also referred to as "the March of Hardship," the term used by the state to rationalize the suffering that citizens endured in the 1990s. However, many North Koreans

refer to it simply as the “non-ration period.”

<sup>5</sup> The Democratic People’s Republic of Korea (DPRK) country office comes under the umbrella of WHO’s Southeast Asian Regional Office.

<sup>6</sup> These interviewees come from four different regions of the country.

<sup>7</sup> Similar practices involving the partial privatization of state-run businesses have been documented in other contexts (Lankov 2013, 85).