Political Analysis of Chronic Disease Management System at Outpatient Clinic in Korea

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Abstract. This article examines the major political challenges associated with chronic disease management system at outpatient clinic using The PolicyMaker program. The article briefly presents major issues on the management of chronic disease in Korea, and the efforts of changing chronic disease management system at outpatient clinic that were initiated in 2010. The PolicyMaker method of applied political analysis is described and the results of its application are presented including analysis of the policy content of chronic disease management system at outpatient clinic, and assessment of three groups of major players (private sectors, public sectors and non-governmental organizations). Given situation, opportunities, obstacles were developed. The conclusion presents factors of insufficient negotiation with key players.

Keywords: political analysis, chronic disease management system, outpatient clinic

1 Introduction

With carelessness establishment of the policy on utilization of healthcare institutions, there has been rivalry between outpatient clinic, general hospital and university hospital, which is so called primary, secondary and tertiary institution respectively. Medical institutions are classified by its size and function in Korea [1]. In case of non-emergency case, patients should have visited firstly primary outpatient clinic and obtained special document for consultation at secondary and tertiary hospitals. This is regulated by the MOHW for the effective use of healthcare resources. However, People go to big and upper level of hospitals for better quality of healthcare service without first visiting primary outpatient clinic because of less credibility on outpatient clinics around their residence. Being convenient for transportation, high level of living standard, no strict regulation on visiting general hospitals without first visiting primary clinic and little gap of medical cost of each institution accelerate people’s leaning toward tertiary hospitals [2]. With these phenomena, business environment of outpatient clinic is getting worse condition. People with chronic disease who are required special care for prevention of complications, medication with no omission, regular check-up, and proper guidance for lifestyle modification might be neglected at general hospitals. This is caused by different functions of medical institutes designed by the government. Secondary hospital is designed for caring in-hospital patients and tertiary hospital is projected for caring complex patients such as with cancer and...
researching for advanced medical technology. This means that people with early stage of chronic disease could not receive effective care at secondary and tertiary hospitals. Though patients visit outpatient clinic for primary medical care, many of them visit several different outpatient clinics and see doctors irregularly for their check-ups of chronic disease. Then it is hard to receive effective and consistent medical care.

With ineffective management of healthcare institution and non-effective care of patients with chronic disease, number of patients with diabetes or hypertension who developed complications and hospitalized due to severe complications has recently increased 9.8% in annual and medical cost had increased from 400 billion Korean won in 2005 to 3,000 billion Korean won in 2009. It is an example of ineffective use of healthcare resources [2].

Given situation, new effective and sustainable healthcare delivery system was necessary. On the occasion, the government announced several policies for better healthcare management system such as reorganization of healthcare institutions by its function and management of chronic disease. Chronic Disease Management System at Outpatient Clinic (hereafter CDMSOC) for the patients with diabetes or hypertension is one of the policies that the government targeted for. It is to clarify the function of each medical institution, to guide people effective use of medical institutes, to advance the management of medical resources, and to increase the quality of medical service. Though it was initiated a few years ago by the government and announced September 2010, it was implemented on April 2012 with far different measures from originally designed due to strong objections and resistance of key players.

**Chronic Disease Management System at Outpatient Clinic (CDMSOC)**

Main idea of the policy of CDMSOC is that patient with diabetes or hypertension appoints an outpatient clinic around their residence and visit the doctor after that time for regular medical check-up. Patient who visits the appointed outpatient clinic is expected to receive more qualified medical service such as consistent medical care including monitoring patients’ medication, medical tests and education related to disease management and lifestyle modification. At the same time, patient obtains 30% discount of consultation fee as monetary incentive. The purpose of the policy of CDMSOC is to increase the effectiveness of medical resources utilization and people’s quality of life. Through systemic and consistent management of chronic disease by appointed doctor, it expects to reduce the rate of complications, and hospitalization due to uncontrolled condition, and medical cost for managing complications. It starts with patients’ asking his or her doctor for application at the first visit of outpatient clinic and the doctor apply it to the National Health Insurance Service (hereafter NHIS) for the patient. The patient then gets monetary benefits, customized education and designed medical care [3].

To doctors who are appointed by patient, they will get monetary benefits of 950 Korean won (almost equivalent to 0.8 US $) by a patient per visit and special incentives according to the quality of management at the end of certain period from NHIS. Doctors get 2 types of incentive, one is by number of patient that they see and the other is by the quality of patients’ management [4]. The former limits maximum 10 times per patient in a year. In order to obtain incentives, the appointed doctor
keeps the medical record for each patient and reports it to NHIS regularly. It contains information related to patients’ progress.

Fig. 1. Work flow for Chronic Disease Management System at Outpatient Clinic

The ministry of health and welfare (hereafter MOHW) planned “a clinic per patient” system and doctors’ reporting patients’ medical record to NHIS. Prior to implementation, doctors were required to receive training for managing patients with diabetes and hypertension. It is mandatory. It is projected to reduce complications and patients’ hospitalization due to advanced condition with preventive management of chronic disease.

However, the policy implemented on April 2012 was far distant from originally designed by the government. Number of clinics that patient could appoint was changed from one to two, which means “two clinics per patient” and the document recorded and reported by doctor was much simpler with no much information. Doctors participating in this system may not require mandatory training. Most of all, the contents was overlapped the policy existing chronic disease management system.

It has been almost two and half years since its implementation. However there was no attempt to analysis of its politics and impact and the effects of CDMSOC. The purpose of this article is to analysis the politics of CDMSOC and to provide decision-makers relevant information for establishment of healthcare policy in the future.

2 Method

The method of applied political analysis known as Policy-Maker (http://www.polimap) was used in this project to assist decision makers in analyzing and managing the politics of CDMSOC. The method provides a systemic analysis of the probable consequences of the proposed policy and the positions of support and opposition taken by key players. Then it assists decision –makers in initiating the process to develop strategies for managing the politics of policy reform [5]. It comprises 5 steps of political analysis. 1) It helps to identify the contents of considering policy, 2) it support to find the interests of participants and its relationships, 3) to verify the opportunities and weakness, 4) to support strategy development and 5) to evaluate the potential and realistic impacts of policy [6].
This research was based on systemic review of press release from government, position letters of key players, news reports by media, and research papers about chronic disease management system at outpatient clinic

3 Results

3.1 Stakeholders

3.1.1 Korea Medical Association

At the beginning of government announcement for the policy, Korea Medical Association (hereafter KMA) welcomed the policy with good reasons of improving quality of medical service through effective utilization of medical resources and the improvement of chronic disease management [7]. Most of all, KMA accepted it as a solution for resolving the hardship of outpatient clinics. However, on the course of negotiation, the KMA changed their position from support to opponent to the policy because of conflicts between subordinates of KMA.

3.1.1.1. Clinic Medical Associations (CMA)

This is a subordinate of KMA, which are composed of doctors’ group by region and cities. CMA strongly opposed to the policy. They argued that CDMSOC was the policy for preparing the Doctor Appointment System which the government considers as fundamental healthcare delivery system in the future. The government insisted that the policy of CDMSOC is different from. The Doctor Appointment System is believed the prior step of Lump-Sum Contract which the government gives doctor fixed money for certain number of patients for their medical service. KMA and CMA positioned against Lump Sum Contract. Another reason they presented was that the preparation or submission of patients’ record to NHIS is an interference of their autonomic activities [7].

3.1.1.2. The Korea Doctors

This is a subordinate of KMA, comprise of clinicians who work at outpatient clinics, mostly responsible for primary care. They were against the policy because most of patients with diabetes or hypertension would go to the outpatient clinics where internal medicine doctors work at and then other than internal medicine doctors would not see many patients. Family doctors and internal medicine doctors were supposed to be the beneficiary of the policy of CDMSOC. However, they did not agree on the policy though they were on support position [8].
3.1.1.3. Korean Physicians’ Association

A subordinate of KMA constitute internal medicine physicians who mostly work at outpatient clinic and they basically agreed on the policy but they could not express their opinion to the public due to possible conflict with other associations. They were expected to be a beneficiary for the policy [8].

3.1.2. Doctors’ Union

3.1.2.1 The Korean doctor’s union

Doctors’ union was one of the strong opponents. They argued that submission of patient’s medical records to NHIS was to domesticate doctors and they considered it as an interference of doctor’s right. They also claimed that giving discount of consultation fee to patients would be concluded as ineffective use medical resources due to patients’ hospital shopping.

3.1.2.2. The Korea Intern Resident Association

This group was also against the policy. They insisted that if the policy is applied, patients are allocated to already existing clinics and as they complete their training and start business, there will not be many patients remained for them. They argued that it is the right to live.

3.1.3. Civic groups

The Citizens Coalition of Economic Justice and Health Right Network support the policy of CDMSOC with good reasons of effective use of medical resources and activation of primary medical care. Though they had positions of support, they were not active on the supporting activities.

3.2 Position Map

Political environment for the policy of CDMSOC were analysis using the PolicyMaker and result were as follows. As reviewing the power distribution of key players, it was weighted to opponents. Though civic groups placed on the position of support together with the government, the power was not as big as opponents. This meant that in order to have negotiation power of the government, the supporters had to be more powerful through coalition with supports, bringing supporters from opponents or weakening the power of opponents.
3.3 Opportunities and Obstacles

The biggest opportunities were the good reasons of effective use of medial resources with chronic disease management system. There had been issues on the lack of function of healthcare institute, unhealthy healthcare delivery system, ineffective management of chronic disease and medical resources [9]. The civic groups and the government recognized the needs of new policy for the effective management of chronic disease and the activation of primary medical care [8].

However, the obstacles were distrust and strong opposition of medical association which is the suppliers of medical service. Opposition was grounded in mistrust between the government and KMA, which was provoked by the separation of prescribing and dispensing of ethical drugs [9]. The KMA believed and insisted that the policy of CDMSOC was a prior step of preparation of Doctor Appointment System and Lump-Sum Contract System. They said that they could not accept it although the government denied it.

4 Conclusion

With lack of systemic organization of power, the policy of CDMSOC had been implemented with the measures far different from originally designed by the government. Distrust of KMA to the government and insufficient collaboration of supporters were considered main causes of unsuccessful negotiation. It concluded that the policy of CDMSOC is overlapped existing policy for chronic disease management system and degraded to the policy for providing additional incentives to doctors who work for patients with diabetes and hypertension.

References