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Review

Priority setting in health care as portrayed in South Korean and Israeli newspapers

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ABSTRACT

Studies have reported differences in the public's understanding of, trust in, and satisfaction with its priority-setting processes and outcomes across countries. How the media frames and reports decision making processes and outcomes may both reflect and affect the public's knowledge of and attitudes toward them. Nevertheless, no studies have analyzed how priority-setting decision making processes are portrayed in the media. We analyzed 202 newspaper articles published over a decade, from January 2000 through December 2009, in leading newspapers of Israel and South Korea. The findings reveal intriguing differences between the countries in both the number and content of the reports. The issue of priority setting is much less salient in Korean than in Israeli society. While the complexity of the task was the most prevalent theme in the Israeli reports sampled, benefits package expansion decisions were most common in the Korean reports. Similarly, the Israeli reports emphasized the qualifications and backgrounds of individual members of the decision making committee, but the equivalent Korean committee was not portrayed as a major actor, and so received less attention. The least reported theme in both countries was priority-setting procedures and principles. These findings, along with results from previous studies which indicate that public satisfaction with the two systems differs between the countries, provoke several interesting future research questions.

1. Introduction

The limited resources of nations and health care providers, along with the rapid development of expensive new health care technologies, make priority setting in health care systems unavoidable [1–3]. Priority setting is a complex task involving difficult, value-laden choices and painful decisions affecting various stakeholders, including the public and health care professionals [4]. Finding ways to ration and set priorities for limited public resources while making the process more systematic and transparent has thus become a critical policy agenda in many countries [5–7].

Across countries there seem to be differences in the public's understanding of, trust in, and satisfaction with its priority-setting processes. For example, studies from Israel have found high trust in the country's priority-setting procedures, with over two-thirds of the general public said to have trust or some trust in the system, and even greater levels of support among physicians [8]. On the whole, Israelis do not feel the public should have more say about the inclusion of new technologies in the health services basket offered citizens under the country's national health insurance system, and they are comfortable not having a larger voice in the relevant ethical issues. In South Korea,

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however, the public are more likely to report a desire to participate in health care resource allocation. In one Korean survey conducted in 2005, 62.1% of the respondents said that such decisions should be made in consultation with the public or patient representatives [9].

The media are a mirror of public opinion on the one hand, and an instrument of social influence on the other [10,11]. Thus, how decision making processes and outcomes are reported in the media may both reflect and affect the public's knowledge of and attitudes toward them. Nevertheless, although priority setting in health care systems has been extensively discussed in the literature [6,12–16], and a number of studies have surveyed or interviewed members of the public or patients in various countries [17–20], to the best of our knowledge, no studies have analyzed how these priority-setting decision making processes or outcomes in health care systems are portrayed in the media.

To help fill this gap, the current study aims to explore the ways through which priority-setting mechanisms are presented to the public via the media in Israel and South Korea. Israel and South Korea have been in recent years the subject of several comparative studies in different fields [21]. Indeed, the two make good subjects for comparison, because while differing in important respects, including historical development and culture, they have a great deal in common. South Korea and Israel were both established in 1948, and both have democratic regimes (a parliamentary democracy in Israel, a presidential republic in South Korea). Both societies have been involved in continuous political and military conflicts, giving security issues an important role in policy making. The two countries had similar GDPs per capita (PPP) in 2011 ($28,809 in Israel and $29,786 in South Korea), and have similar levels of literacy [21–23]. Notably, for the purposes of the present study, both countries respect press freedom, which is protected by law or court rulings, and both have a thriving privately owned printed media: in 2010 Israel had nine dailies and South Korea had 11 [21–26]. And finally, both countries have publicly funded social insurance systems that have relatively short histories. The two systems provide mandatory and universal health insurance coverage to all citizens with a uniform benefits package.

Despite these similarities, and particularly the similar histories of their health insurance systems, South Korea and Israel differ in key aspects of their priority-setting procedures, as well as levels of public satisfaction with health care decision making [3,25,27]. While to some degree these differences can doubtless be traced to aspects of the two society's cultures and historical development, such an investigation is beyond the scope of the current study. Indeed, our concern here is less with the deeper origins of these differences than with the current role of the media in reflecting and propagating them. Specifically, using a comparative content analysis of news reports published in leading newspapers in South Korea and Israel, we aim to understand how the work of resource allocation decision makers is presented in the media of each country, and the implications of these media portrayals for both policy making and future studies on priority-setting processes.

2. Background

2.1. The health care systems in Israel and South Korea

The Israeli health care system is a mixed system with public and private components. The publicly funded social insurance system provides mandatory and universal health insurance coverage to its citizens. As stipulated by the Health Services Basket of the National Health Insurance (NHI) Law of 1995, basic services are funded through a tax paid by each adult citizen (currently 4.8% of the individual's income) through Israel's National Insurance Institute, and by direct government contributions. The law specifies a uniform benefits package – the National List of Health Services or Health Services Basket (HSB) – which provides coverage for basic care, delivered through four not-for-profit sick funds. The sick funds deliver services to their members through contracted providers or their own facilities based on a model similar to health maintenance organizations in the USA. In addition, the four sick funds are allowed to sell members supplemental coverage for services not included in the basic basket, and private insurance firms can offer insurance that covers both basic and additional services [1,2,5,28–31].

Like Israel, Korea has a compulsory social insurance system that provides universal health insurance coverage to its citizens, who pay a mandatory contribution. The scheme is financed by contributions from employers, employees, the self-employed, and from government subsidies. As of 2012, employees contribute 5.80% of their wages or salary, the same amount contributed by the employer. For the self-employed, contributions are calculated based on various factors, including the householder's income, assets, age, and gender. One of the distinct features of the Korean health care system that may be relevant to priority-setting decisions is the dominance of the private sector in the delivery of health care services. In the event of sickness or injury, the insured and their dependents are entitled to health insurance benefits, which consist of benefits in kind and in cash. The benefits package is the same for all population groups [27].

2.2. Priority setting in Israel and South Korea

2.2.1. Israel

Israel's National Health Insurance law provides two mechanisms for adjustment of the health services basket. The first is an automatic annual update of the total cost of the HSB based on several economic and social indices, including a health costs index, population growth figures, and aging rates. The second gives parliament the right to add items to the HSB on condition that the government makes a sufficient budget available.

The process of updating the HSB began toward the end of 1998, with the creation of a National Advisory Committee charged with considering the addition of new services [1–3,5,8,30]. The committee has about 20 members (the exact number varies from year to year) who are appointed by the Ministers of Health and Finance; they include Health and Finance Ministry representatives; medical doctors from the four sick funds and public hospitals;