DEMOCRATISATION AND DOCTORS' POLITICAL INFLUENCE: THE SEPARATION OF PRESCRIBING AND DISPENSING (SPD) IN KOREA

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Summary This paper is about the relationship between democratisation and doctors' political influence in health policy, in the case of the separation of prescribing and dispensing (SPD) in Korea. Due to their professional as well as institutional features, doctors have been regarded as one of the most powerful pressure groups. Democratisation may have two mutually conflicting influences: (1) doctors' veto capacity may increase with their strengthened voice vis-à-vis the government; and (2) it may decrease, as not only doctors' central association but also other social groups, such as medical consumers and sub-groups of doctors, acquire stronger voices. This paper analyses the case of the SPD in Korea, which prevented doctors from dispensing drugs. It compares the SPD process in the authoritarian period (1982-1985), the transition period (1987-1991) and the democratic period (1998-2000). It concludes that doctors' political influence increases in the transition period, and then decreases as democratisation matures.

Keywords democratisation, doctors' political influence, separation of prescribing and dispensing (SPD)

1. Introduction

1.1. The aim of this paper

This paper examines the impact of democratisation on doctors' political influence on health policy changes. Considering that doctors monopolise medical expertise and deliver medical service in medical institutions, securing their co-operation is indispensable for the successful implementation of a health care policy. Thus, the politics of profession needs to be considered for analysing the policy-making process of the health care policy.

Democratisation seems to change doctors' political influence in the process of health care policy-making. On

the one hand, democratisation alters the structure of the policy-making process by inviting wider social actors in the process. On the other hand, democratisation promotes the freedom of assembly and association which facilitates social actors to conduct collective actions outside of formal policy-making processes.

The analysis of doctors' influence on health care policies in this paper is based on the case of the separation of prescribing and dispensing (SPD) policy in Korea. The SPD is a policy which regulated doctors not to dispense drugs but to issue prescriptions for pharmacists. A study of the process of the SPD in Korea helps examine the impact of democratisation on doctors' veto capacity. The Korean government attempted to implement this in three periods: 1982-1985, 1987--1991, and 1998-2000. These periods overlap with distinctive sequences of democratisation. An authoritarian government ruled during the first period; the transition to democracy was under way in the second; and the democratic opposition finally took power in the final period. Therefore, examining doctors' efforts to hinder the SPD will help analyse the relationship between democratisation and doctors' veto capacity.

1.2. Method

This paper conducts empirical research on three periods in which the government attempted to implement the SPD: 1982-1985, 1987-1991, and 1998--2000. These periods belong to distinctive phases of democratisation: an authoritarian regime, a transitional regime and a democratic regime.

This paper applies a new institutional approach. It analyses how political institutions transferred actors' ideas and preferences into policy results. Among various forms (and meanings) of institutions, this paper focuses on structures of the policy-making process. It examines how structures of the policy-making process change doctors' influences on policy outputs. Some scholars put this approach in the category of historical institutionalism (Rothstein, 1996; Thelen and Steinmo, 1992), while others create a new category, such as 'structural institutionalism' (Peters, 1996) and 'organizational institutionalism' (Immergut, 1998). In this way, this research analyses the structures of the policy-making process of the SPD to see how these structures facilitate or limit doctors' influences on the SPD policy.

The main materials for this research are documents and interviews. Such documents as records, announcements and reports published by the government, especially the Ministry of Health and Welfare (MoHW) and the National Assembly, and by interest groups, are reviewed. The author conducted thirty semi-structured interviews with politicians, civil servants, and interest group leaders.

1.3. Plan of this paper

Section 2 describes the features of the SPD and its policy-making process. This section also demonstrates doctors' organisational position in the policy-making process. Section 3 reviews the impacts of democratisation on doctors' political influence. Then, section 4 analyses the process of the SPD and doctors' veto efforts in the light of democratisation. It describes and compares the SPD processes of the authoritarian period (1982-1985), the transition period (1987-1991) and the democratic period (1998-2000). Finally, section 5 dis-

cusses the implication of this research. It concludes that in the first stage of democratisation, i.e. the transition period, doctors' political influence may increase. By contrast, as democratisation matures, doctors' political influence may decrease.

2. SPD and its policy-making process

2.1. SPD and doctors in Korea

The separation of prescribing and dispensing (SPD) is a policy which regulates doctors only to prescribe drugs, and pharmacists to dispense them only according to prescriptions. It is important to understand the SPD for studying health politics in East Asia. The SPD has been related to other more popular policies, such as the reform of the National Health Insurance (NHI), resolving conflicts between Oriental and Occidental medicines, regulating generic substitution, promoting the transparency of the pharmaceutical market, and even ensuring the patients' right to information. The very fact that the SPD, which is hardly a serious issue in Western countries, has been related to many other policies makes it an interesting topic for understanding the unique character of the East Asian health care system.

In East Asian countries, the roles of doctors and pharmacists were not clearly separated, and medical consumers could take medical examination and dispensation of drugs at the same place (one-stop system). Thus, the SPD was considered not only in Korea but also in Japan and Taiwan (Howells and Neary, 1995; Rodwin and Okamoto, 2000; Chou et al., 2003).

In Korea, although the government has regulated the health care system by the National Health Insurance (NHI) scheme, more than 80 per cent of hospital beds have been privately owned (Cho, 1999: 79), and the expenditure for health care has remained below 2 per cent in the total government expenditure (Yang, 2003: 33). In this dominantly privatised medical system, distribution of drugs has been one of significant income sources for hospitals and clinics, considering that expenditures for drugs have comprised about 30 per cent of the total health care expenditures (Chung et al., 1997: 102). In addition, doctors have been willing to be publicly recognised for their expertise in drugs. Therefore, doctors have generally been little supportive to the implementation of the SPD, which would deprive them of this income, as well as damage their professional pride as experts in drugs.

2.2. Policy-making process of the SPD

Until 2000 the Pharmaceutical Affairs Law allowed doctors to distribute drugs to their own patients (Pharmaceutical Affairs Law, enacted on 13 December 1963, Supplementary Provision No. 1491, Article 3). Therefore, if the revision of the Pharmaceutical Affairs Law was the instrument for the SPD, the Legislature – the National Assembly – made the final decision.

However, a government ministry – the Ministry of Health and Social Affairs (MHSA; The Ministry of Health and Welfare [MoHW] since December 1994) – was in charge of issues of the health care system, including the implementation of the SPD. Without revising the Law, the MHSA could encourage doctors to issue prescriptions for pharmacists, instead of distributing drugs by themselves. The MHSA could provide guidelines on prescription and distribution of drugs, or give financial incentives

for the SPD. In other words, the MHSA could promote the SPD by utilising its administrative discretions.

Even if the revision of the Pharmaceutical Affairs Law would be at issue, the MHSA could play a significant role by providing a government bill of the Law. Instead of providing all details of the Law, the National Assembly usually asked the MHSA to propose a bill, and then the National Assembly reviewed the bill and revised it. In this way, the MHSA not only executed the decisions of the National Assembly, but also helped the legislating process by preparing a government bill.

Doctors could directly participate in the policy-making process by attending government committees. When a health care policy was discussed, the MHSA usually set up a consultative committee which was joined by representatives of professional groups, including doctors. Doctors also contacted Assemblymen and MHSA officials for persuading their policy preferences. In addition, doctors may be able to mobilise collective actions outside of the policy-making process.

In these processes of representing doctors' society, the Korea Medical Association (KMA) was at the centre. The KMA has been doctors' central association, not only socially but also legally. The Medical Law has stipulated compulsory membership in the KMA, compelling all doctors to register in the KMA (Medical Law, revised on 20 May 1962, Article 17; Article 52). The KMA represented doctors in government committees, contacted government officials and Assemblymen, and organised and led doctors' society.

3. Democratisation and doctors' political influence

3.1. Doctors' political influence

Inside of the formal policy-making process

Doctors may utilise the structures of the policy-making process for exerting pressure. They may participate directly in the decision-making process by attending the committees for health care policies under a corporatist regime or utilise various veto points which the existing constitution allows.[1] Immergut holds that Swiss and French doctors hindered the introduction of the National Health Service (NHS) in their respective countries by exploiting veto points: the Swiss doctors used the referendum, while the French doctors utilised the multi-party parliamentary system where doctors positioned themselves in the parliament as important coalition partners (Immergut, 1992). Hacker also argues that a general reform of the health system is less feasible in a fragmented political system which provides many veto points (Hacker, 2002).

According to this view, doctors' influence on a policy can be both constrained and facilitated by the structures of the policy-making process. Considering corporatist committees, they are sometimes designed to reduce the direct participation of the medical profession. Giaimo explains the decline of doctors' influence in the UK and Germany during the late 1980s and the early 1990s

[1] Immergut names the institutions involved in a policy-making process as 'veto points' which doctors could exploit for hindering a health care reform, such as the parliament with a multi-party system in France and the referendum in Switzerland (Immergut, 1992: 8).

with challenges against corporatist bargains between the government and doctors (Giaimo, 1995). In a similar way, Döhler presents the 'architectural' activities of the German government which has reduced doctors' voice *vis-à-vis* sickness funds in the corporatist system (Döhler, 1995). Considering political structure, some constitutional systems make it difficult for doctors to find veto points. Immergut attributes the successful introduction of the NHS in Sweden to the executive-centred centralised system (Immergut, 1992). Hacker also agrees that the UK and the Netherlands which have centralised systems achieved reforms at least in a visual sense (Hacker, 2002).[2] Moreover, other political factors such as party politics and salient contemporary issues have influence on doctors' utilisation of veto points.

The structures of the policy-making process provide public authority with institutions within which it makes decisions on a policy: some of them facilitate doctors' lobbying and participation in the policy-making process and others do not.

Outside of the formal policy-making process

With all constraints of the structures of the formal policy-making process, doctors may try to exert influence on policy-making by collective actions outside of the formal policy-making process. Doctors' monopoly of medical expertise can make their collective actions more powerful. As doctors are recognised as the sole experts in medical scientific treatment in modern (or Western) medicine, it is almost impossible to implement a health care policy without their co-operation. Freidson holds that doctors are recognised both publicly and socially as the dominant medical profession. According to him, as medicine became more complex and scientific, doctors claimed that they were the sole experts in medicine and struggled against quackery. The state supported this professionalisation in medicine by way of providing a public licensing system, and society also recognised doctors as the only qualified providers of medical treatment (Freidson, 1970). Moreover, doctors' indispensability tends to be augmented by a demanding and time-consuming medical training. As Marmor and Thomas put it, if doctors strike against a medical policy, the government 'can seldom provide a short--run substitute' for them (Marmor and Thomas, 1972: 436). In sum, their potential threat of boycott is likely to make them a very powerful pressure group.

For mobilising collective actions, doctors' organisational solidarity will be important. Doctors may be divided into various factions according to working places and departments, and these factions tend to have different interests in a policy. Even if there is an established and influential representative medical association, it would be relatively difficult for this association to combine diverging interests and represent them effectively. Freddi argues that one of the reasons why French and Italian doctors have a weak influence is because their associations are fragmented (Freddi and Bjorkman, 1989). Döhler also points out the fragmentation of German doctors, which hindered them from effectively responding to the cost-containment reform of health care in 1992 (Döhler, 1995).

[2] Actually, however, Hacker criticises these reforms as 'reform without change', as the title of his article shows.

In addition, the government's response to collective actions will also matter. If the government hardly tolerates any collective action against government policies, the mobilisation of a collective action will be costly, so that the possibility of collective action becomes low. On the other hand, the government may be little responsive to the demands of the groups conducting collective actions. In other words, under an oppressive government, collective action may be a less efficient instrument for doctors to achieve their policy preferences.

3.2. Democratisation and doctors' political influence

Democratisation denotes a political shift from a non-democratic system to a democratic one. Dahl defines democracy as 'the continuing responsiveness of the government to the preferences of its citizens, considered as political equals', and a political system should provide all citizens with means to formulate and signify their preferences; these preferences should be 'weighted equally in the conduct of the government' (Dahl, 1971: 1-2). Therefore, democratisation systematically alters a political system from one little responsive to the preferences of citizens to a responsive one.

In this sense, democratisation fosters a diversified policy-making process by providing a wider range of freedom to organise associations and mobilise collective action. As Dahl puts it, 'the greater the opportunities for expressing, organizing, and representing political preferences, the greater the number and variety of preferences and interests that are likely to be represented in policy-making' (Dahl, 1971: 26).

Democratisation also tends to provide wider opportunities for social groups to participate in the policy-making process. As movements for democratisation are usually against centralised and hierarchical authoritarian rules, democratisation can result in stronger egalitarian claims for more devolved and open decision-making structures. Thus, democracy can be defined as 'the extent to which the political power of the elite is minimized and that of the nonelite is maximized' (Bollen, 1980: 372).

Democratisation may promote doctors' influence on policies, as it enhances their voices *vis-à-vis* the government. The policy-making process will not be as much of the 'command-and--control' type as under an authoritarian government. In committees doctors will be regarded as discussion partners rather than as subjects of government control. In addition, the strengthened Legislature will be a new veto point available for doctors to check the executive-centred policy-making. Outside of the policy-making process, the enhanced freedom of assembly will make it less costly for doctors to mobilise collective actions against policies, and the government will be more responsive to their demands.

However, democratisation may also decrease doctors' political influence, as it facilitates the participation of other social groups in the policy-making process. Democratisation enables those groups excluded from this corporatism, such as medical consumers, to organise their own associations and participate in the policy-making process. In addition, the increased freedom of association may hurt internal unity among doctors, as factions of doctors can organise their own associations.

4. SPD and doctors' political influence in Korea

4.1. SPD in the authoritarian period 1982-1985

During the first period, the authoritarian Chun Doo-Hwan government, which had taken political power via a *coup d'état*, ruled over Korea. It attempted to implement an SPD pilot programme in Mokpo City between 1982 and 1985, as a part of the pilot programme of the Second Level Health Insurance scheme that expanded the National Health Insurance (NHI) coverage to farmers and fishers.

This pilot programme was due to the demands of pharmacists, who were generally excluded from the NHI until the end of the 1980s. They felt threatened because the NHI covered prescribed medicines, and its expansion would drive more consumers of medicines to clinics or hospitals. This pilot programme caught doctors' and pharmacists' attention nation-wide, and they believed that the SPD would be applied nationally if universal population coverage of the NHI was accomplished.

The executive-centred authoritarian government bypassed the National Assembly – instead of revising the Pharmaceutical Affairs Law, the Ministry of Health and Social Affairs (MHSA) promoted the SPD with administrative guidelines or by enforcing agreements between doctors and pharmacists.

The central associations representing doctors and pharmacists – the Korean Medical Association (KMA) and the Korean Pharmaceutical Association (KPA) – were the main interest groups. Although freedom of assembly was denied, the KPA managed to close down pharmacies in June 1982, demanding a compulsory implementation of the SPD, while the KMA warned that there was a possibility of boycott. However, the authoritarian government responded to this collective action in a harsh manner. It assembled an emergency cabinet which even the Minister of Defence attended, and threatened to arrest the KPA leaders unless they stopped the boycott immediately. The KPA could not but open pharmacies on the following day.

The MHSA set up a committee attended by representatives of the KMA and the KPA: the Consultative Committee for the Medical and Pharmaceutical Cooperation (CCMPC). However, the Consultative Committee did not play a crucial role in the process of the SPD. Instead, the MHSA assumed all responsibility, and the KMA and the KPA contacted its officials and politicians individually. The KMA's lobby effort was rather successful; the vice minister of the MHSA, who used to be a surgeon general, promised not to enforce the SPD, and the administrative guideline on the SPD included no compulsion.

However, when the MHSA was determined to implement the SPD with a stronger measure, it even bypassed the KMA and the KPA. As the number of prescriptions that doctors issued for pharmacists did not increase sufficiently, the MHSA worked directly with medical and pharmaceutical associations in Mokpo City in 1984, and strongly persuaded regional medical and pharmaceutical associations to make an annual contract so that the National Health Insurance (NHI) would not reimburse for the costs of drugs that doctors dispensed instead of issuing prescriptions to pharmacists. In fact, the MHSA had already outlined the contents of the contract before they met with representatives of re-

gional medical and pharmaceutical associations. The contract came into force commencing May 1984 and terminated in December 1984. It increased the number of prescriptions dramatically from 1,244 in April 1984 to more than 35,000 in May 1984. Though expressing its dissatisfaction, the KMA could not but confirm this enforced agreement at the central level.

Nevertheless, the MHSA was not willing to extend this contract against the will of the KMA. When the KMA refused to extend the contract in the following year, the MHSA decided not to disappoint doctors with the SPD issue. It ended the SPD pilot programme in 1985.

All in all, the policy-making process in the early 1980s shows features of an authoritarian style of corporatism. Doctors (and pharmacists) were represented in the policy-making process through central associations, such as the KMA (and the KPA). The government contacted these central associations and even invited them in committees. The government tried not to dissatisfy either of these corporatist partners.

However, neither the KMA nor the KPA was an equal policy partner of the government. Committees did not work very well. Instead, the government made direct contacts with the KMA and the KPA individually. The government did not allow them to dare and challenge any of its decisions. Once the government made a decision, the KMA and the KPA could not but follow it.

In this situation, the KMA could play a limited role as a veto player. The KMA could utilise the government's will to avoid dissatisfying either side. However, the KMA could not directly oppose the decisions of the government. Consequently, the resulted policy output was the implementation of the SPD by economic incentives. The KMA succeeded in dissuading the government from utilising a compulsory regulation for the implementation of the SPD. However, when the government chose a strong economic incentive for the SPD, the KMA could not but follow it.

4.2. SPD in the transitional period 1987-1991

During the second period, Korean politics began the process of democratisation, in which the government allowed more freedom to organise associations. In 1987, the transition to democracy began in Korea with the introduction of a free electoral system. However, in the presidential election held in this year, Rho Tae-Woo, the candidate from the authoritarian ruling party, was elected. Wishing to distance itself from the authoritarian image, this government was reluctant to be repressive towards society. Consequently, freedom of association and assembly increased.

Nevertheless, newly organised civic associations were not directly involved in the policy-making process. In the first place, they were still under construction, and as most of their members were devoted to democratisation movements, pharmaceutical reform did not yet attract their attention as much as other political issues. Secondly, they were hostile to the government, the successor to the former authoritarian regime. Thus they avoided the committees that the government sponsored, and the government was also reluctant to invite NGOs to those committees. As a result, the KMA and the KPA were, again, the main interest groups.

The government tried to achieve universal population coverage of the NHI as a means of political legitimation, and the MHSA organised committees for this aim. Here, the SPD issue arose again between doctors and pharmacists. Though the National Assembly was also involved in the policy-making process, its role was essentially limited to passing the government bill based on the decisions of the committees.

In those corporatist committees the MHSA suggested an incremental increase in compulsory SPD. Faced with the KMA's objection, however, it eliminated doctors' legal obligation from the SPD. This new proposal brought about a series of strikes and rallies by pharmacists. The government was not willing to repress them, yet nor was it willing to arbitrate in the conflict between doctors and pharmacists.

Instead, the government suspended any decision on the SPD. As compensation for pharmacists, the MHSA provided a Pharmaceutical Insurance System (PIS) that reimbursed for certain medicines dispensed without prescription.

Indeed, the MHSA provided a government bill on the revision of the Pharmaceutical Affairs Law, and submitted it to the National Assembly in November 1989. The bill contained the implementation of the SPD commencing July 1991. Nevertheless, the National Assembly refused to accept this revision, as the KMA did not agree with it. As a result, the bill was not even discussed in the National Assembly for two years until November 1991, and then the article of the bill on the SPD was deleted.

All in all, the second period shows increasing influence of social participants in corporatism in the first stage of democratisation. The late 1980s was a period where democratisation started, while the existing framework of authoritarian corporatism remained. As democratisation increased social groups' influences *vis-à-vis* the government, the KMA and the KPA could volume up their voices in committees and meetings with the government. In addition, the promoted freedom of association enabled these social actors to mobilise collective actions more easily.

Moreover, the traditional participants in corporatism – the KMA and the KPA – were not checked by newcomers. As new actors had not yet been well organised and included in the policy-making process, traditional corporatist partners kept enjoying the monopoly of participation in the policy-making process as social groups.

In this situation, doctors' veto effort increased. The government did not attempt to enforce the KMA and the KPA to produce an agreement for the SPD. Moreover, the National Assembly, which was strengthened due to the democratisation, required a voluntary agreement between the KMA and the KPA, which made these associations clear veto players. Instead of enforcing the KMA to make any concession with the KPA, the government could not but just give up the SPD. Instead, the government created a new institution, the PIS, in order to satisfy the KPA. The transitional stage of democratisation made doctors, represented by the KMA, a strong veto player, and the policy output was abandonment of the SPD.

4.3. SPD in the democratic period 1998-2000

During the third period, Kim Dae-Jung, a prominent former opposition leader, was President. His government

actively invited new associations, such as consumers' associations, to corporatist committees, and recruited some NGO members into the government and the ruling party. NGOs were no longer hostile towards the government. As Korea became increasingly democratised and the former opposition party gained political power, they began to turn their attention from political to more social issues, such as consumers' rights, and launched a 'legal' route for social movements.

With the participation of those associations, the government launched the SPD as a pharmaceutical market reform. It was intended to promote the transparency of the market as well as consumers' rights by disclosing prescriptions to patients and pharmacists. Such committees as the SPD Steering Committee (SPDSC) and the SPD Executive Committee (SPDEC) were organised, in which not only the representatives of the KMA and the KPA but also consumers' associations participated.

The Ministry of Health and Welfare (MoHW – the former MHSA) led the SPD process again by organising those committees and prepared the government bill for the revision of the Pharmaceutical Affairs Law. However, in this period the National Assembly played a more active role in guaranteeing that the bill would be the result of a mutual agreement between doctors and pharmacists – it did not allow the MoHW to arbitrate on the SPD issue. However, the National Assembly strengthened consumers' associations, a strong supporting group to the SPD, by authorising them to mediate between the KMA and the KPA. In December 1999 it passed the government bill based on the agreement among the KMA, the KPA and consumers' associations. The revised Pharmaceutical Affairs Law banned clinics and hospitals from dispensing medicines for outpatients.

This intensified internal division among doctors. Those who had more economic interest in dispensing medicines, such as physicians and paediatricians, organised themselves inside and outside of the KMA, occupied leading positions in the KMA, and led a series of rallies in 2000, which then developed into general medical strikes. Nevertheless, although they succeeded in changing details of the SPD, they failed to hinder its implementation in July 2000. Public opinion was hostile to these medical strikes, and the government and the ruling party, as well as consumers' associations, were not willing to surrender to them.

The late 1990s show a waning influence of doctors in the SPD policy-making process. Newcomers, such as progressive experts and consumers, finally appeared in the policy-making process, and challenged the corporatist system and its partners. Consequently, the KMA lost its privileged position in the negotiations between the government and social groups.

On the other hand, the tide of democratisation entered into doctors' society, so that doctors became divided according to their factional interests. Factions of doctors distrusted leaders of the KMA and even organised their own associations. Therefore, the KMA could not set a clear policy orientation.

Indeed, doctors finally succeeded in mobilising medical strikes. However, the timing was too late, since the Pharmaceutical Affairs Law had already been revised according to the ideas of pro-SPD groups. Medical strikes achieved

only partial revisions of the details of the SPD, failing to hinder the implementation of the SPD itself.

Therefore, at least with respect to the SPD, doctors' political influence became even weaker under the democratic government in the late 1990s than under the authoritarian one in the early 1980s, so that the policy output was the implementation of the SPD in a coercive way by revision of the Law.

5. Discussion

This paper examined the impacts of democratisation on doctors' influence on policies, especially their veto capacity on the separation of prescribing and dispensing (SPD). Democratisation diversified the policy-making process, and increased the freedom of association and assembly. Would these political changes have positive or negative impacts on doctors' veto capacity?

An empirical study over three periods – 1982-1985, 1987-1991 and 1997--2000 – demonstrates the changes in doctors' veto capacity during different sequences of democratisation. It shows that doctors' veto capacity increased in the early period of democratisation, but decreased in the later period. Moreover, when comparing the first and third periods, doctors' veto capacity was higher in the former than in the latter.

This result suggests that democratisation can improve doctors' veto capacity in the first stage and then reduce it. Even an authoritarian government may well invite doctors into a corporatist system, although this system is still under control of the authoritarian government. In this system, doctors will be represented by a central association (in the Korean case, the KMA), in order to facilitate its regulation over doctors' society.

In the transition period, democratisation can increase doctors' political influence. A top-down relationship between the government and social groups under the previous authoritarian regime will change to a more liberal and equal relationship. However, outsiders of the authoritarian corporatist system are not yet ready to organise themselves and join the committees among the government and social groups. In this situation, the central medical association, a partner of the existing corporatist system, can enjoy the liberal and equal atmosphere of the corporatist system without challenges from outside.

By contrast, as democratisation comes to be consolidated, doctors' voice can decrease. On the one hand, new social groups, who are now organised and ready to participate in the policy-making process, challenge the corporatist system. The voices of these new actors will cancel out doctors' voice in the policy-making process. On the other hand, doctors' central association, which itself is a heritage of the previous authoritarian regime, can face challenges from the rank-and-file.

This research gives an implication to the study of democratisation. It suggests that, instead of merely comparing the pre- and post-democratisation periods, a research on democratisation needs to consider the flow of the democratisation process in a wider time horizon. In a short period, democratisation may strengthen the social groups which have already been powerful under the previous authoritarian regime. They have developed their political and organisational resources under the authoritarian corporatist system, while outsiders of the system have not. However, in the long run, those outsiders will accumu-

late their resources, and finally be able to challenge the corporatist system. In this sense, a study of democratisation needs to review and analyse a longer historical flow of political and organisational changes, as well as the resulting changes of the policy-making processes and their policy outputs.

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Demokratizacija i politički utjecaj liječnika: razdvajanje propisivanja i izdavanja lijekova u Koreji

SAŽETAK U ovom je radu riječ o odnosu između demokratizacije i političkog utjecaja liječnika u zdravstvenoj politici u slučaju razdvajanja propisivanja i izdavanja lijekova u Koreji. Zahvaljujući svojim profesionalnim i institucionalnim značajkama liječnici se smatraju jednom od najmoćnijih skupina za pritisak. Demokratizacija možda ima dva uzajamno suprotstavljena učinka: (1) pravo veta koje imaju liječnici može se povećati s njihovim sve većim pravom glasa nasuprot vladi, i (2) ono se može smanjiti jer ne samo središnja liječnička komora nego i druge društvene skupine, kao što su medicinski potrošači i podskupine liječnika, stječu veće pravo glasa. U ovom se radu analizira slučaj razdvajanja propisivanja i izdavanja lijekova u Koreji, koje je sprečavalo liječnike da izdaju lijekove. Proces razdvajanja propisivanja i izdavanja lijekova uspoređuje se u autoritarnom razdoblju (1982-1985), prijelaznom razdoblju (1987-1991) i demokratskom razdoblju (1998-2000). Zaključuje se da se politički utjecaj liječnika povećao u prijelaznom razdoblju, a zatim počeo opadati sa sazrijevanjem demokratizacije.

KLJUČNE RIJEČI demokratizacija, politički utjecaj liječnika, razdvajanje propisivanja i izdavanja lijekova