Divergence of Healthcare Policies - By Comparing Medical Professional Groups' Different Influences in UK, and Korea

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I. Introduction

This study seeks to answer why countries with advanced economies have different tendencies in reforming healthcare policies in the era of neo-liberalism. This paper explores this topic by analyzing the dispositions of medical profession groups. I compare their characteristics in three countries focusing on two independent variables: the power of medical associations, and the governments' attitudes regarding medical policies. The first is specified by policy orientation and active-reactive inclinations of the government: specialized workers are much more autonomous and influential in coordinative-active countries such as USA, in contrast to hierarchical-active countries such as Korea. The second variable is concerned with how classifications and conflicts resulting from discriminative profits given by policies split the medical profession, weakening interest groups. The degree of fragmentation within a field determines the size of groups and the amount of power in each interest group. This results in different groups influencing a country's healthcare policies by different extents, which explains the divergence of policies; especially in the lever of privatization in health policies.

1) Why Welfare Politics in Healthcare Policies Differentiated from Others?

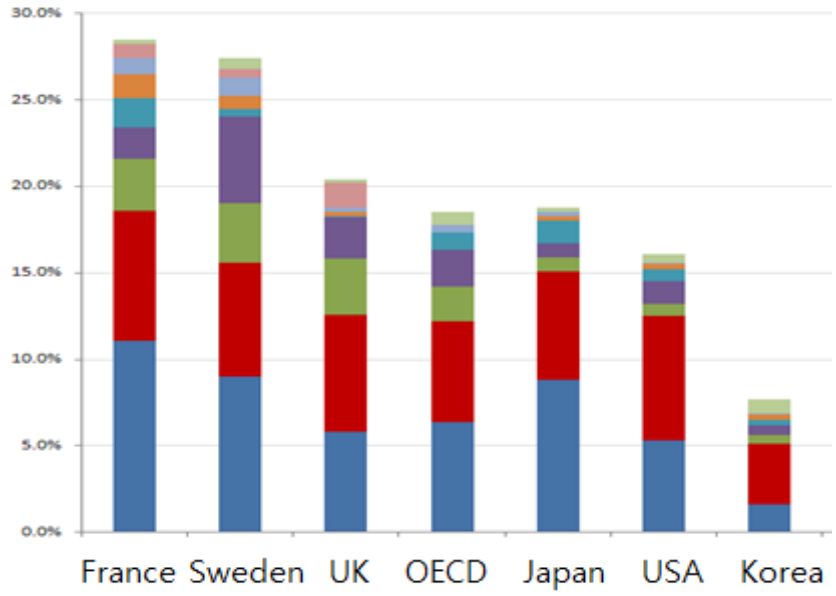
In the arena of medical and health care policy, ‘welfare state clients’ are atomized and reactive followers, not the issue maker. This does not conform to Pierson’s theory on ‘new politics of welfare state’ (1994). Even though the benefit ‘welfare state clients’ receive from welfare policy is a life or death matter, they merely follow left-wing parties’ slogans and policies. Surely they vote for the left-wing party, but they do not lobby congress to increase health care coverage. They are just ‘clients’ who accept reformed policy from the government. Likewise, Pierson’s theory based on power resource theory (Korpi, 1978) has little explanatory power. There are two reasons. First, although the health care issue is directly related to the whole population’s wellbeing, matters of medical and health care policy require a high degree of expertise. So ‘the clients’ are excluded from the negotiating table when it comes to medical and health care issues while medical profession groups who have professional expertise play the main role. Moreover, the main actor who participates in legislating the health care and medical policy with the government is the few number of elite groups. Unlike atomized customers, they have peak association to protect their interests. These groups of certified doctors such as BMA(British Medical Association), AMA(American Medical Association) and KMA(Korean Medical Association) had strong control over revenue sources. For example, they could negotiate the amount of government payments and fees from patients. Further, they managed who could and could not be certified as well as who could or could not be a member.

2) Why Healthcare Policies are Significant?

In dealing with the budget issue, governments have always tried to minimize

spending on health care policy and also reform it for efficiency since the era of neo-liberalism. Indeed, the following graph about OECD countries' SOCX (social expenditure) shows that public health care issues are the second highest source of expenditure.

[Figure 1: SOCX(Social Expenditure) of OECD Countries in 2007]



* Red part indicates the expenditure for public health care policy

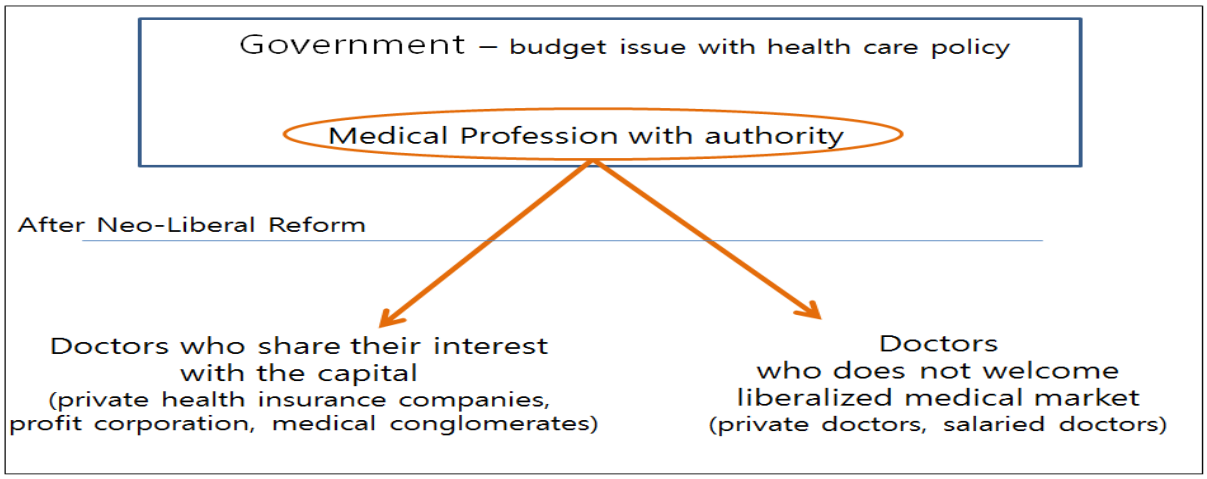
To lessen this burden, governments in advanced economies have encouraged private health insurance and for-profit hospitals. Indeed, Medicine has been at the center of much heated debate due to the fact that it is closely related to the problem of life and death, which some argue has made medical policy reforms a major driving force in advanced democratic nations' political agendas (Hacker, 2004). Medical programs have some characteristics that distinguish them from other welfare programs. First, it is associated to all citizens, unlike programs concentrated on specific brackets such as pension and unemployment insurance, which signifies all citizens react sensitively to any proposed changes to the medical program. Second, medical program reforms also have an economic nature along with the political,

making various interest groups compete to gain economic profit through policy reforms (Pierson, 1994). Third, there are various powerful pro-welfare interest groups that aim to make medical benefits more universal while on the opposing side are also various potent anti-welfare interest groups associated with the medical industry and private medical insurances. This thesis sees the medical interest group as the main agent, defined by Pierson to be anti-welfare. In this paper, main actors are those anti-welfare groups that have obvious economic interest.

II. Independent variable and hypothesis

In this context, the unitary peak association who leads the collective power of medical interest groups is fragmented into those who hold capital and those who do not, so that doctors in small and medium sized hospitals – such as general practitioner - formed one group and those in large hospitals formed another – such as medical conglomerates. The reason is that their economic interests are different. Earlier studies about the relations between interest groups and partisan politics assume that the medical profession is unified by the same interests. However, neo-liberal government reforms render this assumption out of touch with reality. Rather, what we see now is diverging interests within the medical profession group. Initially, the medical profession group constituted united elite monopolizing the medical market. However, it fragmented into two groups because of diverging economic interests when governments reform healthcare policies.

[Figure 2: Disaggregation of Medical Interest Groups]



Doctors who work for medical conglomerates supported neo-liberal reforms because they welcome new markets. On the other hand, doctors who work for small hospitals or have their own private hospital did not welcome privatization because it would threat their interests. According to Olson (1965), the number of members within a group determines the effectiveness of its collective action, and splitting the medical field into many smaller interest groups eventually enervates them.

H1: The less unified a medical profession group is over diverging interests, the more it will submit to health policy reforms.

H2: When the government reforms welfare policies, the level of healthcare's privatization is affected by the level of fragmentation of medical profession group.

1) Characteristics of Medical Profession Groups

Friedson(1986) views the authority of professionals as a derivative of market monopolization. The reason doctors have authority in society is because their monopoly over the medical service market is institutionalized. Profession group's characteristics are made by the government. First, the governments' attitudes regarding medical policies these are specified by policy orientation and policy implementation (Freidson, 2001). Policy orientation and active-reactive inclinations of the government effect on the level of profession groups' influence on the policy. For instance, specialized workers have considerably more autonomy in coordinative-reactive countries such as the USA than those in hierarchical-active countries such as Korea, who have had less influence on policy making than their governments. Second, Professionalism is specified by following characteristics. The professional has exclusive jurisdiction and sheltered position based on their specialized skill. Also, they control their formal training program that authorized by the government. To sum up, the professional groups' authority in their field and monopolizing their specialized market is possible with the government's endorsement.

'Power elite theory' also assume these characteristics of profession groups. With these characteristics, profession group has huge influence on government's policy. Moreover, when these elites have conflict of interest, they compete against the other group (Marmor, 2000; Alford, 1975). In this case, they lose their sole authority and monopoly in their specialized field that they used to shared inside, and pursues each other's own economic interest.

Because Freidson and Marmor's researches have focused on the characteristics of medical profession groups before the government's neo-liberal healthcare reforms, the updated and modified version of their models is following.

[Figure 3: Characteristics of Medical Profession Groups]

Characteristics / Countries	UK	US	Korea	Germany
Ownership of Medical Facilities – Predominantly Public	O			
Ownership of Medical Facilities – Mixed Public-Private		O	O	O
Financing Source(s) – Single Payer	O			
Financing Source(s) - Multi-Payer			O	O
Policy Orientation – Active	O	O	O	
Policy Orientation – Reactive				O
Policy Implementation – Coordinative		O		
Policy Implementation - Hierarchical	O		O	O

III. Analysis of the differences in influence levels resulting from segmentations in the medical community

Most developed Western welfare countries have all of the following four types of programs, but which of the four they chose to put the most weight on defines their welfare character (Choi, 2011).

First, universal program. Mares and Carnes's (2009) definition of national welfare program states that it must include all citizens. This type of program mainly gives payment and service to all citizens as their right, and those become sufficient to make the citizens'

reliance on private welfare secondary. Britain's National Health Service (NHS) is a primary example. Second, contributionary insurance, is an insurance service provided by the government and managed like a private insurance – it takes into account the amount paid for insurance and the client's income level. Third, selective program, also called public assistance, gives welfare benefits to the socially vulnerable, such as the poor and the disabled, without the need for any separate insurance payment. The United States' Aid to Families with Dependent Children (AFDC), Medicare and Medicaid are primary examples. Fourth, privatization is a complete switch from national welfare benefits to private. Governments of countries leaning towards privatization do not actively provide welfare benefits. The United States had a completely privatized medical insurance system before introducing a comprehensive medical insurance in 2010.

Considering the above programs, this thesis categorizes the United States, Britain, South Korea and Germany respectively as a residual and selective healthcare state, universal healthcare state, and contributionary healthcare insurance state. Taking each state's welfare characteristic into account, this thesis explores how the fragmentation and unification of medical interest groups affected government medical policy plans. In other words, each country's degree of medical interest group fragmentation is the independent variable, while the successfulness of their government's implementation of new medical policies is the dependent variable of this research.

1) Comparative analysis by countries

Pierson's (1994) research comparing the United States and Britain's welfare states can be credited to have identified interest groups within welfare politics for the first time. He shifted the focus of analysis from the classic organized labor to a wider range of individual program supporters and saw interest groups affiliated with certain social policies as important agents.

These include organizations of beneficiaries, groups associated with the supply of welfare services (medical, housing, education, etc.), interest groups with differing agendas depending on the type of public schemes introduced to the market (such as labor unions), and various advocacy organizations devoted to introducing welfare programs for the socially deprived and underrepresented (Pierson, 1994). This thesis focuses on the fragmentation of medical professional interest group, which exerts a powerful influence on public health policies. When disparities in economic benefits happen within the medical professional groups due to government attempts to reform medical policies, the group loses integrity and its power is weakened (Olson, 1965). On the other hand, if the medical reforms proposed by the government go against the interests of the entire group, solidarity among the group's members strengthen against the government, and there is no choice but to drastically change the direction of policies, even if the interest group did not originally possess much influence. This phenomenon is evident in the each case of UK, and Korea. Therefore, government's reformed public health policies result in a range of changes depending on the country if the medical interest group weakens due to internally conflicting economic benefits. The most conspicuous conflict happens between medical conglomerates and general practitioners (GP). If government policies endanger their individual stable economic gains (ex, capitation), GPs issue official statements and affiliate with beneficiaries of medical welfare programs to go against these changes, even if the representing association they are part of could benefit from such policies. In South Korea, GPs gained the support of patient groups by arguing for morality and the public aspect of medical welfare, stalling the extensive reforms introduced by the government (medical-pharmaceutical division controversy). With the support of the press, the medical interest groups successfully made the government change its plans to better accommodate their benefits.

2) Medical interest groups fragmentation and reformed Healthcare policy in UK and Korea by comparison.

With the view of corporatism, on the other hand, political phenomena are a product of structuralized relations between the state and a limited number of groups. It differs from pluralism in that it considers the state to be in charge of interest groups and behave as an active participant in interest group politics, instead of being a passive mediator. Under corporatism, interest groups are subject to regulations but have exclusive representation rights, which let them maintain a cooperative relationship with the state and become institutionalized to resolve social conflicts. Corporatism appeared as an alternative to pluralism, which was unfit for the European situation (Schmitter, 1974, Lee, 2010). This approach can explain the reform of public healthcare policy and movement of medical interest groups of UK and Korea. Both of countries are hierarchical-reactive in policy orientation. Also, financing source of both countries are fundamentally organized by strong government. Healthcare budget allocation and capitation for doctors were up to the government. NHS was a cardinal part of non-contributed universal welfare with Beveridge Report since 1942. Public healthcare system of Korea was built by Park Jeong Hee, the dictator. He introduced that universal healthcare to get more vote and supporters for his dictatorship. Since his ruling period, medical profession group in Korea has subordinated their economic interest to the government.

The organization of interest groups in both countries is characterized by limited numbers, compulsory membership, non-competitiveness and hierarchical order, which guarantees them exclusive representation rights. In other words, it is a system that gains exclusive rights to represent the interests of the group's members at the cost of being hierarchically organized by the state and accepting state regulations on the selection of the group's leaders and on the method of

expressing demands and endorsements. However, different action of medical profession of two countries brought opposite result in the policy reform.

Britain's conservative party reform of 1989 adopted a quasi-market principle on the NHS, introducing an internal market into its system (Choi, 2011). This reform let the internal market take over the centralized NHS's guidance and official planning. In other words, it planned to allocate resources by making numerous interest groups within NHS to compete for their own benefits. As opposed to the original NHS system, in which the government was responsible for both the supply and purchase of medical services, the new system assigned the supply part to suppliers (hospitals, budget-holding private practitioners, etc.) and limited the governmental role to buying from the best suppliers. The conservative government aimed to improve the efficiency of the delivery of medical services by separating the supply from the demand and encouraging competition. This reform was opposed by patients who were benefitting from medical welfare and by large-medical-trust-affiliated GPs who were earning stable profits from the original NHS system; GPs did not hold nearly as much budget as large hospitals and medical trusts, which put them at a severe disadvantage in the supply competition. Britain's medical interest group, which formed a powerful independent profession group, fell apart into smaller groups with colliding interests, thereby losing the power to change the government's reform plans. As the result, the level of privatization in health policy was increased.

Even though they have similar characteristics, medical group in Korea was strongly against to the government's reform to decrease public healthcare budget. Under the assumption that each agent is rational and act in order to maximize their gains (Silverman, 1971), the professional community has the power to influence the government's policy reformation in the event that such changes are expected to compromise their utility. If they show strong solidarity and strive to improve their gains, it is possible that policies end up following a

direction not originally intended by the government. The new policy so called 'the pharmaceutical separation' was originally intended to cut long-term welfare budgets by relying on the medical community to fill uncoverable costs, because it was difficult for the Daejung Kim government, which strongly advocated an increased national treasury support on local insurances, to propose insurance fee advances. However, the strong solidarity among the medical community and the resulting political influence lead to an increase in insurance fees and personal expenses – an outcome directly opposite to the government's intentions (Lee, 2006). As the result, unlike the case of UK, the level of privatization was decreased.

The medical community triumphed over the government thanks to such solidarity and profit-maximizing behavioral patterns, increasing medical fees and vesting the right to prescribe to themselves. The medical-pharmaceutical agreements of November 2000, which reflected this situation, resulting in an increase in individual medical expenses and a postponing of patient accommodation improvement operations, contrary to government intentions.

[Figure4: Healthcare Expenditure of Public and Private Part in Korea]

General government expenditure on health as a percentage of GDP ①+② **= 100%**	① (General government expenditure on health as a percentage of total expenditure on health)	② (Private expenditure on health as a percentage of total expenditure on health)
2013	53.4	46.6
2012	54.5	45.5
2011	55.5	44.5
2010	56.6	43.4
2009	56.5	43.5
2008	54.5	45.5
2007	54.7	45.3
2006	54.7	45.3
2005	53	47
2004	52.6	47.4
2003	52.2	47.8
2002	54.2	45.8

2001	55.3	44.7
2000	49	51

Figure4 shows that public expenditure in healthcare services is dramatically escalated from 2000 to 2001. This is because the government's healthcare reform was frustrated by strong medical group in Korea at that time.

2-1) Government's second pro-market reform and fragmented medical interest group in Korea

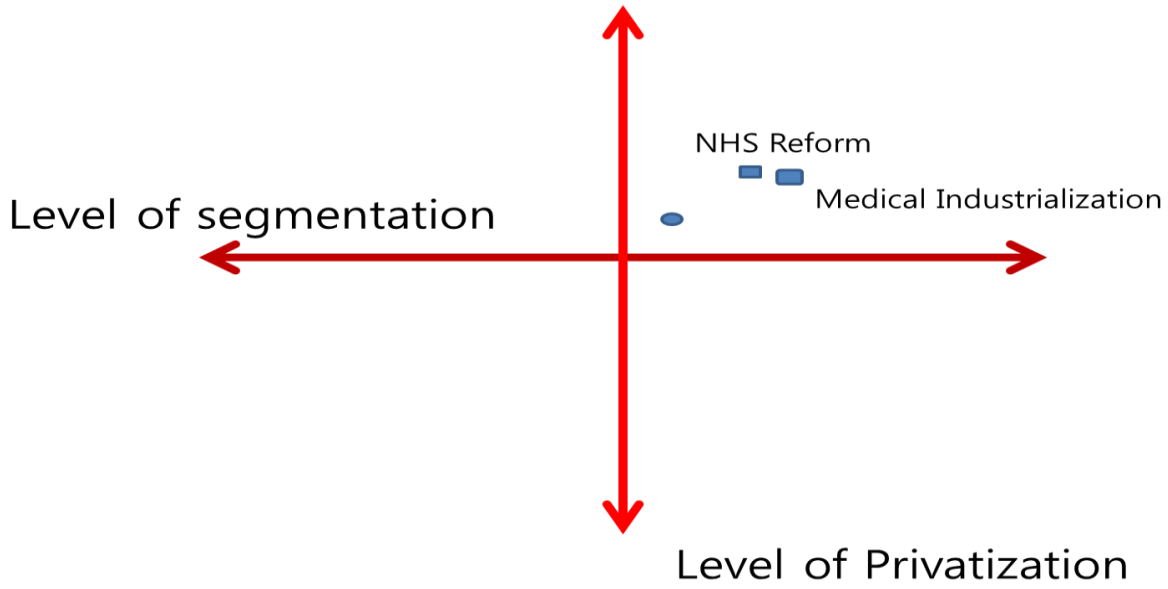
As an aftereffect of the neo-liberal financial globalization, the Ro-Muhyun government – left-wing and pro-labor party - started a macro-economic project, and actively tried to internalize the new post-IMF-crisis financial order. This was an effort to improve not only the international economic situation, but also the inefficiency of the domestic public services. Medical industrialization was proposed as a part of the above neo-liberal economic reformation (Lee, 2008; Hong, 2007). Medical industrialization can be seen as a part of a service industry advancement project that bases on the idea of privatizing public services in order to attract foreign and domestic investors, enabling high profits. In particular, it aimed to commercialize nonprofit organizations to nurture the capital market, and open up the possibility of investing the so-earned profits to non-medical fields for the ends of gaining more profit (Gu and Choi, 2008). After the Muhyun-Ro government, privatization in Korea is essentially a 'systemic' privatization (Feigenbaum and Henig, 1994) in that it decreases the role and power of the government, lowers citizens' expectations on political administration, and aims for a change in the nature of public policy itself (Song, 2012). The Ministry of Strategy and Finance administrators of the time advocated the privatization of the medical

industry in order to increase international competitiveness of domestic medical services, to amass profit from foreign investors, to increase available job offerings, to provide investment options for liquid capitals, to increase the quality of services, and to decrease medical fees through competition. Furthermore, even the Ministry of Health and Welfare, which insisted that medical services should have a public nature, agreed to let private hospitals in the Free Economic Zone diagnose local residents, under the condition that public medical services are expanded (Lee, 2008). Pierson's pro-welfare alliance is not applied here because contrary opinions by civic organizations were not taken into consideration during these decisions.

It can be said that medical industrialization can be attributed to external changes triggered by the government, rather than to the profit-maximizing behaviors of monopolistic community of medical professionals. Similar to the aforementioned case of the medical-pharmaceutical separation policy, the government led the privatization of the medical industry in order to cut welfare budgets. However, the medical community's reaction to this policy was far from unanimous. Different from the medical-pharmaceutical separation policy, in which the medical community could profit from solidifying into a single opposition group, privatization of medical services would clearly split the community into a winning side and a losing side. This is because small clinics would lose patients to larger hospitals built upon larger capital, and if they turn into profit organizations, they could be absorbed by larger firms and become a subsidiary company. Furthermore, the 'u-health' program advertised by the government, which promised increased profits and better patient accommodation, was difficult for small clinics to implement. Big hospitals, on the other hand, could look forward to expanding their business by investing in a larger variety of opportunities, and welcomed the birth of a new market for medical services.

IV. conclusion

In summary, in the case of the medical-pharmaceutical separation policy, the medical community in Korea showed great solidarity in going against the rivaling the government. In contrast, the medical interest group in UK was internally separated, NHS reformed as government intended. Their unity was strong to the point that their political influence warped the government's original purpose of implementing this policy. Though healthcare issue is specialized and unsymmetrical, medical profession group's monopolized dominance is enervated in the market. However, in the case of the privatization of the medical industry in 2000's Korea, the opposing stance between small and large hospitals brought internal segmentation, and the policy is being implemented according to the government's intentions due to the resulting plunge in the political influence asserted by the medical community.



In addition, in the latter case, it was difficult for medical communities to gather supporters by appealing to the inherent public nature of the medical market, over which they had monopoly. Unlike the main thesis from Pierson's welfare state clients, the issue of

protecting public health rights was not a part of the discussions concerning the privatization of the medical industry. Also, unlike Korpi's power resource theory, financial burden make the left-wing government follows the market rule in the welfare policy issue, especially in healthcare. Different from the medical-pharmaceutical separation case, the government's position in proposing this policy was clearly a financial one, involving the issues of 'efficiency' and 'financial integrity'.