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Stakeholders in the Public Policy-Making Process: The Case of the Separation of Prescription and Dispensing in South Korea

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[Case study]

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Background

After the end of the Korean War in 1953, the Korean government made desperate efforts to recover infrastructure and to promote economic growth after the devastation from the War. Healthcare was mainly delivered by the private sector, such as physicians, pharmacists, and hospitals. In 1997, the government came onto the healthcare stage as key player when it established a national health insurance plan for government and industrial employees. The government also planned to implement universal health insurance to cover all citizens through a network of local as well as employer-based communities. The payment method was fee-for-service (FFS) by which the physicians were reimbursed for as much as they provided, but the physicians thought the fee schedule that the government set up was not enough. To supplement the insufficient reimbursement, physicians dispensed drugs in their clinics. The insurance policy provided the reimbursement for drugs that both physicians and pharmacists dispensed, and the reimbursement rates

were higher than the prices that physicians paid for them. This price difference, called the "drug margin," made up almost half of the net income for physicians who had private clinics.

Meanwhile, South Korea experienced a shortage of physicians, especially in rural areas. In these places, pharmacists played the part of primary physicians by diagnosing patients and dispensing drugs. In other words, physicians and pharmacists were both able to prescribe and dispense drugs for outpatient care. This resulted to the over-prescription and erroneous prescription of prescribed drugs to maximize the economic profits of both physicians and pharmacists. Abuse of drugs, especially antibiotics, stimulated the call for healthcare reform in pharmacy practice.

Both physicians and pharmacists blamed each other for excessive misuse and abuse of drugs that caused an increase in the portion of the national debt attributable to the insurance reimbursement method (FFS). For example, the rate of antibiotic resistance in South Korea was the highest in the world before the pharmaceutical reform. The high drug spending in Korea was a critical factor that promoted pharmaceutical reform. Drug costs occupied almost 30% of national healthcare spending before the reform.

These problems and the overlapping roles of both physicians and pharmacists came from confusion about the roles and function of the two groups. The public got more attention of the separation of the function and roles of two groups. But implementation of the reform was failed due to interests of stakeholders in pharmacy practice.

In response to the increased social negative externality and in order to provide the public with better quality of healthcare services and prevent the misuse and overuse of medicine by ensuring that the two major healthcare providers (i.e., physicians and pharmacists) operated within a framework of checks and balances, policy stakeholders, especially government, tried

to reform the process of drug prescription and dispensing. The separation of prescription and dispensing has more critical policy implications than the separation of labor between physicians and pharmacists.

Policy Stakeholders in the Separation of Prescription and Dispensing in South Korea

Starting in the early 1980s, pharmaceutical reform (the separation of prescription and dispensing, or SPD) was attempted several times. Physicians, pharmacists, government and civic organizations participated as stakeholders in the policy-making process of pharmaceutical reform. However, each stakeholder had different degrees of political powers or influence in the policy-making process depending on the government regime in power.

Physicians

Physicians are the key players in health politics in South Korea, the Korean Medical Association (KMA) was always the most influential policy player in SPD reform. Physicians are recognized as the sole experts in the complex and scientific field of medicine. It is impossible to implement health policy without their cooperation. In the case of SPD reform, physicians wanted to maintain the status quo by opposing the reform. Even though the government set drug prices on the basis of the information that pharmacy companies and wholesalers released, physicians and hospitals purchased the drugs at lower prices than payers (insurance providers) reimbursed. To maximize their profits, physicians and hospitals wrote prescriptions and dispensed as much medication as they could. With their excellent political lobbying powers, they campaigned against SPD on the ground that it would be

inconvenient and disadvantageous to patients. Physicians had critical influence on SPD through several nationwide campaigns and mass demonstrations that paralyzed the entire healthcare system in South Korea. These activities pushed the government and National Assembly to distort the elements of reform and address their interest, including increasing reimbursement rates to cover loss of physicians' income during the strikes and rallies. Physicians who were employed by hospitals and sole practitioners participated in strike and rallies.

Pharmacists

Pharmacists also opposed SPD reform at beginning. However, they later recognized that several serious conflicts existed between physicians and themselves. Physicians always got the upper hand over pharmacists in healthcare practice as well as in political power in the policy-making process. The professional power of physicians and was stronger than that of pharmacists, and the widespread demonstrations by physicians had the primary effect on policy decision-making in SPD reform. Even though pharmacists got a fee schedule with higher rates schedule in return for not striking, the SPD fundamentally changed the position and role of pharmacists who had played the role of primary care providers for a long time, especially in rural areas. The professional and political power of pharmacists in the SPD reform rapidly ran out and they depended on physicians, though they still were influential in the SPD reform.

Government (Ministry of Health and Welfare)

Government (in this case, the Ministry of Health and Welfare) is crucial

in the policy-making process. Government sets the reimbursement rates for healthcare services and decides the price of drugs in the universal healthcare system. While government allowed a narrow margin for inpatient and outpatient services, it permitted healthcare providers to get higher profits from prescribing and dispensing drugs. It still was skepticism about the feasibility of SPD reform, because there was an iron-triangle of the pharmaceutical industry, healthcare providers and government. The Ministry of Health and Welfare failed to be the major key player in SPD reform. Later the Ministry of Health and Welfare yielded to physician strikes by substantially increasing physician fees.

Civic Organizations

Healthcare was not a focus of civic organizations, which were more concerned about political and economic agendas than about social issues such as SPD. However, they played a critical role in breaking the "iron triangle" among the pharmaceutical industry, healthcare providers and government and in formulating healthcare policy such as SPD reform. Civic organizations were especially powerful in the Kim Dae-Jung government. They made SPD into a major social issue and forced the KMA and the KPA to come to the bargaining table to resolve the SPD reform.

Policy Context in South Korea

Democracy is unlike dictatorship or tyranny in that it provides opportunities for people to hold their leaders accountable and to oust them without the need for a revolution. It continues responsiveness of the government to the preference of its citizen. It achieves political and social equality and provides all citizens with means to formulate and signify their political and social preferences. Democratization is the process that changes an authoritarian

political system to a responsive democratic system.

Democratization should promote a public policy-making process by a wide range of political and social spectrums to organize relationships and mobilize collective action. It also allows wider opportunities for social members to participate in public policy-making process. The result of democratization is to enlarge egalitarian rights and transparent decision-making structures. This case study focuses on how democratization influenced the result of public policy decision-making in South Korea in the specific case of SPD policy.

The Road to Separation of Prescription and Dispensing

During the period of rapid economic growth and progress in political democratization in the 1980s, the public became concerned about healthcare in South Korea. Before 2000, physicians were able to dispense medications directly to their patients in their office. Pharmacists were also allowed to dispense medication. Both physicians and pharmacists used this situation to maximize their profits, while patients were at a disadvantage. In the early 1960s, the Korean government had tried to separate the two functions of prescription and dispensing by enacting the Pharmaceutical Affairs Act, but the effort failed repeatedly due to government irresolution and opposition from both physicians and pharmacists.

Between 1982 and 1985, the Chun Doo-Hwan administration, which had taken power via coup d'état in 1980, ruled over South Korea. Chun's administration tried to implement the Separation of Prescription and Dispensing (SPD) program in the city of Mokpo, where physicians and pharmacists relatively practiced equally, and promoted it with an enforcement ordinance or by enforcing agreements between doctors and pharmacists,

as a part of the pilot program of the 2nd Level Health Insurance Plan that expanded the National Health Insurance (NHI) to cover farmers and fishermen. The Korean Medical Association (KMA), which represents physicians, and the Korean Pharmaceutical Association (KPA), which represents pharmacists, were the major interest groups at this time. The KPA took the lead of a one-day shut-down to support compulsory implementation of SPD in May 1982, while the KMA did not support SPD and hinted at the possibility of boycott. None of the interest groups (KMA, KPA and government) would cooperate. There was no official or unofficial committee or organization that each interest groups did take participate in the SPD reform. Government assumed all charge of implementation. The KMA and the MPA individually contacted policy stakeholders, such as politicians and senior government officials related with SPD to address their interests. The lobbying of the KMA was more successful than that of the KPA. The deputy secretary of the Ministry of Health and Social Affairs (MHSA), confirmed that the government would not enforce SPD and promised that compulsion would not be included in the policy. After a one-day strike by pharmacists in May 1982, the government organized a national-level committee that the KMA and the KPA participated in. Unfortunately, this committee did not contribute to the decision-making process, although it met three times in this period.

In 1984, the government implemented a SPD pilot program. MHSA worked directly with local KMA and KPA representatives in the city of Mokpo and forced them to make an annual contract that physicians have to issue prescriptions to pharmacists. The KMA did not support and refused to extend the annual contract in the following year. MHSA accepted KMA's opinion and terminated the SPD pilot program in 1985. In this period, the winner in this scenario was the KMA.

In 1987, with the transition to democracy in South Korea, Rho Tae-Woo,

the presidential candidate from the authoritarian ruling party as well as the successor of authoritarian president Chun Doo-Whan, was elected by direct election. Although the Rho administration had an authoritarian image, his government worked to prevent popular unrest and allowed freedom to society. His government allowed citizens had the right to freedom of assembly and association. After 1987, many civic organizations were established and organized, but they did not participate in the policy-making process. Because these civic organizations were still new and not well organized in this period, and the most critical priority was democratic movements such as freedom of speech and augmentation of political and economic freedom, SPD policy did not draw as much of their attention as other democratic agenda items in this period. The civic organizations refused to participate in committees that the authoritarian government sponsored, and the Rho government also was reluctant to request that they join the committees. As a result, government, the KMA and the KPA were again the main stakeholders in SDP issues.

The Rho administration tried to enact universal National Health Insurance (NHI) that covered all the population to solidify the base of his regime. The MHSA comprised the committee for this goal. Again, SPD surfaced as a political agenda between physician and pharmacists. Political parties (National Assembly) were also involved in the policy-making process, but their influence was limited and meager in this period. Political parties just rubber-stamped bills based on the decisions of the committee.

The MHSA requested the committee to accept an incremental increase in compulsory SPD, but the new proposal reflected the KMA's intention that eliminated physicians' legal duty from the SPD. The KPA strongly opposed the new proposal and held a series of strikes and demonstrations. The government did not intend to break up a demonstration of pharmacists and was not willing to mediate in the conflict between physicians and pharmacists.

Therefore, the government took a noncommittal attitude between physicians and pharmacists and suspended any decisions on the SPD. Instead, to reflect the interests of pharmacists, the MHSA offered the Pharmaceutical Insurance System (PIS) that reimbursed for certain medications dispensed without prescriptions.

In the Rho administration, the KMA increased its political power in policy-making. New public policy players, such as the People's Solidarity for Participatory Democracy, were not yet organized or did not intend to join the SPD reform committee. Although the KMA and the KPA were still key players in the policy-making process, the Rho administration favored the KMA and avoided any oppressive measures against the KMA. The KMA was able to become the most powerful player in the policy-making process.

After former opposition political leader Kim Dae-Jung won the presidential election in 1998, the government focused more on social and economic agendas than political ones. Kim's administration actively invited civic organizations into the policy-making process. These organizations were also friendly to the Kim administration, which had hired many members of these organizations to work for the administration and the ruling party. Through these social, economic and political environment changes, South Korea became more democratized in this period.

In May 1998, the Kim administration officially lunched SPD as a pharmaceutical market reform designed to promote the transparency of the market and the rights of consumers by disclosing the prescriptions to patients and pharmacists. The Ministry of Health and Welfare (MoHW-formerly the MHSA) organized committees, such as the SPD Steering Committee (SPDSC) and the SPD Executive Committee (SPDEC), in which the KMA, the KPA, MoHW and civic organizations joined. After South Korea became democratized, the civic organizations were no longer hostile to the

government.

The MoHW organized those committees and prepared to pass bills for the revision of the Pharmaceutical Affairs Law (PAL). In this period, National Assembly played a critical role in getting stakeholders to accept and pass the bill that all policy stakeholders accepted for. The MoWH was not allowed to arbitrate on the SPD reform. The National Assembly endorsed the civic organization, The People's Solidarity for Participatory Democracy, that strongly supported SPD reform by authorizing it as an arbitrator between the KMA and the KPA. Ultimately, a bill that banned physicians and hospitals from dispensing drugs for outpatient services was passed based on agreement among all the policy stakeholders. Even though the KMA, which had an economic disadvantage from SPD, organized and led a series of anti-SPD rallies in 2000, they failed to stop the revised PAL. Public opinion did not support the KMA strikes , and government, ruling party and civic organizations were not willing to surrender to the KMA strikes. In spite of the KMA strikes, The KMA failed to hinder the implementation of the SPD. AS the civic organizations that support the SPD participated in the SPD reform committee, the KMA's influence relatively had waned. While the civic organizations had maintained friendly ties with Kim administration and were trusted by the national Assembly, the KMA did not expect government support in the manner that the KMA had once received it.

This case study focuses on how democratization influences the stakeholders in the public policy decision-making process. Specifically, democratization increased the opportunity of various stakeholders to participate in the public policy-making process.

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