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## **Changing Health Policy Process: Politics of Health Care Reform in Korea**

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## **Changing Health Policy Process: Politics of Health Care Reform in Korea**

### **Abstract**

Korea recently had major health care reform in financing, pharmaceuticals and payment system for providers. The change in administration and the political will of the new president opened the policy window for the reform. The active role of the president and civic groups in policy formation, represents a major change in health policy process in Korea that for a long time government bureaucrats dominated. However, the gradual departure from the authoritarian regime has also empowered interest groups in policy process, and they became the major stumbling block in the policy implementation. In addition, due to the lack of strategic implementation plans as well as reform overload, government failed to effectively overcome a strong veto power of physicians, and the implementation failure resulted in greater social costs than expected. As democratization changes the nature of health policy process from authoritarian or policy elite domination to more pluralism, the success of health care reform in Korea will depend not only on policy adoption but also on strategic implementation, which also hinges on interest mobilization to counteract the dominant influence of health care providers.

## I. Introduction

Health care system of Korea has been in turmoil since the beginning of the new millennium due to three major reforms –reforms in health care financing, pharmaceutical policy and the payment system for health care providers. In July of 2000, all health insurance societies were merged and the national health insurance in Korea became a single insurer. In July 2000, a mandatory separation of drug prescribing and dispensing was implemented, and physicians can no more dispense drugs and nor can pharmacists prescribe. Physicians responded to the pharmaceutical reform by a series of nation-wide strikes, which had huge impacts on the reform process. In January 2001, government planned to extend the DRG(Diagnosis Related Group)-based prospective payment system, which had gone through 3-years of pilot program, to all health care providers for selected disease categories in the inpatient sector. Physician opposition pushed the government to defer its nation-wide implementation.

The purpose of this paper is to examine the changing health policy process associated with the health care reform in Korea. The process of health care reform is inherently political and health care reform has critical implications for the interests and power of major stakeholders in health care (Freeman and Moran, 2000; Geva-May and Maslove, 2000; Reich, 1995). A comparison of those three health care reforms in Korea provides important lessons for changing health policy process and the politics of health care reform. The change of administration opened a policy window for the reform, and the new president along with civic groups played a pivotal role in the formation of reform, which is in big contrast to the previously dominating role of bureaucrats in the formation and implementation of health policy. However, the reform lacked the strategy of managing vested interest groups, which were eager to increase their voice in the policy process following the regime change. As the authoritarian political regime is over, there is a gradual change in the policy process, from a policy elites-dominated to a more pluralistic one, but new political entrepreneurs failed to fully appreciate the change. Through nation-wide strikes, the medical profession in particular had a huge leverage in the reform process and became the major stumbling block in the policy implementation. Nonetheless two out of three major health care reforms survived in spite of the distortions in the policy contents. The future of health care reform in Korea is likely to depend on the

interest mobilization to counteract the dominance of health care professionals.

This paper briefly overviews the health care financing, delivery and pharmaceutical sector in Korea as the context of the health care reform. It also explores the effect of the reform in terms of throughput measures such as implementation and short-term impacts on physician behavior with preliminary data. Then this paper examines the changing policy process in the health care reform in Korea. More specifically, it examines the roles of president and civic groups in the policy adoption, roles of vested interest groups in the policy implementation and the role of strategy in the policy process as well as future challenges.

## II. Health Care System and Reform in Korea

### 1. Health Care Financing

Before the health care financing reform of the merger of all health insurance societies in July 2000, the national health insurance system consisted of more than 350 independent quasi-public insurance societies. There were three different types of health insurance societies: 1) 142 health insurance societies for industrial workers and their dependents, 2) single health insurance society for government employees and teachers and their dependents, and 3) 227 health insurance societies for the self-employed, so called, the regional health insurance (NHIC, 1999). Each insurance society covered a well-defined population group, and beneficiaries were assigned to insurance societies based on employment (industrial workers) and residential area (self-employed). There was no competition among health insurance societies to attract the insured and no selective contracting with health care providers. There is no difference in the statutory benefit package (although difference in ancillary benefits) among insurance societies.

Before the merger, health insurance societies used different methods of setting the contribution. The contribution in self-employed groups depended on income, property and the number of dependents while income was the only basis for contribution in employee groups. Differences in the method of setting contribution and the rate of contribution across insurance societies, in spite of

quite similar benefits, have caused concerns on the inequity in the economic burden of social health insurance. Members of the insurance societies for the self-employed (regional health insurance) in poor areas had to pay the contribution as a greater proportion of their income. Many of regional health insurance societies in rural areas have experienced chronic financial distress (Kwon, 2002d). In rural areas, the population is ever decreasing and in poor health, the proportion of the elderly is increasing but their members' ability to pay is lower than in urban areas.

Many health insurance societies were too small in size to pool the risks of their members efficiently. Consequently, they had a limited capacity to pool health risks of members. Many small insurance societies were not able to utilize the economies of scale in management either, and the proponents of the merger maintained that the merge would save a lot of administrative costs of the national health insurance system.<sup>1</sup> Self-governance of insurance societies was almost never realized in Korea. Health insurance societies were subject to strict regulation by the Ministry of Health and Welfare (MOHW).<sup>2</sup> The ruling political party and the MOHW had a great influence on the appointment of the CEOs of health insurance societies. Decentralization in social health insurance system in Korea failed to improve responsiveness to local preference, as some of central and eastern European countries have experienced recently (Preker, Jakab and Schneider, 2002).

## 2. Health Care Delivery and Pharmaceuticals

National health insurance in Korea reimburses providers by the regulated fee-for-service system. Besides the increase in volume and treatment intensity, physicians substitute uninsured medical services, of which fees are not regulated, for insured services in order to avoid the effect of fee regulation. Differential margins from different medical services also induce physicians to provide more services with higher margins, resulting in the distortion in the mix of medical

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<sup>1</sup> Before the reform, the proportion of the administrative cost in total expense was the smallest (4.8%) in the former health insurance for government and school employees (single insurance society) and the greatest (9.5%) in the former health insurance for the self-employed (NHIC, 1999).

<sup>2</sup> For example, contribution rate should be set within a given range and is subject

care for patient treatment. For example, the Cesarean delivery rate was over 40 percent in 1999 (NHIC, 2000). Much higher margin from the Cesarean section is the major contributing factor to the explosion of the Cesarean delivery. Distortion in the relative price of medical services affects the relative supply of medical specialties, too.

In late 1990s, government decided to adopt two approaches to reform the payment system for providers: DRG for the inpatient sector and RBRV (Resource-Based Relative Value) for the outpatient sector. The idea of the case-based payment such as DRG faced tough oppositions from providers in Korea. In 1997, government implemented a pilot program of DRG-based payment for selected disease categories to voluntarily participating health care providers. In contrast to the DRG-based payment, the RBRV system faced little opposition from providers because it is still a fee-for-service system. Although the RBRV is a relative price adjustment by setting a fair price of one medical care relative to others (Hsiao, 1992), physicians in Korea expected that the fee scheduling based on the RBRV would raise fees uniformly rather than redistribute income among different specialties.

When there was no separation of drug prescribing and dispensing, physicians and pharmacists dispensed more drugs and those with higher margins for them. Since the fees for medical services were strictly regulated, dispensing drugs was more profitable for physicians than providing medical services. Physicians actually purchased drugs at costs that were much lower than the price that the insurer reimbursed. Higher margins from drugs induced physicians to prescribe and hence dispense more drugs in order to increase profit. For internal medicine, family medicine, dermatology, urology and pediatrics, the revenue from drugs accounted for more than 40% of the total revenue of the physician clinic (MOHW, 2000). In tertiary hospitals and general hospitals, the proportions of drug revenue were 43.7% and 45.4% respectively of their total revenue. Pharmacists were also happy before the reform because they had the right to prescribe. Due to the perverse financial incentive of physicians and pharmacists and consumers' easier access to drugs, the proportion of pharmaceutical spending in total health care expenditure in Korea was 31% whereas that in

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to the approval by the MOHW.

OECD countries was below 20% on average (NHIC, 1997; OECD, 1995).

### III. Throughputs of Health Care Reform

#### 1. Implementation Failure

Since the pharmaceutical reform eliminates the physicians' profit from drugs, it encountered severe physician strikes, which paralyzed the health care system. Most physicians in hospitals as well as office-based physicians participated in the strikes. In February 2000, about 40,000 physicians had a demonstration against the separation. Physicians went on strikes during April 4-6, June 20-26 and August 11-17. The second strike was the biggest, in which more than 90% of office-based physicians participated. Some unique features of the Korean health care system make physician strikes more influential. Health care delivery in Korea is predominantly private – less than 10% of hospitals are public, which makes the Korean health care system quite vulnerable to physician strikes. Since almost all private hospitals are owned and managed by physicians, the Korean Medical Association and the Korean Hospital Association are close allies against the health care reform, resulting in an even greater influence of the medical profession.

Physician strikes proved to be very effective in pushing the government to change the original version of the reform package in its implementation. Physicians blocked the generic prescription and protected their right to prescribe brand-name drugs. They also increased the proportion of prescription drugs relative to non-prescription ones, which, along with the brand-name prescription, will definitely put a pressure on the pharmaceutical expenditure. They overturned the government plan of including injectable drugs in the reform package. Physicians are now likely to substitute injectable drugs for oral medicines, exacerbating the chronic problem of the overuse of injectable drugs (Kwon, 2002c). Most notably, physician strikes drove the government to raise the fees for physicians by 44% in one year. In the short run, consumers have suffered from both the inconvenience and the financial burden - two-stop shopping and separate fees for prescribing (physicians) and for dispensing (pharmacists) after the reform, both of which have been amplified by the physician strikes and the fee increase.

Physician strikes against the pharmaceutical reform had a spillover effect on the payment system reform. Through a three-year pilot program for voluntarily participating providers, the DRG-based payment system proved to be effective in reducing the length of stay, medical expense, the average number of tests and the use of antibiotics without a negative effect on quality measured by complication and re-operation (Kwon, 2002b). Physicians succeeded in overturning the government plan to extend the DRG-based prospective payment system to entire health care institutions for given disease categories in January 2001. When government implemented the RBRV system in 2001, physicians had stronger voice after the series of strikes of 2000. Facing the pressures by physicians, government increased the fees for relatively under-priced services but did not cut the fees for over-priced ones, which is far from the goal that the RBRV system aims to achieve. As a result, in addition to the inherent tendency toward over-provision under the fee-for-service payment, the RBRV system in Korea will also fail to neutralize physician incentives among different medical services.

All health insurance societies were merged into a single payer in July 2000, but there are still two separate funds for the self-employed and industrial workers. Therefore, at this stage, the merger can at best achieve the horizontal equity among the self-employed and among employees, not across the entire population. The critical barrier to the merger of funds is the difficulty of income assessment of the self-employed. Reform in tax administration, which serves the basis for accurate income assessment of the self-employed, will be a critical step toward the fair economic burden of the national health insurance system. Then a real single payer system encompassing both the self-employed and industrial workers with a nationwide contribution schedule will emerge.

## 2. Impacts on Physician Behavior

According to the recent report by the MOHW, there seems little change in the physician behavior, which has a critical impact on the outcomes of the pharmaceutical reform. The percentage of insurance claims (made by physician clinics) with prescriptions was 94.8% before the reform and slightly down to

94.0% after the reform (Lee, Jang et al., 2001).<sup>3</sup> Almost all episodes of illness leading to a visit to physician clinics in Korea result in prescriptions. The high prescription rate even after the pharmaceutical reform is also due to the separate physician fee for prescription, which gives incentives for physicians to prescribe rather than provide consultation only. The average number of medicines per prescription was 5.2 before the reform but it is still 5.1 after the reform, which is much higher than 1-2 recommended by the WHO. There is also little change in the percentage of prescriptions that contain antibiotics, which was 55.7% before the reform and 56.0% after the reform. Physicians still prescribe antibiotics in more than half of all prescription cases. Although there was a huge drop in the use of antibiotics for upper respiratory diseases, a closer look gives worse news. The use of stronger and new generation of antibiotics such as cephalosporin increased by 30% while the use of old generation of antibiotics like tetracyclines dropped as much as 80%.

Although it is currently too early to evaluate the long-term effect of the pharmaceutical reform, pharmaceutical reform at its current form is not likely to significantly change physician behavior and affect the trend in the increase in pharmaceutical spending. First, the current package of the pharmaceutical reform –particularly the principle of brand-name prescription and the large proportion of prescription drugs compared with nonprescription ones- grants too much power on physicians and clearly puts a limit on the role of generic drugs that are effective in containing overall drug prices (Davis, 1997). Second, long-term distortion in the physician behavior under the no separation of drug prescribing and dispensing may already have led to the change in the norms of physician prescription. Finally, although the separation of drug prescribing and dispensing reduces the physician incentive to over-prescribe, it does not encourage them to prescribe cost-effective drugs. After the pharmaceutical reform, physicians in Korea prescribe more expensive drugs and the market shares of brand name drugs and those produced by global pharmaceutical

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<sup>3</sup> Numbers in this paragraph are all from that report, which, based on claim data from a sample of 20% of all physician clinics in Korea, compared the prescription pattern of physicians before (January 2000) and after the reform (December 2000). Although the time span is too short and this type of before-and-after comparisons cannot control for the impact of a potential change in patient or disease factors, it still gives us some crude measures of the reform effect.

manufacturers have been rapidly increasing (Lee, Jang, et al, 2001).

### 3. Survival of the Reform

Health care financing reform and pharmaceutical reform were finally implemented in spite of vested interest groups. With an exception of the payment system reform, interest groups failed to entirely block the reform although they distorted the contents of the reform package in its implementation. Survival of the health care reform is meaningful because it still leaves open the possibilities of incremental improvement of the contents of the reform in the future. For example, in July 2001 the fee for physician prescription was merged into the regular fee for physician consultation. An incentive was recently introduced for pharmacists who substitute generics for brand-name drugs when bioequivalence-tested generics are available.

## IV. Changing Health policy Process in Korea

### 1. Nature of the Change in Health Policy Process

For a long time, the administration or the executive branches of the government dominated policy and policy reform in Korea. The important role of Korean bureaucrats in public policy is related to the legacy of rapid economic development led by the authoritarian and military regime where technocrats played a key role particularly in economic policy making. Dominating role of bureaucrats and the top-down process of policy making also characterized health policy in Korea.<sup>4</sup> The typical example of the bureaucrat-driven top-down policy process is the introduction of the national health insurance and fee scheduling for providers in the 1970s and 1980s, which were made possible by the military and authoritarian government (Kwon, 2002a). Policy implementation was never a problem. Lack of interest in health care issues by former presidents and very high turnover of ministers in Korea helped career civil servants of the MOHW play major roles in agenda setting, policy formulation and implementation. During the presidency of Chun Doo-phan (1980-1988) the average term of the Minister of Health and Welfare was 2 years. The average terms were only one

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<sup>4</sup> In general bureaucrats have power in health policy making thanks to expertise, information and experience (Walt, 1994).

year and half year during the presidency of Ro Tae-woo (1988-93) and Kim Young-sam (1993-98), respectively ([www.mohw.go.kr](http://www.mohw.go.kr)).

Recent health care reform in Korea introduced a fundamental change in health policy process in that bureaucrats of the Ministry of Health and Welfare (MOHW) played only a minor role in the policy process. The president and civic groups led the initiation and adoption of the health care reform. At the same time, democratization and the end of authoritarian regime has changed the health policy process toward more pluralism, which helped interest groups play a critical role in the policy implementation. Therefore the management of interest group competition and creating strong constituencies, which can mobilize supporters who will have an interest in the continuation of the reform becomes critical (Glassman, Reich, Laserson and Rojas, 1999). The decreasing role of bureaucrats in Korea is in contrast to the increasing role of them in the U.S., which is more or less an unintended result of fragmented, technical and piecemeal health care programs (often supported by scientific research) such as practice guidelines and rate-setting systems (Morone, 1994).<sup>5</sup>

The success of a reform in Korea depends not only on policy adoption and formulation but also on implementation because interest groups now can exert their influence in policy implementation much more actively than before. (For example, strikes by professions in the former authoritarian political regime were hardly imaginable.) Although the president and civic groups succeeded in adopting the reform without incorporating vested interests, they have not fully appreciated the change in the health policy process, the art of policy implementation and the importance of the political management of interest groups.<sup>6</sup> They mistakenly assumed that health care providers would not exercise a veto power once the policy was adopted and would eventually comply with the policy as in the previous cases of the introduction of the national health

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<sup>5</sup> The increasing role of bureaucrats and the resultant administrative approach to containing health care costs in the U.S. is to some extent related to the public ambivalence toward government (Jacobs, 1994), which is not the case in Korea.

<sup>6</sup> This is the common problem as noted by Walt (1998: 374), "Many citizens (whether in formal government positions or outside government) of formerly centrist and authoritarian regimes lack experience in the mechanism of dialogue, negotiation and pressure that characterize democracies".

insurance and fee regulation. However, because the impact of the pharmaceutical reform and payment system reform is much bigger than that of the fee regulation (which will be mentioned later), physicians desperately needed to block the reform at the implementation stage, and the end of the authoritarian regime enabled them to do it with much smaller cost.

## 2. President and Civic Groups in Policy Formation

Political ideology of the new president has been the most important factor in initiating the health care reform in Korea. Political motivation of leaders or their need for popular legitimacy often plays an important role in health and social programs (Immergut, 1992). In Korea, there were no discernable changes in public attitude or in major indicators of health care such as cost and aging. For example, the total health care expenditure as a percentage of GDP has been stable and below 6 percent (Chung, 2001). Health care reform in Korea was not motivated to reduce the budget outlays in health care, which is in contrast to developed countries, where fiscal imperatives have been a major driving force of health care reform as a part of welfare state restructuring (Freeman and Moram, 2000; Giaimo, 2001; Pierson, 2001). To the contrary, health care reform measures in Korea were expected to increase health expenditure at least in the short run. By unbundling the fee for pharmaceuticals into prescription fee for the physician and dispensing fee for the pharmacist, the pharmaceutical reform should increase drug expenditure in the short run. In the single payer system after the merger of health insurance societies, government will have to directly take policy measures (e.g., subsidy) in case of the fiscal distress of the NHI. The DRG-based payment system initially increased the fee level substantially high to encourage the provider participation.

Regime transitions can provide an opportunity for reform because it is easier to dismantle existing policies and introduce new policies with increased legitimacy and expectation (Reich, 1995). Change of government in early 1998 for the first time in 40 years of modern political history and the overall reform drive after the economic crisis added more legitimacy to the health care reform by the new president. President Kim Dae Joong, who used to be a famous leader in democratic movement, has relatively progressive political ideology. Compared with former presidents, he is more interested in social and welfare policy. He

included health care reform issues in the presidential election campaign for the first time in history. The new president's ideology contributed to the regulatory rather than market-based and comprehensive rather than incremental characteristics of the health care reform.

President has been critical in public policymaking in Korea (Hahm, 2000). Nature and history of political institutions make the strong presidency possible. Dominance of executive power over legislature is prevalent because political power is concentrated in the president, which was particularly the case in the former military and authoritarian regimes. Political negotiation on policy making is usually in the executive arena rather than the legislative body. The president almost always has the parliamentary support because the presidential party is usually the stable majority. Members of the legislature have a strong party loyalty and cross voting is not allowed. The political party can enforce strong party discipline on their members because the candidates who run for (re)elections are initially screened and selected by the political party.<sup>7</sup>

Because the policy windows opened in the 'politics' stream rather than in the 'problem' stream, the nature of health care reform in Korea is to some extent 'doctrinal' – finding a problem for an already existing solution (Kingdon, 1995; Zahariadis, 1999). Separation of drug prescribing and dispensing has long been regarded as needed to mitigate the problem of the overuse and misuse of drugs although it was not adopted because of the vested interests of major stakeholders, that is, physicians and pharmacists.<sup>8</sup> In justifying the pharmaceutical reform, the new president added the problems of unfair trade practices of pharmaceuticals and maintained that physician income from drugs were unethical. However, without the financial incentive for physicians to prescribe the optimal type and amount of drugs, separation of drug prescribing and dispensing cannot reduce the drug overuse and pharmaceutical expenditure. The merger of health insurance societies has been supported for a long time but by a minority of constituency -the rural population and the labor union of regional health insurance societies. The health care financing reform was adopted because the

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<sup>7</sup> Even the incumbent member of the parliament should survive the initial screening by their own party before they run for reelections in their districts.

<sup>8</sup> The first legislation on the mandatory separation of drug prescribing and dispensing was made in 1963.

idea of a nation-wide uniform insurance scheme appealed to the new president rather than the underlying problems got worse. However, without the improvement in the income assessment of the self-employed, the merger into a single payer cannot improve equity related to the social insurance contribution. The merger of insurance societies and the separation of drug prescribing and dispensing may not be the sufficient condition or the optimal policy tool to solve existing health care problems in Korea.

In spite of the pivotal role that the new president played in initiating the reform, the new government lacks the experience and strategy that are needed in the policy implementation because it never held office before. It overestimates the political feasibility of the reform, fails to appreciate the change in policy process and the importance of implementation, and is not skillful in the political management of interest groups. Consequently, the reform was more ideology-driven with little appreciation of providing incentives to major actors. Furthermore, the single-term presidency (5 year) contributed to the reform overload, trying too many reforms before the president's term is over.

Although the general public did not pay enough attention to health care issues, civic groups played a pivotal role in the formulation of the health care reform. They pushed the presidents of the Korean Medical Association and the Korean Pharmaceutical Association to the table and to sign on the agreement. They also played a critical role in a coalition with support groups in health care financing reform. Many of the leading members of civic groups are progressive academics or active members of the democratic movement in the former military regime, and president Kim Dae Joong has been supportive of civic groups.<sup>9</sup> Despite the critical role in the policy formulation, civic groups played a limited role in policy implementation. The history of civic groups is rather short, and hence they have little experience especially in the implementation stage. Rather than grass-root organizations, civic groups in Korea are led by progressive policy elites. Consequently, civic groups could not mobilize the broad support of the general public, which has clearly limited their role in the policy implementation.

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<sup>9</sup> They played the role of policy entrepreneurs who “play a major part in joining the previously separate streams by hooking their solutions to problems or by ensuring that proposals from the policy stream are considered when the political conditions are right” (Kingdon, 2002: 101).

### 3. Vested Interest Groups in Policy Implementation

Vested interests were crucial in the implementation of health care reform in Korea. Health care reform faces the typical problem of the collective action dilemma (Olson, 1965). Although health care reform can benefit the majority of consumers, the benefits are so diffused to them that they can hardly mobilize support for the reform. In contrast, the costs of the reform are concentrated on providers, who can make the reform fail using their superior resources. Therefore the distribution of political benefits and costs of the reform has a critical impact on the success or failure of the reform. Vested interest groups are very influential when public preferences and understanding about the reform are relatively undeveloped (Jacobs, 1992), which is one of the major characteristics of health care reform in Korea. Consumers or the general public have not been concerned about health care issues for a long time. The general public had difficulty understanding the details of health care financing system, payment mechanisms for providers and the separation of drug prescribing and dispensing. More critically, democratization opened a wide political space for interest groups to participate in the health policy process. The influence of interest groups in the policy formation was blocked by the active roles of the president and civic groups, but they had a huge influence in the policy implementation.

Unwillingness of the MOHW also contributed to the problems in implementation. Bureaucrats in the MOHW were rather passive in the reform not only because of their perception of the feasibility of reforms but also of their financial interests in the status quo. MOHW bureaucrats preferred multiple small insurance societies to a single payer because they could exert more influence over insurance societies such as CEO appointment and revolving doors under the former system rather than the larger insurer. MOHW bureaucrats also had a close relationship with domestic pharmaceutical manufacturers and distributors and revolving doors are prevalent in this area, too. Except for the conflict over fee control, MOHW had a favorable relationship with health care providers. In contrast to physicians' claim that the introduction of the NHI made them unhappy due to the tight fee scheduling, the NHI expanded the market for health care substantially (Yang, 1998). Increased demand for health care and the subsidy by the MOHW for capacity expansion of health institutions contributed

to the steady increase in the number of physician clinics and hospitals.

Compared with the pharmaceutical and payment system reform, financing reform was implemented more easily. The health care financing reform had strong supporters of labor unions and rural residents but faced the weak opponent of employers. Physicians were largely indifferent to the health care financing reform. The merger of insurance funds was expected to have little effect on physicians because the function of insurance societies in terms of its relationship to physicians (e.g., payment system) was centralized and regulated by the government even before the reform. Business, which pays the half of the contribution for their employees, was a potentially powerful opponent because it was concerned that the difficulty of income assessment of the self-employed could result in employers' and industrial workers' bigger burden of contribution. But business could not afford to pay much attention to the health care financing reform because it faced the tough challenge of structural adjustment following the economic crisis (Kwon, 2001).

Labor unions of the workers in the health insurance societies for the self-employed played an important role in the health care financing reform. In the former system of independent health insurance societies, people working in the self-employed (regional) health insurance societies had very limited career path because those localized societies were very small in size and there was no job rotation among them. They were also fully aware of the structural problems that resulted in chronic financial distress of regional health insurance societies. The labor union representing the workers in the self-employed health insurance societies allied with rural residents and became the strong constituents of the health care financing reform.

Pharmaceutical industry played little role in the pharmaceutical reform. Before the reform, physicians preferred drugs that provided them with higher margins, and high quality drugs did not necessarily have larger market share. Consequently the domestic pharmaceutical industry had a unique and inefficient structure in which there were more than 450 manufacturers and the two thirds of them were small companies with less than 100 employees (KAPM, 1998). Most of them had little capacity for research and development and survived by producing copy drugs and offering deep discounts or under-the-table bargains to

physicians. Because the pharmaceutical reform would lead physicians to prescribe high-quality drugs, many small firms would have to exit the market and the market share of domestic pharmaceutical companies was expected to decline. On the other hand, the pharmaceutical reform would to some extent reduce their burden of promotion expenses to physicians. Although the pharmaceutical reform was more a threat than an opportunity to the domestic pharmaceutical manufacturers, they were fragmented and not strong enough to be against the government. To the contrary, multinational pharmaceutical companies supported the idea of the pharmaceutical reform. They however pretended to be neutral in the policy process because they did not want to antagonize physicians who were desperately against the reform.

Physician group is one of the most powerful interest groups in Korea and has characteristics to be influential in the political market, namely information, resources, large and dispersed membership, and particularly strong cohesion with shared core interests (Peterson, 2001). Physicians became the major stumbling block to the implementation of pharmaceutical and payment system reform. Besides the huge impact on income, the effect on physicians of the pharmaceutical and payment system reform is much stronger than the medical fee regulation that used to be regarded as a strong constraint on physicians. For the NHI accounts for only about 50% of total health care expenditure due to its limited benefit coverage and huge cost sharing, the fee regulation under the NHI affects only the half of physician practice –insured sector. At the same time, fee schedule regulates only the price of medical care, leaving the quantity at the providers' discretion, and has a limited effect on physician income. In contrast, the pharmaceutical reform affects the entire practice of the physician, both insured and uninsured sector. Payment system reform toward the DRG-based system is different from the fee regulation because it constraints not only the price but also the quantity of medical care. It introduces a paradigm change in the provision of medical care toward the concept of product line management with a due balance between cost and quality, a potentially bigger challenge to physicians' clinical autonomy. Therefore physician resistance to pharmaceutical and payment system reform must be stronger than to the fee regulation. The strong influence of physicians in the Korean health care reform is in big contrast to many industrialized countries where state autonomy has increased in health care and has tended to triumph over effectively mobilized health care providers

in health care reform (Wilsford, 1995). For example, the medical profession was ignored in the NHS reform (Klein, 1995).

#### 4. Lack of Strategy in Health Policy Process

##### 1) Scope of the Health Care Reform

The path of institutional change is usually incremental, and radical and comprehensive change is more difficult due to the path-dependence (North, 1990; Wilsford, 1994). However, health care financing reform and pharmaceutical reform in Korea represent radical departures from the past, initiated by the big change in the political arena. Political feasibility of a comprehensive reform is relatively low because it offends many established interests and adds costs and complexity, which usually increases uncertainty and makes measuring the effect of the reform more difficult (Weissert and Weissert, 2002). An alternative to the radical change in health care financing would be to merger insurance societies to bigger ones incrementally rather than to merger into a single insurer. In the pharmaceutical reform, an incremental and less comprehensive approach would be to mandate the separation to antibiotics, which had the most serious problem of overuse, and then later to extend to all medicines.

An incremental reform is particularly important for the separation of drug prescribing and dispensing because the reform introduces a sudden and nontrivial inconvenience in the way that consumers get an access to drugs.<sup>10</sup> There are cultural and historical aspects associated with the pattern of drug consumption in Korea. Consumers are accustomed to the non-separation of drug prescribing and dispensing and the resultant easy access to drugs for a long time. There is no separation of drug prescribing and dispensing in traditional medicine that is very popular in Korea. Traditional medicine also relies to a great extent on drugs, and many people take traditional medicines for prevention and health promotion. Therefore the pharmaceutical reform, in order to accomplish its goals, needs to change not only the rules and regulation but also the public attitude toward drugs in the long run, which cannot be achieved by a radical reform

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<sup>10</sup> In contrast, health care financing reform itself does not enforce any behavioral change to consumers.

alone.

The absence of the separation of drug prescribing and dispensing has been a big problem in many East Asian countries. Pharmaceuticals were an important source of net income for health care providers, and the overuse of drugs were prevalent in Japan, China and Taiwan (Chou, Yip, et al., 2001; Rodwin and Okamoto, 2000). Japan has a voluntary scheme in which the physician can choose whether he/she dispenses drugs or refer patients to the pharmacy. However physicians still dispense approximately 80% of medications under the voluntary system (Rodwin and Okamoto, 2000). In Taiwan, physicians can employ on-site pharmacists for dispensing and they still have a financial interest in prescription. As a result, there are differences in prescription and pharmaceutical expenditure among health care providers who employ on-site pharmacists and those who do not (Chou, Yip, et al., 2001). In Korea, the separation of drug prescribing and dispensing is based on a mandatory scheme and providers are not allowed to hire on-site pharmacists. Japan and Taiwan incorporated the interest of physicians in the design of the pharmaceutical reform, which contribute to a smoother implementation than in Korea. It will be worthwhile to examine to comparative performance of the pharmaceutical reform in those three countries.

## 2) Sequencing of the Health Care Reform

Health care reform in Korea clearly faced the problem of reform overload. Attempts to implement three major reforms at the same time caused large-scale oppositions by interest groups and faced the problem of the insufficient capacity of the MOHW to implement the reforms. It also suffered from a coordination failure. The sudden and huge increase in physician fees was in conflict with the schematic fee adjustment based on RBRV system. After the merger of insurance societies, the fiscal impact of the pharmaceutical and payment system reform is more difficult to be absorbed because the increase in contribution now should be approved by the fiscal committee of the new single payer, which is represented by payers including labor unions and employers. A carefully designed strategy of prioritizing and sequencing health care reforms would have been more effective.

In terms of sequencing, payment system reform should have been given the highest priority. The reform of the payment system for providers has a strong and immediate effect on the provider behavior and health care expenditure. The DRG-based payment system accumulated relatively sufficient evidence through three years of pilot study and many health care institutions voluntarily participated in the project.<sup>11</sup> The merger of health insurance societies however has little effect on providers who indeed have a crucial effect on health care expenditure. The separation of drug prescribing and dispensing can eliminate the physician incentive to over-prescribe but it does not provide incentives for them to minimize pharmaceutical spending. In addition, the separation is applied only to the outpatient sector and the pharmaceuticals in the inpatient sector are still out of control. In contrast, the DRG-based payment significantly reduces the use of antibiotics in the inpatient care as mentioned earlier. Furthermore the pharmaceutical reform only affects the use of medicines, and when physicians substitute other inputs (like tests) for drugs total health care expenditure rises. Although the DRG-based payment is not free from perverse substitutions of unregulated areas to regulated ones (Coulam and Gaumer, 1991), payment system reform toward a larger unit of payment can be a better alternative to the pharmaceutical reform in improving the efficiency of health care delivery.

## 5. Future Prospects for Health Policy Process

There existed constituents (rural population and labor union) for the financing reform although they were a minority out of entire population. But there were almost no constituents among consumers in case of the pharmaceutical and payment system reform. Government should have provided consumers with the vision of the reform and persuaded them of its long -term benefits. Making consumers strong constituents of the reform was particularly important for the pharmaceutical reform. First, for it faced strong oppositions by physicians and

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<sup>11</sup> In the third year of the pilot program (February 1999 - January 2000), 798 health care institutions participated in the pilot program voluntarily. The third-year pilot program covers nine disease categories (lens procedure, tonsillectomy/adenoidectomy, appendectomy, cesarean section, vaginal delivery, anal/stomal procedure, inguinal/femoral hernia procedure, uterine/adenexa procedure, and normal pneumonia/pleuritis) with 25 DRG codes depending on the severity and age of the patient. It accounted for 25% of inpatient cases.

pharmacists, building a coalition with consumers for the reform was crucial. Second, since the pharmaceutical reform imposes tangible financial burden and inconvenience on consumers, they can become opponents of the reform. In the health care financing reform however, costs to the general public such as the potential cross-subsidy in contribution payment are still hidden, and the reform does not cause any inconvenience to consumers.

Labor unions in general have not paid attention to social policy issues for a long time. They were concerned about wages and working conditions rather than job security because rapid economic growth never made unemployment a serious issue in Korea. Following the economic crisis however, employment adjustment suddenly became the major social issue and the tripartite commission consisting of government, labor and business was formed in 1998. Now labor unions give high priority to health policy and social safety nets and the national federation of labor unions has begun to play a crucial role. Viewing the social democrat or corporatism as an ideal model, labor unions now try to increase their voice in the societal decisions. In Korea, labor unions can be an ideal candidate that can challenge the powerful stakeholders of health care providers.

With an increasing role of interest groups in policy and policy reform, the nature of the health policy community will be crucial. A representational community of organized interests plays a critical role in health policy (Peterson, 1994). Health policy community in Korea used to be characterized by a ‘block’ of homogeneous and powerful health care providers. If employers and labor unions become active participants of health policy process, the ‘network’ of competitive stakeholders and stake-challengers will be possible and a reform coalition is able to prevail. For example, employer and employee coalition for pharmaceutical and payment system reform could have effectively counteracted the strong influence of health care providers in Korea. The change in the nature of health policy community is likely to lead to the change in the governance structure in the health care sector with respect to the role of health care providers in particular (Giaimo, 1995).

## VI. Concluding Remarks

Recent Korean health care reform in financing, pharmaceuticals and payment

system is very different from previous policy changes not only because of its nature of comprehensiveness but also because it represents a major change in the health policy process. Previously government bureaucrats played a major role in health policy making. Since health care has not been of major interest to the general public, former presidents did not pay much attention to health care policy. Implementation was never a problem because an explicit veto such as strikes would impose too much political costs on interest groups in the era of authoritarian political regime.

The change of government and the new president's keen interest in social policy opened a major window for health care reform in Korea. The president with the support of progressive civic groups played a pivotal role in the adoption of health care reform. However, the end of authoritarian regime gradually changed the policy process and strengthened the role of interest groups. Bureaucrats and top-down implementation can no longer dominate health policy process, but pluralistic interest competition becomes critical. Since for physicians recent reform meant a much more critical challenge to their financial interest than previous ones, they desperately attempted to block the reform in the implementation stage. Although health care financing and pharmaceutical reform survived, physicians distorted several critical elements of the pharmaceutical reform and pushed the government to raise physician fees substantially and defer the payment system reform. To the contrary, civic groups failed to mobilize the public because rather than being grass-root organizations they were mainly led by policy elites.

Health care reform in Korea is in contrast to that of mature welfare states because it was not driven by fiscal imperatives or by the process of welfare state restructuring. Compared with other countries, the lack of public attachment to health care policy in Korea contributed not only to a more radical reform proposal but also to the more powerful influence of the medical profession as the stumbling block to the reform. In the future, strategic implementation and interest mobilization to counteract the powerful interest group of health care providers will be an essential element of health care reform in Korea.

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