Configuring the New Topography of Korea's Professional Interest Group Politics:

An Investigation into the Declining Power of Organized Medicine in Health Politics

Soon-yang KIM

Abstract

The purpose of this article is to spell out the changing landscape of Korea's professional interest group politics through an investigation into the factors that brought about a reduction in the monopolistic power of organized medicine in Korean health politics. To this end, the article first debates two theories concerning organized interests and their relationship with the government—pluralism and corporatism—and then summarizes changes in the Korean healthcare subsystem. The forces that made possible the role of the Korean Medical Association (KMA) as the sole representative of medical interests are also detailed. The main part of this article strives to use diverse angles to illuminate the principal factors that brought about the decline of the KMA's monopolistic power: the environmental context, the changing relationship between the government and the KMA, health policy changes, and the KMA's internal affairs.

Keywords: professional interest group, organized medicine, Korean Medical Association (KMA)

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Introduction

Traditionally, Korean professional interest groups such as medical and pharmaceutical associations have been political giants in relevant areas of specialized policy such as health policy. They have helped to establish the closed policy system by making adequate use of their professional knowledge and information, and their distinctive professional jargons further secured their autonomous activities without oversight from the public. For a long time, professional groups have effectively advocated their own interests in the policymaking process through channels of institutional access to the government and Parliament, and have wielded great power in Korean interest group politics by various methods of interest input.

Among the policy areas in which the influence of professional organizations prevails, health policy has particularly been dominated by conflicting healthcare professionals, thus making the policy process particularly noisy and turbulent (Walt 1994). In Korea, while the bickering of physicians, pharmacists, and herbal medical doctors surrounding occupational jurisdiction is particularly serious, physicians have traditionally been the most influential on the affairs of health care, and as such their interests have been a main source of influence on health policies. Although Korea's health policymaking system has been considerably opened in recent years, physicians still wield great power over health policy by conveying their interests through the Korean Medical Association (KMA).

The KMA, the sole authority in the field of medical interests, is a key player in Korean health politics.[1] It is financially independent and boasts a large membership. The KMA possesses high-quality information and professional knowledge on health policy, and its members

1. As used in the title of this article, the term "organized medicine" is quite a broad concept that includes all kinds of medical interest groups irrespective of their size and the level of interest representation. However, in the case of Korea, the KMA is the only legally acknowledged medical interest group, as well as the sole nationwide umbrella association of physicians. Accordingly, this article, when needed, uses the term "organized medicine" interchangeably with the KMA.

are socially respected. Owing to these extraordinary resources, the KMA is of great importance in health politics. The KMA maintains access channels to the government, both formally and informally, in every important decision-making venue, and the government acknowledges the KMA as a key policy partner.

However, this does not mean that the power of the KMA supersedes that of the government. Although the government greatly depends on the KMA for collecting medical information and enforcing health policies, it has several measures at its disposal to control the KMA. In actuality, the KMA's monopoly in representing the country's medical interests has been, in large part, allowed by the government with the aim of effectively managing health policy. Moreover, the KMA's influence has decreased sharply in recent years. The closed healthcare subsystem that enabled the KMA to exercise power in health politics is undergoing transformation along with the democratization of Korean politics and society. The general public and civic groups now keep a close watch over the health policy process, and that has opened Korea's health policymaking system to a wider variety of stakeholders. The government can no longer offer special courtesy to the KMA, as the checks and balances between conflicting healthcare interest groups have increased. Under these changing circumstances, the monopolistic power of the KMA has been in jeopardy.

Considering this context, a primary goal of this article is to narrate the changing terrain of Korea's professional interest group politics through an investigation of the forces that have brought about the decline in the monopolistic power of organized medicine in Korean health politics. This article first examines the two competing perspectives on organized interests—pluralism and corporatism—to lay the foundation for a theoretical framework. Next, the article discusses the changing nature of the Korean healthcare subsystem, the fluctuating power of organized medicine in the subsystem, and the development of the KMA as the sole representative of medical interests. The next section explores the many causes for the power decline of the KMA such as the environmental context, the changing relationship between the government and the KMA, changes in health policy,

and the KMA's internal affairs. With regard to methodology and data collection, this article mainly relies on qualitative document research by referring to a variety of official and unofficial materials including government statistics, healthcare-related newspapers, KMA documents, and statute books. With regard to the unit of analysis, this article mainly considers the KMA as an interest group that individual physicians formulated to articulate their interests in the process of medical and healthcare policymaking. Therefore, the fluctuation in the power of individual physicians or the notion of physicians as an occupational group is not a main concern of this article, and thus is mentioned only in a limited way when relevant.

Competing Theories on Organized Interests

Despite many theories on organized interest groups and their relationships with governments, the most common way to classify them is in terms of two contrasting perspectives: pluralism and corporatism. Pluralism defines an interest group as a group of individuals sharing similar attitudes and demanding something of other social groups, and puts interest group politics at the center of the political process (Truman 1971). To pluralists, interest group politics maintains political equilibrium, due to mechanisms of countervailing powers and overlapping memberships; thus, policy is the balanced state reached through the competition among interests (Hill 2005).

Meanwhile, corporatism is "a system of interest intermediation in which the state mediates conflicts by incorporating interest groups in the policy process in the situation where there are conflicts between more than two interest groups, and these interest groups accomplish self-regulation functions through the monopoly of interest representation" (Young 1990, 76). Corporatism gained popularity as a useful tool for analyzing the stable relationship between the government and interest groups in the policy process. It is particularly advantageous when explaining the government's control over interest groups in developing countries and the making of social partnerships

in advanced countries in efforts to tackle economic stagnation (Minnich 2003). Corporatism has widened its applicability from the macro-level relationships between the government and peak associations to the meso-level relationships between government departments and sectoral interests (Cawson 1986).[2]

It is typical to categorize corporatism into societal and state corporatism. While societal corporatism emerges in advanced capitalist societies with an aim to build the democratic welfare state through the mediation between conflicting interests, state corporatism tries to secure social order through the government's leadership in developing countries. Albeit similar in appearance, they are opposite in their motives and the processes by which they are shaped. While societal corporatism comes from the autonomous penetration of interest groups, state corporatism is largely formulated by government coercion (Williamson 1989).

The two perspectives have contrasting opinions on the government, interest groups, and their relationship. To begin with, they adopt different versions on the nature of the government. Pluralists regard the government as a neutral player moderating conflicting interests by setting rules and supervising the observation of those rules (Hill 2005). However, corporatists view the government as not just a neutral referee, but instead as an entity that pursues its own interests (Shively 2003).[3] The government controls interest groups through measures of constraints and inducements.

Pluralism draws a strict boundary between the government and interest groups. Interest groups compete with each other and exert pressure on the government externally. Meanwhile, in corporatism, the boundary between the government and interest groups is blurred.

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2. Meso-corporatism is based not on a class interest but on a sectoral one, which cuts vertically across class interests (Young 1990), and it is outstandingly effective in analyzing the symbiotic relationship between government departments and professional interests in particular policy areas (Cawson 1986).
3. In corporatism, "not only does the state routinely finance, encourage and consult interest groups, but the system of involving them in the policy making process is an important institutional feature" (Gould 2001, 188).

The government privileges authorized groups, whereas interest groups moderate interest articulation and support the enforcement of agreed policies. Interest groups engage in systematic dialogue with the government (Shively 2003).

Pluralists envision an open and fluid interest intermediation system in which diverse groups possessing different concerns can freely participate in the process of interest advocacy (Baumgartner and Jones 2009). Although some actors such as business groups and organized professions are more influential, no group is intentionally alienated, as each interest group has its own share. In contrast, a corporatist interest intermediation system is generally closed and stable. Only small numbers of authorized groups are invited to be corporatist partners, and they are obliged to abstain from making strong demands and to observe agreements.

With regard to membership affiliation, pluralists assert that individuals voluntarily affiliate to or secede from interest groups depending on shared values or potential benefits (Mundo 1992), but mechanisms of membership affiliation in corporatism are complex and mixed. While membership affiliation is relatively autonomous in societal corporatism, it is largely coercive in state corporatism in order to induce general compliance in implementing decided policies.

Under pluralism, interest groups mobilize their diverse methods of interest input. Power-level methods include lobbying, formal or informal one-on-one meetings with key officials, recommendation letters, the supply of technical information, and drafts of legislation. Mass-level methods include public rallies, signature-seeking campaigns, telephone campaigns, press conferences, the issuance of statements, public ads, attendance at public hearings, and litigation (Watts 2007). Meanwhile, under corporatism, interest groups advocate for their interests mainly through institutional channels including participation in government committees or councils. However, while these channels are bilateral in societal corporatism, the government dominates them in state corporatism.

To pluralists, interest group power is determined by many factors, particularly internal factors. Among them, the following are

most frequently discussed: membership size, financial capability, leadership, members' social status, strategic importance in society, intimacy with and access to policymakers, members' cohesion, and the degree of profession (Ainsworth 2002; Mundo 1992). In contrast, corporatism contends that interest group power is mainly reliant upon the functional significance of interest groups and their acceptance by the government. Of course, this does not necessarily mean that interest group power is completely unrelated to internal factors. Interest groups with weak internal resources may be of little functional importance (Parsons 2003). Table 1 compares the contrasting views of the two modes of interest intermediation.

In this way, pluralism and corporatism are the most popular theoretical frameworks for explaining the interest intermediation system. While pluralism is advantageous in exploring the diverse methods that interest groups employ to pressure the government, corporatism

Table 1. Differences between Pluralist and Corporatist Perspectives

	Pluralism	Corporatism
Nature of the government	Neutral arbitrator	An entity pursuing its own interests
Government-interest group relationship	Strict boundary between them and external pressure	Blurred boundary and systematic dialogue between them
Nature of the interest intermediation system	Open and fluid, free participation of many relevant interests	Closed and stable participation of authorized interests
Affiliation to interest groups	Voluntary	Mainly compulsory
Methods of interest input	Very diverse sets of input	Mainly through institutionalized channels
Determinants of interest group power	Diverse, but mainly internal factors	Functional significance of interests and the relationship with the government

defines well the symbiotic relationship between the government and particular interest groups in the policy process. Meso-level corporatism is particularly useful for the explanation of health policymaking (Cawson 1986).

Although each perspective has its own merits in examining interest politics from different points of view, depending on a sole perspective cannot bring about a complete explanation of the complicated interest intermediation system in politically turbulent countries such as Korea (S. Kim 2006). In particular, it is necessary to incorporate the two perspectives to conduct a historical review of interest politics in Korea. While pluralism effectively develops theories based on interest group strategies and activities, it fails to provide a good explanation of the stabilized relationship between the government and interest groups. Meanwhile, corporatism better explains the dialogue between the government and interest groups, but it may not explain the diversity of interest articulation methods and also excludes other key players such as Parliament and political parties.

This article combines the two perspectives in order to analyze the fluctuating power of organized medicine in Korea. Pluralist ideas are mainly applied when exploring organized medicine's internal resources and strategies, while corporatist ones are employed to examine the stable relationship between the government and organized medicine. However, both perspectives pay little attention to the environmental context within which interest politics operate. Policies are not formulated in a vacuum, but are made under the constraints of environmental and policy contexts (Cochran 2003). In particular, in politically turbulent countries like Korea, political context is critical for characterizing interest politics. Thus, this article analyzes in depth the declining power of Korea's organized medicine by investigating four factors—the environmental context, the relationship between the government and interest groups, the health policy context, and internal resources (organization, finance, and strategy)—following the conceptual framework of Figure 1.

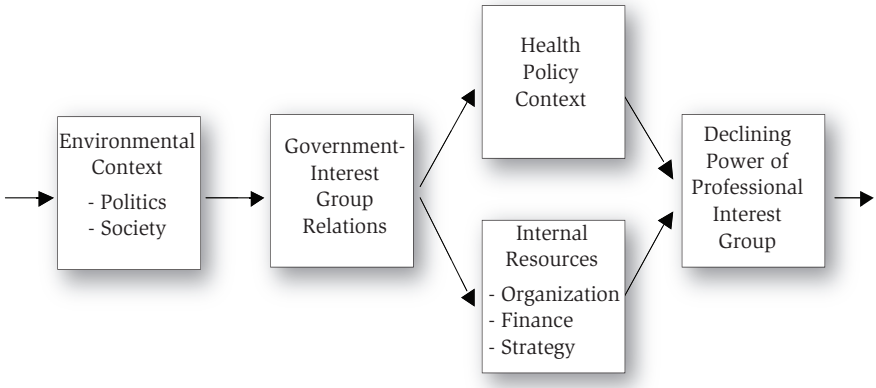

Figure 1. The conceptual framework of this article

Organizing of Korea's Medicine and Changing Healthcare Subsystem

Organizing of Korea's Medicine: The Korean Medical Association

Before the introduction of Western medicine in the late nineteenth century, Korea's medicine was entirely herbal, and there were no distinctions between herbal medicine and pharmacy. Herbal medicine monopolized medical and pharmaceutical affairs, and the social status of people in herbal medical professions was not high. However, since the twentieth century, Western medicine has rapidly supplanted herbal medicine and highly upgraded physicians' social status. Now, physicians are one of the highest-paid occupations and medical schools attract the nation's most accomplished students.

Korean physicians first organized in 1908 by founding the Medical Affairs Research Society. During Japanese colonial rule, physicians in the city of Seoul established the Hansung Medical Association in 1915 and the Chosun Medical Doctors' Association in 1930, but they came into conflict with the colonial government and were forcibly disbanded in 1941 and 1939, respectively. Shortly after

Korea's liberation, the Chosun Medical Association was established in 1947 and authorized as the sole national association of medicine-related professionals. It was renamed the Korean Medical Association in 1948 and this name has been maintained since then. The KMA became a statutory association in 1951 (KMA 1979).

The KMA was disbanded in 1961 by the military government, but its status was restored before long. Until the 1980s, the KMA maintained a corporatist relationship with the government under political dictatorship. While the government guaranteed the KMA's monopoly on representing medical interests, the KMA cooperated with the government in making and managing health policy (Cho 2006). More specifically, the then corporatist relationship between the government and the KMA was maintained by the exchange of mutual benefits, and that greatly reinforced the KMA's monopolistic power in matters of healthcare. Under the corporatist system, the KMA played the role of mitigating the demands from physicians and providing the government with professional knowledge and information, whereas the government contributed to strengthening the KMA's monopolistic power through diverse methods such as offering exclusive access channels to policymaking, contracting out the government's affairs, and co-opting KMA leaders into governmental posts. In particular, the government enabled the KMA to be the sole entity to represent physicians by suppressing the emergence of similar interest groups, facilitating the KMA's membership recruitment and membership fee collection processes, persuading physicians to affiliate to the KMA, delegating many government tasks, such as follow-up courses and qualifying examinations for medical specialists, and requiring physicians to regularly report to the KMA.

Since the late 1980s, however, this corporatist relationship has changed along with the progress of democracy and the intensifying conflict between healthcare professions. The KMA began to mobilize typical pluralist methods of interest input such as hunger strikes and lawsuits in order to protect medical interests (Choi 2003). Meanwhile, the KMA established the Korean Society for Medical Politics (Uijeonghoe in Korean) in 1970 as a political action committee, but it

was dissolved in 2007 because of the KMA's illegal lobbying of politicians (*Hanguk uiryo sinmun*, May 10, 2007). The KMA celebrated its centenary in 2008. Although its monopolistic power has diminished in recent years, it is still the sole politically active representative of medical interests and a powerful figure in health politics.

Korea's Changing Healthcare Subsystem

The Korean healthcare sector has maintained a closed subsystem characterized by the exclusiveness and intimacy among the healthcare department (Ministry of Health and Welfare), National Assembly (Korean Parliament) standing committee, and healthcare professions. In particular, the government and professional interest groups established a corporatist relationship. In this respect, Smith's (1993, 164) claim is true in Korea, too: "Professional groups are seen to be in a stronger position than the majority of groups because they have, through their professional status, a resource that is unavailable to most groups." Of healthcare professions, medical interest groups are overwhelmingly represented within the subsystem, through its functional importance and highly professional knowledge. Thus, Smith's (1993, 164) other allegation also applies to Korea: ". . . in determining health policy, the government is dependent on the medical profession for their expertise and their assistance in the implementation of health policy. This places doctors in a very strong position. The government is reliant on the doctors for both the information they can provide and their cooperation in ensuring that decisions are implemented . . . ."

The KMA was deeply engaged in health policymaking, and its members were appointed to government posts, making possible strong personal ties between the government and the medical circle. Until the 1970s, many of the government's healthcare department heads were selected among physicians (MHSA 1991). Legislators with medical backgrounds well represented healthcare-related interests in Parliament. Moreover, the KMA provided professional knowledge and information in health policymaking and participated in

implementing the policies decided upon by the government. In response, the government granted the KMA lucrative benefits. The KMA was able to monopolize the representation of medical interests thanks to the government's prohibition on the formation of alternative medical associations. Unlike labor or business associations, the KMA enjoyed great autonomy even under authoritarian regimes, due mainly to its monopolistic specialty in health affairs (S. Kim 2006). Compared to other healthcare professions, medical interests were better reflected in health policies.

However, since the 1990s, the closed healthcare subsystem and prevalence of physicians in the system underwent fundamental changes.[4] Above all, public supervision over healthcare matters has increased greatly, as political democracy has progressed—no more was the general public to be bystanders to health policy (Cho 2001). Increasing conflicts with other healthcare professionals surrounding sensitive matters such as occupational jurisdiction consistently weakened the monopolistic power of organized medicine in the healthcare subsystem. In particular, the increasing counterbalancing power of the Korean Pharmaceutical Association (KPA) in the healthcare sector became worthy of close look as the great debate over the separation of

4. Physicians' power can be measured from diverse angles—their relations with the government, influence on health policymaking, relative status compared within healthcare professions, general social status, relations with patients, and relations with market or capital (Cockerham 2003; Wilsford 1991). Thus, we may understand physicians' power differently according to the target of analysis. For example, even though physicians' power resources are declining in their relationship with the government, they can be increasing in relation to power over patients. However, among diverse targets of analysis, this article mainly discusses the declining power of the KMA, physicians' umbrella association, in terms of its relations with the government, the influence on health policymaking, and the relative status change of physicians within the healthcare sector. This article demonstrates the declining monopolistic power of the KMA in these three aspects, by exploring the changing social and political contexts, the changing pattern of the government-KMA relationship, changes in health policy, and the KMA's internal affairs. In addition, this article's unit of analysis is not physicians themselves as individual professionals or as a professional occupation, but the association that they formed.

prescription and dispension of medications gained momentum.[5] Confronted with this changing context, the closed subsystem became unstable and the government could no longer show special favoritism to physicians. Instead, physicians carried out inflamed protests over health policies such as the establishment of National Defense Medical School, the inclusion of herbal medical treatments in insurance benefits, the compulsory assignment of medical institutions to the health insurance scheme, and an extension of the attendance period required for pharmaceutical school. Together, these policy issues undermined the KMA's stable relationship with the government.

The Declining Power of Organized Medicine in Korean Health Politics

Despite its continuing influence on health polices, the power of the KMA has greatly decreased for many complex reasons. With an increase in external supervision, the government would no longer provide the KMA with special privileges. Furthermore, the people asked for a broader expansion of the healthcare subsystem. Even within the medical circle, the KMA was confronted with challenges for its dissatisfactory representation of medical interests. Many KMA members were reluctant to pay membership fees, and some harsh critics openly

5. With the opening of the healthcare subsystem, the KPA's general power resources also decreased along with those of the KMA. However, it might be possible to allege that the KPA's influence within the healthcare sector increased relatively considering the KMA's decreased monopolistic power in the sector and the provision of an exclusive right of the KPA to compound and dispense medicines by the enforced separation of prescription and dispension of medications. In particular, the KPA employed a strategy to derive benefits from a niche between the government and the KMA in the process of the separation debate. That is, the KPA's neutral position in the debate helped it maintain a degree of power in the healthcare sector. However, it seems far-fetched to contend that the KPA's power resources were strengthened stably and structurally, because that situation was possible due to the congruence of strategic interests between the government and the KPA in the separation debate.

asserted the necessity of an alternative medical association. As the size of the KMA expanded, physicians tended to associate with more focused professional organizations within their own areas of specialization. The KMA was met with both external and internal difficulties in terms of its finances, organization, status, and influence.[6]

The Environmental Context: Democration of Politics and an Active Civil Society

The decisive factor in weakening the KMA power in health politics was the changing context of politics and society. Until the June 1987 popular protest, Korea was under a political dictatorship marked by state dominance and an incapacitated civil society (Kihl 2005). The state managed policies away from the public eye, and only a small number of authorized groups were invited into the closed subsystem. Civil society was forced to be silent and the National Assembly only functioned as a puppet for legitimating administration's decisions (Buzo 2002). According to Yishai's terminology, the system of health policymaking under Korea's political dictatorship was closer to an "iron curtain" (1992, 94) dominated by government bureaucracies or, at best, an "iron duet" managed by government departments and authorized interests of the field. Thus, health policymaking was monopolized by the Ministry of Health and Social Affairs and related

6. Here, we need to understand the KMA's declining power in a relative sense. In fact, while the power resources of physicians and the KMA are as strong as they used to be, their relative power is declining in the healthcare sector, due to complicated factors. In particular, the changes in the environmental context, facilitated by political democratization, urged a breakdown of the closed healthcare subsystem and weakened the KMA's monopolistic power. For ages, the KMA had exerted great influences on health policymaking under the corporatist system that made the secret honeymoon with the government possible. Even under the authoritarian Chun Doo-hwan administration of the 1980s, the KMA achieved its goal by mobilizing diverse measures of interest articulation, including taking to the streets, sit-in protests, and signature-seeking campaigns. However, since the 1990s, the KMA's cozy relationship with the government has been broken down because of the increased checking and balancing power from outside, greatly encroaching on the KMA's overall power resources.

organized professions such as the KMA and the KPA. When physicians protested in order to demand higher fees for medical treatment in the mid-1980s, civil society was excluded from the matter, leaving the issue exclusively to negotiations between the government and the KMA.

The political democratization that began in the late 1980s fundamentally changed the landscape of Korean politics and the policymaking system (Kihl 2005). The healthcare subsystem was transformed from a closed policy community into an open issue network. Maintaining the closed and exclusive subsystem became impossible because of intensified supervision by the general public and civic groups. With these changes in politics and society, the KMA could no longer preserve its monopolistic status in healthcare policymaking. In particular, the emerging power of civic groups was noteworthy (Y. Kim 2003). Large general purposive civic groups, such as the Citizens' Coalition for Economic Justice and the People's Solidarity for Participatory Democracy, and many healthcare-focused civic groups, such as the Association of Physicians for Humanism, the Korean Pharmacists for Democratic Society, the Korean Health Professionals for Action, the Association of Korean Doctors for Health Rights, the Korean Federation of Medical Groups for Health Rights, the Health Solidarity, and the Health Right Network, actively engaged in health policymaking, in order to break down the closed healthcare subsystem and protect public interests in health policy. Although the KMA continued to represent physicians' interests as before, it became only one of many groups engaged in health policymaking.

Two examples demonstrate how much the healthcare subsystem changed with the engagement of civic groups and how much the power of healthcare professions has fluctuated. The first example is the 1993 debate on the jurisdiction of pharmacists versus herbal doctors in the prescription of herbal medicines. At the time, civic groups, particularly the Citizens' Coalition for Economic Justice, were involved in protecting public interests and successfully coordinated the two conflicting voices of pharmacists and herbal doctors in the midst of each group's fierce protests. Meanwhile, the debate over the

separation of prescribing and dispensing of medicines, which took place between 1998 and 2000, showed a typical type of issue network in which many actors were involved. Thus, the situation was very different from the first debate on the separation of prescribing and dispensing in the early 1980s, which showed a tight policy community only comprised of the government and healthcare professions. Civic groups and healthcare-related advocacy groups played pivotal roles in the debate (Chun 2005; Kwon 2002), and the government propelled the separation despite physicians' intense opposition. In fact, the new governing elites thought that such professional interests were anti-reformist and they worked to dilute the power of the KMA.

The Inauguration of Liberal Governments and Changes in Government-KMA Relations

A key factor that made the KMA a powerful body was its corporatist relationship with the government. The government needed the KMA's knowledge and cooperation in policymaking and implementation and, in return, provided the KMA with various methods to secure compliance from physicians (H. Kim 2003). In detail, the government endowed the KMA with diverse access channels and privileged the KMA by restricting the emergence of competitive organizations and compelling physicians to affiliate with it (Medical Affairs Act, Article 26). In addition, the government obligated physicians to periodically report their present situations via the KMA, and continuously entrusted items of government affairs to the KMA. Such privileges helped the KMA to more easily control its members and represent medical interests. The following are the areas that were entrusted to the KMA: affairs on physicians' regular reports of income, investigation into hospitals for intern training, qualification examinations for medical specialists, training and refresher courses for physicians, and supervision of physicians' medical treatment and license leases.

Political democratization and the inauguration of politically liberal governments between 1998 and 2007 fundamentally changed the

corporatist relationship between the government and the KMA to a more pluralistic one. Liberal governments allied with civic groups to propel healthcare reforms targeted at breaking down the closed healthcare subsystem. In the 1997 presidential election, liberal-minded Kim Dae-jung defeated the conservative government of the Grand National Party. Kim considered public bureaucrats, the business circle, and professional interest groups as privileged groups who benefited from the previous pro-military and conservative governments. Kim's power base was particularly fragile from the beginning, as his opposition, the Grand National Party, held a parliamentary majority and privileged interests opposed him (Y. Kim 2003). In response, the Kim administration (1998-2002) incorporated civic groups into its governing regime. An example of this partnership was the illegal engagement of civic groups in the April 2000 general election to defeat politicians on its blacklist.

The Kim administration also introduced several healthcare reform agendas such as the separation of prescribing and dispensing and the enforcement of the single payer system, triggering serious disputes between healthcare professionals. The new governing elites mobilized civic groups again in propelling these reforms (Wong 2004). To them, public officials and professional interest groups were all anti-reformists adhering to the outdated healthcare system. The Kim administration intended to weaken professional powers by making them cross-check each other; in this process of healthcare reform, the power of the KMA could not help but diminish greatly.

The Rho Moo-hyun administration (2003-2007) was even more liberal and antagonistic towards the privileged. Business and professional interest groups, including the KMA, were targets of reform. New power elites were recruited from among student and union activists who harbored animosity against privileged groups. The Rho administration reinforced surveillance on physicians' tax evasion and attempted to reform the political circle dominated by money politics and interest group politics. In this process, Jang Dong-ik, the then President of the KMA, was prosecuted for illegal lobbying in 2006. The KMA was also called on to disband the Korean Society for Med-

ical Politics in 2007, suffering even greater losses of political power sources (*I'm Doctor*, November 17, 2008).

The Changed Health Policy Context

The health policy context saw decreases in the KMA's monopolistic power. At first, the compulsory separation of prescribing and dispensing of medicines from 2000 onward brought physicians under the surveillance of the general public. Physicians' incomes were completely exposed to tax authorities, placing the position of the KMA and physicians below that of the government. Furthermore, conflicts between healthcare professionals intensified, with growing numbers of disputes over occupational jurisdiction. The government did not side with the KMA in disputes over healthcare matters, and other healthcare professionals no longer recognized the dominance of the KMA.

1) Introduction of the Separation of Prescribing and Dispensing Medicines

Until July 2000, when the compulsory separation of prescribing and dispensing medicines was enacted, medicine dispensing was a key source of physicians' incomes (Lee and Kwon 2004). For many years, the Korean healthcare system maintained a system of voluntary separation that enabled healthcare professions to enjoy great autonomy in carrying out their businesses under the pretext of preventing patients' inconvenience. These high levels of autonomy and the incomes physicians were able to enjoy made the general public respect them, and pharmaceutical manufacturers lobbied physicians to increase their sales. The government could not properly monitor physicians' businesses and their excessive claims of medical treatment fees, providing physicians with an opportunity to consolidate their power.

In response to this situation, the Kim Dae-jung administration decided to introduce a compulsory system of the separation of functions in order to reduce the overuse and misuse of medicines (Cha 2006). Through this system, the government could control physi-

cians' medical treatment processes and easily obtain information about physicians' incomes. For the progressive Kim administration, the compulsory separation was necessary to actualize tax justice and control the privileged.

Furthermore, under the compulsory separation system, physicians, deprived of the right to dispense medicines, would see a decrease in their incomes (Lee and Kwon 2004). Against this backdrop, the only way for physicians to maintain their incomes was to provide excessive medical treatments and to claim fraudulent medical insurance fees, but these tactics produced two side effects. In the first instance, excessive medical treatments damaged physicians' credibility, and this again weakened the KMA's monopolistic power. Second, when physicians tried to compensate for their reduced incomes through illegal means such as the overcharging of medical treatment fees and tax evasion, the government could intimidate physicians who were engaged in illegal activities through tax investigations and lawsuits. Inevitably, physicians would become weaker than the government, and the KMA would arguably have had fewer chances to exert their authority and influence on the government when its members were less powerful than the government.

2) Intensified Conflicts between Healthcare Professionals

The government's plan to reform the outdated healthcare system inevitably produced disputes between healthcare professionals who previously benefited from the commonplace blurring of jurisdictional boundaries and tacitly admitted physicians' supremacy in the healthcare system. Moreover, with the increased interest in herbal medicine, accompanied by growing concern for the quality of life, the status of herbal doctors became stronger in the healthcare system and they began to assert their own occupational jurisdiction, producing great feuds among those in the three major healthcare professions: physicians, pharmacists, and herbal doctors. Figure 2 illustrates the major conflicting healthcare professions in Korea.[7]

7. As a result of the dispute on the right to prescribe herbal medicines in 1993, the

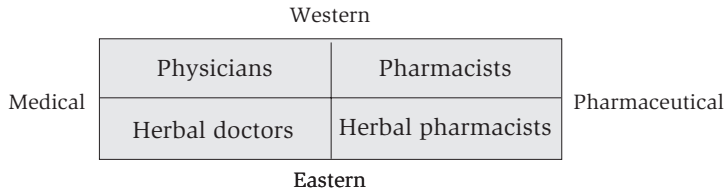

Figure 2. Conflicting healthcare professions in Korea

Of these debates, the most heated one was between physicians and pharmacists on the compulsory separation of prescribing and dispensing medicines. Until 2000, both professions enjoyed economic benefits from the voluntary separation system and, therefore, were very sensitive about new efforts to delineate the occupational boundary between their roles (Cha 2006). They fought fiercely to keep their interests in the enforcement process of the compulsory separation. Even though the compulsory separation system was introduced in 2000, physicians did not acknowledge pharmacists as healthcare partners. Physicians often had a strong sense of their own importance and enjoyed many perks over pharmacists. They tended to regard pharmaceutics as subordinate to medical treatment.

Disputes between herbal doctors and pharmacists have also become another area of contention in Korea. Herbal doctors maintained that both the prescribing and dispensing of herbal medicines were part of their jobs, while pharmacists alleged that herbal medicines should also be prescribed through medicine dispensaries (Y. Kim 2004). In the early 1990s, there was a big dispute between the two groups surrounding the right to dispense herbal medicine. They also argued over the duration of pharmaceutical schools. Herbal doctors worried that the extension would lead to the doubling of herbal

herbal pharmacist system was introduced. However, as its mission and role were obscure in a situation where herbal doctors and pharmacists could both prescribe herbal medicines, its function became ineffective.

medicine classes in pharmaceutical schools and eventually to pharmacist invasion of their jobs.

The relationship between physicians and herbal doctors was also not amicable. Physicians did not accept the practice of herbal medicines as a legitimate medical service. To physicians, herbal medical treatments were more allied to body care services than medical practices. Meanwhile, herbal doctors worried about physicians' possible invasion into their jurisdiction under the pretext of complementary medical treatment. In contrast, many herbal doctors, who acknowledged the limitation of traditional herbal medical treatment that mainly depended on pulse examination and acupuncture, made physicians angry by providing semi-medical services.

Table 2 exemplifies recent areas of conflict between these diverse healthcare professionals.

With the intensifying competition between healthcare professionals, each occupational group kept its eyes on the activities of

Table 2. Recent Disputes between Healthcare Professionals

Objects of conflicts	Conflicting parties	Contents
Use of modern Western medical devices	Physicians vs. herbal doctors	Herbal doctors' use of CT, MRI, and X-ray
Acupuncture treatment performance	Physicians vs. herbal doctors	Occasional physician performance of acupuncture treatments
Acupuncture and moxa cautery	Herbal doctors vs. acupuncturists	Legalization of acupuncturists and moxa cautery
Skin care	Physicians vs. skin cosmetologists vs. massagers	Disputes over cosmetic treatment and care of skin
Facial plastic surgery	Physicians vs. dentists	Dentists' performance of cosmetic surgery in the process of tooth correction

rival professions and tried to maximize its interests at the expense of others. The government also could not side with particular interests in a situation where rival interest groups scrutinized its activity and this contributed to the reduction of the KMA's monopolistic power.

The Internal Affairs of the KMA

1) Organization and Leadership: Disruption and Distrust

The KMA boasts a high level of membership cohesion. Members share scholastic backgrounds and are connected through alumni relationships. Physicians' high self-esteem regarding their profession also contributes to the KMA's cohesion. In Korea, many students aspire to become physicians but only a small number of the most accomplished among them are permitted to enter medical schools, producing strong sentiments of elitism. Also, most health policies directly threaten the very survival of physicians' businesses, as many physicians manage their own clinics. Therefore, physicians are motivated to come together and advocate for their own interests.

However, in actuality, physicians are not so homogeneous, despite their surface-level cohesion. Interests of practitioners versus employed doctors are frequently discordant as well as the interests of specialists versus those in general medicine, and intern-residents versus general physicians. Unlike pharmacists and herbal doctors, who generally do not have specialized fields, physicians are often highly specialized. Although physicians are well-united against threats from outside, this diversification of functions is a source of internal disputes.

With the advancement of political democracy and ideological diversification, some progressive physicians have begun to criticize the KMA's conservatism and egoism, greatly weakening the KMA's power base. Among the critics, the Association of Physicians for Humanism (APH) was established in 1987 by young activist physicians as a part of the civil movement for advocating healthcare as human rights. Since its founding, the APH has advocated political and healthcare reform, and has allied with civic groups to oppose conservative health policies. Their efforts are in opposition to the

objectives of the KMA, which has supported the government in general political affairs. The APH advocated the compulsory separation policy and the single payer system in the late 1990s, whereas the KMA opposed them.

The introduction of the system of direct election for the KMA presidency in 2000 also agitated the KMA's internal discord. Traditionally, candidates for KMA presidency have depended on regional or alumni connections to win votes and typically have appointed their closest associates to key KMA positions. This kind of nepotism makes physicians distrust KMA leadership and eventually diminished the power of the KMA.

The widening gap between the opinions of the KMA and the Korean Hospital Association (KHA) is another factor that has weakened the KMA's power. Traditionally, only physicians could be hospital managers, and thus shared common backgrounds and values (Cho 2006). The KMA was recognized as the sole influential authority in the medical circle, but recently the KHA has voiced opinions different from those of the KMA on critical healthcare issues, and this has greatly enfeebled the KMA's power to negotiate against the government and rival professional groups. For example, while the KHA followed KMA opinions opposing the compulsory separation in 2000, the two organizations differed in details of the separation, such as the exclusion of general hospitals from the separation system.

The KMA's deteriorating leadership is another internal factor that weakens its power. The KMA's well-structured leadership greatly contributed to strengthening its power. As an umbrella organization, the KMA exerted great control over its regional chapters, councils, and medical societies. While providing general autonomy to its subordinate chapters, the KMA still possessed diverse measures to control them: supervising chapters' general affairs, summoning chapters' general assemblies, approving the enactment and revision of chapters' statutes, asking for reports on chapters' general affairs, and taking disciplinary measures on ethical violations (KMA Statute, Articles 43-59). However, the KMA has faced a leadership crisis for complex reasons. Due to its growing size and complexity, the KMA has trou-

ble in satisfying members' needs. Recently, physicians have quarreled frequently regarding their particular interests. For instance, practitioners and hospital doctors have held differing views in many cases. Confronted with this delicate situation, the KMA's limitations in mediating interest conflicts between members became clear.

The low level of leadership representation under the direct election system is pointed out as another source of leadership crisis. In 2000, the KMA introduced the direct election system for the presidency, and restricted voter eligibility to those members who had paid their membership fees for a certain period. As result of this process, voter turnout became lowered, whereas a successful candidate became less represented. In the March 2009 election, five candidates ran for presidency and Kyung Man-ho was elected, gaining 33.9% of votes (6,081), while runner-up Joo Su-ho gained 31.3% (5,607). Other votes were as follows: Kim Se-gon, 20.8%; Jeon Ki-youp, 7.8%; and Yoo Hee-tag, 6.1%. Voter turnout was only 42.2% among 43,284 eligible voters (*Medical Today*, March 21, 2009).

The direct election system exposed many problems such as low voter turnout rates, excessive election expenses, and aggravated conflicts between members of various medical occupations. As a result, the KMA revised its statute during the 2009 General Assembly to resurrect the indirect electoral-college system. However, many regional chapters opposed this decision by assailing its legitimacy and some chapters filed lawsuits against the revision.[8] Song Young-min, Information Director of the Gyeonggi Chapter, said:

> We conducted a survey on the legitimacy of the statute revision that was voted by a small number of delegates in the April 2009 General Assembly. The survey showed that a majority of members do not agree with the revision and wish to keep the direct election system. We hope this survey ignites debate on the maintenance of

8. In a survey conducted by the Gyeonggi Chapter in 2009 66.7 % of 4,337 respondents preferred the direct election system while only 32.3 % preferred the indirect election system (http://www.ggkma.org/_new/bbs/tb.php/community1/3736; accessed September 12, 2009).

> the direct election system . . . .[9]

A series of embezzlement scandals involving KMA directors and staff significantly eroded the KMA's credibility. In 2006, six KMA directors accused KMA President Jang Dong-ik of misappropriating 337 million won of public money and embezzling membership fees. Additionally, the KMA's former Managing Director insisted that ex-president Kim Jae-jung raised a slush fund amounting to 7,300 million won during his presidency; this caused prosecutorial authorities to open an investigation into the KMA's general affairs and account books. These scandals greatly damaged the KMA's public image and came as a great shock to KMA members. In 2004, two KMA staff members embezzled 1,300 million won and were sentenced to three years' imprisonment (*Newsis*, April 27, 2007). Of the opportunities and likelihood of staff to engage in embezzlement, one KMA auditor said:

> While board members serve only for 3 years, general staff take offices for a long time and they are very well informed on financial matters. They can easily embezzle public money under the current shabby accounting system. Until now the KMA managed membership fees thoughtlessly and lacked an inspection system. Of course, the moral vulnerability of KMA staff accustomed to outdated habitual practices is serious, but the most urgent thing to do is to rearrange the control and feedback systems . . . (*Medical Today*, April 27, 2007).

2) Finances: Declining Financial Capability

Most of the KMA's budget is accounted for by membership fees. According to Table 3, the total amount of membership fees collected in 2007 was 7,743 million won and the percentage of physicians who paid their membership fees was about 70 percent. At present, yearly

9. Gyeonggi-do Medical Association, "Uisa 10 myeong jung 7 myeong, uihyeop hoejang jikseonje chanseong" (Seven of Ten Physicians Favor Direct Election for KMA Presidency), http://www.ggkma.org/_new/bbs/tb.php/community1/3736 (accessed September 12, 2009).

membership fee is 330,000 won for practitioners, 242,000 won for appointed physicians, 137,000 won for interns, and 105,000 won for public health doctors. The first-time entrance fee is 100,000 won for all types of medical doctors (*Hanguk uiryo sinmun*, August 12, 2008).

Table 3. Changes in Membership Fees and Payment Rates

(Units: 1,000 won and %)

Year	The amount of payment	The rate of paying membership dues
2003	6,794,000	78.4
2004	6,958,000	79.0
2005	7,671,000	80.8
2006	7,265,000	68.0
2007	7,743,000	70.1

Source: Adapted from *Hanguk uiryo sinmun*, August 12, 2008.

Recently, however, the participation rate of paying membership dues is declining due to structural problems with the fee payment system, members' distrust in the KMA, and physicians' financial difficulties, resulting in strains on the KMA's finances. With regard to the fee payment system, members voluntarily pay their fees to county chapters, which in turn distribute those funds among county chapters, provincial chapters, and the KMA. The KMA Statute calls for collecting membership fees in one-time sum, because many members would not pay KMA fees if they were collected separately. When county chapters collect membership fees, they deduct their shares and convey the remainder to provincial chapters. But each chapter manages its finances independently from the KMA and thus pays little attention to KMA finances. A staff member from the Seoul Metropolitan Chapter says:

> We always urge county chapters to convey the shares of the KMA and Metropolitan Chapter, but they do not pay attention to our request, as they have no difficulty in managing their own finances.

> Each county chapter does not convey collected fees immediately, holding them for several months (*Medipana News*, December 10, 2008).

A more serious problem is physicians' reluctance to pay membership fees because of their distrust of KMA leadership and dissatisfaction with KMA activities. Recent criminal cases involving embezzlement by KMA directors and staff have greatly increased members' distrust in the management of membership fees. According to the survey conducted by *Daehan uisa hyeophoebo* (November 12, 2008) targeting 1,000 physicians, over 50% were unwilling to pay membership fees. The following breakdown indicates physicians' attitudes regarding KMA fees: "Despite paying membership fees, I think that it is wasteful" (44.9%), "I should pay membership fees and recommend colleagues to pay" (27.5%), "I will try to pay fees after evaluating activities of KMA leadership" (14.7%), and "I will not pay fees" (9.3%). Reduced incomes of physicians caused by recent economic stagnation and the separation of prescribing and dispensing of medicines have also influenced the decreasing payment rate of membership fees.

The KMA and its chapters have introduced diverse measures to encourage the payment of membership fees, but this has added to members' complaints. For example, members who do not pay fees are deprived of voting rights and internship applications. Some chapters prohibit members who have not paid their fees from participating in educational training and restrict their access to information. However, despite these measures to raise the rate of payment, general unwillingness to pay membership fees remains unchanged.

3) Ineffective Strategies of Interest Input

The KMA was an extraordinary interest group in the field of health politics in terms of its ability to mobilize diverse interest input strategies. Its high quality of professionalism, financial independence, and large membership size provided the KMA with broad options regarding strategies for interest articulation, ranging from participating in

government committees to organizing hunger strikes (S. Kim 2006). While its relationship with the government had long been closer to that of corporatism in certain ways, the KMA frequently resorted to classical pluralist ways. While it is common for interest groups to mobilize every possible means to make their voices heard in policy-making (Ainsworth 2002), what made the KMA unique was that it could resort to both types of interest input—pluralist and corporatist methods—and that its resources were very powerful. The KMA participated in almost all health-related advisory or deliberative committees, while simultaneously employing very aggressive methods such as street protests and the collective closing of clinics to force its agendas (Cha 2006).[10]

In addition, the KMA was very active in lobbying legislators and public officials. The KMA established the Korean Society for Medical Politics in 1970 to encourage physicians to be legislators and support the KMA's external activities. As expected, it played a central role in protecting medical interests. The KMA also maintained regular contacts with legislators who were once physicians and playing key roles in advocating medical interests in Parliament. In addition to KMA-level lobbying, individual physicians donated political money to legislators and others.[11]

However, despite the KMA's generally unchanged capability to mobilize diverse strategies for interest input, its effectiveness is sharply diminishing. Above all, with the collapse of its corporatist relationship with the government, the KMA's monopolistic power over government committees is decreasing, while voices of other healthcare interest groups are becoming louder. In particular, civic

10. Even under the authoritarian politics of the early 1980s, the KMA employed every possible means to frustrate the government's intention to separate prescribing and dispensing of medicines in Mokpo City. The KMA and its Mokpo Chapter encouraged their members to close clinics and to return their certificates as a protest. They also staged signature-seeking campaigns and demonstrations (S. Kim 2006).

11. According to the *Daehan uisa hyeophoebo* survey targeting 1,000 physicians, 66% donated to politicians. Among them, 1.1% donated more than 10,000 thousand won yearly and 24.1% donated between 500 and 10,000 thousand won, while 74.8% paid below 500 thousand won (*Daehan uisa hyeophoebo*, November 12, 2008).

groups now participate in every important government committee to curb the over-representation of professional interests in health policy-making.

The KMA also encounters difficulties in employing radical methods such as demonstrations and strikes due to the government's harsh criteria for what can be considered illegal protest. Korean politics, which is in a transitional period of democracy, will not tolerate illegal protests, and not even public opinion supports professional strikes because they are viewed as proof of "group egoism." Moreover, the KMA's deteriorating leadership makes it difficult to mobilize large numbers of members in strikes or campaigns.

In the meantime, the KMA's ability to lobby politicians and high-ranking officials faces limits. In particular, the illegal lobby scandal of 2006 was a serious blow to the KMA's reputation. The then President of the KMA, Jang Dong-ik, was prosecuted for illegal lobbying and sentenced to one and a half years in prison after his first trial (*I'm Doctor*, November 17, 2008). This kind of scandal forced the KMA to disband the Korean Society for Medical Politics in 2007, thereby obliterating one of its key sources of power.

The KMA's ties with Parliament and government departments have also gradually diminished. Currently, the National Assembly's Health and Welfare Committee maintains a tight balance between its composition of healthcare professions: two former physicians, two former pharmacists, one former herbal doctor, one former dentist, and one former nurse (*My Daily*, August 26, 2009), and particular healthcare professions cannot monopolize the power to lobby Parliament. In addition, the appointment of physicians to relevant government posts has become less common with the intensifying conflict between healthcare professionals and the increase in bureaucratic professionalization. Until the 1970s, many physicians were appointed as Ministers of Health and Social Affairs,[12] but since the 1980s only

12. Four Ministers of Health and Social Affairs in the 1960s were all physicians (Jang Duk-sung, Park Ju-byung, Oh Won-sun, and Jeong Hee-sup) and two of them were former KMA presidents (KMA 1979).

two physicians, Kwon Ui-hyuk and Moon Tae-joon, have been appointed (MHSA 1991). Proportional representative positions are also rarely distributed to physicians by the ruling party, as these are largely allotted to the socially disadvantaged. This severance of personal ties between physicians and official posts diminishes the KMA's ability to diversify its strategies of interest articulation.

Discussion and Conclusion

For many years, the KMA was a power player in Korean health politics. It monopolized the right to represent medical interests with the government's sponsorship, and was most powerful organization in the healthcare sector. With its highly respected members, the KMA was a premier professional interest group. Its capable resources enabled the KMA to mobilize diverse methods for advocating medical interests. Above all else, its corporatist relationship with the government was the chief source of the KMA's power. The government, which needed the KMA's professional knowledge and cooperation in the health policy process, incorporated the KMA into the policymaking system. Governmental affairs were contracted out to the KMA, and the emergence of competitive medical interest groups was prohibited. Physicians were obliged to affiliate with the KMA. Furthermore, until the political democratization of the 1980s, the environmental context, characterized by authoritative politics, inactive civil society, indifferent general public, and the closed policy system, provided the KMA with a good set of conditions for power consolidation.

There are allegations that the strong government dominated interest politics until the 1980s under the then state corporatist system of interest intermediation and, thus, many researchers downplayed the relevance of pluralism based on the idea of dispersed political power. According to them, the KMA was also subordinated to the government under the authoritarian regime of the time. However, this contention can explain only part of the reality. It was true that, under the corporatist system, the government intervened in disband-

ing and re-establishing the KMA in the early 1960s and engaged in the financial and organizational management of the KMA. In addition, the government provided the KMA with a bundle of benefits to maintain their corporatist relationship. The government employed both constraints and inducements as a way of securing cooperation and compliance from the KMA. In this respect, the strong government prevailed in health policymaking in the 1970s and 1980s. However, despite the government's strength, the KMA was an extraordinary interest group that possessed the capacity to input its interests, mainly due to the functional importance of physicians in implementing health policies and their critical professional knowledge. Even under the authoritarian regimes, the KMA mobilized tough and extreme methods of interest input such as the closure of clinics, street protests, nonimplementation, and sabotage, as was shown during the debate on the pilot separation of prescribing and dispensing medicines in the early 1980s. Thus, despite acknowledging the government's superiority in the corporatist relationship with the KMA, it might be unfair to argue the KMA's unilateral subordination to the government. By establishing the corporatist relationship with the government, the KMA could enjoy monopolistic power in health policymaking and in its relationship with other healthcare professionals.

However, since the 1990s, the KMA's monopolistic power in health politics has been diminished for several reasons: political democratization and the vitalization of civil society, the emergence of progressive governments and changed health policy, the separation of prescribing and dispensing medicines, intensified interest conflicts between healthcare professionals, and internal problems such as organizational bickering, fragile leadership, and financial instability. In particular, with the progress of democracy, the government could not maintain its corporatist relationship with the KMA due mainly to increased public supervision and intensified interest conflicts. Civic groups also closely watched interest group politics in order to open the health policy system once dominated by healthcare professions. Young physicians founded progressive organizations to protest the KMA's attachment to vested interests. Furthermore, 10 years of liber-

al governments deprived the KMA of privileges, as those governments viewed the KMA as one of the privileged groups that supported conservative government. The KMA peacefully coexisted with other healthcare professional groups under the healthcare system of blurred occupational jurisdictions, but many conflicting issues have emerged since the 1990s. The separation of the functions of prescribing and dispensing medicines greatly intensified conflicts between physicians and pharmacists. Under these situations of interest conflicts, the government could no longer side with physicians and, in due course, the KMA's monopolistic power waned. Figure 3 narrates the intertwined factors that brought about the declining monopolistic power of the KMA in both health policymaking and its relations with other healthcare professional groups, following the analytical framework formulated in this article.

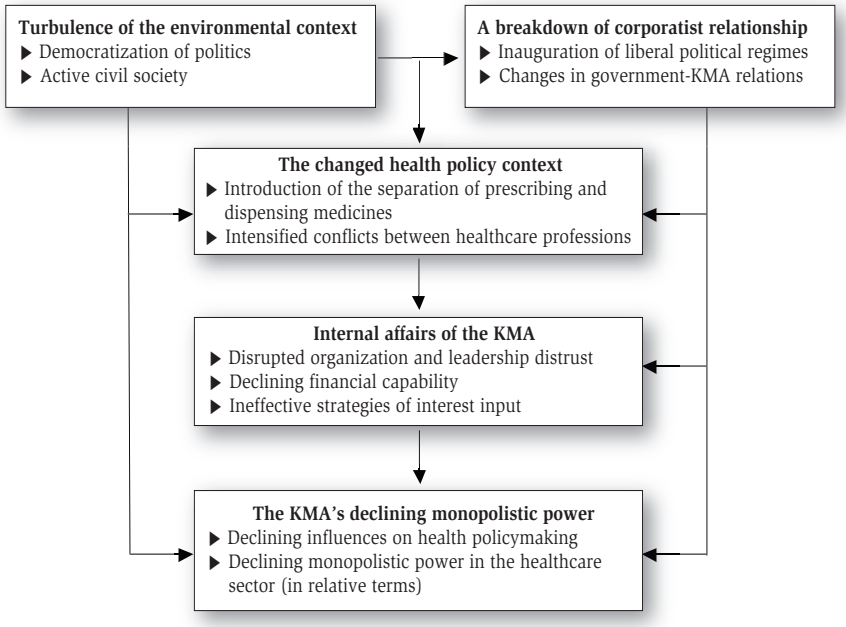

Figure 3. Intertwined factors that brought about the decline of the KMA's monopolistic power

Even though the KMA's monopolistic power is declining in health politics, it is far from reality to assert that the power of medical professionals has been equalized with other healthcare professions. The KMA remains the strongest force in health politics and continues to represent medical interests as monopolistically as it once did. The KMA's strong internal resources and functional importance in health policy remain unchanged. However, it is clear that the intermediary system of Korea's health politics is gradually changing from a closed corporatist system to a more open pluralist one, following the democratization of politics and the activation of civil society. The weakening monopolistic power of the KMA in the healthcare sector and the KMA's disrupted relationship with the government are bringing about new systems of health policymaking in Korea.

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