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Letter From the Korean Academy of Tuberculosis and Respiratory Diseases (KATRD)—Navigating Reform: South Korea's Healthcare System at a Crossroads

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South Korea is internationally recognised for combining universal health coverage with advanced medical technology and a highly trained workforce. Universal coverage is delivered through the single-payer National Health Insurance Service (NHIS), launched in 1989 after rapid expansion from initial coverage in 1977 [1]. Everyday care, however, is delivered predominantly by private providers, producing a unique public-purchaser/private-provider model. This structure supports rapid access and swift technology adoption, while South Korea's digital infrastructure, led by the Health Insurance Review and Assessment Service (HIRA), ensures near-universal electronic medical records and coordinated quality review. These strengths underpinned South Korea's effective responses to Middle East respiratory syndrome (MERS) and coronavirus disease 2019 (COVID-19), facilitating near-real-time triage and resource deployment. In respiratory health, the system has leveraged these strengths to implement low-dose computed tomography (LDCT) lung cancer screening, sustain tuberculosis control, and coordinate outbreak responses across levels of care.

Nevertheless, vulnerabilities underlie this system. Fee-for-service incentives foster fragmentation, low reimbursement rates weaken essential specialties, and limited public ownership complicates regional planning. These weaknesses became clear during the country's largest medical dispute in decades.

On February 6, 2024, the government announced plans to increase medical school admissions by 2000 annually, aiming to add 20,000 physicians by 2035. While framed as a response to population aging and rising demand, the medical community argued that expanding numbers without addressing low reimbursement, poor training environments, and high legal risks would fail to solve underlying problems. The backlash was immediate. By late February, more than 10,000 interns and residents at major hospitals had submitted resignations, and 9000 had left their posts [2]. Emergency and intensive care services were curtailed, cancer operations postponed, and remaining staff reported severe burnout. Government return-to-work orders polarised relations further, portraying physicians as a "cartel of self-interest" and eroding public trust [2].

These tensions reflect deeper structural issues. Persistently low reimbursement has undermined institutional viability and created shortages in essential specialties [2]. Dependence on non-covered services has intensified competition and overtreatment, whereas the combination of South Korea's high rate of criminal prosecution for medical errors and escalating compensation payouts has discouraged younger physicians from pursuing high-risk but essential fields [2].

By July 2025, political change, including the impeachment of President Yoon Suk Yeol, intersected with fatigue among students and residents. On July 12, medical students unexpectedly declared their return. The government pledged no penalties, reinstatement to original training posts, and military service deferrals. A joint training council was formed, including the

FIGURE 1 | The 3rd Training Meeting of Resident Physicians, the Korean Academy of Medical Science, and the Ministry of Health and Welfare, Whosaengsinbo, 7 August, 2025. On the morning of the 7th, the Ministry of Health and Welfare (Minister Jeong Eun Kyung) held the 3rd Training Committee meeting in Seoul. In this meeting, the participants continued discussion of plans for recruiting residents in the second half of 2025. The attendees agreed that it is necessary to support residents who have resigned to return to training through a recruitment process but emphasised the need to consider the measures that had been applied up to that point (permission from Whosaengsinbo).

Ministry of Education, the Ministry of Health and Welfare, the Korean Academy of Medical Sciences, the residents' association, and the hospital training council (Figure 1).

Still, the crisis left scars. Avoidance of essential care, collapse of regional services, and unresolved legal burdens continue to undermine the system. The return of more than 7500 students—including those who had taken leave and new entrants—has raised fears of degraded education quality due to faculty and facility shortages, potentially affecting patient care. Medical school professors and faculty have reported loss of research and teaching autonomy, moral injury, diminished social standing, and weakened relationships with students and residents [3]. Standards for education and training have been shaken, interest in essential care has declined, and more physicians are seeking training abroad. In addition to service gaps, the dispute reshaped hospitals through increased reliance on physician assistants, weakened the influence of residents in policymaking, and eroded public confidence in healthcare.

The dispute highlighted fundamental weaknesses of South Korea's healthcare system. While universal coverage and digital infrastructure provide strong foundations, distorted incentives undermine essential services. Low reimbursement drives fragmentation, rewarding procedures over continuity, prevention, and coordination. Training policies, focused on expanding numbers, have not ensured distribution across essential and regional specialties or preserved educational quality. The heavy legal burden surrounding medical errors discourages physicians from pursuing high-risk but indispensable fields. Finally, the absence of residents revealed the vulnerability of research and education: faculty diverted to clinical duties experienced low morale, research output decreased, and the country's academic visibility diminished [4]. Together, these lessons show that universal coverage alone cannot guarantee sustainability without reform of financing, workforce planning, and institutional trust.

South Korea does not need to rebuild its healthcare system from the ground up; instead, it must focus on recalibrating its strengths. Reimbursement reform is critical, as are rewarding continuity, care coordination, prevention, and patient-reported outcomes, with HIRA's digital infrastructure providing accountability. Training reform should protect competency-based milestones, safeguard duty-hour limits, and align fellowships with public need rather than procedure volume. Equitable distribution requires targeted training tracks and bonded scholarships in essential specialties, including internal medicine, paediatrics, general surgery, obstetrics and gynaecology, and emergency and critical care. At the regional level, county and provincial hospitals must be stabilised through bundled staffing and equipment support, service-availability contracts, and networking intensive care unit links to tertiary centres.

Referral incentives and transportation assistance can ensure that patients experience a connected network rather than fragmented care. Finally, digital health should be institutionalised through careful regulation and guided by triage protocols, privacy protections, and continuous quality monitoring. If incentives, data, and training are effectively aligned, South Korea may transform this crisis into an opportunity to establish a healthcare system that is more equitable, sustainable, and resilient, while preserving the efficiency and excellence for which it has long been recognised.

The South Korean experience demonstrates that healthcare reform cannot rely on access alone. For countries grappling with aging populations, workforce shortages, and rising expectations, the recent dispute highlights the need to balance universal coverage with fair reimbursement, supportive training, and trust across stakeholders. Turning disruption into opportunity may allow South Korea and others to create systems that are not only efficient and rapid, but also sustainable and just.

Conflicts of Interest

The authors declare no conflicts of interest.

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