Occupation's Influence on the Usage of Korean Medicine

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Introduction

Basic study on its usage by profession is required to demonstrate the function of Korean medicine in the field of occupational medicine. The purpose of this study was to determine who utilises Korean medicine and whether this varies by profession. Jobs in Korea have become more specialised and diverse as a result of industrial growth. The Korean government developed the Industrial Accident Compensation Insurance in 1964 and passed the Workplace Safety and Health Act in 1982 in an effort to reduce and pay for occupational health hazards. A Korean medical facility was recognised as a nursing institution for industrial accident compensation insurance in 1999 [1].

Description

In Korea, research has been ongoing throughout this period and between 2000 and 2010, 40 publications on occupational health were published in the Korean Medical Journal. These specifically included one paper on industrial accidents, 13 papers on occupational illnesses, 9 papers on health-related habits and 13 papers on health examination initiatives. The management strategies and specifics of how Korean Medicine will handle occupational medicine are still being worked out, hence there hasn't been much written on its usage in relation to occupations. Four million dollars, or around 0.7% of the total industrial accident insurance payouts in 2018, were the costs of Korean medicine that were paid by insurance for workplace accidents in 2018 [2].

The Andersen model's first version divided the influencing elements into three categories: predisposing, enabling and needs components. The predisposing component is made up of traits that emerge prior to medical usage, such as sociodemographic traits, social structure traits and attitudes about medical treatment (medical people) and illness. Family or personal resources, accessibility, features of the healthcare system and a tendency or predilection to employ a certain doctor's services are all examples of the enabling component. The last component of medical requirements is evaluated by people reacting and assessing the symptoms and level of handicap they perceive from the condition, or by a medical examination of their health and the urgency of their disease diagnosis. According to Andersen's approach, each of the three variables influences medical usage on its own. Although there are other medical use models, the Andersen model was chosen as the theoretical model for this investigation. First, although the Becker and Sucman models identify individual perception as the primary driver of medical use behaviour, it is challenging to locate data on personal perception factors like religion and beliefs.

Together with the Korea Institute for Health and Social Affairs (KIHASA) and the Korean National Health Insurance Service, the Korea Health Panel gathers data. The only data that can distinguish between medical costs and secondary data by employing representative samples of Koreans is the Korean Medical Panel data, thus we used that. The health insurance claim data from Korea may also be used to identify Korean medical bills, however it is challenging to determine each subject's work and how to use non-benefits [3,4]. 90% of the information from the 2005 Population and Housing Census was used to sample the Korean Medical Panel. The sampling technique is a second stage stratified cluster sampling approach in probability proportion, with stratification variables consisting of 16 major cities and towns across the country. Because of this, the Korean Medical Panel's sample data is representative of the whole Korean population. The Korean Medical Panel eventually comprised 6437 families and 17,424 persons in 2016 owing to fatalities and a refusal to do an investigation, down from 7009 households and 21,283 people when it first began in 2008. The Korea Health Panel Data from 2008–2016, Version 1.5, were utilised in this investigation. Although the emergency, hospitalisation and outpatient categories of the Korea Health Panel's medical use data are separated, the outpatient medical utilisation data were examined in the greatest depth since the emergency and hospitalisation data were insufficient. Data from the most recent year (2016), which was utilised in this cross-sectional analysis, was used [5].

This study made use of anonymous, publicly available data from the Korea Health Panel. KIHASA provided the data and granted permission for their usage and analysis.

Conclusion

According to the study's findings, different employment levels have different probabilities of utilising Korean medicine and incurring medical costs. It is unclear, nevertheless, if this outcome is related to the fact that each employment has a varied geographic accessibility and availability. To further understand how Korean medicine is applied and used in occupational medicine, more research on the subject is required.

References

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