Public Participation in the Process of Local Public Health Policy in South Korea : using Policy Network Analysis

PARK Yukyung, MD, MPH

YOU Myoungsoon, PhD

LEE Kun-sei, MD, PhD

KIM Chang-yup, MD, PhD*

Preventive Medicine Program, Graduate School of Public Health, Seoul National University

Background

- Long history of state-dominated system in South Korea
  - Strong bureaucracy, weak tradition of participation in policy process
- Since the late 1980s, civil society as well as political democracy has grown rapidly
- The attention to the public participation is evidently increasing in many public policy dimensions
  - Policy trials, enactment of local ordinance about participation

Public participation in health policy

- Impact of civil society to the national health policy since 1990s
  - Inaugurate a single-payer system, separation of dispensary from medical practice, and medical privatization
- Little empirical research about participation in the 'local' health policy

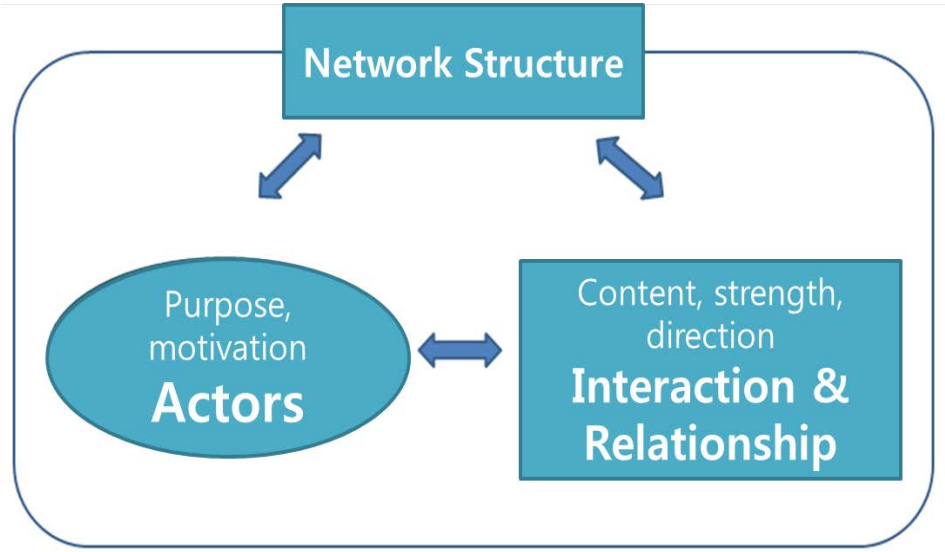
Purpose

- To understand the current state of participation through the policy network in the process of local health policy
- To find some barriers and the ways to overcome them for the active public participation in public health policy

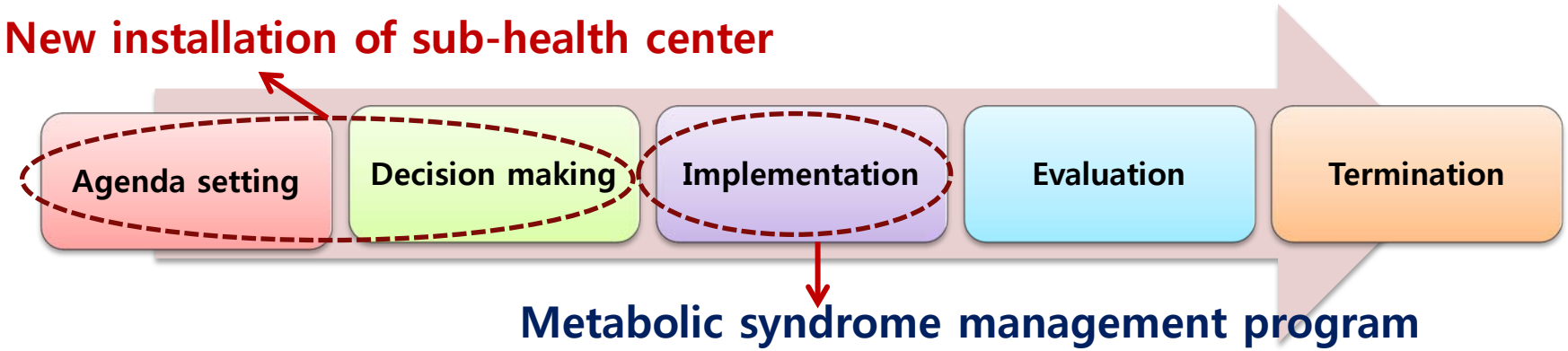
Research tool: Policy Network Analysis

- Policy network
- Policy network analysis
- Utility of PNA
  - Visualization
  - Focus on the relationships
  - Broaden cognition about policy participants

Set of autonomous and interdependent actors who cooperate in the process of policy making (Schneider, 1992)



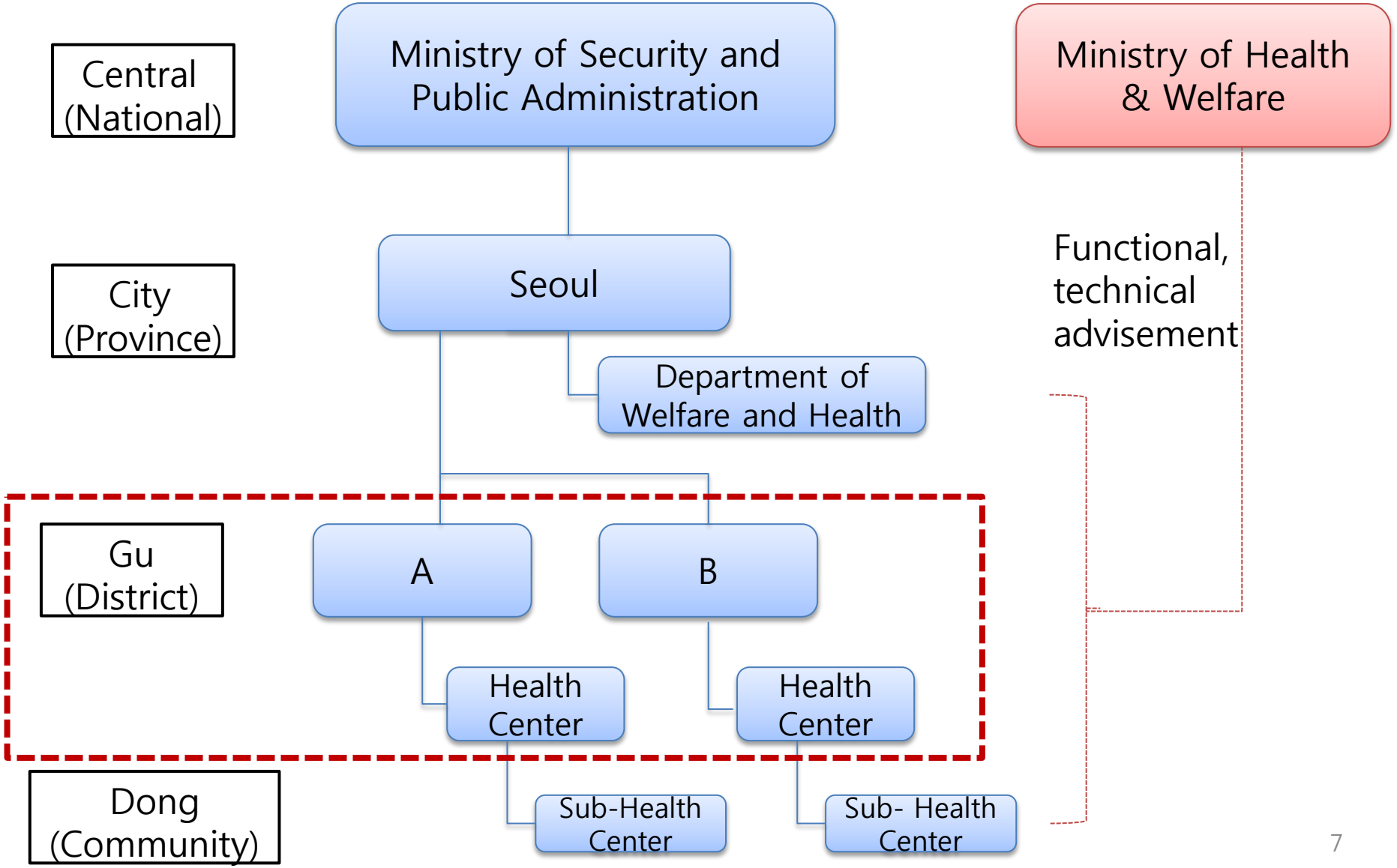
Method



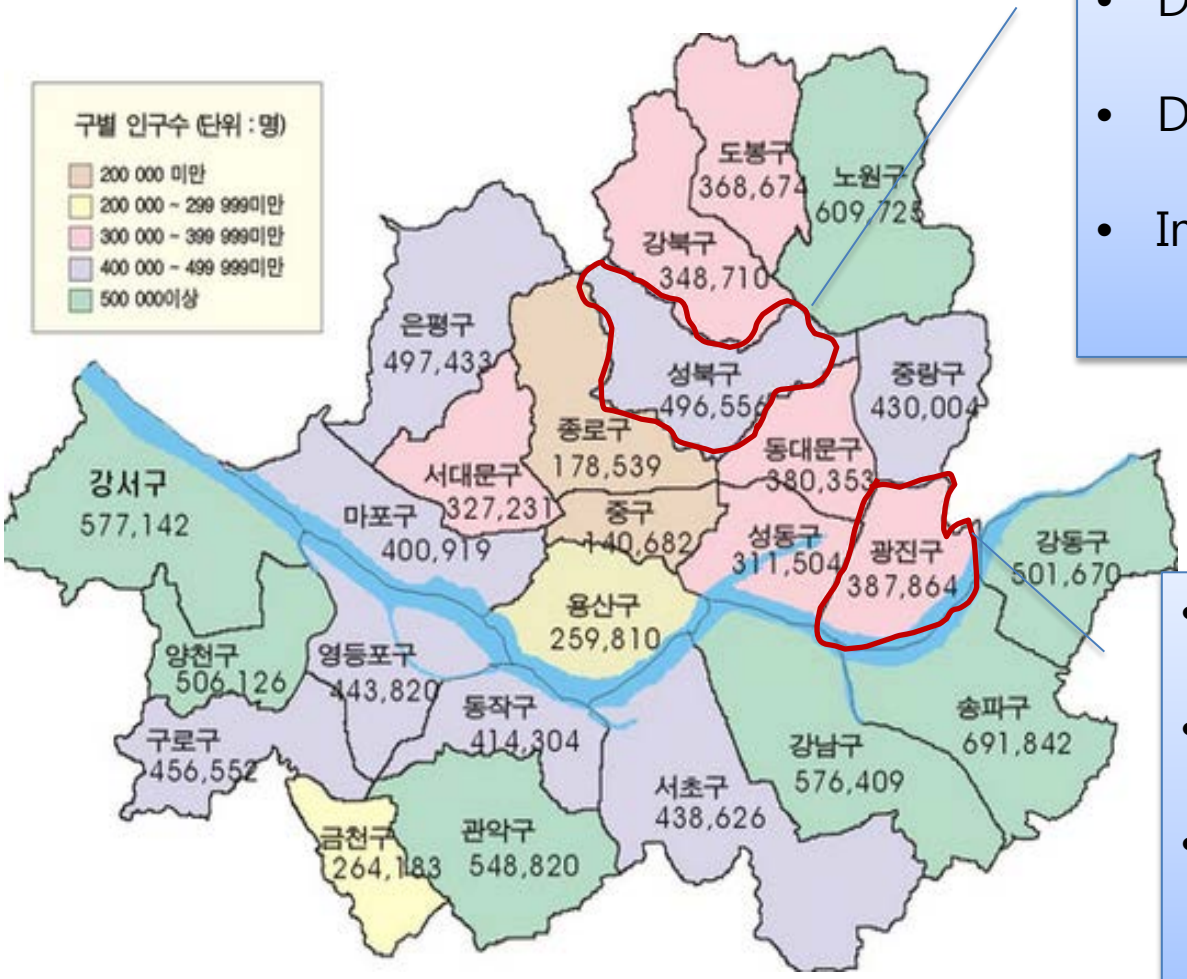
- **New installment of sub-health center**
  - Confliction was expected between private and public sector
- **Metabolic syndrome management program**
  - Recommend community connection to achieve its goal

Case Study(descriptive)	→	Two Districts(Gu)
Questionnaire Survey	→	'Snow Balling' method
Investigation Records	→	Official documents
Social Network Analysis Package	→	Netminer 4

❖ Organization of Public health administration in South Korea



❖ General characteristics of case area



- District A
  - Population-496,000
- Decision making process
  - 8 actors
- Implementation process
  - 30 actors

- District B
  - Population-387,000
- Decision making process
  - 9 actors
- Implementation process
  - 32 actors

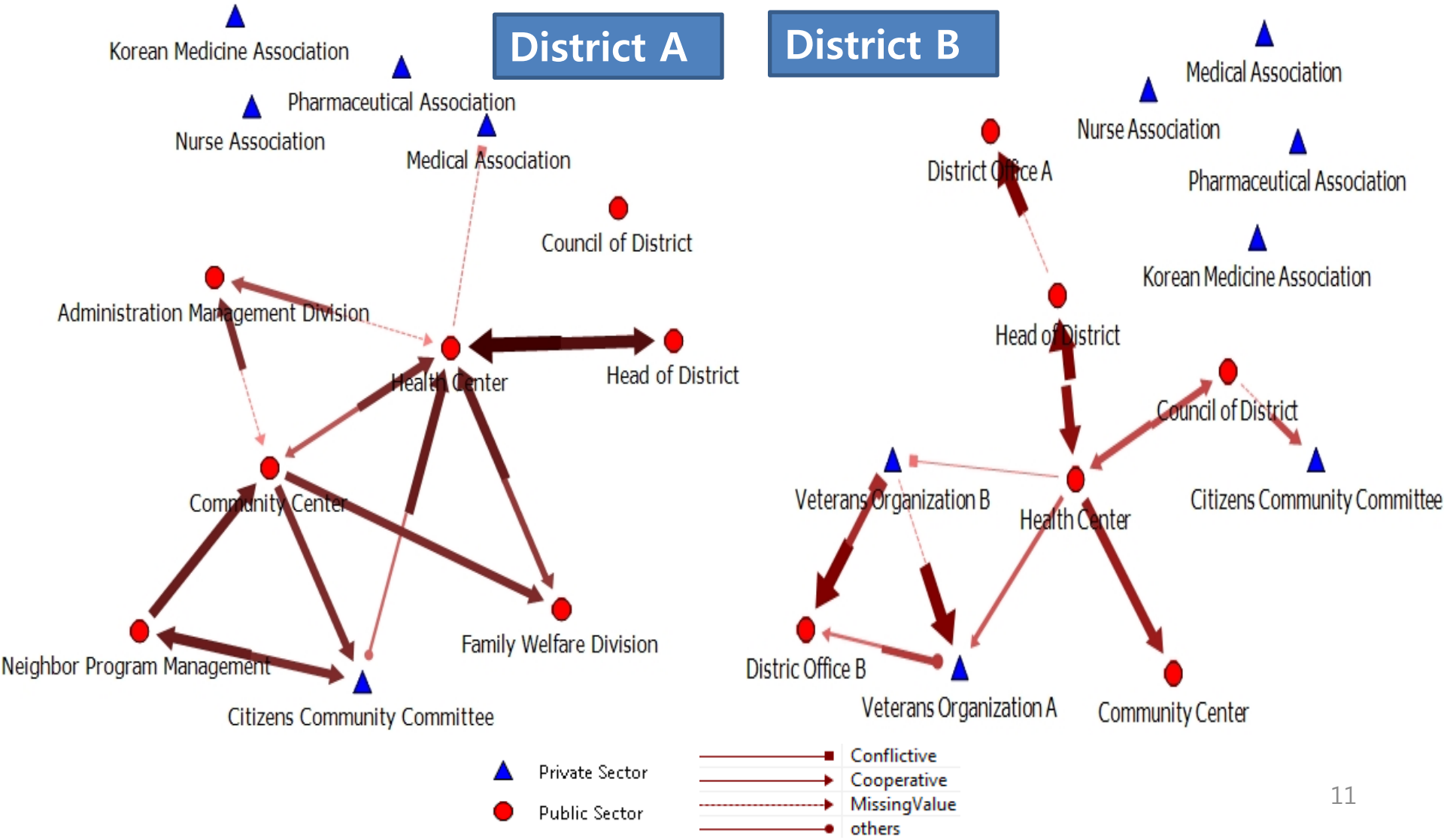
Variables

Elements			
Actors	Public sector	District office, Community center, other public agencies	
	Private sector	Interest group(Medical association, Labor union, etc.), NGO, School, Research agency, Hospital/clinic, Voluntary organizations Social service organization …	
Interaction (formal/ informal)	Exchange of Information	Exchange of information or data for the policy process , Promotion, public relations(PR)	
	Exchange of Resource	Exchange of financial, Human resource for the policy process, Political support, Alliance	
	Channel for mutual interchange	Committee, Meeting, Seminar, Visit, Face-to-face talk, Channel for communication among actors	
Characteristics of linkage	Direction	**Network formation**	Reason for participating the policy process
	Cooperative / Conflictive		Reason to interact with other actors
	Strength of linkage, trust of relationship		Relationship evaluation / reason
	Frequency, continuity		Possible actor(linkage)


RaphaelWimmer
jknp
GadgetMan4U
beka2410
localization
azinman
maxharp3r
erant
havasi
mefiers
blixten
pobs
rndblnch
ebuie
musingvirtual
ayman
dubroy
jsiarto
bbbCHI2010
bkeegan
tobold
eegilbert
numptygeek
andrewmiller
clifflampe
plbogen
HCIR_GeneG
redlog
walt_man
timsohn
bbrynn
marmon
sharoda
tinkholt
jewelia
bjornrud
hadleybeeman
shikohtwit
paulesque
jwnichls
cyberdoyle
gingdottwit
bcjordan
preclubboy
nicktaylor3

RESULTS

1-1. Policy network in decision making : new installation of sub-health center



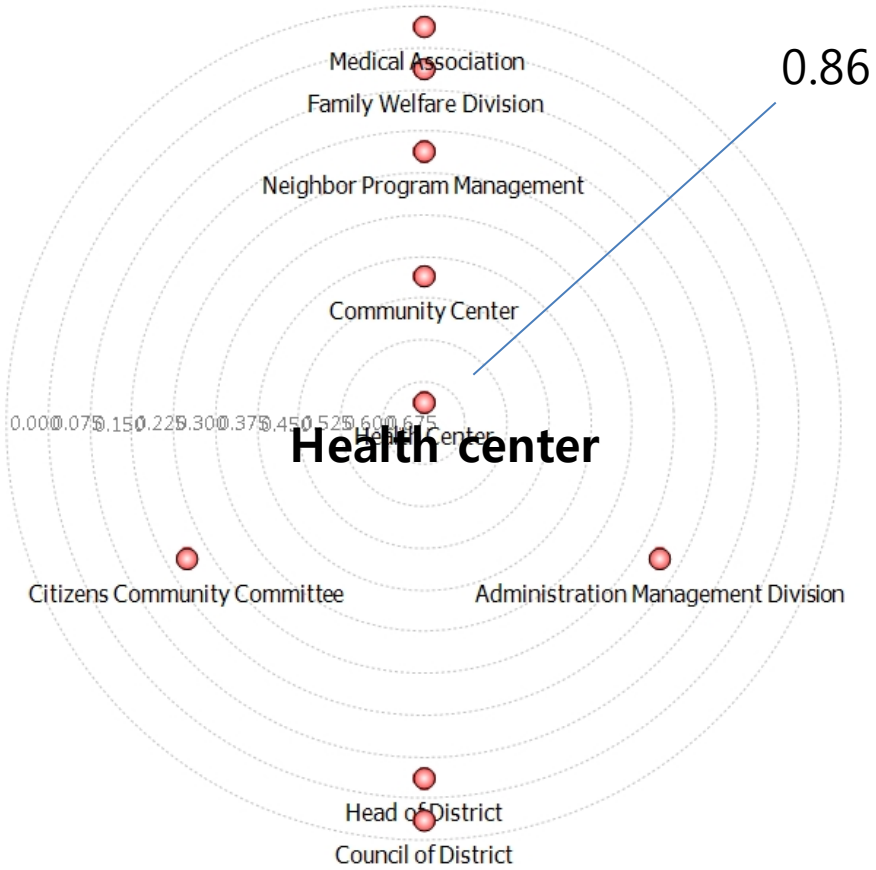
1-2. Structural characteristic
: new installation of sub-health center

- District A and B have similar patterns
  - Political leader(of the district) was the most important actor
    - Health sector of the district just obey directions
  - Public actors compose a large proportion
  - Private sectors participate only when they protest against the local authority
  - No meaningful linkage with local health professional associations or civil groups

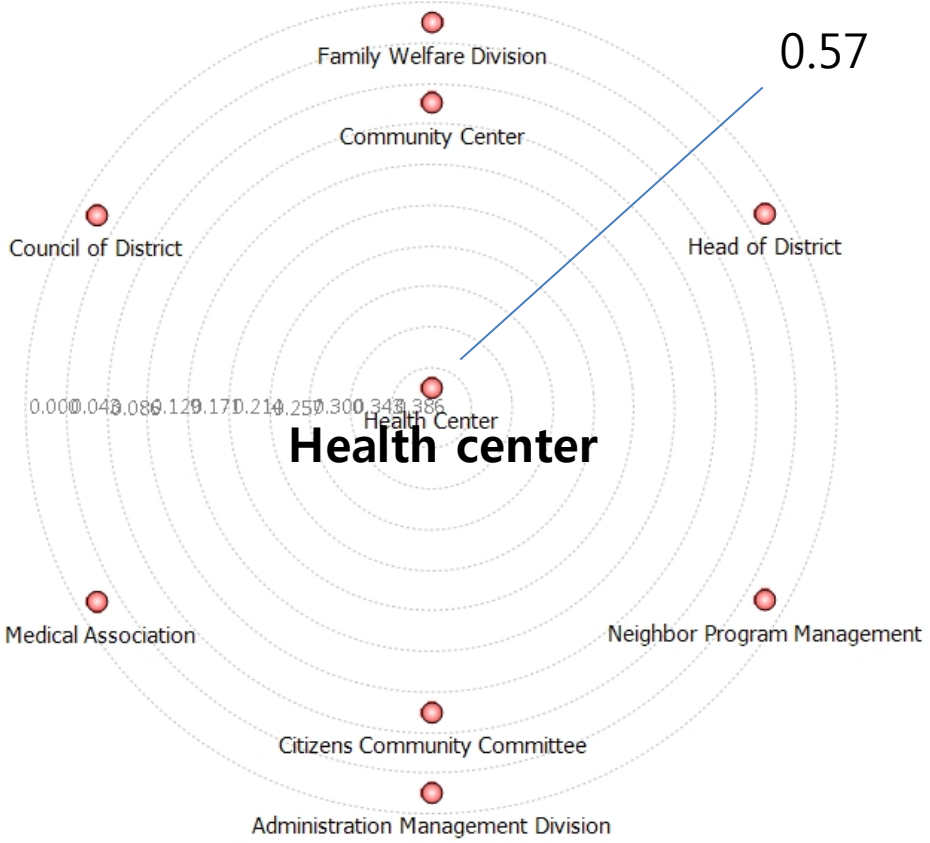
"No-network Network"

1-3. Centrality analysis A

❖ Centrality: the power(position) of each actors among the network



Out-degree centrality



Betweenness centrality

1-3. Centrality analysis B

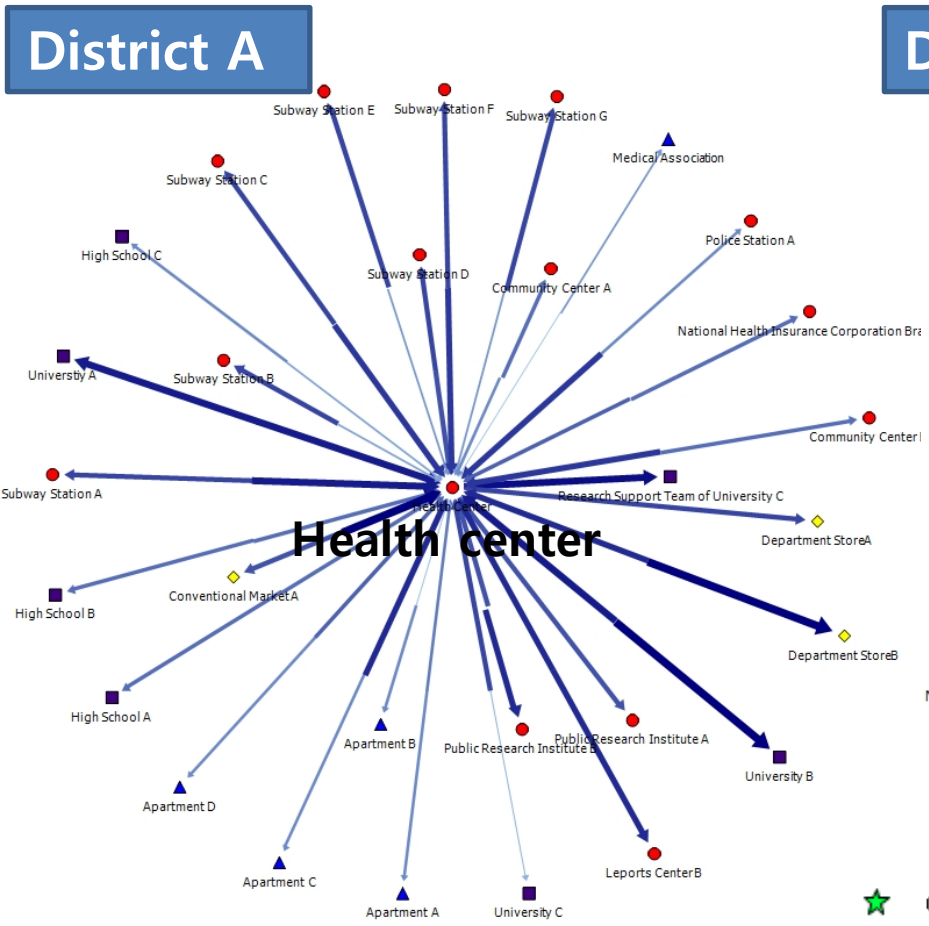
Out-degree centrality

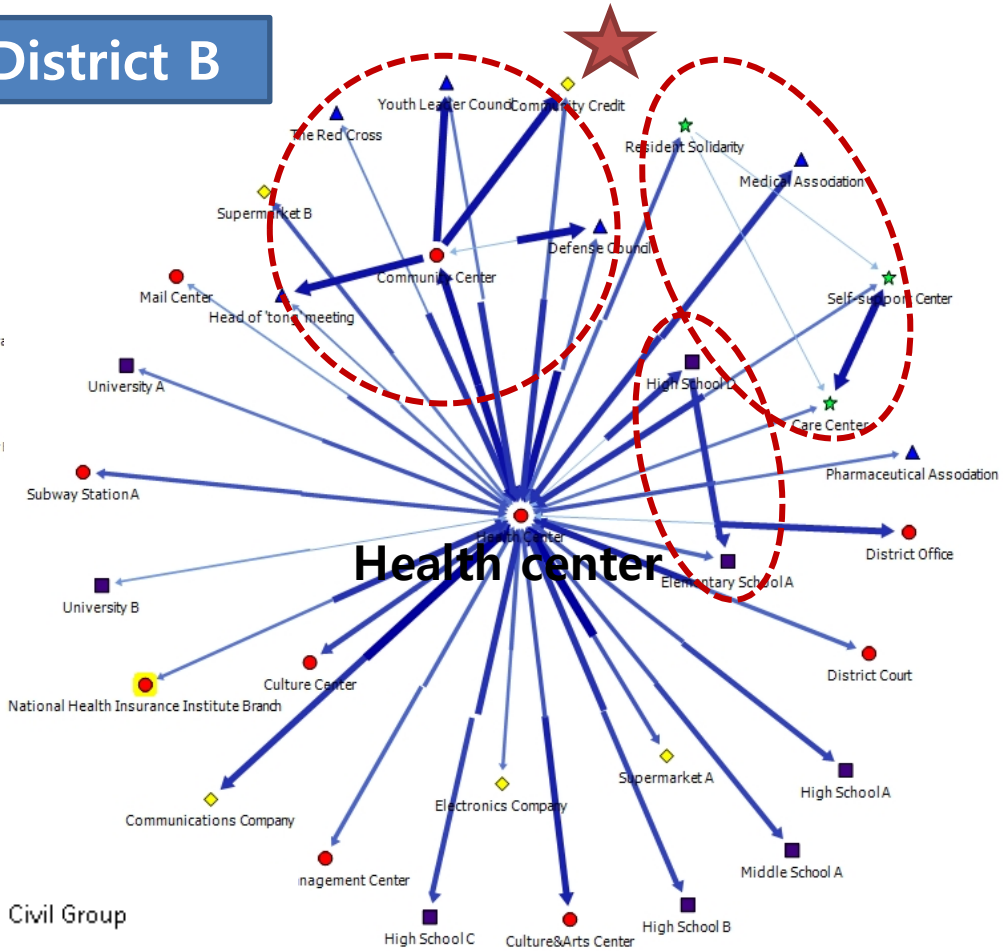
Betweenness centrality

1-4. Problems of Decision Making Process Network: No-network Network

- No discussion about the purpose, function and operation of sub-health center in advance
- Private sector were regarded as a mere formality for legitimacy
- Lack of long-term vision to the community health governance

2-1. Policy network in implementation : metabolic syndrome management program





"Mono-centric Network"

"Mono-centric Network?"

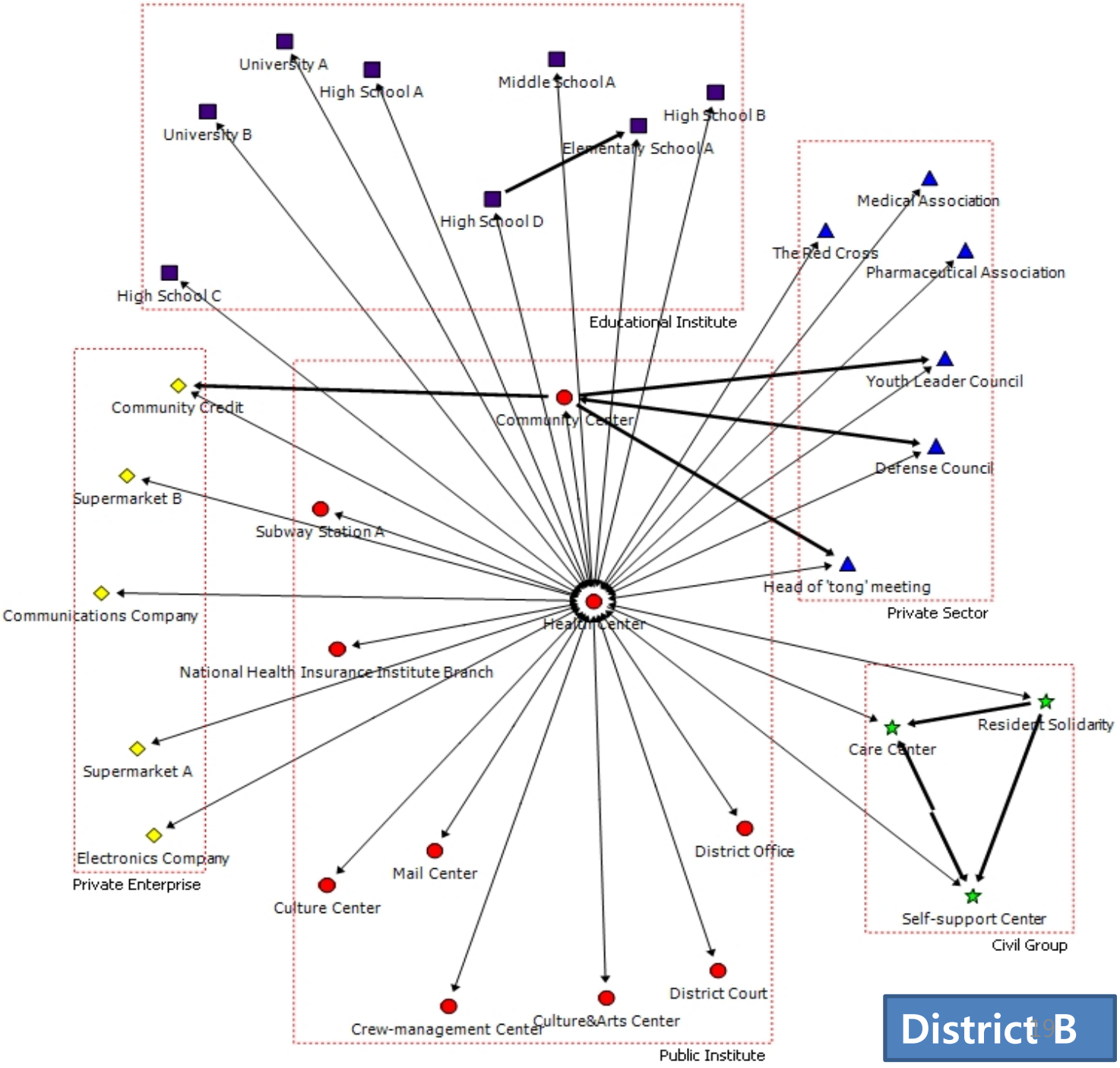
2-2. Structural characteristic
: metabolic syndrome management program

- Cooperate relationship on the surface
- Linkages formed by ‘visiting check-up’ program(almost), consult and post management(partly)
- Project manager had to find, visit and persuade each institutes to participate
  - Inefficient, effort consumptive(wasteful)

2-2. Structural characteristic
: Differences from district A to B

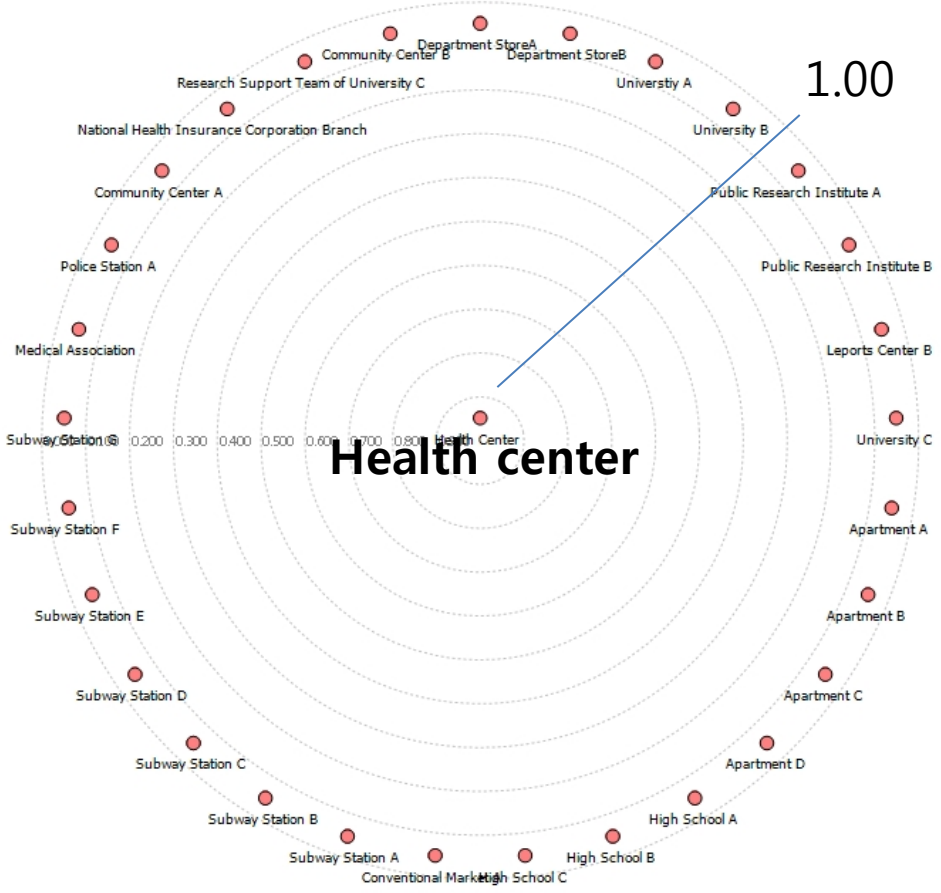
- No more secondary linkages in District A
- Some secondary linkages in District B
  - See the next slide
- Factors ?
  - Willingness of program manager
  - Use existing community networks actively
  - Get more trust from the other actors
- Nonetheless…

Cluster
by Actor Classification



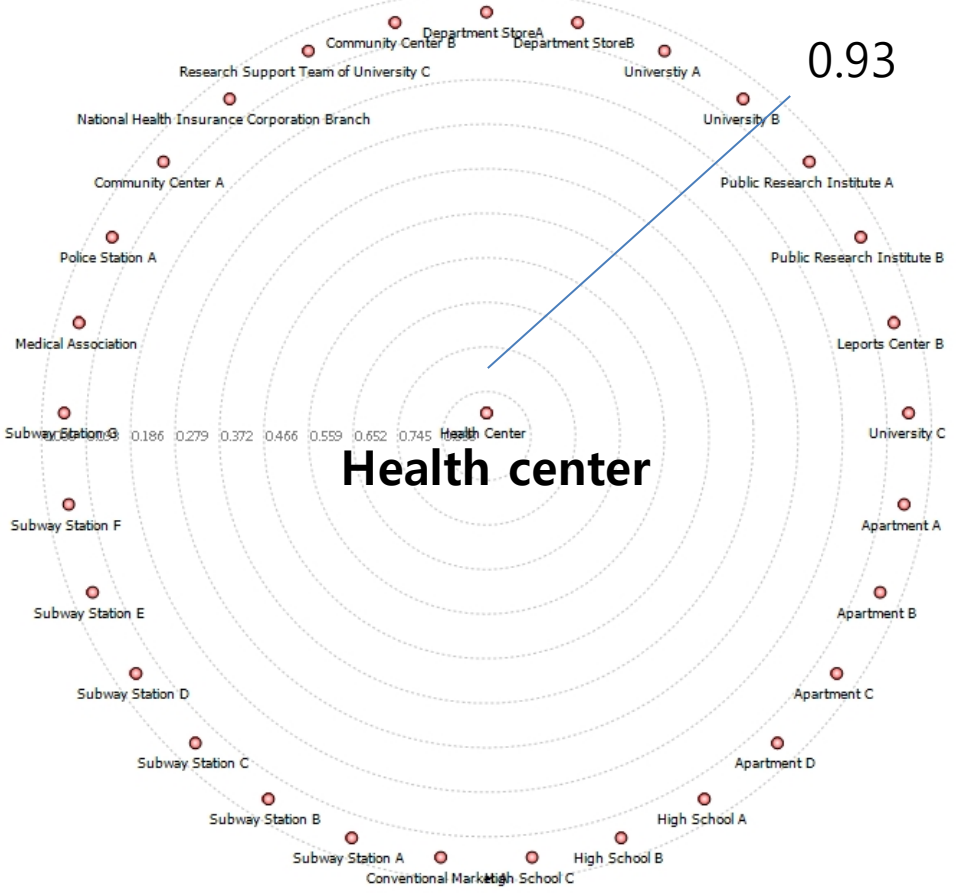
2-3. Centrality analysis A

❖ Centralization: the degree of centralization of the whole network



Out-degree centralization: 100%

Out-degree centrality

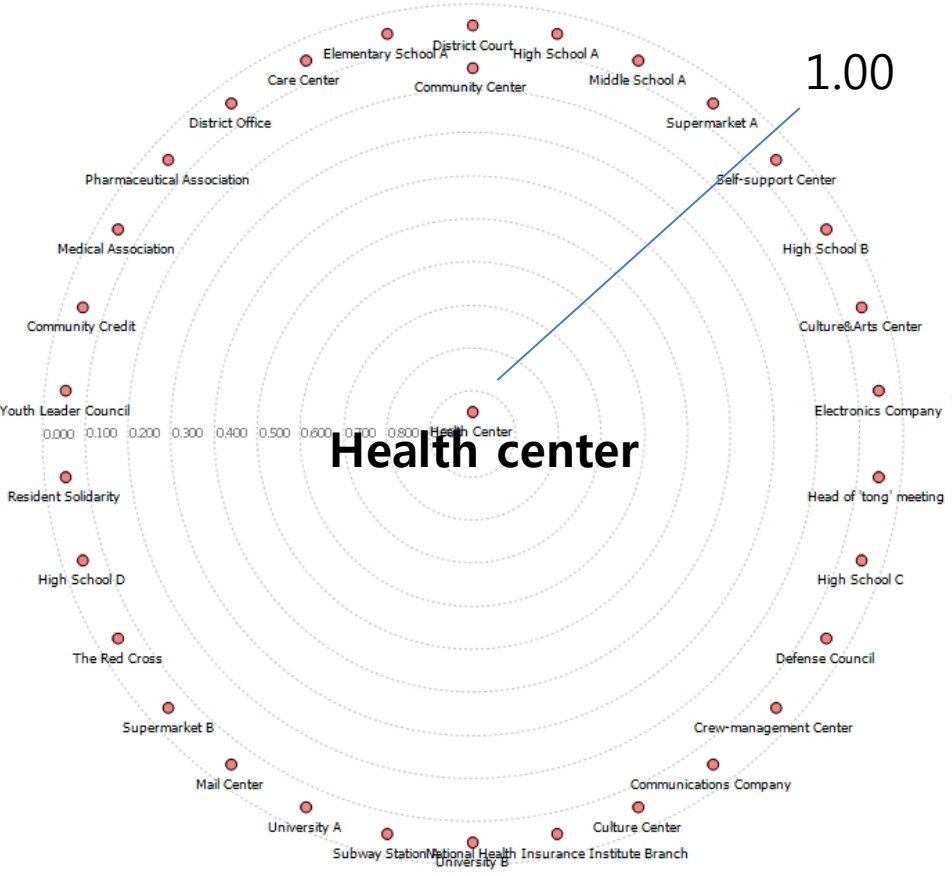


Betweenness centralization: 93.1%

Betweenness centrality

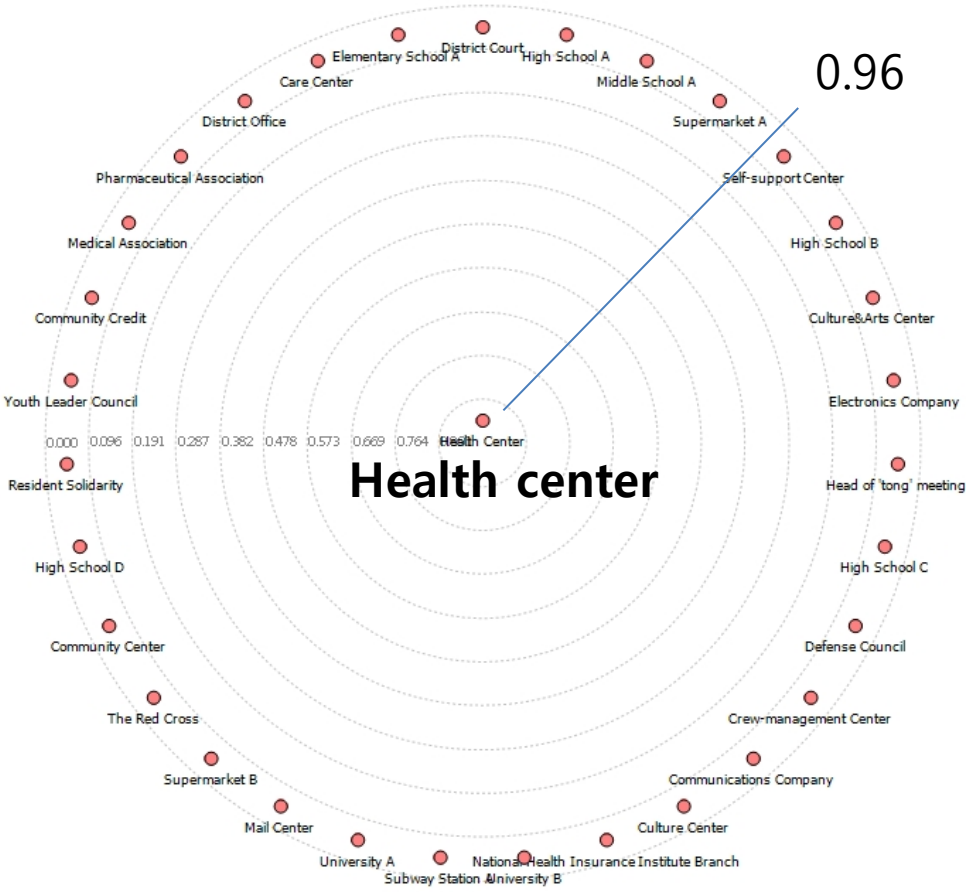
2-3. Centrality analysis B

❖ Centralization: the degree of centralization of the whole network



Out-degree centralization: 99.1%

Out-degree centrality



Betweenness centralization: 95.4%

Betweenness centrality

2-4. Problems of Implementation Process Network: Star shape(mono-centric)

- Extremely weak, influenced by central actor's variation(e.g. change of manager)
- Lack of initiatives
  - Performance indicator : 'screening rate'
  - No incentive to make active, long term, meaningful scale of network
  - Initially burden to both public and private actors

Future directions

- In policy agenda setting & decision making
  - Stakeholder communication
  - May take more time, but need more discussion in advance
- In policy implementation
  - Health sector leadership
  - Political support should be institutionalized to encourage participation
  - Consider social capital such as preexisting community network

Conclusion

- Network analysis can be useful to describe policy process and participation
  - Despite of different social, institutional setting, accumulation of empirical evidences is needed
- Empirical results show us that we have a long way to go for a better democracy

THANK YOU

Preventive Medicine Program,
Graduate School of Public Health,
Seoul National University

e-mail: yukyungpark@gmail.com

Appendix. 1

Centrality analysis of network : new installation of sub-health center

❖ Centralization: the degree of centralization of the whole network

❖ Centrality: the power(position) of each actors among the network

District A	In-Degree	Out-Degree	In-Closeness	Out-Closeness	Node Betweenness
Centralization	52.4%	71.4%	51.9%	59.7%	53.1%
Centrality					
Health center	0.71	0.86	0.73	0.88	0.57
Community center	0.43	0.57	0.57	0.70	0.12
Citizens community committee	0.43	0.29	0.57	0.58	0.15
Family welfare division	0.29	0.14	0.51	0.50	0
Administration management division	0.29	0.29	0.51	0.54	0
Head of district	0.14	0.14	0.43	0.50	0
Culture program section	0.14	0.29	0.37	0.50	0.01
Medical association	0.14	0	0.5	0	0

Centrality analysis of network : new installation of sub-health center

District B	Degree(I)	Degree(O)	Closeness(I)	Closeness(O)	Betweenness
Centralization	17.9%	50.0%	36.7%	70.9%	37.3%
Centrality					
Veterans organization A	0.38	0.25	0.47	0.25	0.04
Veterans organization B	0.38	0.25	0.47	0.25	0.04
Health center	0.25	0.63	0.33	0.73	0.43
Head of district	0.25	0.25	0.29	0.50	0.18
Council of district	0.25	0.25	0.29	0.50	0.18
District office B	0.25	0.25	0.34	0.25	0
District office A	0.13	0.13	0.20	0.35	0
Citizens community committee	0.13	0.13	0.20	0.35	0
Community center	0.13	0	0.28	0	0

Appendix. 2

Network formation – Decision making process -

	Reasons	District A	District B
Policy participation	Because of formal·informal request	0%	16.7%
	Public obligation	50%	66.7%
	It will help my community or organizational health promotion	33.3%	16.7%
	It will help my community or organizational improvement other than health	0%	0%
	Others	16.7%	0%
Linkage with other actors	Have existing linkage already	12.5%	42.9%
	Suitable for my needs	75%	35.7%
	Deserve to get trust and reputation	0%	11.1%
	Have acquaintance with the person in charge	0%	0%
	Others (as a subordinate office)	12.5%	21.4%

Appendix. 3 Centrality analysis of network

: metabolic syndrome management program

District A	Degree(I)	Degree(O)	Closeness(I)	Closeness(O)	Betweenness
Centralization	92.9%	100.0%	92.7%	93.2%	93.1%
Centrality					
Health center	0.93	1.00	0.93	1.00	0.93
Department store A	0.03	0.03	0.47	0.51	0.00
Supermarket B	0.03	0.03	0.47	0.51	0.00
University A-C	0.03	0.03	0.47	0.51	0.00
Public research institute A	0.03	0.00	0.49	0.00	0.00
Public research institute B	0.03	0.03	0.47	0.51	0.00
Leports center B	0.03	0.03	0.47	0.51	0.00
Apartment A-D	0.03	0.03	0.47	0.51	0.00
High school A-C	0.03	0.03	0.47	0.51	0.00
Conventional market A	0.03	0.03	0.47	0.51	0.00
Subway station A-G	0.03	0.03	0.47	0.51	0.00
Medical association	0.03	0.03	0.47	0.51	0.00
Police station	0.03	0.03	0.47	0.51	0.00
Community center A, B	0.03	0.03	0.47	0.51	0.00
National Health Insurance Corporation	0.03	0.03	0.47	0.51	0.00
Research support team of University C	0.03	0.00	0.49	0.00	0.00

District B	Degree(I)	Degree(O)	Closeness(I)	Closeness(O)	Betweenness
Centralization	92.3%	99.1%	91.3%	97.3%	95.4%
Centrality					
Health center	0.94	1.00	0.94	1.00	0.96
Self-support center	0.10	0.06	0.51	0.52	0.03
Care center	0.10	0.03	0.51	0.34	0.00
Head of 'tong'meeting	0.06	0.03	0.49	0.51	0.00
Defense council	0.06	0.06	0.49	0.52	0.00
Community center	0.06	0.16	0.49	0.54	0.00
Youth leader council	0.06	0.03	0.49	0.51	0.00
Community credit Cooperative	0.06	0.03	0.49	0.51	0.00
Elementary school A	0.06	0.00	0.51	0.00	0.00
Public institution A-G	0.03	0.03	0.48	0.51	0.00
High school A-C	0.03	0.03	0.48	0.51	0.00
Middle school A	0.03	0.03	0.48	0.51	0.00
Supermarket A, B	0.03	0.03	0.48	0.51	0.00
Electronics company	0.03	0.03	0.48	0.51	0.00
Communications company	0.03	0.03	0.48	0.51	0.00
University A, B	0.03	0.03	0.48	0.51	0.00
Subway station A	0.03	0.03	0.48	0.51	0.00
The Red Cross	0.03	0.03	0.48	0.51	0.00
High school D	0.03	0.06	0.48	0.52	0.00
Resident solidarity	0.03	0.10	0.48	0.53	0.00
Medical association	0.03	0.03	0.48	0.51	0.00
Pharmaceutical association	0.03	0.03	0.48	0.51	0.00

Appendix. 4

Network formation – Implementation process -

	Reasons	District A		District B		
Policy participation	Because of formal·informal request	22.2%		21.4%		
	Public obligation	14.8%		7.1%		
	It will help my community or organizational health promotion	55.6%		71.4%		
	It will help my community or organizational improvement other than health	3.7%		0%		
	Others	3.7%		0%		
Health center: HC / Other institution: O		**HC→O**	**O→HC**	**HC→O**	**O→O**	**O→HC**
Linkage with other actors	Have existing linkage already	3.5%	18.5%	3.2%	85.7%	32%
	Suitable for my needs	96.5%	59.3%	77.4%	0%	40%
	Deserve to get trust and reputation	0%	11.1%	3.2%	0%	28%
	Have acquaintance with the person in charge	0%	0%	6.5%	14.3%	0%
	Others	0%	11.1%	9.7%	0%	0%