

The Changing Process and Politics of Health Policy in Korea

Soonman Kwon

Seoul National University, Korea

Michael R. Reich

Harvard University

Abstract Korea recently introduced three major health care reforms: in financing (1999), pharmaceuticals (2000), and provider payment (2001). In these three reforms, new government policies merged more than 350 health insurance societies into a single payer, separated drug prescribing by physicians from dispensing by pharmacists, and attempted to introduce a new prospective payment system. This essay compares the three reforms in Korea and draws important lessons about the country's changing process and politics of health care policy. The change of government, the president's keen interest in health policy, and democratization in the public policy process toward a more pluralist context opened a policy window for reform. Civic groups played an active role in the policy process by shaping the proposals for reform—a major change from the previous policy process that was dominated by government bureaucrats. The three reforms also showed important differences in the role of interest groups. Strong support by the rural population and labor unions contributed to the financing reform. In the pharmaceutical reform, which was a big threat to physician income, the president and civic groups succeeded in quickly setting the reform agenda; the medical profession was unable to block the adoption of the reform but their strikes influenced the content of the reform during implementation. Physician strikes also helped block the implementation of the payment reform. Future reform efforts in Korea will need

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to consider the political management of vested interest groups and the design of strategies for both scope and sequencing of policy reforms.

In recent years, the health care system of Korea has been thrown into turmoil by three major reforms: health care financing, pharmaceutical policy, and the payment system for providers. In December 1999, the Korean parliament passed a law that required all health insurance societies to merge, resulting in a single insurer of the national health insurance system. This financing reform sought to solve problems associated with the inequality among insurance societies and the chronic financial deficit of many rural insurance societies. In January 2000, a law was passed on the mandatory separation of drug prescribing and dispensing, thereby preventing physicians from dispensing and pharmacists from prescribing. The lack of separation between prescribing and dispensing has been blamed for the overuse and misuse of drugs and high pharmaceutical expenditure in Korea, but strong opposition by physicians and pharmacists in the past was a powerful barrier to change. In January 2001, the government planned to extend a prospective payment system based on a diagnosis-related group (DRG) pilot program to all health care providers for selected disease categories. This new payment system reform was intended to correct inefficiencies in health care delivery caused by Korea's fee-for-service system, but it was deferred due to opposition by physicians.

This essay examines the changing process and politics of health policy in Korea, as illustrated by these three major reforms. Health care reform in Korea had significant distributional consequences on various interest groups, particularly on the medical profession. A comparison of these three recent reforms provides important lessons about the changing policy process in Korea, in the context of major political shifts. The election of Kim Dae-jung as president in December 1997 and the change of administration in early 1998 opened a policy window for major reform, supported by the new president's keen interest in health policy. In addition, democratization in the public policy process brought fundamental changes from a policy-elites-dominated style to a more pluralistic one. The major political changes that occurred in Korea in the late 1990s have critical implications for health as well as other sectors.

The change in the public policy process brought both good news and bad news to health policy. Previously, bureaucrats and vested interests had dominated health policy. The active participation of civic groups in health policy played a pivotal role in the formulation of recent reform proposals, and made it possible to adopt reform in spite of opposition from powerful

interest groups. However, a more pluralistic policy process also allowed key interest groups to intervene at critical points in implementation (sometimes in support, sometimes in opposition), with smaller political costs than before. The recent wave of health reform in Korea involved the introduction of three comprehensive reforms at nearly the same time. These experiences indicate that the success of future health reform in Korea will depend on the effective political management of interest groups and the design of strategies for the scope and sequencing of reform.

After reviewing three major health reforms in financing, pharmaceuticals, and payment, this essay examines the interest group influence in health policy and the politics and process of health policy change in general and in Korea. It then examines the changing policy process in Korea, as shown by the three reforms. The impact of the change in health policy process is discussed, with specific attention to critical actors and levers in policy formulation and implementation. The next section analyzes the role of interest groups in the three reforms, to show their evolving roles under the changed policy process and political context. The essay concludes by examining the lessons and future prospects for health policy change in Korea.

The Three Reforms in Korea's Health Care

Financing Reform

Before the recent health care financing reform, Korea's national health insurance system covered the entire population through more than 350 independent quasi-public insurance societies.¹ There were three different types of health insurance societies: (1) 142 health insurance societies for industrial workers and their dependents, (2) a single health insurance society for government employees and teachers and their dependents, and (3) 227 health insurance societies for the self-employed, called regional health insurance (National Health Insurance Corporation [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). Health insurance societies did not compete to attract the insured, nor did they selectively contract with health care providers.

1. See Kwon 2002, 2005a for detailed descriptions of the health care system and policy in Korea.

Health care financing reform was intended to solve problems associated with the fragmented health insurance system by merging all health insurance societies into a single payer. Before the merger, health insurance societies used different methods to set the contribution. In self-employed groups, the contribution depended on income, property and the number of dependents whereas in employee groups income was the only basis for determining the contribution. Differences in the method of setting the contribution and in the rate of the contribution across insurance societies, in spite of identical statutory benefits, raised concerns about inequity in the economic burden of social health insurance. Members of insurance societies in poor or rural areas had to pay a greater proportion of their income for the contribution compared to those in wealthy areas. Revenue sharing mechanisms among insurance societies, based on the elderly population and catastrophic expenses, did not solve the fiscal insolvency of many regional insurance societies in poor or rural areas (Kwon 2003a). The decentralized social health insurance system in Korea failed to improve responsiveness to local preferences, and self-governance of insurance societies was rarely realized in Korea, because health insurance societies were subject to strict regulation by the Ministry of Health and Welfare (MOHW).²

Previously, the government had favored national health insurance based on multiple insurance societies, rather than a single-payer system. In introducing national health insurance in the late 1970s, the government sought to minimize the role of direct government funding. Under the new single-payer system, the financial status of national health insurance is likely to become a national issue, and the process of adjusting the contribution will become a political issue with reduced flexibility (whereas under the system of multiple insurance societies, individual insurance societies were responsible for their fiscal status, and they could adjust their contribution more flexibly). Government officials worried that a single-payer system would call for a more active role of government financing and increase the burden on the government budget. The new administration and the new president, with his keen interest in social solidarity, opened a window of opportunity for a major policy change in health care financing.

2. For example, the contribution rate was supposed to be set within a given range and was subject to approval by the MOHW. The ruling political party and the MOHW also exerted influence on the appointment of the CEOs of health insurance societies.

Pharmaceutical Reform

Under the previous policy of combined prescribing and dispensing, physicians and pharmacists in Korea both prescribed and dispensed medicines. The system created financial incentives for physicians and pharmacists to dispense more drugs and to select products with higher margins. Because the government strictly regulated the fees for medical services, dispensing drugs was more profitable for physicians than providing medical services. Physicians purchased drugs at prices much lower than the reimbursement fee provided by the insurer. Drugs with higher margins induced physicians and pharmacists to prescribe and dispense large volumes of those products to increase their net income. In many physician clinics, the revenue from drugs accounted for more than 40 percent of total revenue. The financial incentives for physicians and pharmacists and the easy access for consumers to drugs contributed to the high proportion of total health care expenditure for pharmaceuticals in Korea, about 31 percent compared to an average of less than 20 percent in Organisation for Economic Co-operation and Development (OECD) countries (NHIC 1997). In addition, under the system of combined prescribing and dispensing, patients had limited access to information about the medication they received, and the patients' right to know was neglected.

The problems of this system had been recognized for a long time in Korea, but change seemed impossible due to strong opposition by physicians and pharmacists. Physicians sought to retain the dispensing of drugs, because it was a major source of income, and pharmacists favored the combined system, because they wanted to keep the right to prescribe. Physicians and pharmacists had been influential in health policy formation and effectively blocked change for a long time. The recent changes in the health policy process and the emergence of civic groups engaged in policy formation in the new government provided a window of opportunity to break up the combined system of dispensing and prescribing.

Payment Reform

National health insurance in Korea reimburses providers according to a regulated fee-for-service system. In addition to incentives for increased volume and treatment intensity, the system encourages providers to substitute uninsured medical services (with fees that are not regulated) for insured services to avoid the effects of fee regulation. Differential margins from different medical services also induce physicians to provide more

services with higher margins, which distorts the mix of medical care for patient treatment. For example, Korea's cesarean delivery rate was over 40 percent in 1999 (NHIC 2000), because of the high margin generated by the reimbursement rate for a cesarean section.

In the late 1990s, the Korean government decided to adopt two approaches to reform the payment system for providers: a DRG policy for the inpatient sector and a resource-based relative value (RBRV) policy for the outpatient sector.³ Faced with opposition from providers, the government began a pilot program in 1997 to introduce DRG-based payment for selected disease categories for voluntarily participating providers. The RBRV system encountered little opposition from providers, because it was still based on a fee-for-service system. The RBRV system readjusts prices for reimbursement, by setting the price for one medical procedure relative to others (Hsiao et al. 1992). Korean physicians expected (incorrectly) that a new fee schedule based on the RBRV system would raise fees uniformly and would not redistribute income among different specialties. Physicians believed that regulated fees under the national health insurance were below their costs of providing medical care and that the new fee-setting method would benefit them across all specialties.

Korea's payment system reform differed from the health care financing and pharmaceutical reforms in three important respects. First, the previous government formulated the payment system reform, and the new government needed to decide whether the ongoing pilot programs should be extended to a nationwide policy. Second, the previous government adopted an incremental approach, starting with only five disease categories, and applied the system only to voluntarily participating providers through a pilot program. Third, the payment system reform involved some very technical issues (such as disease classification and fee setting) compared to the financing and pharmaceutical reforms. However, after a series of physician strikes against the pharmaceutical reform, Korean physicians increased their bargaining power, and they succeeded in pushing the government to defer its planned nationwide extension of the DRG payment system to all health care providers.

3. These changes in the payment system for providers did not require a law to pass the parliament.

Politics and Process of Health Policy Change: Theoretical Background

The process of health care reform is inherently political, and health care reform has critical impacts on the interests and power of major stakeholders in health care (Freeman and Moran 2000; Geva-May and Maslove 2000; Reich 1995). The medical profession in particular has had a powerful influence in the health sector through professional control of knowledge and claims to professional autonomy, and dominant concepts of health (or the medical model of health) serve the interest of the medical profession (Ham 1999). The medical profession also has several characteristics that raise its influence in the political market, namely, information, resources, a large and dispersed membership, and strong cohesion and homogeneity with shared core interests (Peterson 2001). Health care providers in Korea have been very influential in the health sector, not only as medical professionals but also as successful entrepreneurs. Health care delivery in Korea depends heavily on the private sector, and about 90 percent of hospitals are private, more than half of which are owned by physicians.

Health policy or 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 that it is very costly for them to mobilize support for a health policy change. In contrast, the costs of the reform are concentrated on interest groups or health care providers, who are well organized. In the United States, strong interest groups in the private sector including medical professionals, insurers, and employers, coupled with a weak presidency have been a barrier to major health policy changes (Morone and Belkin 1994). Nonetheless, the political power of the medical profession varies over time in the United States, depending on the supply of physicians, changing organizational forms of medical care and insurance, corporatized control over physician autonomy, and the increasing role of purchasers and employers (Wailoo, Jost, and Schlesinger 2004). In other industrialized countries, state autonomy has increased in health care and has tended to triumph over the mobilization of health care providers in health reform or cost containment policy (Klein 1995; Wilsford 1995), although there were still differences in the nature of political bargains between the state and the medical profession, as in the case of health care reforms in the United Kingdom and Germany (Giaimo 1995).

Interest groups are especially influential when public preferences and understanding about policy reforms are relatively undeveloped (Jacobs

1992). This was a major characteristic of health reform in Korea. Consumers and the general public had been more concerned about politics, democracy, and overall economic development than health policy issues, and until recently, health care issues were not included in campaigns for presidential or general elections. For the three reforms, the general public had difficulty understanding the details of the health care financing system, the separation of drug prescribing and dispensing, and the payment mechanisms for providers. Influences and responses of interest groups depend on the scope of health policy change, too. Political feasibility of nonincremental reform is relatively low because it offends many established interests (Weissert and Weissert 2002). As a result, the path of institutional change in health care is usually incremental, and radical and comprehensive change is more difficult due to the path dependence (Wilsford 1994). Health care financing reform and pharmaceutical reform in Korea, for example, the merger of all insurance societies into one and the closure of all hospital outpatient pharmacies, represent radical departures from the past, resulting in strong opposition by vested interest groups.⁴

Political leadership is also critical in health-policy making. Facing the strong influence of health care providers, 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 et al. 1999). Political leadership has an influence on the effective mobilization and management of interest groups. Furthermore, many cases in other countries show how the political motivation of leaders and their need for popular legitimacy can play an important role in health and social policy programs (Immergut 1992). The president can occupy a central position in the process of introducing nonincremental policy changes, based on the structure of political incentives and the institutional capability to mobilize authority (Tuohy 1999). Korea has a strong presidency, and the president plays a critical role in public policy making in Korea (Hahm 2000). Political negotiations on policy making therefore usually occur in the executive arena rather than the legislative body. The president almost always has parliamentary support because the presidential party is usually the stable majority. Members of the legislature have a strong party loyalty, and cross voting is rare.

4. An alternative to the radical change in health care financing would be a merger of health insurance societies into incrementally larger ones rather than to merge into a single insurer. In the pharmaceutical reform, an incremental change would apply the separation only to physician clinics and would allow the outpatient pharmacies of hospitals to continue dispensing drugs to the patients of their outpatient clinics.

Political parties can enforce strong party discipline on their members, because the candidates who run for (re)election are initially screened and selected by the party.⁵

Regime transitions provide an opportunity for reform, because they generate increased legitimacy and expectations that make it easier to dismantle existing policies and introduce new policies (Reich 1995). Korea fell victim to the Asian financial crisis, and facing the exhaustion of foreign reserves, the Korean economy was bailed out by the International Monetary Fund in 1997. Korea's change of government in early 1998—for the first time in forty years of modern political history—and the overall reform drive after the economic crisis added more legitimacy to major health care and social policy reforms proposed by the new president. One of the major characteristics of the political leadership of new president Kim Dae-jung was his progressive political ideology and keen interest in health and social policy.⁶ In addition, economic crisis and the resulting increase in unemployment raised public awareness of the importance of social safety nets. The new government extended unemployment insurance to all firms with fewer than 30 employees in 1998, and the National Pension Program was extended to the urban self-employed in 1999. The rapid extension of social policy programs has invited debates regarding whether the welfare state regime of Korea has changed (Kwon and Holliday 2005).

For many years, policy formulation in Korea was usually followed by smooth implementation. The executive branch of government dominated the health policy process, with a relatively minor role for the parliament. Implicit incorporation of vested interests in policy formulation also contributed to a smooth implementation process. When bureaucrats and the medical profession, as key members of the policy community, monopolized the policy process, radical change in health policy rarely occurred. Public debate, controversy, and opposition were also not part of the health policy process, and the role of consumer organizations was minimal. The new government introduced a sea change in Korea's public policy process.

5. Even incumbent members of parliament must survive an initial screening by their own party before they can run for reelection in their districts.

6. The preceding president, Kim Young-sam, was also a former leader of democratic movements but later became a member of a conservative party that had its roots in the former military political regime, and became the first civilian president in thirty-five years. Political democratization was achieved when Kim Young-sam became the president in 1993 (or even earlier, with Roh Tae-woo, who was a former military general elected to be president in 1988). But a change in political regime from conservative to progressive government was achieved when Kim Dae-jung became president in 1998, and he actively introduced democratization of the public policy process.

New groups, in addition to bureaucrats and vested interest groups, could now participate in the policy process, and most important, President Kim Dae-jung actively involved civic groups in the design of health reform, which created opportunities for a significant policy change. The civic groups quickly and actively pursued chances for health reform, making it possible for policy changes that threatened vested interests of the medical profession. In the suddenly expanded policy community, interest groups and bureaucrats failed to dominate the stage of policy formulation.

Policy Formation in Health Care Reform

In this section, we consider three of the key actors in policy design (the president, civic groups, and bureaucrats), before examining the role of interest groups in implementation.

The President

President Kim's keen interest in health policy opened the window of opportunity for major reform in Korea. None of the three reform issues was new. All had been debated for a long time in Korea, but dominant stakeholders maintained the status quo. No discernible changes occurred in public attitude or in major indicators of health care (such as cost, aging, or health status). For example, total health care expenditure as a percentage of gross domestic product remained stable and below 6 percent. Health reform in Korea was not motivated by a desire to reduce budget outlays in health care—in contrast to other countries, where fiscal imperatives have been a major driving force of health reform as part of restructuring the welfare state (Freeman and Moran 2000; Giaimo 2001; Pierson 2001). To the contrary, all three major health reforms in Korea were expected to *increase* expenditure, at least in the short run. Under the new single-payer system, after the merger of all health insurance societies, the government would have to assume responsibility for any problems of fiscal distress in national health insurance. Pharmaceutical reform was expected to increase drug expenditure in the short run by creating two fees, as the combined fee for pharmaceuticals was unbundled into a prescription fee for physicians and a dispensing fee for pharmacists. Finally, the DRG-based payment system initially set fees at a high level to encourage provider participation.

President Kim Dae-jung, who was well known in the national movement for democracy, had a relatively progressive political ideology. Compared with former presidents, he was more interested in health and social

policy and included health care reform issues in the presidential election campaign. His values promoted a regulatory rather than a market-based (incentives) approach and a comprehensive rather than an incremental reform. The single term of the presidency (five years) contributed to the reform overload, as the president sought to accomplish many comprehensive reforms while in office. The president gave higher priority to the financing and pharmaceutical reforms, compared to changes in the payment system, because of their greater visibility for the public and the resulting political implications.

In important ways, health reform in Korea was *doctrinal*: seeking to identify a problem that fit an existing solution (Kingdon 1995; Zahariadis 1999). The merger of health insurance societies had been proposed for a long time, but by minority constituencies—the rural population and the labor union of regional health insurance societies. The health financing reform was adopted because the idea of a nationwide uniform insurance scheme appealed to the new president, not because the underlying problems became worse. The separation of drug prescribing and dispensing had long been debated in Korea, but it was not adopted due to the vested interests and strong opposition of physicians and pharmacists. What changed for all three reforms were the political circumstances rather than the nature of the problems—changes in what John Kingdon (1995) calls the “politics” stream rather than the “problem” stream. The existence of well-defined policy solutions contributed to the rapid process of policy formulation by the president and his allies.

Civic Groups

With the change in the public policy process in the new government, civic groups gained a new role in the health policy process, as shown in the three reforms. Korea’s civic groups did not emerge as grassroots organizations, but were led by progressive academics or active members of the former movement for democracy. Leadership of civic groups by famous progressive academics and their professional expertise contributed to the legitimacy that civic groups rapidly obtained in the policy process. President Kim Dae-jung actively incorporated civic groups into the policy process. In Korea’s health reforms, civic groups served as policy entrepreneurs that, according to Kingdon (2002: 101), “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.”

Civic groups played different roles in the three reforms. In health financing, civic groups created a coalition with other supportive groups. They mobilized the rural population, the poor and labor unions of insurance societies, and progressive academics provided the civic groups with a theoretical rationale for the financing reform. In pharmaceutical reform, civic groups served a more pathbreaking role. Progressive academics helped formulate the content of the pharmaceutical reform, such as the classification of drugs into prescription and nonprescription drugs, brand name versus generic prescription, injectable drugs, and hospital outpatient pharmacies.⁷ Civic groups prepared a reform proposal and finalized it after several public hearings. They pushed the presidents of the Korean Medical Association and the Korean Pharmaceutical Association to the table and pressured them to sign the agreement. Civic groups did not pay much attention to payment system reform because they thought that financing and pharmaceutical reforms were more fundamental changes needed in the Korean health care system.

Bureaucrats

Until the recent reforms, health policy in Korea was characterized by the dominant role of bureaucrats and a top-down policy process. Typical examples are the introduction of national health insurance and the fee schedule for providers in the 1970s and 1980s. The central role of bureaucrats in public policy making is related to the legacy of rapid economic development, under the authoritarian regime, where technocrats dominated, particularly in economic policy making. The lack of interest in health care issues by former presidents and the rapid turnover of health ministers in Korea also helped career civil servants in the MOHW play major roles in policy formation and implementation.⁸

In the three recent reforms, however, bureaucrats failed to play a leading role, especially compared to the president and civic groups. Bureaucrats in the MOHW were passive in these reforms because of their skepticism about the feasibility of reforms and their interests in maintaining the status quo. Ministry bureaucrats preferred multiple small insurance societies to a single-payer system, because they could exert greater influence over the multiple insurance societies through chief executive officer

7. See Kwon 2003b for the details of the reform content.

8. During the presidency of Chun Doo-whan (1980–1988) the average term of the minister of health and welfare was two years. The average terms were only one and one-half years during the presidency of Ro Tae-woo (1988–1993) and Kim Young-sam (1993–1998) (MOHW n.d.).

appointments and revolving doors. Ministry bureaucrats also had a close relationship with pharmaceutical manufacturers and distributors, and revolving doors operated in this area, too. Bureaucrats did not enforce the maximum allowable margin in medicine sales between physicians and the pharmaceutical industry. The MOHW also had a favorable relationship with medical care providers, except for conflict over reimbursement fees.⁹ Korea experienced a steady increase in the number of physician clinics and hospitals due to the increased demand for health care and subsidies from the MOHW for capacity expansion. In sum, the president and civic groups led the policy process and succeeded in a rapid adoption of the reforms, while the formerly influential actors—elite government bureaucrats and vested interest groups—lost their dominant role over the process.

Reform Implementation and Interest Groups

The changes in the health policy process allowed civic groups to block the dominance of interest groups in policy design and also helped interest groups influence policy implementation by exercising veto power with a smaller political cost than before. In addition, after a reform law was passed by parliament, important decisions existed on implementation, which became the target of physician influence. The change in health policy process offered new opportunities for both opponents and supporters of the different reform efforts, contributing to the success of the health financing reform and the serious problems of the pharmaceutical and payment reforms.

Health Care Financing Reform

Korea's health financing reform was implemented more easily than the pharmaceutical and payment reforms, due to several factors. First, the financing reform had strong support from a labor union and rural residents. The labor union of workers in health insurance societies for the self-employed (the regional health insurance scheme) played an important role in promoting the health care financing reform. Under the former system of independent health insurance societies, people working in the

9. In contrast to physicians' claims that the introduction of national health insurance made them unhappy due to the tight fee scheduling, national health insurance expanded the market for health care substantially (Yang 1998).

self-employed health insurance societies had very limited career paths, because the localized insurance societies were small, with limited chances for job mobility. These workers were also aware of the structural problems that caused chronic financial distress in many regional health insurance societies. The labor union representing these workers allied with rural residents and the poor and became strong supporters for the single-payer system under the health financing reform.

A second factor was the weak opposition to the financing reform. Business, which pays half of the contribution for employees, was a potentially powerful opponent because it was concerned that a unified health insurance system would result in a bigger burden for employers and industrial workers in paying the contribution, due to the difficulty of assessing the income of the self-employed. But business gave little attention to financing reform, because at the same time it faced tough challenges from structural adjustment following the economic crisis (Kwon 2001). Physicians were largely indifferent to the financing reform, because they did not perceive the proposed changes as a direct threat to their interests. The merger of insurance funds was expected to have little effect on physicians, because the insurance societies were already highly centralized and regulated by the government, in terms of their relationship to physicians (e.g., the payment system and the review of insurance claims made by providers).

Third, employees at the health insurance societies for industrial workers (the firm-based employee health insurance scheme) opposed the reform, but with little effect. They organized a labor union only at a later stage of policy formulation and did not have much influence on the reform process. They organized strikes against the reform in the implementation stage. Those strikes, however, had little impact, because their job positions were easily replaced by workers from the labor union (regional health insurance) that supported the reform.

The main obstacles to implementation of the health financing reform arose from technical problems rather than interest groups. All health insurance societies were merged into a single payer, but two separate funds remained for the self-employed and employees because of the difficulty of assessing the income of the self-employed. Therefore, at this stage, the merger could at best achieve horizontal equity among the self-employed and among employees, not across the entire population. The financing reform will not be able to achieve its objectives of equity and solidarity through the national health insurance system without a reform in tax administration, which serves as the basis for accurate income assessment of the self-employed.

Pharmaceutical and Payment Reforms

After the pharmaceutical reform was passed, physicians organized a series of strikes and became the major stumbling block to the pharmaceutical and payment reforms. Although Korean physicians failed to block the adoption of the pharmaceutical reform, their strikes had a critical impact on the implementation of the pharmaceutical reform and on the adoption of the payment reform. However, those who led the policy reform—the president and civic groups—underestimated the potential veto power of physicians in the implementation stage. They did not fully appreciate the art of policy implementation and the importance of the political management of interest groups. They also 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 national health insurance and physician fee regulation.

However, the pharmaceutical and payment reforms were expected to have major impacts on physicians, even more than changes in the reimbursement fee schedule for medical services. Korea's national health insurance accounts for only about 55 percent of total health care expenditure, due to its limited benefit coverage and high cost sharing. Fee regulation under the national health insurance, therefore, affects only about half of a physician's practice: the insured sector. In addition, the 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 promised to affect the entire practice of a physician, both the insured and the uninsured sectors. And the proposed payment reform, moving toward a DRG-based system, would constrain not only the price but also the quantity of medical care. It introduced a paradigm change in the provision of medical care toward the concept of product line management with a balance between cost and quality, creating a potentially major challenge to physicians' clinical autonomy. These factors enhanced physician resistance to the pharmaceutical and payment reforms, compared to prior policy debates over changes in reimbursement fee regulation.

The strikes organized by physicians (both office-based and private-hospital-based) in 2000 panicked the entire health care system, in part because public hospitals account for only about 10 percent of the hospital system. After a series of nationwide strikes, physicians gained a much stronger voice in policy decisions—and the government had to deny civic groups a seat at the negotiation table. Physicians pushed the government

to change the original version of the pharmaceutical reform package. Physicians blocked the use of generic prescriptions, protected their right to prescribe brand-name drugs, increased the proportion of prescription drugs relative to nonprescription drugs, and overturned the government plan of including injection drugs in the reform package (which the government hoped to include in order to reduce the chronic problem of overuse). Most notably, physician strikes drove the government to raise the reimbursement fees for physician services by 44 percent, as compensation for income loss caused by the pharmaceutical reform.¹⁰ The strong influence of physicians on the Korean pharmaceutical reform is in contrast to pharmacists, who did not develop a political power as strong as physicians and accepted the reform reluctantly.

The pharmaceutical industry played a minor role in pharmaceutical reform. Before the reform, physicians preferred drugs that provided them with higher margins, and high-quality drugs did not necessarily have larger market shares. Consequently, the domestic pharmaceutical industry had a unique and inefficient structure in which there were more than 450 manufacturers, and two-thirds of them were small companies with fewer than 100 employees (Korean Association of Pharmaceutical Manufacturers 1998). Most domestic firms had little capacity for research and development and survived by producing copy drugs and offering deep discounts 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. Although the pharmaceutical reform was more a threat than an opportunity to the domestic pharmaceutical manufacturers, they were fragmented and not strong enough to oppose the government. To the contrary, multinational pharmaceutical companies supported the pharmaceutical reform. They pretended, however, to be neutral in the policy process, because they did not want to antagonize physicians who were desperately against the reform.

Physician strikes against the pharmaceutical reform had a spillover effect on the payment reform. A three-year pilot program for voluntarily participating providers showed the DRG-based payment system to be effective in reducing the length of stay, medical expenses, average number of tests, and use of antibiotics, with little negative effect on quality

10. The increase in physician fees contributed substantially to the fiscal crisis of the national health insurance in 2001 (Kwon 2005b).

measured by complication and reoperation (Kwon 2003c).¹¹ The strikes against pharmaceutical reform gave physicians increased political bargaining power and allowed them to dominate the process of the payment reform. With these resources, physicians succeeded in overturning the government's plan to extend the DRG-based prospective payment system to all health care institutions (for inpatients) in January 2001. Physicians also influenced the implementation of the RBRV system (for outpatients) by pushing the government to increase the fees for relatively underpriced services but not to reduce the fees for overpriced ones, which is far from the goal intended for the RBRV system. As a result, the RBRV system in Korea will fail to neutralize physician incentives among different medical services—in addition to the continuing problems of incentives for overprovision under the fee-for-service payment system.

Lessons and Future Prospects

Reform proponents in Korea might have achieved better policy outcomes with more carefully designed strategies in terms of the scope and sequencing of the reforms. With regard to scope, an incremental reform would have been particularly important for the separation of drug prescribing and dispensing, because the reform introduced a sudden and nontrivial inconvenience in the way that consumers obtain their medicines. In contrast, the health care financing and payment reforms do not require any behavioral changes for consumers. In addition, the pharmaceutical reform confronted cultural and historical patterns of drug consumption in Korea. There is no separation of drug prescribing and dispensing in traditional medicine, which remains 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. To accomplish its goals, therefore, the pharmaceutical reform had to change not only the formal rules and regulations but also the culture and public attitudes toward drugs, which are difficult to achieve by a radical reform alone.

Japan and Taiwan have adopted less comprehensive approaches to pharmaceutical reform, and it will be worthwhile to compare policy per-

11. In the third year of the pilot program (February 1999–January 2000), 798 health care institutions voluntarily participated in the pilot program. The third-year pilot program covered 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 twenty-five DRG codes depending on the severity and age of the patient. It accounted for 25 percent of inpatient cases.

formance in these three countries over time. Japan adopted a voluntary scheme in which the patient has a choice between the pharmacy and the physician clinic for the dispensing of medicines (Rodwin and Okamoto 2000). Although in theory the patient had a choice, in reality, it was the doctor who had the choice. By squeezing the profit margin on drugs, and by increasing the dispensing fees for doctors, the separation rate is now more than 40 percent (Ikegami 2003). In Taiwan, physicians can employ on-site pharmacists for dispensing, a policy that allows them to maintain a financial interest in prescription. As a result, the probability of prescription and drug expenditure per visit was different among physician clinics with and without on-site pharmacies (Chou et al. 2003).

Health care reform in Korea also faced the problem of reform overload, as the country introduced three major reforms at nearly the same time. A different sequence and priority in the introduction of these three reforms might have improved the chances for success and the ultimate performance of Korea's health care system. The payment reform probably should have been given the highest priority, because it has a strong and immediate effect on provider behavior and health care expenditure. The DRG-based payment system accumulated substantial supporting evidence over a three-year pilot study, and many health care institutions voluntarily participated in the project. The financing reform, however, with its merger of health insurance societies, promised little effect on health care providers, who have a crucial role in health care expenditure. The separation of drug prescribing and dispensing had the potential to reduce physicians' incentive to overprescribe, but it provided few incentives for them to minimize pharmaceutical spending. In addition, the pharmaceutical reform was applied only to the outpatient sector, with no effort to address the out-of-control dispensing in the inpatient sector. In contrast, the pilot program on payment showed that a DRG-based system significantly reduced the use of antibiotics in inpatient care. Furthermore, the pharmaceutical reform only affected the use of medicines, thereby allowing physicians to substitute other inputs (e.g., tests) for drugs and potentially contributing to an increase in total health care expenditure. Strategic implementation of the sequencing or a greater emphasis on payment reform toward a larger unit of payment could have different outcomes on health care reform in Korea.

An active participation of civic groups in the policy process has been a major change in health-policy making in Korea. But over time, the public tends to view the civic groups as allies of the progressive political party, and a tension frequently exists between government bureaucrats and civic

groups over policy measures. Despite their pathbreaking role in policy formulation, civic groups played a limited role in policy implementation in the health care reform. The history of civic groups in Korea is rather short, and they still have limited resources. Civic groups participated not only in the health care reform but also in broader economic and social issues. For example, two of the most active civic groups are the Coalition for Participatory Democracy and the Coalition for Economic Justice, and as their names suggest, they cover a very broad area of socioeconomic issues. These civic groups are not grassroots organizations with a broad constituency of supporters, but instead are small organizations led by progressive policy elites. Consequently, for pharmaceutical reform, the civic groups were unable to mobilize broad support of the general public, particularly when the reform's implementation faced physician strikes.

A representational community of organized interests plays a critical role in health policy (Peterson 1994). With an increasing role for interest groups in health policy and policy reform in Korea, the nature of the health policy community will be more crucial in the future. The health policy community in Korea used to be characterized by the domination of technical bureaucrats and medical professionals, and civic groups just began to play an active role in the policy process. When employers, as the payer of half of the social insurance premium for their employees, and employees, who are now concerned about the role of health insurance as a safety net in the labor market, become active participants in the policy process, the health policy community will change and a stronger coalition of reform may be able to counteract the veto power of health care providers in the future. The change in the nature of the health policy community will transform the governance structure of the Korean health sector, particularly with respect to the powerful influence of the medical profession.

Concluding Remarks

Major health care reforms are possible under political conditions favorable for a big change—and these conditions do not occur often. In Korea, the change of government, and the new president's keen interest in health and social policy, opened a large policy window for major health care reforms. More pluralistic policy processes made it possible for progressive civic groups to participate in the health policy process and play a pivotal role in the formation of health care reform. In a suddenly expanded policy community, new members quickly set the reform agenda, and government

bureaucrats and medical professionals failed to dominate the policy formulation process. The progressive political ideology of those who drove the reform process—the new president and civic groups—affected the nature of the reform. Contrary to health care reforms in other industrialized countries, Korea's reforms focused on improving equity and strengthening social solidarity (financing reform) and enhancing performance by changing basic rules (pharmaceutical reform)—as well as controlling costs and changing physician behavior (payment reform).

Pluralistic policy process also affected the role of interest groups in health policy, contributing to different outcomes in the three reforms. Interest groups explicitly supported or tried to veto the reform in policy implementation. In the financing reform, strong support by the rural population and a labor union, with weak opposing groups, contributed to a smooth implementation. The financing reform did not have a direct effect on the financial interest of physicians and they were neutral, whereas the pharmaceutical reform promised to eliminate an important source of physician income. Although physicians failed to block the adoption of the pharmaceutical reform, they exerted a strong influence on the implementation of the reform through a series of nationwide strikes. They changed the original version of the pharmaceutical reform package to fit their interests, pushed the government to raise their fees substantially, and blocked the payment system reform, which potentially had a direct impact on the efficiency of health care delivery. The previous bureaucrat-driven top-down process no longer dominates health policy, as pluralistic interest competition has become accepted and common in Korea. The Korean experience shows how the democratization of policy process did not simply strengthen the pro-reform advocates, but also gave new opportunities to anti-reform groups, affecting the political calculations and behaviors of all groups involved in health policy.

Progressive actors who led the health reform efforts in Korea played a key role in setting the policy agenda, designing new policies, and driving the adoption of major reforms of the health system. However, they paid less attention to the critical role of policy implementation. The social values and political ideology of health reform proponents contributed to the big-bang approach rather than incremental change and to the high priority given to financing and pharmaceutical reforms rather than payment reform. Future efforts at health care reform in Korea will need to consider not only the design and adoption of policy but also strategies for implementation, especially with regard to scope and sequencing and political management of vested interests, if those efforts are to succeed.

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