

## The Politics between State Power and Professional Power in Korean Health Care System

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*Since the late 1970s, the Korean health care system has changed significantly. The state increased its intervention into the health care system to expand health services to people and to improve the efficiency of medical practice. But physicians tried to protect their privileges and private ownership of medical institutions, and to buffer "hazardous" state intervention. Between the state and physicians, a group of physicians, called "medical reformers" in this paper, tried to compromise both sides. While such an attempt was not fully successful, their goal to rationalize the structure of the health care system significantly impacted the current debate on the Health Care Delivery System and the politics between the state and the medical profession.*

This paper will examine the convergence of interests among the state, medical reformers, and practicing physicians from the mid-1970s to the mid-1980s. Recent changes in the health care system have provided medical reformers with new ground to strengthen their power and realize their desire for reform. Two important factors were increasing state intervention and the emphasis on medical entrepreneurship. By the mid-1970s, the state faced a crisis in its political legitimacy and in the growing pressure from workers for better living conditions. As a response, the state enacted the National Health Insurance program and the medical aid program for the poor in 1977, as well as implementing primary health care programs in rural areas. But the economic planners of the state noted a serious problem in the delivery system. In order to improve the health care delivery system while, at the same time, expanding health services, the state became active in planning and controlling the health care system.

Physicians were also confronted with a crisis, that of severe competition among themselves. Successful economic growth and a state policy to expand health services induced rapid growth in private hospitals. Physicians were active in transforming their clinics into hospitals, an action that was considered the apex of medical entrepreneurship. However, rapid growth of profit-oriented private hospitals led to severe competition between private clinics and hospitals, and between large and small hospitals. Physicians and their organized body, the Korean Medical Association, realized the extent of this crisis and argued for the establishment of a Health Care Delivery System (HCDS) to coordinate the conflicting interests among physicians and among medical institutions. On the one hand, this gave *medical reformers\** the chance to seek consent for reform from their fellow clinicians, while on the other, it gave them the opportunity to work with the state to plan for the new health care delivery system. Thus, a coalition between the state and the medical profession was

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\*Medical reformers refer to a group of physicians who argued the reform of the health care system; they were usually specialized in preventive medicine and public health.

established through the mediation of medical reformers.

In the first part of this paper, the state health policy in the late 1970s and the early 1980s will be examined. First, I shall look at the political and economic situations that caused the state to become actively involved in the health sector. Next, the major state policies will be examined. State intervention in this period took place through three programs; a National Health Insurance program mainly for the middle class and workers in the export industries; the medical aid program for the poorest segment of society; and the state implemented primary health care programs for farmers. To expand health services production, the state financially supported physicians in their construction of private rather than public hospitals. All of these policies contributed to the growth of the private sector, resulting in competition among medical professionals and duplication in the health care delivery system. Responding to this problem, the state tried to create a rational and efficient health care delivery system by forming a coalition with medical reformers since they had the experience and knowledge necessary for rigorously planning the health system.

In the second part, the changing structure of the medical care system will be addressed. We will examine why and how the growth of private hospitals induced conflicts between hospitals and clinics. Entrepreneurism, the underlying cause of these conflicts, deterred the development of a hierarchical differentiation in performance among physicians and blurred the boundary of medical practice between hospitals and clinics. Given this situation, competition among physicians and medical institutions was inevitable. But as the conflict became severe, private practitioners and the owners of small hospitals, who were disadvantaged by the competition, began to seek the coordination of conflicting interests. Thus, the concept of the establishment of HCDS was accepted by physicians. Medical reformers were able to refine their model by expanding the scope to the national (were able to refine their model by expanding the scope to the national) level, and by including the role of private hospitals and clinics within the HCDS and the division of labor between the public and private sector.

In the final section, the politics engaged in the establishment of the HCDS will be discussed. Although all three actors—the state, medical reformers, and practicing physicians—agreed with the necessity of reorganizing the HCDS, their respective interests did not always coincide. The state wanted to increase its capacity to control the health care system. Medical reformers tried to make the health care system operate by the principle of professionalism for maintaining quality of care, a principle that was regarded as the mechanism to enhance professional power. Practicing physicians wanted to maintain the system of private ownership. The HCDS was thus the object of political struggle as well as coalition of interests among them. Analysis of this process is the main concern of this section.

## **Section 1 : The State Health Policy in the 1970s**

### **1. Increasing State Intervention**

During the 1970s, the Korean economy continued to grow rapidly through export

-oriented industrialization. The per capita gross national product increased from less than \$100 in the early 1960s to about \$2,000 in 1983. The share of industrial production in the gross domestic production increased from 25 in 1965 to 39 percent in 1983, while the agriculture share decreased from 38 to 14 percent in the same period (World Bank 1985 : 175). However, contradictions in this economic system also intensified since the early 1970s. The export oriented economy was based on "cheap labor", resulting in discrimination against the working class in the distribution of the fruits of economic growth. Income inequality among classes became greater. To avoid confrontation, the state strengthened labor control. The Park regime declared a "state of emergency" in 1971, under which the state could judge any strike illegal or submit any labor dispute to "mandatory mediation." Other mechanisms to control workers were amended thereafter.<sup>1</sup> The state structure itself was transformed into the so-called Yusin system, a bureaucratic-authoritarian ruling structure, in which such "social disturbances" as workers' strikes and political opposition movements were oppressed or tailored toward giving a consent to such a system. However, social control was not so successful that the state could not avoid preparing "carrots" for the people. The state's involvement in the health sector through the enactment of national health insurance and other measures was an example of such an offering to the people.

State intervention in the health sector, however, did not mean fundamental change in state policy, a change from an authoritarian ruling to a democratic and welfare-oriented system. The state used both "stick-and-carrots" to maintain its rule. Welfare measures were used to supplement repressive measures rather than to replace them, so that state intervention was developed in a rather conservative way. The state was reluctant to increase its financial burden while trying to expand health services. The state thus boosted the growth of the private sector ; this trend in the state health policy took place in several ways.

National Health Insurance (NHI) was one such case. The state organized the NHI on the basis of equal copayment by employer and employee, with the state paying only for the operating costs of the insurance offices and the premium for state employees. But the state was able to control insurance money by dominating the insurance organizations and possessing the capacity to set the reimbursement fee schedule. Thus, the state could bureaucratically control the NHI system with a small or nominal share of financing.<sup>2</sup> At first, only persons who were capable of paying the premium were included in the plan : these people represented the middle class, workers in large firms, and state employees. For the poorest segments, the state enacted a Medical Aid program, similar to Medicaid in the United States. However,

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1. See Choi(1983) for the mechanisms of labor control by the state.

2. In 1975, several politicians and social welfare researchers recommended the enactment of the National Health Insurance to President Park. But Park hesitated to accept such a recommendation because he feared that this welfare policy might become burdensome to the government and induce an explosion of workers' demands for welfare, resulting in lowering industrial productivity. The supporters persuaded President Park by arguing that the government would pay only for the operating fund, and that a welfare system like the medical insurance program was needed to overcome the political crisis by rendering material benefits to the people(Shon 1983 : 139-150).

farmers and workers in small factories, too rich to receive the Medical Aids but too poor to pay the premium, were excluded from both plans.<sup>3</sup> As the economy grew, the state incrementally expanded the coverage and benefits of the HNI.

The health care financing structure during this period clearly demonstrated the conservative aspects of state intervention. Table 1 shows that before the enactment of the NHI, 85 to 90 percent of the nation's health care expenditure was paid by the private sector, especially by personal expenses. The state health budget constituted only 10 to 15 percent of the national expenditure on health care, and firms virtually paid nothing. After the enactment of the NHI, the situation changed to some degree. Both the state and firms shared more in health care expenditures, but

Table 1. Health Expenditures in Korea, Selected Years\*  
(unit : billion won)

	Pre NHI				Post NHI	
	1970	1973	1975	1978	1980	1983
Total Expenditure	71.4	155.5	306.5	667.1	1,019.5	2,163.1
Public Sector	14.9%	11.6%	10.7%	17.8%	18.1%	15.9%
Private Sector	85.1	88.4	89.3	77.0	65.0	62.3
Health Insurance	—	—	—	5.2	17.0	21.8
	100.0	100.0	100.0	100.0	100.0	100.0
Public Sector	10.6	18.0	32.8	118.9	184.1	344.8
Central Government	4.7	8.2	15.1	—	—	—
Regional Government	5.9	9.9	17.7	—	—	—
Private Sector	60.8	137.4	273.7	513.4	662.4	1,347.8
Individual	60.0	135.7	271.4	504.2	645.3	1,309.2
Firms	0.1	0.2	0.5	0.4	0.9	1.7
Others	0.7	1.5	1.8	8.8	16.2	36.9
Health Insurance	—	—	—	34.8	173.0	470.5
Health Expenditure as Percent of GNP	2.7	3.0	3.2	—	3.1	3.2

\* Because of differences in Methods estimating health care expenditure of the following two source, some cells remain blank. But these blank cells do not mean that they lack real value.

Source : For 1970 to 1975, Park, J. K. (1979).

For 1978 to 1983, Kwon, S.W. (1986).

3. In some sense, the state might have paid more attention to the political significance of the middle class and the fraction of the working class who were working in the export-oriented economy. A labor dispute in this sector of the economy would have had critical influence over the state, whose rule was legitimized by economic growth based on the export-oriented economy. While farmers and the workers in small factories contributed to this economy by producing cheap agricultural products and cheap industrial products, their political significance was disregarded by the state. This might be due to the fact that farmers and small factory workers were hard to organize large-scale labor disputes, and thus the state could easily control their discontent by using repressive measures.

personal expenses still constituted over 60 percent of the total health care expenditure<sup>4</sup>.

Actually, the state forced firms to pay more for the health care of their employees rather than restructure the health care financing through taxation.

The tendency in state intervention to operate without financial burden was also found in the production side of health services. The increase in demand for health care caused a shortage of medical facilities. The state set up a plan to expand medical institutions.

Though the state was not active in reinforcing the role of public hospitals, it was very active in supporting the construction of private hospitals by raising foreign and domestic funds. From 1978 to 1985, 56 private hospitals were constructed with financial support of the state (IHS 1985:16). While many more hospitals were constructed by "pure" private funds during this period, the state played an important role of promoting the rapid growth of private hospitals.

This trend in state policy was associated with state intervention to control the health care system through bureaucratic measures.

The state had a long history of bureaucratic control over the health sector as well as over other social and economic sectors. But the effectiveness of these measures had become questionable in recent years, mainly because such measures attempted to eradicate the symptoms rather than address the underlying structure causing such symptoms.

One example is the state policy to recruit physicians by increasing the number of physicians. The Korean state held the power to increase the number of physicians. The number of students entering colleges, including medical schools, was annually set by the state.

While physicians were always opposed to increases in their numbers, it was the state's on-going policy to increase these numbers. This trend was especially intensified during the 1970s and 1980s. In the early 1970s, Korea had twelve medical schools. After 1977, the state authorized fourteen new medical schools to be established by 1985. The number of entering medical students increased from 1,477 in 1977 to 3,119 in 1985. The impact of this rapid increase in the number of medical students on the medical profession was obvious: it led to an increase of competition among physicians. Although the state expected the 'trickle-down' effect from increasing the numbers of physicians to so-called "doctorless" rural areas they continued to exist into the 1970s. Since physicians did not want to relocate there. These underserved areas were eliminated in 1983. When the state had sufficient reserves of new medical graduates to be used for the mandatory military service; after the military quota was filled, new physicians were dispatched to rural areas. New medical graduates had to serve in one of these two duties for three years. But the young physicians dispatched to rural areas often lacked the motivation as well as experience to perform public health tasks, and they practiced medicine without sufficient equipment so that their performance and productivity were quite low.

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4. The 60 percent was calculated by dividing individual expenses(1, 309. 2) by the total expenditure(2, 163. 1) in 1983. When we consider that both employee and employer split the cost of health insurance, the portion of personal expenditure increases to over 70 percent of the total expenditure.

The same problem was found in the management of the NHI. By controlling significant portions of health care money, that is, controlling the process of reimbursement to physicians for their services, the state tried to contain the cost of health services in the Insurance plan. When the state set the first fee schedule in 1977, it was decided to set the fees at a level 40 percent lower than conventional physician charges. Such a fee schedule was revised upward only with a rise in the consumer price index, rather than increases claimed by physicians, who argued that medical costs were increasing much faster than general consumer prices. Nevertheless, physicians raised their fee levels for non-insured patients as an attempt to compensate for their lost income. Even under the Insurance plan, physicians were able to perform "over-treatment and over-doctoring" to compensate for the low rate of reimbursement. As medical practice became more complex in hospitals, it also became difficult to prevent the abuse of professional decision-making in the clinical process. And since physicians owned and controlled most medical institutions, it became more difficult to control the actions of physicians.

It thus became evident that these rather "simple" strategies of bureaucratic control were not effective to control physician's behavior. New methods of control were needed. Accordingly, the state became involved in health planning. As welfare measures became significant within the state, the EPB, whose concern had been only economic issues, tried to become involved in the area of health services research and health planning. When the state implemented the primary health care (PHC) project in 1976, the new institutions of the National Health Council and the National Health Secretariat were established under the EPB. The former functioned as the highest authority for health planning and health care development of the nation. The latter functioned as the research and evaluation agency to support the former. Although these institutions were established in relation to the PHC project, their activities were not confined to PHC but rather concerned with the entire health sector. Within MOHSA, the Korean Health Development Institute (KHDI), an implementation agency, was established (KHDI 1980 : 19-22).

Economists employed by the EPB participated in planning, with their main concern being the efficiency of the health care system. They argued that the current system of health care delivery caused a great deal of inefficiency, such as inequality in the distribution of health services, competition among medical institutions, etc.

Correcting this market failure necessitated the introduction of a non-market system of health services delivery. However, it was difficult for the state to restrict a professional monopoly and the private ownership of medical institutions.<sup>5</sup> Hence,

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5. The state attempted to restrict the private ownership of medical institutions in 1972. In order to promote the public nature of health services, the state redefined the role of (private) hospitals toward serving "public good" rather than profit-making. Under the condition that National Assembly was forced to stop its legislative function under martial law (so called, the "Yusin" coup), the government passed the revised medical Law in 1973, which restricted the establishment of hospitals only to the state and a body corporate medical corporation. Up to that time, individual physicians had been able to establish a hospital. Now, in order to establish a hospital, physicians had to create a medical corporation. The state believed that non-profit corporations would serve the public much more than private hospitals. However, most private hospitals owned by individual physicians responded to this revolutionary regulation by reducing the number of

“rationalizing the medical market” required a more sophisticated level of techniques and ideas. The participation of medical reformers in the planning process seemed to be natural in this context, since they had accumulated the knowledge necessary for managing the ever-growing complex health care system. The state and medical reformers agreed with the principle of upgrading the efficiency of the HCDS through a “rational” reorganization of the HCDS. By segmenting the medical services market and tying this to adequate size, types, and functions of medical institutions, efficiency seemed to be upgraded. To operate this segmented medical market system, the state needed to undertake the establishment of a corresponding organization of health administration, that would be an effective mechanism to control physicians and the health care system. This effort resulted in the creation of a master plan to establish a health care delivery system, by the early 1980s, the contents of which will be discussed below.

The idea of the HCDS itself was not new to the state. Even in the 1960s, the state aimed at the formulation of a “Network of Health Care,” Which meant that the channels of health services would flow from the National Medical Center and other central health agencies through public hospitals to health centers and subcenters (Chung 1962 : 9-10 ; MOHSA 1981 : 77-78). This Network of Health Care contained the concept of the functional division of labor among public medical institutions. However, because of the state’s inattention to health care, the idea was not further developed. The decline of the public sector and the growth of the private sector over the last few decades had made the problem more complex, since the state had to plan for the private sector based on private ownership. As the state had planned the economy sector, it also attempted to plan the health sector.

Thus, a new way of health policy-making was formulated on the basis of the coalition between the state and medical reformers, though there were differences among the final goals. For the state, this was the means to expand its capacity to control physicians’ actions and the health care system. For medical reformers, this was the means to restrict competition among physicians and to obtain a stable and upgraded status of the medical profession within the health care system. The problem of who would control the health care system remained ambiguous. However, both the state and medical reformers agreed with the necessity for reforming the HCDS as a first task in reorganizing or rationalizing the medical market. Thus, a coalition between the state and medical reformers became the major force for enacting the health policy.

## **2. The Coalition between the State and Medical Reformers**

This section will address two specific policies based on the colition between the state and medical reformers : the plan for the health care delivery system and the implementation of the primary health care project. From 1981 to 1984, the Korean Institute of Population and Health, a research agency evolved from KHDI, and the Institute of Hospital Services of the SNU Hospital drafted the HCDS master plan.

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hospital beds and by degrading the legal status of the hospitals into a clinic. Only three hospitals in this category were transformed into Medical Corporations(Rhue 1975). The state acknowledged this reality and returned to the freedom of private ownership in 1975.

This plan aimed at constructing the model for the spatial and functional allocation of medical personnel and facilities on the basis of the estimation of the nation's health care needs. The rational allocation of health care resources and the establishment of functional division of labor among medical institutions were both attempted. The plan divided the nation into thirteen large Health Services Districts, which were to be subdivided into 112 Subdistricts, depending on administrative boundaries, travel distance to health care facilities, and the estimated population increase, etc. The plan defined the types and functions of medical institutions (primary, secondary, and tertiary institutions) and determined the necessary medical personnel and equipment for each institution (MOHSA 1984).

This plan was an attempt at a fundamental reorganization of the health care delivery system. For patients, the entry point into the health care system would be restricted; they would have to seek health care within the defined district, first visiting primary institutions staffed by general practitioners in clinics or health centers, and then be referred to the next level of medical institution. Thus, primary services institutions were supposed to serve out-patients, and secondary and tertiary institutions to deal only with referred out-patients and in-patients (see Figure 1). For physicians, the private practice of specialists would be restricted: they would be expected to work in hospitals or in group practice. Physicians would be forced by the state to practice as generalists or specialists depending on the level of their practice. Specialists who opened private clinics were expected to forego their specialty and to perform only within the role of a general practitioner. Private practice by specialists would thus be discouraged.

Once drafted, the plan became state policy (cf. MOHSA 1983: 119-128). But implementation could not take place since certain prerequisites were to be satisfied in advance: the improvement of medical facilities and quality of care in the public sector which was to be comparable to that in the private sector: the development of group practice and open system hospitals: the establishment of an administrative structure to control the new localized health services, etc. (Shin, Y.S. 1985). When we consider its grandiose scope, this plan can be seen as a master plan for the reform of the health care system. In most respects, the ideas and strategies of medical reformers were realized in the plan. In actuality, medical reformers took the major initiative for drafting the plan, with the support of specialists in health economics, business administration, and medical technology. Thus, the creation of this plan was clear evidence of the coalition of interests between the state and medical reformers. Medical reformers finally realized their decade-long desire for reform with this innovative plan.

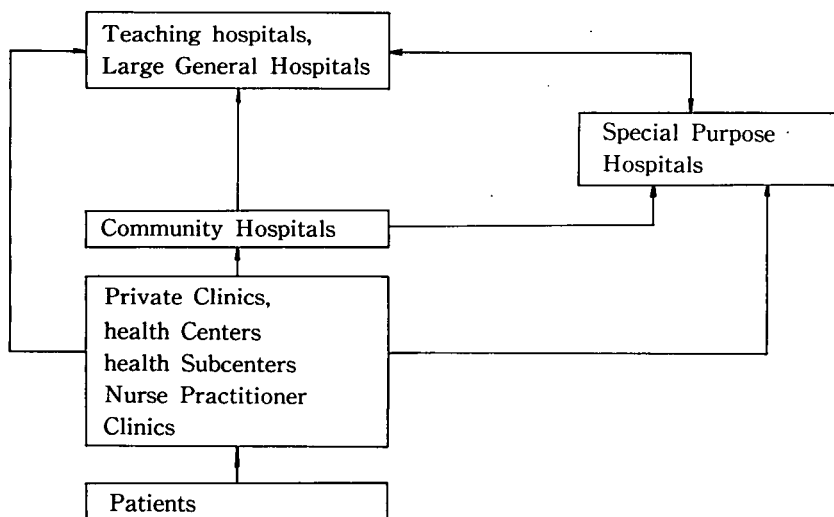
The state's involvement in primary health care is another example of the tendency toward health policy-making by way of the coalition between the state and medical reformers under the planning principle. Up to the early 1970s, the state had no concept of primary health care. The impetus initially came from foreign sources. In its attempt to expand medical services to rural areas, the state tried to borrow foreign funds to construct rural hospitals. But foreign funding agencies recommended that the health system provide low-cost but comprehensive health services to low-income rural families.<sup>6</sup> It was suggested that such approach would be a more

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6. In 1972, the state applied for a loan to the International Economic Commission for



Figure 1. The Model of the Patient Referral System



Source : Ministry of Health and Social Affairs(1984 : 28)

feasible and affordable strategy to satisfy health needs of the poor rather than the construction of hospitals. Although this new concept of health care delivery had been implemented in many developing countries in the 1960s in varying ways, such an idea was new to Korean bureaucrats. But the state accepted the recommendation and began to implement PHC demonstration projects after 1976 on the basis of a Loan Agreement between Korea and U.S.A. Government (KHDI 1980). The implementation of the PHC project was carried out by the Korean Health Development Institute (KHDI), established on the basis of the Agreement. The demonstration project was implemented in three Guns(counties) for five years, and by the mid-1980s expanded to all rural areas.

Unlike the previous rural health programs, the PHC project was based on rigorous planning, implementation and evaluation. Similar to the HCDS plan, the PHC required expertise to draw up the short-and long-term scenarios and to develop strategies to implement them. The state had to rely heavily on medical reformers' experiences in the Geoje, SNU and Yonsei Projects(Yeon 1981 : 19). Both the state and medical reformers agreed with the goal that PHC was needed to guarantee the "minimum essential care" necessary for maintaining health. Thus, the principles and general programs of the project were not basically different from those of the SNU, Yonsei or other community medicine projects.

One issue that must be explained is why the state so easily accepted the idea of PHC. The obvious answer is that the state seemed to be persuaded by its

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Korea, made up of a group of economically advanced countries which provided loans for Korean economic development. But the commission and related agencies such as AID reviewed the Korean health care system and recommended the implementation of primary health care. Finally, the budget was set with \$5million AID loan and \$1,670,000 from the Korean government's matching fund.

“feasibility” and low-cost. The idea that trained, non-physician health workers could provide curative and preventive services and satisfy the health needs of rural areas to a considerable degree was attractive to the state’s economic planners. The planners knew that the inefficiency of the health care system was partly due to the medical monopoly held by physicians. But to break such a monopoly by developing non-physician practitioners was by no means an easy task. The ideology of PHC helped overcome this dilemma ; that is, it allowed the non-physician practitioners to practice under the control of physicians. The state economic planners noted :

One assumption [of this approach] is related to the confidence most people have in the technical skills of doctors. Our experience to date indicates that if non-doctor providers of health services are taught on a scientifically sound basis, using the same logic to define and manage problems that doctors use, and if doctors can have significant input into program policy, training, supervision, and referral processes, then the medical profession will more readily support a system that in effect extends their professional capacities into rural areas…… A program of extending doctor’s capacities through health practitioners trained at less sophisticated levels also does not pose the kind of economic threat to doctors that is produced by someone outside a “doctor-controlled” system(Yeon 1981 : 4).

This argument presupposed that non-physician practitioners, unlike physicians, would stay in rural areas. In Korea, such a non-physician practitioner was necessary not because of the shortage in numbers of physicians but because of physicians’ reluctance to work in rural areas. Thus, the state needed practitioners who were willing to stay in rural areas. Also, the state assumed that non-physician practitioners would come under the control of physicians, thus legitimizing such a policy. The aim of the KHDI project was to develop practical and specific strategies to be applied to other areas in the nation. In addition, the KHDI had to justify the PHC project over hospital construction. In other words, the KHDI project had no choice but to develop certain medical services for rural areas by using the non-physician practitioner.

But the medical reformers held a different stance from that of the state. Medical reformers primarily were concerned with the functional connection of the basic health services to the existing medical care system. Medical reformers emphasized that PHC should be strengthened but that it also should be associated with secondary and tertiary health services to be effective. Without such a functional connection, the PHC would remain at a status marginal to the existing dominant medical care system. Thus, both medical reformers and the state agreed that PHC would come under the control of physicians or a higher level of medical authority in the state. Nevertheless, the goals of medical reformers seemed to be different from those of the state. Medical reformers were trying to strengthen the existing medical system by including the domain of PHC. But they were reluctant to utilize non-physician workers since they felt that physicians were not organized and lacked the capacity to effectively control other practitioners.

However, opposition to allied health workers seemed to be a dilemma for medical reformers. If physicians were to delegate routine tasks that require less professionalized knowledge to non-physician workers, the dimension of their medical

practice could be expanded and their productivity be significantly increased. However, medical reformers were opposed to this idea, as demonstrated in their objection to the introduction of the MEDEX system recommended by foreign consultants to the Korean Government in 1976 (Smith 1976; KPHA 1976); and again in 1984, to the introduction of an assistant-physician system. They feared the consequences that might develop with the introduction of non-physician workers performing certain physician functions, and were concerned that it might provoke the appearance of outside competitors, as was the case in the 1960s. Since physicians were neither organized nor able to collectively control medical practice, it would be hard to control the practice of workers outside physician clinics. Physicians were not ready nor strong enough to accept a system of allied-health workers.

The introduction of the nurse practitioner (NP)<sup>7</sup> system seemed to be a compromise to conflicting interests between the state and medical reformers. In community medicine projects, the role of nurses was confined to public health nursing and midwifery. However, under the KHDI project, NPs were the major component in delivering services. NPs were selected from the pool of regular nurses and trained for six months. They were able to perform diagnosis and treatment of patients for "common and uncomplicated symptoms", provide emergency care, normal delivery, prescribe drugs, administer vaccinations and other preventive services, and instruct patients in health education. About 2,000 NPs were trained and dispatched to rural areas by 1984. Patients were satisfied with these services and shifted their reliance on pharmacists to visits to NPs. In many cases, they visited NPs more than public health doctors, whose inexperience and inattentive attitude were discussed above. Overall, patients considered NP services "satisfactory, easily accessible and cheap" (Kim, J. S. 1986: 29, 52). Unfortunately, NPs had to spend too much of their time performing curative services and too little for other PHC programs like preventive services and health education.

The state enacted a special Law for Rural Health in 1980 to authorize the practice of NPs, which was the first break in professional monopoly held by physicians, as stated in the Medical Law. This policy, however, did not change the basic direction of state health policy since a NP system was an exception to the existing medical system. Unlike other categories of medical workers, new educational institutions for training nurse practitioners were not established, but their training (e.g., re-training of experienced nurses for NPs) was delegated to existing medical schools and schools of public health. NPs' employment was virtually tied to specific rural communities designated by the state. The state estimated that about 2,000 NPs were needed, trained only such a number of NPs, and dispatched them to the designated rural areas. Once NPs had filled the designated slots, only a few NPs were newly trained to replace vacant seats. Thus NPs were produced depending on the demand that was defined by the state in advance of training and employment. This structure of the NP system implies that the state could terminate the training and employment of NPs at any time, depending on the situation. Obviously, the NP system was not aimed at creating an alternative system of medical practitioners to disrupt the professional monopoly. Hence, in time, medical reformers did not

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7. The formal name of the nurse practitioners in the project was "Community Health Practitioner." But I use the term NP because of its universality.

actively oppose the introduction of NPs.

Other components and programs of the KHDI project will not be discussed in detail. Suffice to say that the state determined that PHC programs were successful in delivering the efficient and low-cost health services (Yeon 1981), and decided to expand this model to other rural areas, as well to implement it in urban areas for the poor.

At present, the PHC project faces many "old problems", such as unmotivated health workers, unsupportive local administration offices, low interest and participation of community members, etc. (Kim, J. S. 1986 : 52-69). But the state understands these problems and has designed plans to correct them under the HCDS Master reform plan. In this process, the state and medical reformers complemented each other: the state was strong in implementation and medical reformers in planning. We now turn our attention to the conditions faced by physicians that led to the support of medical reformers.

## **Section 2. The Changing Structure of the Medical Care System**

### **1. The Growth of the Private Sector**

The growth of hospitals after the mid-1970s was impressive. Not only did the number of hospitals increase, but they also became larger in size and adopted new, high-technology medical equipment. In Korea, hospitals were legally defined as "general hospitals" and "hospitals." General hospitals referred to hospitals that have at least 80 beds and eight specialties and other supporting facilities<sup>8</sup>, while "hospitals" are those which have at least 20 beds for in-patients and fewer specialties and lower standards for facility requirements. The number of general hospitals increased from 37 in 1975 to 183 in 1985, and hospitals from 128 to 317 in the same period (see Table 2). But the number of private clinics increased from 6,087 to 8,069. Table 3 shows that the increase in the number of all hospitals was initiated by individual physicians in the private sector. The state (public) hospitals remained unchanged in number. While the state made an effort to renovate old facilities in these hospitals, the numbers of hospitals did not change during this period. Thus, the private sector became dominant in delivering medical services. Up to the early 1970s, except for a few private university hospitals, private hospitals were generally small in size, so that they were no different from large clinics. State public hospitals, on the other hand, were generally large. But currently, as shown in Table 4, non-profit corporate and private hospitals have surpassed public hospitals in all categories of hospital size. In the largest size category of "over-300 beds", 18 hospitals were private and only seven public, indicating that the state was no longer the dominant producer of medical services.

Another important trend in the growth of hospitals was that the numbers of both large and small hospitals increased simultaneously. Large general hospitals were established mainly by private universities and medical colleges but also by other "non-profit" organizations. Small hospitals were in most cases constructed by individual

8. These include internal medicine, general surgery, pediatrics, obstetrics-gynecology, radiology, anesthesia, pathology, and dentistry.

Table 2. The Numbers of Medical Institutions and Physicians, 1975-1985

Year	General Hospitals	Hospitals	Private Clinics
1975	37	128	6,087
1976	43	141	6,125
1977	52	187	6,008
1978	61	218	6,044
1979	70	233	6,110
1980	82	240	6,344
1981	89	256	6,604
1982	111	263	6,824
1983	156	282	7,252
1984	170	310	7,584
1985	183	317	8,069

Sources : Ministry of Health and Social Affairs  
(1970, 1977, 1982, 1986)

Table 3. Ownership of Hospitals, 1971, 1985

Ownership	1971	1985
State	65	65
Non-profit organizations	92	116
Individual physicians	109	317*
Total	266	498

\*64 Medical Corporations were included in this Category Since in most cases they were owned by individual physicians.

Source : Korean Hospital Association(1972 ; 1985) .

Table 4. Size of Hospitals by Ownership in 1982

Ownership	Number of Beds				Total
	20-80	81-150	151-300	301+	
State	35	12	8	7	62
Non-profit organizations	36	22	17	16	91
Individual physicians*	182	21	4	2	209
Total	253	55	29	25	362

\*Medical Corporations were included in this category.

Source : Shin, Y. S. (1983) .

physicians. Private university and medical colleges expanded their bed size and constructed new affiliated hospitals to form chains of hospitals. Large hospitals also established medical schools. The private universities related to religious foundations, such as the Yonsei University and the Catholic Medical college, were the major forerunners in this trend. The Yonsei Medical School built five new hospitals since 1977 ; all affiliated hospitals had a total of over 2,000 beds. The Hallym Medical College is an example of a large hospital establishing a college, with a chain of four

large hospitals that offer a total of 1,370 beds. Four other medical colleges can be included in this category. Many other private medical schools have established one or two new hospitals. By 1985, medical-school affiliated hospitals (about 40) constituted 20 percent of the total number of hospital beds. These hospitals have the best medical staffs and medical equipment and have produced the highest quality care in Korea. They have monopolized medical research and developed new medical therapeutics and new standards of medical care. In a sense, they have formed "a health empire" in Korea.<sup>9</sup>

Another force in the private sector was the small hospitals owned by individual physicians. By 1985, these hospitals comprised two-thirds of the total numbers of hospitals and 40 percent of the hospital beds.<sup>10</sup> Unlike university hospitals or other non-profit, corporate hospitals, these hospitals contained in most cases less than 100 beds. Their importance was that they were established through the entrepreneurship of individual physicians and evolved from private clinics through the efforts of owner-physicians. In this respect, they are the successful product of physician entrepreneurship. However, they also reveal the limit of medical entrepreneurship in the sense that their capital volume has been much smaller than that of large "non-profit" hospitals so that their market capacity has remained limited. Their reputation is one of low prestige, insufficient medical equipment, and known difficulty of recruiting specialists. These characteristics have made them vulnerable in their competition with large hospitals. In the next section, this competition will be examined in detail.

## 2. Competition and the Crisis in Entrepreneurism

Competition among physicians is inherent in entrepreneurship. Even in the 1960s, there were conflicts between traditional general practitioners and newly growing specialists. However, such conflicts were a transient phenomenon. Since hospitals were not developed, such conflicts ended in the replacement of specialists with general practitioners in private practice. Yet, recent competition has been qualitatively different from the conflicts of the 1960s, when competition occurred

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9. There was little involvement of industrial capital in the health sector before 1980. A few large capitalists ("Chaebol" in Korean) established several hospitals in rural areas for charity and in industrial sites for treating their employees in the late 1970s. But the situation has changed recently. Industrial capital was invested both in manufacturing of high medical technologies and in hospital and medical school management. Thus, we suspect that industrial capital may influence the structure of the health care system in the near future. However, this research is concerned with the health system up to the early 1980s.

10. In this category of hospitals, two types are included in terms of the legal definition: medical corporate body (64 hospitals) and individual ownership (253 hospitals), and with some exceptions, the former type of hospital was owned by individual physicians. In most cases, the medical corporate body hospitals were financially supported by the state when they were built. The state required the establishment of a corporate body for these hospitals, whose board of directors was in reality governed by a physician just as hospitals were owned by individual physicians. Accordingly, these hospitals are included in the category of "individually owned" hospitals.

between medical institutions. As large hospitals became dominant in the medical sector, they threatened the private practice system itself. Both small hospitals and private clinics grew vulnerable to the power of large hospitals. Evidence of this trend can be shown in the change in patient flow. As the NHI and improved living conditions lowered the burden of medical expenses, patients tried to get better quality of care by utilizing large general hospitals, 38 percent of which were teaching hospitals.<sup>11</sup> According to NHI data (see Table 5), in 1979 general hospitals treated half of the inpatients and about ten percent of the outpatients. By 1984, these figures had increased to 76.1 percent for inpatients and 31.1 percent for outpatients. The shares of both small hospitals and clinics declined in both respects.

**Table 5. The Composition of Patients on National Health Insurance among General Hospitals, Hospitals, and Private Clinics, 1979, 1984**

Type of Institution	Inpatient Days		Outpatient Visits	
	1979	1984	1979	1984
General Hospitals	50.2%	76.1%	9.5%	31.3%
Hospitals	21.6	13.3	8.1	7.6
Private Clinics	28.2	10.7	82.4	61.1
Total	100.0	100.0	100.0	100.0
(N)	(1,057,176)	(2,196,942)	(12,055,163)	(29,108,162)

Source : Korea Medical Insurance Corporation (1979 ; 1984)

Due to the rapid change in patient flow, private clinics were forced to treat only outpatients (KMA 1982), and small hospitals were confronted with the difficulty of having to attract both inpatients and outpatients. If this trend continues, the decline of private practice seems to be inevitable and, as a consequence, the entrepreneurial spirit of individual physicians for establishing hospitals will also decline.

It is ironic that physicians who succeeded in advancing the hospital sector have also simultaneously faced internal crises. Why has this situation happened? One can suggest that it is the result of entrepreneurism, which up to now has influenced medical practice in two major ways. In terms of the organization of the medical profession, it has contributed to making physician performance homogenous. Although the specialist system was introduced, specialists in private practice performed the role of general practitioners in addition to performing their specialty. In other words, private clinics became "specialty clinics" in which general practice was also provided. This trend was inevitable given the condition that hospitals were not developed and private practice in clinics was the dominant mode of health service production. But, as specialists became dominant among physicians, the number of specialty clinics increased, which led to a horizontal division of labor among the specialties. Specialists in private practice began to emphasize their specialty performance. Their practice, however, still contained the function of general

11. Among 179 general hospitals in 1985, 38 percent (66 hospitals) were teaching hospitals for training both interns and residents. Another 56 general hospitals were authorized for intern training (KHA 1985 : 56-101).

practitioners. For instance, specialists of internal medicine in private practice treated a common cold as well as illnesses that required specialist treatment, although they did not perform surgery or other specialties.

In other words, within a specialty, the specialists did not hierarchically differentiate their performance among themselves. This resulted in no systemic network of specialists to which they could refer patients. While physicians' performance changed over time, their mode of practice, that is, the practice in clinics without functional connection with other practitioners, did not change. Since such a mode of practice was tied to private ownership and the motive, physicians were reluctant to refer patients, believing it in their interest to perform every practice possible to attract the largest number of patients.

In terms of organizational structure of the health care delivery system, entrepreneurship induced a lack of functional division of labor among medical institutions. The growth of hospitals began when the performance of physicians was homogeneous. Hospital physicians did not differ from specialists in private practice in terms of their training and qualifications, save for a few medical professors. But hospitals could produce a "better quality of care" because they had better equipment and more qualified supporting personnel, as compared to clinics. As hospitals grew, a division of labor between hospitals and clinics or between large and small hospitals inevitably occurred. However, this division of labor was the result of the "function of capital" because it depended on the capacity to afford better equipment and better facilities. Hospitals offered not only a higher quality of care than clinics, but also practiced a range of tasks to be performed in clinics on the basis of a better market capacity. Thus the strongest hospital in this game was the richest, the hospital that could afford capital-intensive medical technologies to become even richer.

Another aspect of entrepreneurship was the patient-dependent nature of the medical practice. Since physicians competed for patients, patients had the option of choosing or changing physicians. Patients without a family doctor would shop around for a physician who would satisfy their demands. Since patients did not trust physicians as professionals, and regarded them as entrepreneurs, they lacked a reliable source of information about how to choose a physician. Thus the criterion of "good care" for patients became impressive medical technology, so that hospitals equipped with such technology were regarded as a "good" place. Clinics and hospitals had to adopt advanced technologies in order to attract more patients.

Thus it is not strange to note that the recent growth of hospitals has coincided with the adoption of new medical technologies, which are mostly automated and computerized. The first Computerized Axial Tomography (CAT) scanner was introduced to Korea in 1977. By 1985, 94 CAT scanners had been imported and adopted by the hospitals (BSS 1987:166). Other expensive equipment such as Angiography units, Linear Accelerators, Cooximeters, Simulators, Autoanalyzers, Gamma Cameras and Patient Monitoring Systems, etc., have also been adopted by the major hospitals.<sup>12</sup> There is no doubt that these new technologies contributed to the enhancement of quality of care in the fact remains that the main factor behind adopting new medical technology has been to bolster the market capacity for

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12. This trend can be traced in the amount of dollars spent on the import of medical equipment. The import of medical technologies amounted to \$2.63 million in 1970 and



individual hospitals.

As competition among medical institutions grew more severe, it is no surprise that unethical medical practices began to take place. A good example of this tendency is the case of the ultra-sound scanner, which was used to diagnose unusual motion and development in unborn babies. This machine has been the most popular piece of equipment among Korea's adopted medical technology. By 1985, 694 sets had been imported to Korea (BSS 1987 : 166), a number that indicates that not only hospitals but also many private clinics bought this machine despite its expensive cost (over \$200,000 per unit). One problem with this machine is that it has been often used, not for examining developmental abnormalities in unborn babies, but for determining their sex. For example, parents who only wanted a son would request an induced abortion when their fetus was found to be a daughter. Many physicians and hospitals failed to exploit the machine's capacities by using it for this "non-medical" purpose.<sup>13</sup> Although this example is perhaps an extreme case, the inherent disruption in physicians' ethical standards seemed to be wide spread. Over-treatment and unnecessary surgery, for instance, have both been suggested as causes for increases in medical costs in the NHI (KIPH 1985a : 254-255).

Thus, competition among medical institutions in recent years has been an inevitable consequence of entrepreneurial modes of medical practice. The crisis of entrepreneurism has been most obvious in small hospitals. Small hospitals have not been able to find adequate roles and functions for themselves, different from large hospitals and clinics. They have tried to function as large hospitals but with the modest management capacity of clinics. Since small hospitals tried to establish many specialties and to purchase new medical technology to compete with other medical institutions, they lost the "scale of economy," and cost-effectiveness of investment was not achieved (IHS 1984, 1985 ; Moon 1983 ; Kim, Y.I. 1985). Small hospitals had a high ratio of specialists than large hospitals, which lowered their cost effectiveness. By 1983, the ratio of specialists per 100 beds in small hospitals (under 50 beds) was 12.5, while the ratio in large hospitals (over 200 beds) was 11.2 (Shin, Y.S. 1983). Since large hospitals were able to utilize interns and residents, the ratio of the total physicians per 100 beds in large hospitals (34.0) was much higher than that in small hospitals (13.6). Since small hospitals could not utilize interns and residents, they recruited specialists to produce the same magnitude of medical services, as compared to large hospitals. One of clearest indicators of low productivity of small hospitals has been their low bed utilization rate.<sup>14</sup> In 1985, the bed utilization rate was 38.8 percent in hospitals owned by individual physicians, compared to 61 percent for the national average for all hospital beds (MOHSA 1986 :

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\$5.64 million in 1975 (Kang 1982). It increased to \$49.5 million in 1980 and to \$93.2 million in 1983 (KIET 1985 : 41), half of which was for electronic medical diagnosis equipment.

13. Because of the widespread abuse of this medical technology, the state prohibited the use of this machine for detecting the sex of unborn babies in 1987. Physicians who violate this regulation are supposed to be prosecuted in court.

14. Bed utilization rate =  $\frac{\text{Daily average number of inpatients}}{\text{Number of beds}} \times 100\%$

110-111). The fact that about two third of the beds were not occupied at all in small hospitals implied its lack of marketing knowledge, in addition to the inferior market capacity.

Management in small hospitals has not been that different from that in private clinics. Private practitioners have been accustomed to a "sit-and-wait-patients" type of medical practice, which implies that practitioners have enjoyed high incomes without actively seeking patients. They did not consider the problem of marketing when they constructed their facility. Most decision-making was made by owner physicians. Physicians lacked information about the physical and social environment of their hospitals. For instance, in constructing hospitals, they did not consult specialists in hospital construction or management. Systematic feasibility studies were rarely tried. Most decisions were made by consulting informal sources who were no different from themselves (IHS 1985 : 47-48). Social and medical communication among hospital owners and other practitioners in the community has not existed (IHS 1985 : 192). Attention to comprehensive health care issues like discharge services, health education, in-service training of local physicians, and public health activities has been completely ignored. Such a management style implies that the owner physicians simply enlarged their private clinics into "hospitals" without considering the corresponding change in the functional tasks required of medical practice. Thus, these hospitals have functioned like private clinics in attracting patients through advertising "better equipment and better quality of care instead of focusing on the availability of "secondary" medical services provided for more severely ill patients which are referred by private clinics.

These characteristics of the small hospital have contributed to their unstable position within the physician market. They naturally have had difficulty in hiring specialists, unlike the large hospital, which has been able to stabilize its dominant position within the physician market due to a high prestige as a teaching hospital and because of its advanced equipment. Physicians usually want to work in large hospitals, while private clinics have remained the next alternative in the physician market. Although private practice has not given physicians as much social prestige as teaching hospitals, they still have been satisfied by rather high incomes and the freedom from outside intervention. Moreover, the relationship between owner physicians and employed physicians in small hospitals has not been different from any other employer and employee relationship. A high turn-over rate of employed physicians has been common. One opinion survey of medical students found that 72 percent of the students wanted to work in large general hospitals or medical schools and 21 percent in private practice (Lee, K. T. 1985 ; 37) No students wanted to work in small community hospitals. In reality, these small hospitals became a transient place of employment where young physicians accumulated clinical experience and eventually were able to open their own private clinics. Small hospitals, however, did not provide young physicians with opportunities for career development as did large hospitals or teaching hospitals<sup>15</sup>(IHS 1984 : 82).

The crisis of entrepreneurship was evidenced by the majority of physicians

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15. One young medical professor working in a university hospital told me in 1986 that young physicians had only two options in their careers : fame or money : teaching hospitals gave them fame and private practice yielded money.

preferring private practice, but the final result of private practice (i.e., the small hospital) not finding its place within the health care system, certain remedial measures were inevitably needed. Realizing a crisis at hand, physicians argued the necessity of advancing the functional division of labor among medical institutions so as to limit competition. Thus, local physician associations strongly appealed to the Korean Medical Association to establish a plan to prevent the decline of general practitioners and private clinics (cf. KMA 1980 ; Kim, I.S. 1983 : 18). By the 1970s, the Korean Medical Association had improved its financial conditions due to the growth of membership and mandatory physician registration with fees. After 1977, they began to carry out the necessary research and produced health policy proposals addressing important health care issues. The KMA based its claim on "scientific" evidence and rationale instead of simply arguing the old thesis that healing was a calling which called for physicians' privileges to be respected. By 1978, the KMA had reached consensus that the establishment of the health care delivery system (HCDS) was the most important project facing physicians. The KMA organized a special committee for this work and by 1981 drafted a proposal for HCDS (KMA 1981).

An important aspect of this process was that medical reformers headed up the project. Kim Il-Soon, the leader of the Yonsei community medicine project, was its chief architect ; he later became an influential member of the governmental committee that drafted the plan for the HCDS. A coalition between medical reformers and organized medicine was established. The KMA acknowledged the necessity for overcoming competition between hospitals and clinics, which threatened private practitioners. The KMA relied on medical reformers to design the solution—a solution that would protect the vested interests of private ownership of medical institutions. Thus, a satisfactory solution for the KMA was the functional division of labor between hospitals and clinics ; hospitals were to take the function of in-patient care, and clinics were to perform the function of out-patient care. And the establishment of the referral network between clinics and hospitals was the critical factor to maintain this functional division of labor.<sup>16</sup>

The KMA's drafted proposal was very comprehensive. It dealt with such topics as the role of the state and the public sector, methods for constructing the referral system, methods of payment, the structure of health administration, and plans to solve health care needs in rural areas and remote islands. Important to note was that the major contents of this proposal were almost the same as those that the state drafted in 1982 and revised in 1984. Since medical reformers exercised a decisive role in both proposals, the similarity was not by chance, and the event symbolized the crucial role of medical reformers as mediators between the state and practicing physicians. In addition, they were able to realize their long-term goal of upgrading their status. While practicing physicians agreed with the necessity for reforming the HCDS, they did not agree with the entire plan suggested by medical reformers. In fact, the politics between practicing physicians and medical reformers remains unsolved, as will be discussed below.

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16. However, the drafted proposal of the KMA allowed clinics to maintain in-patient care facilities to protect the vested interests of private practitioners. But, overall, this proposal focused on limiting the function of hospitals.

### Section 3 : Politics of the Health Care Delivery System

In this section, political efforts to change the HCDS will be discussed in detail. Two levels of politics will be examined: politics between the state and medical reformers and politics between practicing physicians and medical reformers.

#### 1. Politics of Professional Solidarity

The primary goal of medical reformers has been to construct a health care system which physicians could dominate and control (cf. Rifkin 1981: 380-381). Their guiding principle was to enhance medical professionalism and to operate a health care system which would be based on professionalism rather than entrepreneurship. Professionalism is characterized by group solidarity and collective self-control of medical practice, while entrepreneurship is based on individual practice and business-like success. In other words, entrepreneurship is a patient-dependent mode of medical practice since success in this case means attracting more patients by satisfying their demands regardless of the medical significance of such demands. But professionalism means a colleague-dependent mode of medical practice; medical services are provided according to professional standards rather than patient demands. In a colleague-dependent medical practice, physicians could control the patient flow by referring patients to other physicians. A referral system implies the formation of a functional division of labor among physicians hierarchically and horizontally. Professionals can maintain group solidarity by performing specific types and levels of practice, and relying on other professionals for further patient treatment beyond their specialty and their level of practice. Solidarity among the professionals is essential for collectively achieving professional power. Medical reformers wanted to construct a colleague-dependent mode of medical practice based on a functional hierarchy in performance among physicians.

A functional division of labor existed between large general or teaching hospitals and private clinics, but excluded small community hospitals. Medical reformers believed that the private practice of specialists blurred the division between clinics and hospitals. Private practice by specialists, reformers thought, wasted their talents, since specialists assumed the function of general practitioners by running private clinics. Medical reformers acknowledged that this trend had been inevitable under the past conditions of lack of growth of hospitals, but that it should be now corrected when hospitals have reached maturity. They tried to clarify the role of primary care practitioners and the role of secondary and tertiary care, which required specialists. Without this division, the functional hierarchy in the organization of the medical profession was difficult to put in place. Thus, medical reformers tried to tie specialists to hospitals and to prohibit private practice (KMA 1981: 17-18; SBY 1981: 99). Physicians majoring in family medicine, a newly developing field in the 1980s, were supposed to provide primary care.

However, medical reformers apparently underestimated just how deeply private ownership was rooted in the current HCDS. The title of specialist enhanced their market capacity, so that the specialist system strengthened the structure of entrepreneurship in medical practice instead of changing it. For specialists, the proposed plan to restrict their private practice implied a fundamental change in their

mode of practice. On the one hand, this meant a "proletarianization" of their role and subjection to the authority of hospital owners. On the other hand, this implied the end of the traditional route of successful physicians' upward mobility from being owners of small clinics to being owners of hospitals.

Group practice was suggested as a transient stage for transforming specialist clinics into hospitals. Group practice was unpopular in Korea, but, theoretically, this solution seemed reasonable. But the problem was that physicians did not want to shift their practice based on private ownership to a corporate form of ownership. Group practice presupposes the spirit of sharing facilities, but it was doubtful that physicians were willing to accept such "collective ownership." Although medical reformers invented the ideal model of professionalism, their proposal was weak in strategies of how to change the current medical system into an ideal system.

The KMA has tried to mitigate this radical change. In a 1983 research report that estimated the demand for specialists, the KMA argued that private specialist practice should be maintained and that the transformation of private clinics into a group practice or a hospital should be voluntary (KMA 1983). The attitude of practicing physicians toward this notion was demonstrated when, in 1986, the state tried to enforce a policy of forcing specialists to serve in hospitals during a specified period. Running specialist clinics, moreover, had to be authorized by the state in advance. This state policy faced severe objections from specialists and the KMA. They stated their objections, as follows :

First, this restriction is a violation of the provision of Freedom of Occupational Choice in the Constitution.

Second, bureaucratic control of the production of specialists will result in the distortion of the structure of medical personnel; some specialties will be oversupplied and some undersupplied. This will contribute to the decline of the specialist training system and will lead to the decline of quality of care and the decline of medical science.

Third, when specialists are to work only in hospitals, the tendency that patients are concentrated in large hospitals will be intensified.<sup>17</sup>

The first reason is normative. The second and third reasons are realistic evaluations. The third reason is especially plausible when one considers that patients have been conscious of the specialist title as a determining factor in choosing a physician. However, the fundamental reason behind the objections was the fear about the end of entrepreneurship as a principle in medical practice.

The state has had difficulty in enforcing this policy, given the opposition of specialists, since they have dominated the medical sector. According to a 1985 KMA survey (KMA 1985), 58 percent of the physicians were specialists, and 27 percent were interns and residents, numbers that clearly show the dominance of specialists in the medical system. Half of the specialists were employed by hospitals and half ran their own clinics.<sup>18</sup> Among the 7,995 physicians owning clinics, 5,219 were

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17. This excerpt was summarized and translated by the author from Bogeon Sinbo Sa. 1987. *Yearbook of Health Care*, pp. 150-151.

18. The ratio of specialists to total physicians was higher in small cities than in large

specialists.

The fact that specialists were the major providers in the private practice sector cannot be underestimated. What was important to private practitioners, including specialists, was the protection of their private property : clinics and hospitals were no more than private property. Thus physicians wanted the establishment of the HCDS without changing the existing organization of the medical profession. It meant that any change should not be based on redefining the role of specialists, but rather based on a division of labor between hospitals and clinics. This notion of change occurred in 1985, when private practitioners and teaching hospitals in Seoul made an agreement for patient referral. The hospitals agreed to give priority to the referred patient in diagnosis and treatment, and report the results of treatment to the original clinics. Private practitioners are able to discuss their patients' treatment with the specialists in the hospital(BSS 1987 : 154-155). This agreement was an attempt of private practitioners to recover the trust of patients and to establish a division of labor between teaching hospitals and clinics. This attempt also showed, however, that there was no place in this voluntary division of labor available for small hospitals ; private practitioner regarded large teaching hospitals as their only counterpart. It is too early to evaluate the effects of this voluntary division of labor or to estimate how well this system works. But it is clear that the dilemma of entrepreneurism reflected in small hospitals will continue unless the hierarchical order among physicians changes.

## 2. Politics of Professional Dominance

The different stance between medical reformers and practicing physicians can also be found in the scope of medical practice. Medical reformers wanted to enhance physician productivity by rationally allocating the types of physicians and the types of care to primary, secondary and tertiary care medical institutions. Primary care institutions provide basic services for common and non-complex diseases ; secondary and tertiary care organizations are defined according to the complexity of symptoms and treatments requiring specialist services(cf. Lee, S.W.1983). Regulation of specialists' private practice was the logical outcome of such a idea. Although practicing physicians expected a higher income for higher productivity, medical reformers believed that an increase in productivity of physicians did not necessarily mean increase in their income. Medical reformers also believed that the segmentation of the medical market was a partial solution to the ever increasing number of physicians. Without expanding the scope of medical practice and creating a new dimension for the medical market, an increasing number of physicians would countervail the effect of the segmentation of the present medical market. Within this context, medical reformers emphasized the necessity for advancing the quality of primary care(c.f. Kim, I.S. 1983 : 26).

The domain of the PHC as a means to health care management for the total

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cities, because many new hospitals were established in small cities. Newly trained specialists had to practice in them because large cities were crowded with existing specialists. Thus specialists dominated the medical sector, not only in large teaching hospitals in large cities, but also in small cities.

community would expand the scope of medical practice to new services such as preventive services, regular physical check-ups, emergency care, continuing patient care, etc. (Ahn 1983 : 110). Medical reformers argued that secondary and tertiary care should be based on the PHC model, which would increase physician productivity and provide employment to increasing numbers of physicians without inducing competition.

In brief, medical reformers proposed a change in the role of physician from the healer of disease to the manager of health. Medical reformers ideologically rationalized this claim by introducing the concept of "right to health." Moon Ok-Ryun, a theoretician of medical reformers and professor at the SNU School of Public Health argued that "health care is a right rather than a privilege ; it is a basic right of every citizen to have available adequate health care, as well as clothing, food, and housing"(Moon 1977a : 7). Based on this new definition of health care, Moon insisted that the present health care system was irrational to guarantee the right to health care because of the state's lack of health planning, and because of conservative physicians who did not acknowledge the necessity to change a medical system.

Moon(1977b) also argued that both conditions were associated with a fee-for-service system of payment, which lowered the accessibility of patients to health care and also lowered physician productivity. He suggested the introduction of a Health Maintenance Organization system to solve both the matter of payment and the matter of physician productivity. His suggestions, however, have not been fully examined by other medical reformers since the state enacted and expanded the National Health Insurance. But NHI solved only the problem of payment. As discussed above, the insurance system intensified contradictions of the current medical system since the payment method has not been associated with changes in the mode of medical practice. Thus, medical reformers continued to work on mechanisms to enhance physician productivity.

The segmentation of the medical market was one alternative, if it were defined in terms of regulation of care, since physicians were expected to serve a defined group of people in a region. However, unlike HMOs, segmentation of the medical market had no clear organizational boundary to link physicians with their patients, because patients were not members of certain organizations. Although the regionalized system had an advantage over the current free market system in terms of linking patients to physicians, it did not have any mandatory obligation to serve the people and to enhance productivity.

Medical reformers approached this issue from a different direction, that is, to change the content of health services. The state had power to control the charges for specific treatments, but could not control whether or not a physician performs the treatment since this falls within the area of a professional decision. Under the current medical system, professional decisions were often made to increase profits without increasing physician productivity, as exemplified in the case of ultrasound scanner, as mentioned above. however, medical reformers tried to make use of the positive side of professional decisions, by permitting physicians to expand the scope of health care without undue state restrictions. Emphasis on primary health care thus developed in this context.

In the 1980s, medical reformers turned their attention to linking primary health

care units with hospitals. Yonsei University Hospital(in 1981), Korea University Hospital(in 1983), and Sooncheonhyang University Hospital (in 1986), under the initiative of medical reformers, implemented projects to connect hospitals and primary health care units. Although it is too early to evaluate these efforts, one thing that is becoming clear is that primary health care projects(or community medicine projects)<sup>19</sup> should have a organizational connection with dominant hospital services. Without this connection, primary health care will be regarded as a cheap or inferior service.

This shift in the concern of medical reformers reflects two concerns. First, medical reformers wanted to expand the linking of PHC services to hospitals to the whole nation, based on their experiences with the models at the local community level. Second, the content of programs in PHC needed to change. Improvements in living conditions in the last decade has changed the people's health behavior. Preventive actions like infant vaccination, antenatal care, and family planning practice became rapidly accepted and voluntarily practiced by many people. Thus, medical reformers had to develop new programs in addition to traditional ones to satisfy the people's heightened health needs, although the principles of organizing primary health care such as record-keeping and community participation have been maintained. Examples of such programmatic changes in content were found in the Jeonju Jesuit Hospital project, where a program was developed to control hypertension ; and in the Korea University project, where programs were instituted to control hepatitis, uterine cancer, hypertension, and diabetes, diseases that have arisen in recent years. This development in primary health care required the support of specialists and hospital facilities for both diagnosis and professional consultations. Medical reformers tried to persuade specialists and hospitals to pay more attention to community and epidemiological issues rather than concentrating on attending individual patients or conducting biomedical research. But medical reformers had to contrive techniques to make specialists and hospitals more actively participate in primary health care. However, the general response of specialists and hospitals was to ignore the issue.

Kim Il-Soon said that

Because of the deeply rooted conventional medical care value system, hospital care receives good support from a few politically powerful groups and also from those few who can afford hospital medical care. The hospital usually does not have a concept of target population to be served. Therefore, hospitals and personnel in the hospital do not have the notion for whom they are serving and responsible ..... The hospital does not show interest in community health needs, health problems of a community and socioeconomic factors related to the etiology of all these health problems, which are the very basis of the origination of the concept of primary health care. The present role of the hospital, therefore, has become a major obstacle in implementing the primary health care concept into realization (Kim, I.S. 1984 : 193-194).

19. In the 1980s, the term "primary health care" replaced "community medicine" among medical reformers.



Kim acknowledged that political will through national planning as well as through national health policy was the most important power for turning the PHC into a reality. But medical reformers, including Kim Il-Soon, have wanted specialists to voluntarily participate in primary health care. Medical reformers asked specialists and hospitals to understand that primary health care was not inferior, simple and cheap care, but that the role and functions of primary health care were different from that of hospitals.

Here lies the dilemma in the Korean health care system. Medical reformers claimed that by establishing primary health care connections to hospitals, both hospitals and specialists would benefit. Such a link would enhance the social image of hospital as a community health center which serves the entire community, and the numbers of patients would increase. However, the large teaching hospitals and their specialists have usually been satisfied with the number of incoming patients and did not feel the necessity of approaching patients directly. Small hospitals or private practice specialists have been strongly motivated by entrepreneurship so that they did not appreciate a primary health care system.

For medical reformers, the domain of primary health care encompassed a very large new medical market, one which both primary care practitioners and specialists and hospitals could share and which could eliminate competition between them. It could also upgrade the quality of care in medical practice. Under the current system of medical practice, professional dominance over the health care system was limited because of limited resources. Competition was the natural result of scarce resources coupled with increasing number of physicians. A new dimension of health resources was inevitably needed for upgrading physician productivity and the level of medical practice. Yet the obstacles of entrepreneurship and narrow-minded specialists was hard to overcome. Thus, today's medical reformers may have to rely on the state to enforce the change in the structure of the medical system if they want their reform as soon as possible.

### **3. Politics of Professional Autonomy**

Another factor needed for the formation of a powerful medical profession was to design the mechanism to effectively buffer state intervention in the health sector. This does not mean the rejection of every state intervention but rather implies the tailoring of the intervention. Medical reformers considered that current contradictions in the health care system were rooted in the lack of a state intervention for the development of the rational health care system (Moon 1976). They felt that the state should be involved in the health sector, but in a way that would promote a rational health care system rather than in a way that would restrict and control the autonomy of the medical profession as before. In proposing the reform of the HCDS in 1981, medical reformers agreed with the following principles:

First, since the present health care system was a historical product within the context of political democracy and capitalism, the future path of the health care system should be made within this context.

Second, the state control over the medical sector should be limited to national planning, and the state should not intervene in the private sector as a main

producer of health services. The public sector is to complement the private sector by focusing on the functions that are not able to be satisfied by the private sector (KMA 1981 : 1 ; SBY 1981 : 23-24).

Not only medical reformers but also practicing physicians seemed to agree with these two principles. Physicians felt that their contribution to expanding the national capacity of health services production should be credited. In other words, physicians' efforts to accumulate capital and build clinics and hospitals should be evaluated positively, since such way of providing medical care was inevitable because state funding was insufficient and the community did not participate in the provision of health care (Kim, I.S. 1983 : 20).<sup>20</sup> Physicians thought that the state should acknowledge their role as producer of medical care and should not intervene ; since 1945, the major producer of medical care shifted from the state to the private sector so that, today, the public sector should specialize in providing health services that could not be provided by the private sector, including preventive services and health care for the poor and residents in remote areas (KMA 1981 : 22). They argued that state's involvement in the production of medical care should be minimized because it would result in inefficiency and bureaucratic red tape, as evidenced by the deteriorated public hospitals, and lead to the lowering of the quality of care.

In a word, medical reformers, as well as practicing physicians, argued that the state should be more actively involved in the health sector in order to realize medical welfare of the nation," but should respect physicians' professional autonomy in deciding quality of care and adequate types of services. Behind this argument lay physicians' general suspicion of state intervention. Physicians argued, for instance, that the fee schedule of NHI set by the state was too low and disregarded the customary fees charged by physicians. A low fee schedule resulted in defensive physician behavior that resulted in patient dissatisfaction and conflicts between doctor and patient (KMA 1984a, b). It was argued that quality of care and adequate services could not exist without respecting professional autonomy.

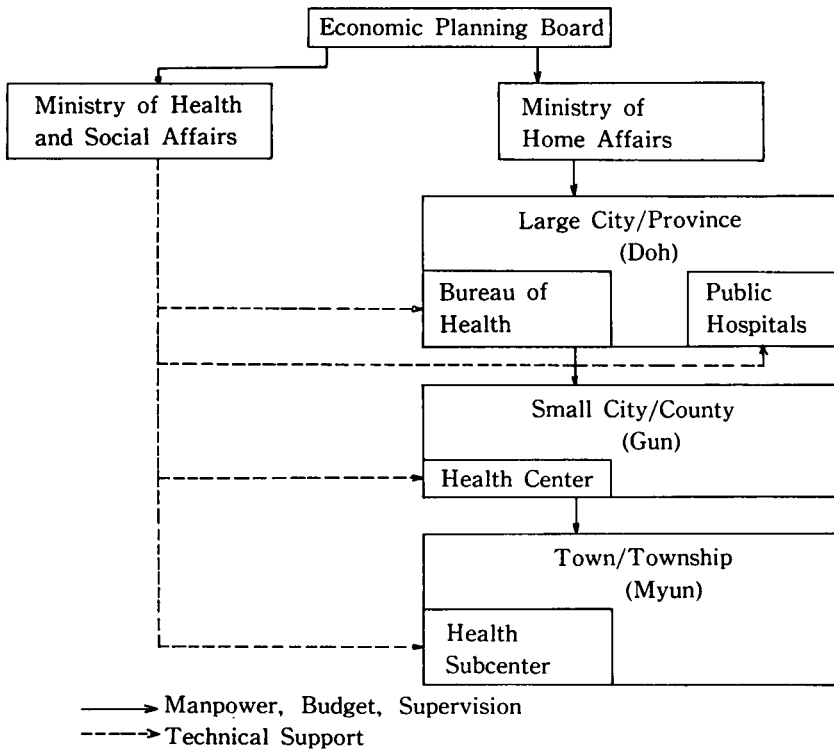
As shown in Figure 2, health administration in the central government is influenced by the EPB.<sup>21</sup> As discussed above, EPB exerted influence over MOHSA since it controlled the budget of MOHSA and the task of national development planning including health planning. Even after drafting the plan for the HCDS, EPB suggested establishing a medical college with a four year course for "assistant-physician", a renewed form of the nurse practitioner. The purpose behind this new title was to establish a "cost-effective" practitioner, based on the success of nurse practitioners in the old scheme. It would thus change the latter into a formal and stable category of health worker, who would contribute to the efficiency of the PHC (cf. BSS 1984 : 41). Although the policy plan was not enacted, this illustrates how EPB tried to intervene in the process of health policy-making. MOHSA, over

20. This argument had some validity in that clinics in the 1950s and 1960s were a form of health service production which provided relatively cheap medical care, compared to hospital services.

21. Although Figure 2 shows only the influence of EPB over MOHSA, this does not mean that only EPB influences MOHSA, as discussed in the previous section. Figure 2 indicates that EPB has a stronger influence than other ministries.

which physicians were able to exercise significant influence, was relatively powerless within the government structure.<sup>22</sup> Thus, physicians' efforts were blocked by inter-ministerial politics, which was an effective mechanism of the state to buffer pressure from interest groups. At the local governmental level, health administration fell completely under the control of general administration. An original policy goal of MOHSA was sometimes blocked or reinterpreted under this administrative structure. For instance, health workers in Myun offices had to support the tasks of general administration rather than to work solely for health issues.

**2. The Current Health Administration Structure**



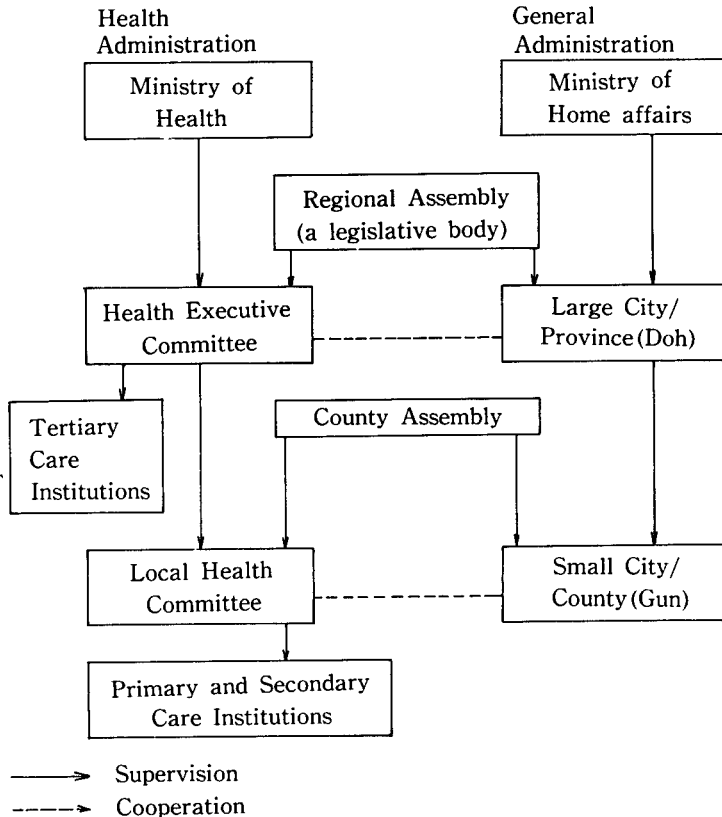
Source : Seoul Bogeon Yonguhoi(1981 : 29)

Medical reformers thus proposed the independence of health administration from

22. The route of influence of physicians over MOHSA was usually made through lobbying with the higher officials in MOHSA. In the 1970s, no physicians were appointed to the minister of MOHSA. But the major position for health administration in MOHSA, the chief of the Bureau of Medical Affairs, has always been filled by a physician-bureaucrat, and that position has become a front line to protect anti-physician policies. One lower-level bureaucrat in MOHSA told me that when they made a policy plan that might negatively influence physicians, it was overturned at the level of the Chief of the Bureau (Personal Interview, March 16, 1988, Seoul, Korea). Also, the physicians becoming National Assembly members played a role mediating between government agencies and the medical profession, promoting pro-physician policies, and preventing the enactment of anti-physician policies in the National Assembly.

general administration both at the central and local government level, which would allow physicians to systematically exert influence over the planning and implementation of a health policy. Figure 3 offers a model of health administration suggested by one group of medical reformers. The most important change suggested by this model is the independence of the Ministry of Health from the EPB and from the Ministry of Home Affairs. Since physicians and organized medicine could strongly influence the Ministry of Health, this independence of health administration within the central government would be an effective mechanism to buffer unfriendly pressures from the other ministries. Regional and local health administration bodies would be newly established under the authority of the Ministry of Health. The focal point in these local bodies was an executive committee to administer local health administration. The proposed model suggested the committee be comprised of representatives of local physicians and civilians, no doubt with the result that physicians would play the decisive role in the committee. In addition, medical reformers allocated prospective functions to each level of the health administration body and defined necessary personnel and their qualification. Under this scheme, physicians would be able to influence all levels of administration of planning, implementation, and evaluation, as well as all other health-related areas. This was an obvious way to restrict the state's arbitrary intervention and to promote pro-professional state policies.

**Figure 3. The Proposed Structure of Health Administration**



Source : Seoul Bogeon Yonguhoi(1981 : 68)

Medical reformers argued that health administration required the expertise to be provided by physicians. However, one questions whether the goal for better health can be obtained only by health experts. Kim Kwang-Woon, Professor of Public Administration at SNU, argued that the present structure of health administration did not guarantee professional autonomy since bureaucrats who were ignorant of professional tasks governed health administration (Kim, K.W.1977). But he suggested a balance between professional and bureaucratic factors in health administration be maintained rather than creating professionalized administrators, since the bureaucratic line represents interests of the general public against professionals' interests. Professor Kim's analysis claims that the current problems in health administration were not due to the lack of the professionalized administration line but due to inadequate resources and techniques to rationally organize existing medical institutions and to effectively administer policies.

The state plan for the HCDS does not address the issue of the independence of the Ministry of Health. The coalition between the state and medical reformers resulted only in agreement in terms of technical issue, rather than of power issues. In other words, the state and medical reformers agreed only with the technical means for reform. The power issue of who would control the reformed HCDS was not discussed. As long as the state maintains the policy direction for low governmental financing and high bureaucratic control, the independence of Ministry of Health seems to be unlikely. As far as the current system of health administration is effective for buffering the physicians' pressure, the state would continue to maintain it.

#### **4. Politics of Professional Monopoly**

The oldest version of professional power began with a monopoly of the medical market. However, Korean physicians were placed in a different context from this conventional model. The competitors such as pharmacists and herb practitioners were legally approved to practice their profession. Medical reformers used the strategy of ignoring the role and function of pharmacists and herb practitioners in the process of creating the HCDS, so that their role and function would remain at a peripheral status or decline. If reform of the HCDS was to be achieved, as medical reformers intended, physicians would dominate the planning, implementation, and evaluation of state health policies both at the central and local levels, under which little significance would be placed on these practitioners. Furthermore, since physicians would control health care needs more systematically, from the community level to the general hospital, patient reliance on these practitioners would decline.

Unlike physicians, organized pharmacists and herb practitioners did not attempt to formulate a rigorous plan to reform the health care system. While they suggested some changes in terms of their own role and function, their proposals for change remained at an abstract level, suggesting merely principles or basic directions rather than giving state bureaucrats sufficient rationales and details for change on the basis of hard evidence. Nor did they try to carry out experimental field research, as did medical reformers. Thus, non-physician practitioners lacked the capacity to compete with physicians and to maintain or enhance their role within the health care system.

As physicians have expanded their capacity in the private sector, their relations

with other practitioners changed. Medical peddlers virtually disappeared. The role of pharmacists has declined. But herb practitioners, however, enjoyed renaissance for the development of herb medicine, a change that was structurally induced. Although the growth of the medical sector contributed to the decline of inferior services provided by medical peddlers and pharmacists, herb medicine, which was not associated with medicine in terms of the philosophical foundation and practices, was able to attract more attention from the middle class.

Patient reliance on pharmacists declined as their reliance on physicians ascended. According to two health surveys carried out by the government in 1982 and 1983 (KIPH 1982 : 129-130 ; 1984 : 48-49), half of the patients surveyed used pharmacist shops, while 40 percent visited hospitals or clinics for treatment. When patients were covered by the medical insurance, the use of hospitals and clinics was higher than the use of pharmacist shops. This change in the pattern of patient behavior increased the power of physicians to the detriment of the pharmacists.

The cause of the decline was rooted in the structure of pharmaceutical practice. The role of pharmacists in the health care system had extended above their qualifications. Their growth in the 1950s and 1960s reflected the decline in the physician's role. But as physicians recovered their role and as the number of pharmacists increased, the market for pharmacists became overcrowded. In 1984, there were about 18,000 active pharmacists ; 85 percent of them ran shops, while 6 percent worked in research and development for pharmaceutical production, and only 4 percent worked in hospitals and clinics<sup>23</sup>. Since the early 1970s, leading pharmacists and professors in pharmaceutical colleges argued for changes in education that would heighten professionalism, that is, educating pharmaceutical students to be professional pharmacists able to deal with pharmaceutical affairs in health care rather than shopkeepers or drug sellers (Hong 1974 : 83-100). Such new roles and functions of pharmacists in patient care in hospitals as managing pharmaceutical history of patients, producing adequate types of pharmaceutical products for special needs of patients, guiding adequate drug taking, consulting with physicians about pharmaceutical effects on patient treatment, etc., were suggested by several pharmaceutical professors. In addition to clinical pharmacology, preventive pharmacology began to be emphasized, a concept that was similar to preventive medicine.<sup>24</sup> However, this change was not realized. The participation of pharmacists in patient care presupposes the consent of physicians. At present, it is obvious that physicians are reluctant to support this proposal not only because they reject any (semi) professional role of non-physicians, but also because such pharmacist participation in medical practice requires a change in physicians' practice, a new dependence on pharmacists in significant parts of medical practice—the importance of medications in treatment. Pharmacists had no leverage to enforce their plan over physicians unless the physicians were willing to accept such participation

23. The data are from : Bogeon Sinbo Sa, 1984. *Yearbook of Health Care*, pp. 317-318. Active pharmacists were calculated by subtracting the non-active pharmacists, such as retired or home-makers, from the total registered number.

24. For further details, refer to the special section on Pharmaceutical Education and Practice listed in : Bogeon Sinbo Sa, 1985. *Bogeonsinbo* (Health Care Newspaper), no. 1906, January 3.

as part of the "best care" for patients.

The case of herb medicine was somewhat different. Herb medicine followed the path of "modernization". Herb practitioners became trained in herb medical colleges, and even post-graduate training was added in the 1970s so that large teaching hospitals were constructed solely for herb medicine.<sup>25</sup> The major portion of medicinal herbs was imported from abroad. Domestic pharmaceutical firms began to produce processed herb products. As the demand for herb medicine increased, the cost of herb medical services rapidly increased and was often more expensive than other medical services. Thus it became the medicine for the middle and upper classes who often used herb medicine after trying "modern" medicine, depending on the situation.<sup>26</sup> Although herb medical practitioners now claimed that herb medicine could deal with most categories of illness, and have tried to specialize their practice like physicians, the medical dominance over herb medicine has not decreased. Most patients used herb medicine secondarily in case of physical weakness or other chronic illnesses for which the therapeutic effects of Western medicine was not well developed. In many cases, the patient who was not satisfied by medicine sought alternative treatment in herb medicine. Despite recent development in herb medicine, the basic structure of medical dominance over herb medicine did not change, which caused physicians to pay less attention to herb medicine.

## 5. Conclusion : Limits of medical Reformers

Medical reformers played the role of intellectuals, understanding the changing structural conditions of medical practice and developing a plan for adapting them to the changing political economic structure of Korean society. They were able to ascertain the weak points of both the state and practicing physicians and develop their own capacity for formulating a coalition with both parts, for bridging the state and practicing physicians. Despite that accomplishment, however, their role did not end because there still remain many structural barriers to be overcome, such as physicians' conservatism for change and the state's adherence to bureaucratic control. Although they were successful in creating the plan of reforming the health care system, their strategies to transform the current system into that goal could not be accomplished without difficulty. In other words, although they succeeded in designing the technical plan for reform, they did not possess adequate political means to persuade practicing physicians or to force the state to enact reform as they envision it. Some compromise among different interests between the state and physicians may be inevitable in the implementation of the plan, which may require some revision in the original plan for reform.

This dilemma faced by medical reformers was fundamentally caused by their historical orientation to social reform. Although the role of medical reformers was

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25. In 1975, there were only two herb medicine hospitals comma but by 1984 the number of herb medicine hospitals had increased to 16. Herb clinics increased from 2,377 to 2,798. Herb medicine colleges increased from 1 to 5 during this period.

26. In 1987, the National Health Insurance Corporations began to reimburse for herb treatment in 1987. If the coverage of the Insurance for herb medicine expands, herb medicine would obtain a new chance for development.

significantly enhanced for the last decade, their power was still limited by their dependence on the state and fellow physicians ; medical reformers did not develop their social basis of power independent of both sources. They did not actively approach the common people for reforms in the health care system. Rather, they approached the state and practicing physicians and tried to persuade them. Medical reformers were basically dependent on the state and practicing physicians for their existence. Thus, medical reformers could not force practicing physicians to make significant concessions, when the latter were strongly opposed, as in the case of restriction of specialist private practice.

Even though the reformers' plan for change would benefit patients in many respects, they could not mobilize the people so as to force practicing physicians to change their behavior. Thus, any change would come from a coalition and compromise among the state, medical reformers, and practicing physicians. Such a coalition and compromise implies the exclusion of the people's needs, except as interpreted by the medical professionals. If these needs are not met, the power of the people could once again come into play.



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