

**Solidarity, labour, and institution:
The politics of health insurance reform
in Japan and South Korea**

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ABSTRACT

Why did South Korea integrate multiple health insurers into a single national health insurance in 2003 while Japan maintained its fragmented insurance system based on labour market status? Why did labour in South Korea support the integration of health insurance schemes whilst labour in Japan was opposed to it? The health insurance systems in Japan and South Korea were both based on the social insurance system and fragmented on the basis of occupation and labour market status. However, these two countries have taken different reform paths.

This thesis argues that the two self-undermining effects and ideas were intertwined and these led to different policy coalitions. Firstly, workers' support for the consolidation reform was dependent on the inclusivity of the decision-making process at company-level health insurance schemes. Labour in Korea was not able to take part in the decision-making process in company-based health insurance societies while Japanese workers were. The absence of self-governance in the Korean health insurance system reduced incentives for the labour unions to protect their health schemes. Secondly, the Korean government conferred small credibility to support for the municipal health insurance. The subsidy for municipal health schemes in Korea was provided at the discretion of the central government and local government had no legal responsibility for its municipal health funds. These regulations were in stark contrast to the Japanese regulations. It made the friction with the idea of universal health care in Korea. Thirdly, the socially oriented unionism and dense network between trade unions and reformers in Korea contributed to the integration of the health insurance system through creating intensive policy learning for solidarity inside labour movements. In contrast, the cooperative labour-management relationship and their strong networks in the Japanese healthcare policy arena led to the coalition to protect their occupational health funds.

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LIST OF ABBREVIATIONS

General

ACF	Advocacy Coalition Framework
CAT	Computer Aided Tomography
DRG	Diagnostic-Related Group
EBM	Evidence Based Medicine
FFS	Fee for Service
GP	General Practitioner
IMF	International Monetary Fund
MRI	Magnetic Resonance Imaging
NHS	National Health Service
PR	Proportional representation electoral rule
SME	Small and Mid-Sized Enterprises

Japan

CEFP	Council of Economy and Fiscal Policy
CHI	Citizen Health Insurance programme
DPJ	Democratic Party of Japan
DSP	Democratic Socialist Party
GMHI	Government-Managed Health Insurance
JMA	Japanese Medical Association
JSP	Japan Socialist Party
LDP	Liberal Democratic Party
MHLW	Ministry of Health, Labour and Welfare
MOF	Ministry of Finance
PARC	Policy Affairs Research Council in the LDP
SMHI	Society-Managed Health Insurance

South Korea

CSS	Committee for Social Security
EPB	Economy Planning Board
GNP	Grand National Party
FKI	Federation of Korean Industries
FKTU	Federation of Korea Trade Unions
KCTU	Korean Confederation of Trade Unions (Minjunoch'ong)
KCTUR	Korean Council of Trade Union Representatives (Chŏnnotae)
KEF	Korean Employers Federation
KIHASA	Korea Institute for Health and Social Affairs

KMIC	Korean Medical Insurance Corporation
KRW	Korean Won
KTUC	Korea Trade Union Congress
MDP	Millennium Democratic Party
MOHSA	Ministry of Health and Social Affairs
NCTU	National Confederation of Trade Unions (Chŏnnohyŏp)
NHIC	National Health Insurance Corporation
PPD	Party for Peace and Democracy
RDP	Reunification Democratic Party
SCNR	Supreme Council for National Reconstruction

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Chapter 1 Introduction

1.1 Research question

This thesis examines why South Korea integrated multiple health insurers into a single insurance scheme in 2003 while Japan maintained its fragmented insurance system based on labour market status. In relation to this question, the thesis also investigates why labour in South Korea supported the integration of health insurance whilst labour in Japan was opposed to it.

The healthcare in South Korea and Japan were based on a social insurance system. Their finance largely relied on contributions and health insurance schemes were divided by various occupations. In both countries, the health system has been threatened by uncontrolled upward trend in health spending. The pace of the increase in the health care expenditures was higher than that of GDP and it has induced serious financing problems in the health insurance schemes. From 1990 to 2001, health spending in South Korea grew at 7.5 percent, compared with a GDP expansion rate of 5.2 percent. The health care expenditures in Japan had grown at around 3.8 percent over the same period whilst GDP grew at 2.3 percent (OECD, 2003, 60). There was an increasing concern on how to control health expenditures in these two countries. In addition, weak gate-keeping function and fee-for-service payment system in both countries resulted in frequent visits and longer stay in hospital significantly increased their health care cost. The cost explosion in health expenditure led to the financial problem in municipal health insurance societies, the most vulnerable health programme among various occupational schemes in these two countries (OECD, 2008, 25).

The municipal health insurance societies for the self-employed and the retired in both countries were substantially vulnerable to these structural problems. Most of these schemes experienced financial distress due to increased health expenditures as well as reduced ability to finance its health insurance benefits. The municipal health societies were supposed to cover those who were old and poor. The elderly comprised 40 percent of the Japanese municipal health funds' members while they comprised only 4 percent of large firm-based health funds (MHLW, 2006). In South Ko-

rea, the elderly comprised 15 percent of the municipal health plans' members in rural areas while they comprised only 9 percent of company-based health plans' members in 1997 (Jo, 1998, 279). In addition, the small size of membership made municipal health insurances more inefficient and vulnerable to external shock (Jo, 1998, 268; Nakagawa, 2009, 92).

In this regard, the municipal health insurance schemes had a hard time in tackling their accrued deficits. In Japan, municipal health insurance schemes recorded deficit of 450 billion yen in 1999 and around 60 percent of municipal health plans went into red. In Korea, around half of municipal health insurance schemes recorded deficits in 1989 (Jo, 1998, 268). Due to the structural weakness, the disparities of health societies among different occupational groups and the financial crisis of health societies for self-employed had been exacerbated.

The voice for the integration of all health insurance schemes was raised in both countries. In Japan, the local governments and municipal health insurance societies became the strong advocates for the full-scale integration of health insurance schemes. In Korea, the insured in municipal health insurance societies became so. The two countries, however, took different reform paths in response to the fiscal crisis of municipal health insurance societies. In South Korea, a full-scale integration of different health insurance programmes was chosen. Multiple social insurers were merged into a single National Health Insurance Corporation in 2000. By contrast, Japan maintained its multi-payer system. Interestingly, trade unions in two countries took quite different stances on the reform in the policy processes. Korean counterpart supported the integration reform while Japanese trade unions supported the fragmented health insurance system.

In terms of risk pooling system, Korea adopted more solidaristic health insurance programme than Japan although Japan still had more generous health care benefits programme. Theoretically, there are four types of the public insurance system based on the degrees of solidarity: 'no risk pooling', 'pure fragmented risk pooling', 'partially integrated risk pooling', and 'unitary risk pooling' (Smith and Witter, 2004). The lowest level is 'no risk pooling', where individuals are responsible for meeting their own health care costs. Under the 'pure fragmented risk pools', there are various segments of the insurance schemes based on occupations. Risks are sharing only within a same risk pool and there is no transfer among different insurance

bodies. In this case, pools with a high proportion of the sicker and older may incur high health care spending, which can give rise to fiscal difficulty in those pools. To solve this problem, ‘partially integrated risk pooling system’ develops the financial transfer or risk adjustment among different health insurance funds. Under the ‘unitary risk pooling’ or ‘single-payer system’¹, which Korea adopted, all citizens become members of a risk pool and revenues are managed within a single pool. In this regard, the unitary risk pooling system holds the strongest form of social solidarity.

South Korea integrated fragmented health insurers in 2003 while Japan maintained its fragmented insurance system based on occupations. In relation to it, the labour in South Korea supported the integration of health insurance whilst labour in Japan was opposed to such trial. The diverse paths of health insurance reforms leave us with unresolved puzzles, which lie at the heart of the thesis. Firstly, how was South Korea successful in the integration of health insurance schemes while Japan kept an occupation-based health insurance system, even though Korean labour unions were less organised than Japanese labour unions and left-wing parties had no seat in the National Assembly (Lee, 2011, 152). Only 11.5 percent of Korean workers were unionised as compared to 20.9 percent in Japan in 2001 (OECD, 2008, 21). In Korea, it was not until the 2004 general election that a left-wing party associated with the labour movement was voted into the National Assembly (Lee, 2006). This contrasts with the conventional explanation that strong unions and left-wing parties bring solidaristic welfare states (Korpi, 1983; Stephens and Huber, 2001). It allows an investigation of the relation between institutions and interests.

The second puzzle is how South Korea achieved the solidaristic reform while Japan kept an occupation-based health insurance system, even though Korea had an obviously smaller welfare state compared to Japan (OECD, 2001). Historically, Japan provided much more generous health care for their citizens compared to Korea through governmental subsidy and financial transfer mechanisms from employment-based to residence-based health funds (Ikegami, 2005). Later, however, Korea adopted more solidaristic health insurance reform in terms of risk pooling. It contrasts with the traditional explanation that welfare policy is highly influenced by pre-

¹ A single payer system also refers to the system that single body provides healthcare service or run its health insurance service (Hussey and Anderson, 2003, 215).

vious policy choices (Haggard and Kaufman, 2008; Pierson, 1994). This allows re-consideration of the “path dependency approach” to healthcare politics.

1.2 Critique of the relevant literature

This study reviews the literature related to these two puzzles. Although there is large literature that attempts to account for the puzzles, existing studies do not adequately explain them. The first theoretical concept to be examined is power resources theory (Korpi, 1983; Stephens and Huber, 2001). It fails to explain the ironic phenomenon that South Korea was successful in the introduction of solidaristic health policy in spite of lower union density than in Japan. It wrongly assumes that labour as a homogenous and disadvantaged class is willing to support comprehensive and solidaristic social policy. In reality, however, *Rengō* (Japanese Trade Union Confederation), the largest national trade union centre in Japan, strongly opposed the integration of health insurance programmes. Worker’s support for the development of an egalitarian welfare state cannot be taken for granted (Nijhuis, 2009). Labour market insiders sometimes form a coalition with business to protect their vested interests in the Bismarckian welfare system (Giaino, 2002).

The professional dominance theory claims that medical providers significantly control health care policies (Alford, 1975; Freidson, 1970). Health politics has one distinctive feature that medical professions, who have a monopoly of supply in medical service, have a *de facto* veto power. The medical providers in Japan and Korea are highly organised on the basis of occupational interests. However, physicians in the two countries were not much dedicating their resources to the reform on the health insurance governance since it had little effect on physicians’ interests (Kwon and Reich, 2005, 1016).

There are some studies that stress socio-economic problems such as inequality and economic crisis. Some scholars claim inequality of health care in South Korea led to the integration of health insurance (Jo, 2008; Lin, 2002). However, they cannot explain how privileged workers in South Korea adopted more solidaristic stance. The inequality of the health system meant that labour market insiders had more generous benefits from health insurance than others. Labour in Korea may have held stronger incentives to keep a fragmented system due to their privileged position. The

studies that emphasise the shock from the “Asian Financial Crisis” in 1997 also face a similar problem (Kwon, 2011). It is claimed that the serious economic crisis prompted negotiations between business and labour and thus it relieved the pressure from those who were against the reform. Yet they fail to explain why the attitudes of labour towards health insurance were different in Japan and South Korea, as Japan had its own financial crisis after the Asian Financial Crisis (Watanabe, 2015a).

1.3 Methodology and data

This study uses qualitative methods to analyse the policy process of health care reform in a comprehensive and detailed manner. Although a quantitative study in welfare policy is suitable to investigate the general relation between two variables, it is not suitable to show political contexts and complexity of health care reforms in Japan and Korea. Instead, qualitative methods enable researchers to identify nuances and complexity in the political processes of health insurance reform in the two countries by avoiding over-simplification (Barakso et al, 2014, 192). Digging deeply into individual cases allows this study to explore how several related variables interacted with one another to impact reform outcomes. In this regard, this study adopts the “small-N” study and qualitative methods in order to show how actors’ ideas and interests in the two countries have shaped the political dynamics in their socio-political contexts.

This study compares Japan and Korea to explore the socio-political factors that determined the divergent reform paths. The choice of these two countries, Japan and South Korea, is justified by the “most similar systems design” (Przeworski and Teune, 1970). Scholars select cases that share a lot of important features and only significantly differ in one of a few crucial respects related to the research topic. This research design can reduce the number of potential explanatory variables for the outcome. The common characteristics act as controlled variables similar to scientific experiments. This makes it easier to find whether the crucial difference between the countries is related to different outcomes.

There are several similarities between these two countries. First, Japan and Korea shared several key components of the health insurance system since Korea emulated the Japanese health insurance system in many respects (McGuire, 2010, 224). It

is suggested that different institutional arrangements of the health care system create different political aspects of health care reform (Giaino and Manow, 1999). Both countries adopted the social insurance system, in which health insurance benefit was provided based on occupation and financing was based on social contributions paid by employees and employers (Hassenteufel and Palier, 2007, 575). In addition, governments in both countries were strongly involved in healthcare policy. Secondly, the structures of trade unions were similar (Gray, 2007; Kume, 1998; Mo, 1996; Suzuki, 2007). It is suggested the different organisational and bargaining structures of trade unions shape their orientation (Anderson and Meyer, 2003; Nijhuis, 2009). More encompassing union structures and centralised bargaining structures are likely to lead to higher level of solidarity within working class as seen in Western European countries. Yet Japanese and Korean trade unions are organised by enterprise unions, largely based on big business. There are relatively weak neo-corporatist arrangements including firm-level wage bargaining in the two countries (Schmitter, 1974). Third, the political aspects of “weak left” have similarity in both countries. Left wing parties were not as important as business groups and a conservative party (Lee, 2011). Conservative parties, the Liberal Democratic Party in Japan and the Grand National Party in Korea, had ruled in both countries most of the time.

Those who criticise the comparison may claim labour in one countries on welfare expansion path is more likely to embrace solidarity than other countries on retrenchment path since governments provide generous financial aids enough to coordinate social actors’ conflicts of interest during welfare expansion period. In the 1990s and early 2000s, Korean welfare state was on expansion path while Japanese one was on retrenchment path. While timing can be sometimes important in shaping social policy, however, this is not a relevant factor to explain the case of health insurance reform in Korea and Japan. In the early 1990s, Korean trade unions were not supportive of the integration reform and they became supportive of it only in the mid-1990s. In addition, the expansion of the Korean welfare state was fairly slow and the government did not provide financial supports enough to reconcile social actors’ conflicts of interest.

This study adopts “process tracing method” because it more focuses on the identification of causal processes that have led to the divergent reform outcomes in the two countries (Elman, 2005; George and Bennett, 2005; Mahoney, 2000b). Pro-

cess tracing refers to “*a procedure for identifying steps in a causal process leading to the outcome of a given dependent variable of a particular case in a particular historical context*” (George and Bennett, 2005, 176). In process tracing method, researchers investigate the chain of events or decision-making process by which initial conditions are translated into final outcomes in a specific case. Process tracing allows researchers who use a case study to go beyond strong telling since it provides an explanation of a casual path and sequence of events (Vennesson, 2008, 235). The process tracing method is different from a pure narrative in three points (Flyvbjerg, 2006, 237–241; Vennesson, 2008, 235). Firstly, process tracing focuses on the sequencing of events. Secondly, process tracing is structured. It means that an investigator is developing an analytical explanation based on a theoretical framework identified in the research design. Thirdly, the ultimate goal of process tracing is to explain a causal path of a specific outcome. The process of health insurance reform can be conceptualised as a multi-level process where policy actors, policy ideas, and institutions interact. This study seeks to show when and under what conditions interactions of these three factors can account for the reform outcome. This study will capture the phase and process through which these factors affects the mobilisation of reformers, coalition formation, and policy adoption.

This study also uses two ways of data collection and analysis: document and interviews. Firstly, this study uses document analysis. This study relies on the data from policy documents issued by the governments, governmental committees, labour unions, and employer associations. It also uses media reports and secondary literature related to the politics of health care reforms in Korea and Japan. Policy reports from governmental sectors, labour unions, and business associations are helpful to identify actors’ interests on a certain policy. It also contributes to identify policy ideas major actors used to justify their claims. Media reports are used to explain the contents of policy debates on health care reforms and broad contexts of political processes in these countries. It is generally acknowledged that media reports could be politically biased (Carey, 2002, 80). To reduce this problem, newspapers representing political conservative and progressive in both countries are used at the same time. In addition, news media sources sometimes contain inaccurate information. To solve this problem, this study seeks to check other materials such as academic journals and official reports at the same time.

The Korean case includes several policy reports from think tanks and related policy committees. The Korea Institute for Health and Social Affairs (KIHASA), a governmental think tank of the Ministry of Welfare and Society, released several important policy reports on health care. The Federation of Korean Medical Insurance Societies also issued the publications to advocate a fragmented health insurance system. NGOs such as “Solidarity for the Integration of the NHI” issued several policy reports and statements to support the integration of all health funds.

Among media reports, this study mainly selects the newspapers which have different political orientation to avoid the political bias. In South Korea, “*Han’györe*”, representing the progressive was supportive of the integration reform while “*Tongailbo*” representing conservative, was opposed to it. In the Korean case, newspapers were very important because labour and business rarely released their official policy reports. Several keywords were used to search these newspapers from 1987 to 2003. “Naver News Library” Database programme was used to search Korean newspaper articles. The term “*ũilyopohõm*” (health insurance), for instance, was founded in 2,897 articles in *Han’györe* and 2,827 articles in *Tongailbo*. The term “*ũilyokae-hyõk*” (healthcare reform) was founded in 266 articles in *Han’györe* and 204 articles in *Tongailbo*. The term “*ũipot’onghap*” (integration of health insurance) was founded in 266 articles in *Han’györe* and 204 articles in *Tongailbo*. In the initial step of analysis, relevant articles were selected and listed. In the next step, they were divided them into three groups - background information, actors’ preferences, and policy process. The articles in the first category provide background information on health care system and expenditure in Korea. The articles in the second group help to reveal actors’ preferences on a certain policy. The articles in the third group help to analyse the decision-making process of the Korean health care policy. It contains the policy-making process in Blue House, the National Assembly, and major political parties.

In Japan, the Ministry of Health and Welfare (the Ministry of Health, Labour and Welfare after 2001) and the Ministry of Finance put forward several proposals on health care reforms. In addition, the minutes of health care policy committees of the MHLW were used to analyse the political conflicts and debates on health care policy. Among media documents, this study mainly selects the two newspapers, *Asahi Shimbun* and *Yomiuri Shimbun*, for the same reason as Korea. *Asahi Shimbun* is the most famous liberal newspaper and *Yomiuri Shimbun* is its conservative coun-

terpart. The “Kikuzo II Visual” Database programme was used for *Asahi Shimbun*, “Yomidas Rekishikan” for *Yomiuri Shimbun*, and “Nexis” for the Daily Yomiuri through Hitotsubashi University Library in Japan. The Daily Yomiuri is English version of Yomiuri Shimbun and it is used as well. Several keywords were used to search these newspapers from 1997 to 2012. The term “*Iryōhoken*” (health insurance) was founded in 5,700 articles of *Asahi Shimbun* and 363 articles of *Yomiuri Shimbun*. The term “*Iryōkaikaku*” (healthcare reform) was founded in 560 articles of *Asahi Shimbun* and 40 articles of *Yomiuri Shimbun*.

Interest groups in Japan were more willing to publish their claims on health care reforms through policy reports than Korean organisations. *Rengō* and *Nikkeiren* (later Nihon Keidanren, Japan Business Federation) issued several policy reports on health care reforms and it has been analysed to understand the policy demand and position of labour unions and employers. Among interest groups, the JMA issued several important policy reports on health care reforms to represent physicians’ position on health care reforms. *Kenporen* (National Federation of Health Insurance Societies) issued several policy reports, periodical publications, and statements on health care reforms to champion company-based health insurance schemes. “All-Japan Federation of National Health Insurance Organisations”, “Japan Association of City Mayors”, and “National Association of Towns and Villages” issued policy reports, periodical publications, and statements for the municipal health insurance schemes.

Secondly, this study used 13 elite interviews in Japan and Korea to supplement document data. Interviews were conducted face-to-face for around one hour by asking several questions related to the health care reforms. This study used “semi-structured” interviews. This approach basically offers pre-planned and standardised questions, or close-ended survey-style questions to be compared with other interview respondents. However, if an interesting topic comes up, the interviewer goes off the prepared script and asks additional questions on the new topic. Such an approach attempts to gain a degree of comparability between different interviewees while the researcher could obtain unexpected important information at the same time (Barakso et al, 2014, 194-5). Interviewees include labour unions, employer associations,

health insurance scheme staff, local governments, medical providers, NGOs, and scholars in academia.²

In the Japanese case, interviewees included an Assistant Director of the Welfare Policy Division in *Rengō*, a head of the Planning Department in Kenporen, the Economic Policy Bureau in Keidanren, three local government officers related to municipal health insurance including a health of Health Centre, a scholar in health care policy, a medical provider, and a director of a company health insurance society. In this process, a professor at Hitotsubashi University helped to arrange the first interview and interviewees were willing to introduce other interviewees. In the Korean case, interviewees include a former Vice Chairperson of the KCTU, a Senior Director of Policy Division in KCTU, an activist in the Solidarity for the Integration of the National Health Insurance, and a Senior Director in Korea Health and Medical Workers' Union. In this process, a Senior Director of Policy Division in the Korean Financial Industry Union helped to arrange the first interview and interviewees were willing to introduce other interviewees.

The main goal of interviews is to illuminate the major actors' interests and ideas on health insurance reforms. Political actors' ideas, perceived interests on health insurance policy, and the relationship between other political actors were demonstrated by these interviews. Interviews contain important data in this thesis because political actors' ideas and political processes are sometimes not fully discovered in documents. There are nine interviews conducted in Japan and four conducted in Korea. This imbalance between the numbers of interviews in two countries is justified by a number of secondary interviews in the Korean reform case conducted by previous academic studies and mass media (Park and Heo, 2001; Sin, 2004; Wong, 2001). The dialogues with interviewees were not recorded and instead summarised through note-taking. This was because interviewees preferred it by mentioning that recording might make themselves nervous. Instead, some of them provided the interviewer with the summary of their responses to pre-planned questionnaire. The data has been strictly used only for this study.

The written informed consent document and participant information sheet were provided to all participants. These forms acknowledge that participants' rights will be protected during data collection. The "participant information form" includes the fol-

² They are listed in the end of the thesis, "Appendix 1: List of interviewees".

lowing: identification of the researcher, identification of the researcher's institution, indication of how the participants were selected, identification of the purpose of the research, guarantee of confidentiality to the participant, identification of the level and type of participant involvement, provision of names of persons to contact if questions arise. And the "consent form" includes the following: identification of that participation is voluntary, guarantee of confidentiality to the participant, assurance that the participant can withdraw at any time, right to decline to answer a particular question, notification that data collected from participants can be used for not only PhD research but also other forms of the future research related to this PhD project such as journal articles. One interviewee in Japan, an Executive of a company health insurance society, requested anonymity on the participants' name and affiliation. Based on the request, the subject and affiliation remain anonymous. This study acquired the ethical approval from the University of Sheffield on 1 December 2014.

1.4 The aim of this research

This study has three purposes. Firstly, this article aims to find the condition of political and social solidarity within welfare states. Solidarity³ is defined as "a general readiness to help those who are in need" (Ullrich, 2002, 124). The welfare state is based on a concept of solidarity that bridges social demarcation between various groups and classes. As Van der Veen mentioned, "*solidarity binds the fates of the lower and the middle classes, the poor and the rich, the young and the old and the sick and the healthy together in welfare programmes*" (Van Der Veen, 2012, 14).

Healthcare policy is a good subject to explain the attitudes of major social actors towards solidarity since public health insurance directly links to solidarity in two points. The underlying principle of public health insurance is the willingness to share health risks and the costs of healthcare. In addition, social health insurance calls for income solidarity by imposing contributions based on subscribers' incomes, not on their potential risk levels. For these reasons, resources move from the healthy and rich to the sick and poor via pooling. These features pose the question of who upholds solidarity with whom. Some actors attempt to exclude a relatively high risk or low income group from their insurance schemes whilst others are willing to partici-

³ The concept in health care arena is detailed in Chapter 3.

pate in such redistributive schemes. This study will investigate the political and social condition to foster the feeling of solidarity.

Secondly, the purpose of this study is to account for the divergence in health insurance policy trajectories between Japan and South Korea. The health insurance reform cannot be treated as a purely economic problem. It should be driven by political as much as by economic and social considerations. The actors including political parties, physicians, trade unions, farmers, scholars, and public servants have a lot of interactions within institutional contexts. Such political interactions and battles make healthcare policy an arena of conflict (Carpenter, 2012; Freidson, 1970; Hacker, 2004; Immergut, 1992; Starr, 1982). This thesis shows the political dynamics of health care reform through the comparative study of health insurance reforms in Korea and Japan in the 1990s and 2000s, focusing on trade unions' roles. The healthcare systems in two countries were both based on a social insurance system (Hwang, 2008; Shimazaki, 2011). In both countries, health insurance programmes were fragmented by occupation, labour market status, and region. However, South Korea chose to integrate all health insurance schemes into one in the early 2000s while Japan stayed in the occupational-based system.

Lastly, this article aims to develop the understanding of policy change by suggesting that the ways in which interaction between institutions and ideas bring into institutional shifts. New institutionalism tends to emphasise institutional constraints and it is useful for explaining policy inertia and stability. However, it has difficulty in explaining institutional change. Some scholars seek to explain policy change by ideational change and (re)interpretation of institutional arrangements (Béland 2005, 2009). This study aims to illuminate the political dynamics of policy change by interaction between ideas and institutions.

1.5 Significance of the research and its contributions

This thesis contributes to several important debates in comparative political economy literatures. The first contribution is to the literatures on institutional change. Historical institutionalism shows how a historically constructed set of institutional arrangements shape the behaviour of political actors such as interest groups (Hacker, 2004; Pierson, 1994; Skocpol, 1992). However, institutional approaches have diffi-

culty in explaining institutional changes. Most of the accounts on institutional changes are largely dependent on exogenous factors such as war and crisis as punctuated equilibriums (Krasner, 1984). Against this background, this thesis shows the ways in which self-undermining effects embedded in institutional arrangements and ideational change of major political actors shape institutional changes. Institutional arrangements often contain the self-undermining effects which gradually weaken a base of institutional setting over time by affecting main political actors' interests, ideas, and capacities (Capoccia, 2016; Jacobs and Weaver, 2014). These effects can undermine an institution itself by creating negative feedbacks on its legitimacy, feasibility, and efficiency. However, self-undermining effects effectively work when they interact with ideational changes of major political actors. Actors reinterpret an institution by reshaping their own preferences and perceptions on it in the long-term, rather than simply repeating same actions decided in an initial stage (Béland, 2009; Blyth, 2002; Kwon, 2003, 2012). Their ideational reflection and social learning from other actors are also important in interpreting the meanings of institutions (Hall, 1993). Through these processes, some groups who were advantaged by a prevailing institutional setting could move to form a coalition with reformer groups.

Secondly, this thesis explains how different styles of health insurance systems are installed. Most of the existing studies – quantitative studies, in particular – focus on the size of welfare states measured by welfare expenditure. They treat Japan and Korea as a typical “small” welfare state and seek to explain why East Asian states have meagre welfare spending (Stephens and Huber, 2001; Wilensky, 2002).⁴ They, however, neglect to investigate the diversity of the welfare systems in governance and financing. This study will pay attention to accounting for the installation of the different health insurance governance styles. It seeks to explain how institutional designs, socio-economic structures, and political ideas make the dynamic of health care reform.

Lastly, this study illuminates the characteristics of the welfare regime in Japan and South Korea in the perspectives of comparative studies. Some studies put the

⁴ There are some studies to illuminate the features of Japan's welfare system not focusing on the size of total spending. For example, Lynch (2006) measures the bias for the old in welfare states in Japan. Estevez-Abe (2008) argues that Japan has developed particular types of social security programs and their functional equivalents – work-based and savings-oriented programmes instead of official welfare programmes.

emphasis on the peculiarity of region (Choi, 2006; Kwon, 2007). The literatures of the so-called 'East Asian model of welfare states' (Goodman et al, 1998) are based on the idea that the East Asian welfare states are too peculiar compared to other welfare states. Most of the studies on health care reforms in East Asia stress unique variables such as civil groups' idea and leaders' personal characters (Choi, 2006; Kwon, 2007; Leduc, 2002). In contrast with these studies that solely focus on the peculiarity of one country based on the literatures of the East Asian welfare states model, this thesis attempts to find the general logic to explain the health insurance reform in the two countries.

1.6 Structure of the thesis

The structure of the thesis is as follows. Chapter two examines the literatures on health insurance reforms. The review shows that existing approaches that focus on the power of political left, interest groups including medical professionals, and advocacy coalitions certainly have their merits but fail to explain systematically the variation between the two countries. It also develops theoretical framework and the hypotheses on solidaristic health insurance reform. Chapter three provides an analysis of health policy in a comparative context. It briefly explains the types of health care regimes and common pressures on health care systems in the Bismarckian system. It also shows how institutional arrangements in a social insurance system lead to potential conflicts among different occupational groups.

Chapters four through seven provide empirical accounts on the health insurance reforms in South Korea and Japan. Chapters four and five explain the health insurance system in South Korea and Japan before the major reform respectively. These chapters offer a brief explanation of the historical development and key features of healthcare policy in these countries. They also analyse the structural problems of health insurance system in both countries. Finally, they illustrate major actors' interests and ideas in the policy area.

Chapters six and seven examine health insurance reforms in the two countries. Chapter six presents the political dynamics of health insurance reform in South Korea. In the late 1980s, there was a reform attempt for the integration of all health funds raised by farmers and yet it was frustrated by the Presidential veto. In the mid-

1990s, trade unions shifted to support the reform and shaped the cross-class coalition for the reform. As a result, Korea achieved the consolidation reform in the early 2000s. Chapter seven presents the political dynamics of health insurance reform in Japan. Although the consolidation idea was raised in the 1990s by the municipal health societies, labour and business formed a coalition for protecting the existing corporate health insurance system. The government of Prime Minister Koizumi decided to maintain the occupation-based health insurance system, separating the elderly from the other health insurance schemes. Later, the government of the Democratic Party of Japan (DPJ) attempted to integrate all health insurance schemes based on its 2009 general election manifesto. However, it was blocked by the corporate actors and weak leadership of the new ruling party.

Chapter eight compares the political dynamic of health insurance reforms in these two countries. This chapter focuses on two institutional features – decision making process and problem solving - and ideational features labour hold. Based on this difference, this chapter identifies the various outcomes of reforms in two countries. Finally, chapter nine summarises the arguments of the thesis and discusses the study's empirical and theoretical contributions. It also considers the policy implications of this study for health insurance reforms in general.

Chapter 2 Literature review and analytical framework

This chapter highlights several important theoretical approaches to health insurance reforms and discusses their respective shortcomings in relation to the understanding of the health insurance reforms in Japan and South Korea from the late 1980s to the 2000s. This will be followed by delineating a theoretical framework that analyses the preferences of various actors and identifies the political and institutional conditions that facilitate or impede healthcare reforms in the two countries.

2.1 Literature review on health care reforms

This section conducts a critical review of previous studies relevant to health insurance reforms. Existing studies such as the power resources theory, professional dominance theory, policy process theory, democratisation approach, advocacy coalition framework, and multiple streams model in policy process studies do not adequately explain the divergence of health insurance reform in both countries.

Power resources theory

One of the most dominant approaches in the literatures on the political economy of welfare politics is power resources theory. This theory explains different levels of solidarity and equity in social policy based on the strength of organised labour (Korpi, 1983). The theory argues that labour's political power is positively linked to the level of solidarity in welfare programs as well as the size of welfare spending (Esping-Andersen, 1990; Stephens and Huber, 2001). This approach assumes that there is power imbalance between capitalists who control the means of production and workers who have to sell their labour for wages, and workers collectively attempt to limit the power of capital by organizing themselves. In this regard, welfare states are the outcome of the struggle between labour and capital over social policies. The power resources theory posits that welfare states have potentially the distributive mechanism to intervene and resolve economic conflicts that involve class-related interest groups. This particular school of thought believes that the size of social

spending is strongly correlated with labour's political resources (Korpi, 1983). Union density and the proportion of left-wing parties in parliament are used as key indices of political resources of pro-welfare policy groups.⁵

While power resources theory emphasises the importance of workers' mobilisation in accounting for reform outcomes, it fails to explain why organised workers support solidaristic reforms in one place while not in another place. This is because this theory presumes that labour will support solidaristic welfare programmes by default (Carnes and Mares, 2007, 873). Workers in big businesses are privileged under the Bismarckian healthcare system, as compared to those outside the formal labour market, such as workers in small corporations and irregular workers.

They are often interested in protecting their company-based health funds (Giaino, 2002). Theoretically, literatures that focus on the "varieties of capitalism" stresses shared interests between labour and businesses based on company-specific interests so that the workers can preserve their comparative advantages vis-a-vis workers from other sectors (Hall and Soskice, 2001). The exclusive health insurance and pension programmes, which are enterprise-based, are strong incentives for firm specific training and low labour mobility (Estevez-Abe et al, 2001, 161). Not surprisingly, when employers and unions collaborate to shape policies, they are eager to block reforms that subvert the corporatist framework (Giaino, 2002).

Literatures on the unification of healthcare insurance in South Korea that draws on the power resources theory is extensive (Baek, 2001; Lim, 2010). They argue that the mobilisation of workers aligned with the farmers and the progressive NGOs enhanced their power resources to achieve a solidaristic health insurance system. The transition of political power from conservative to liberal government in Korea's 1997 election is also a crucial factor in explaining Korea's recent health insurance reforms (Lim, 2010). However, they leave many crucial questions unanswered. Why did unions in Japan and South Korea differ widely on the health insurance systems they supported? Japanese trade unions preferred a more fragmented and corporatist form of national health insurance system (Hwang, 2008; Jeong and Niki, 2012). In

⁵ Political left has been frequently mediated by alliance with rural farmers and the middle class. Historical studies in welfare expansion across Europe stress the importance of cross-class alliances between blue-collar workers, white-collar workers and agrarian interest (Baldwin, 1990). Cross-class coalitions also became an effective vehicle to legitimise mainstream social welfare ideas (Lim, 2010; Wong, 2004).

this regard, power resources theory tells us little about the empirical preference formations and coalition configurations in these two countries.

Some who defend power resource theory may claim that Korean labour had more political resources through strong internal cohesion than Japanese labour which were weakened due to the low level of integration and the gap of political power between Korean and Japanese labour may lead to the different outcome. However, trade unions in both countries achieved what they wanted to get on the health insurance reform. In this regard, we need to find out the condition under which trade unions in both countries shaped different policy interests.

Interest group politics and the medical profession

The theory of pluralist politics explains the development of welfare state as the outcome of negotiations between various interest groups and politicians' responses within competitive democracies (Dahl, 1958; Feltenius, 2007). For instance, doctors, unions, employers, and other interest groups actively engage in the formulation of medical care policies. The pluralist approach thus suggests that competing interest groups are hugely influential in the formulation of welfare policies. According to them, social policies are negotiated and shaped by the political strengths of various interest groups (Carpenter, 2002).

Health politics, however, is distinctive in that the medical profession can monopolise the supply of medical services. The medical profession is the most powerful and influential interest group in health care policy in most countries, including Korea and Japan (Freidson, 1970; Ikegami, 2006; Kwon and Reich, 2005). Medical providers have a monopoly over medical services. In most countries, health professionals are licensed by governments. The medical association is an extremely exclusive and protectionist occupational group. In addition, their interests are substantially cohesive and mainly related to their economic gains and professional autonomy. For example, an increase in the number of physicians might diminish their earnings and they, in turn, lobby governments to restrict the number of entrants into the profession (Carpenter, 2012, 298). Reimbursement methods for medical providers also shape their incentive structures and earnings (Freeman, 2000, 95-6; Langwell and Nelson, 1986, 5). In this regard, the medical profession has veto power in healthcare policy-

making. There is extensive literatures that discusses the role of medical professional groups (Alford, 1975; Freidson, 1970; Light and Levine, 1988; Starr, 1982). When doctors' organisational power is strong, they can shape health policies in their favour. According to Quadagno (2005), there is no universal health insurance in the United States precisely because of the strength of organised physicians. This asymmetry of interest, however, fundamentally challenges the ideal of pluralist politics, which strive to forge compromises among competing interests.

Based on the theory of "professional dominance", the medical associations are extremely influential on health policymaking. Hence, the struggle between physicians and the state over health policies represents a very real conflict of interests between the 'sellers' and the 'buyers' of medical services. The professional dominance theory, however, cannot be applied to some parts of healthcare reforms physicians do little care for. Existing research shows that physicians in Japan and Korea tend to be less interested in health insurance reforms which might have a marginal influence on their income and working conditions (Jeong and Niki, 2012; Kwon and Reich, 2005). They are much more concerned with policies that directly and significantly affect their revenue, such as the payment system and the separation of drug prescription from dispensing. They would prioritise reforms of pharmaceutical prices and the fee payment system rather than the integration of health insurance.

Rigid institutional approach

The school of new institutionalism focuses on the ways in which the "rules of the game" shape political actors' behaviours and structure political battles (North, 1990). Scholars in the strand call attention to the processes by which initial decisions constrain structures the political actions of political actors such as interest groups during the policymaking process (Immergut, 1992; Pierson, 1994). Initial decisions or existing institutional arrangements can reinforce themselves mainly by shaping political actors' behaviours and capacities over time through three mechanisms.

Firstly, an institutional arrangement strengthens its base of political support (Esping-Anderson, 1990; Pierson, 1994). A new institutional arrangement creates two competing groups between those who gain benefits from it and incur loss from it, which could be called beneficiaries and the disadvantaged or "winners" and "losers".

Institutional settings tend to mobilise beneficiaries than the disadvantaged since benefits are concentrated in a small proportion of beneficiaries while its burden would be diffused (Pierson, 1994). It also empowers beneficiaries by granting more resources to them. For instance, some of the generous welfare states have “de-commodification” effects, which means an individual does not need to be reliant upon market for one’s welfare (Esping-Anderson, 1990, 22). When workers are completely dependent upon market, they are difficult to mobilise for solidaristic action by atomising workers into individuals. In contrast, workers who are less dependent upon market are more willing to take part in collective actions. In turn, these institutional arrangements might bolster the power of trade unions.

Secondly, an institutional arrangement could enhance efficiency of whole institutional settings (Pierson, 2004; Tang, 2010). A new institution, once created, results in “learning effects”, “coordination effects”, and “adaptive expectations” (Arthur, 1994; Pierson, 2000, 2004). Over time actors within an institution arrangement become more skilled at this institutional setting (Deeg, 2005, 171). In addition, as benefits from an institutional arrangement are increasing, other actors adapt their behaviour to those accrued benefits (Pierson, 2004). It also creates positive “network effects”. New institution becomes a part of the overall social system and is usually compatible with existing institutions (Tang, 2010).

Third, institutional arrangements are strengthened by legitimation process (Jordan, 2010; Rothstein, 1998, 2005). An institutional arrangement, once created, makes specific practices and ideas to support itself by changing how individuals and interest groups interpret their preferences. Rothstein (1998, 2005) shows how the welfare state in Sweden has strengthened the support for universal welfare programmes by creating citizens’ social trust and moral sentiment of solidarity. Jordan (2010) also demonstrates that when a state has a hierarchical health care system rather than decentralised one, it is more likely to obtain high public support for national health care.

However, such a rigid institutional approach has difficulty in explaining endogenous institutional changes. Less attention is paid to ways in which existing institutional settings are weakened by endogenous factors over time while most explanations of institutional changes rely on exogenous factors such as war and crisis and fail to explain changes from within institutions. Rational choice institutionalism as-

sumes an institution is in equilibrium with its environment (Hall and Soskice, 2001; Levi, 2009; Weingast, 2002). Self-interested individuals coordinate their best responses and thus actors in this institutional setting are resistant to institutional changes. This theoretical school relies on exogenous changes in some of the parameters⁶ which undermine institutional self-enforcement to explain institutional changes (Greif and Laitin, 2004, 634). Sociological institutionalists tend to examine the processes of institutional formation and reproduction through socially constructed norms and roles (Powell and DiMaggio, 1991) but they fail to explain endogenous changes because of their static cognitive framework.

There are some studies, which apply the framework of new institutionalism to health insurance reforms, particularly in Japan and South Korea (Hwang, 2008; Kwon, 2011). Nonetheless, most of them arrive at the same impasse when explaining institutional changes. Hwang (2008) investigates how Japan and South Korea are so different in their health insurance reforms. He asserts that specific political events and opportunities in each country shape different political opportunities and the capacity of its main actors. Confronted with the Asian Financial Crisis in 1997, Korea's newly elected centre-left government could achieve integration of all health funds. In contrast, the weakening of medical providers, *Kenporen's* opposition and the merger of municipalities in Japan's Koizumi government has led to very different policy opportunities (Hwang, 2008, 431). However, his study overly relies on contingent conditions for its analytical framework. As Thelen (1999, 397) mentions, "*What we need to know is which particular interactions and collisions are likely to be politically consequential*". Moreover, economic crisis in Korea can either push the state towards en masse retrenchment or compensation for the 'losers'. Whether economic crisis leads to retrenchment or compensation depends on an array of social and political factors. Hence, this theoretical approach does not sufficiently explain why labour in both countries chose different reform options.

Some historical institutionalists emphasise "negative feedbacks" or "self-undermining effects" in explaining institutional changes (Baumgartner and Jones, 2002; Jacobs and Weaver, 2014; Mahoney, 2000a; Wlezien, 1995). Mahoney (2000a,

⁶ Parameters in game theory refer to the specific given conditions of a game which can affect its outcome such as "*the payoffs from various actions, time discount factors, risk preferences, wealth, and the number of players*" (Greif and Laitin, 2004, 634).

527) said, “*Whereas self-reinforcing sequences are characterized by processes of reproduction that reinforce early events, reactive sequences are marked by backlash processes that transform and perhaps reverse early events*”. Negative feedback provides the basis for an explanation of endogenous institutional change. For instance, Skocpol (1992) showed how the patronage pension programme for Civil War veterans from the 1860s to the 1890s led to its demise and, later, constrained the development of social policy in the US. These pensions became associated with patronage, fraud, and profligacy and thus it had created widespread concern of its degeneration into a government handout.

However, most of the studies in this approach fail to develop more elaborate accounts of negative feedback effects. The concept of negative feedback usually overuses the explanation of homeostatic reactions (Baumgartner and Jones, 2002, 20). For instance, Wlezien (1995) has used the metaphor of “thermostat” in the explanation of negative feedback in mass politics. When politicians implement policies that are too liberal from the public opinion, as he states, the public react to move in a more conservative position. It can be a just “metaphor” rather than an analysis. Moreover, an institutional arrangement contains positive and negative feedbacks at the same time and thus these studies fail to elaborate how negative feedback effect works and when it outperforms positive feedback effects.

In the similar vein, Jo (2008) and Lin (2002) argue that institutional context and effects and historical sequences have played important roles in the development of the Korean health insurance system. They stress that institutional arrangements in critical junctures created negative historical legacies and social cleavages and these in turn, led to institutional change. According to them, a fragmented health insurance system established at a critical juncture has resulted in serious inequality between company-based and residence-based health insurance schemes and social conflicts between various subscribers to different health insurance schemes. These legacies have led to the single-payer reform in South Korea.

They, however, fail to properly explain how negative institutional legacies of the previous system had resulted in political actors’ mobilisation. They assume that significant inequalities in the health insurance system have ultimately led to health insurance reform because of organised actions by disgruntled rural residents who suffered the brunt of these disparities. Their claims are based on the two assumptions.

First one is that grievance among population leads to social mobilisation. However, dissatisfaction alone cannot account for collective actions and social movements mainly arise based on sufficient groups' resources and organisation (Jenkins, 1983). Collective action theory also claims that common interests do not necessarily produce concerted political actions because of the costs of collective actions (Olson, 1965).

Second one is median voter theory, which predicts that redistribution tends to increase when resource distribution is skewed as the median voter becomes supportive of redistribution in a democratic society (Meltzer and Richard, 1981). In contrast to their intuitive argument, several empirical studies deny the positive relation between inequality and the amount of redistribution (Alesina and Rodrik, 1994; Moene and Wallerstein, 2003). Research on political economy describes this phenomenon as the Robin Hood paradox, meaning "redistribution is least present when and where it seems to be most needed" (Lindert, 2004, 15). Scholars have pointed out that redistributive social spending is largely attributed to organised political actions by established interest groups and political parties (Bradley et al, 2003). In sum, these studies had difficulty in explaining institutional shifts since they had the gap between institutional problems and collective actions.

Recently, instead of static, rigid, and simplistic institutional accounts, several studies within institutional approach open up the space for new approaches that can explain institutional changes. Some historical institutional approach focuses on the "ambiguity" of institutions and their "interpretative" process which can provide the micro-foundation of institutional changes. Mahoney and Thelen (2009) show how actors exploit the ambiguity of rules and their imperfect enforcement to change prevailing institutional arrangements. They see institutions as active objects of political contestation in that political actors seek to interpret the meaning of ambiguous rule for their sake. These conditions open up space for actors to challenge institutional setting. In addition, Lieberman (2002) has suggested the alternative model of linkage between institution and mass mobilisation by incorporating ideational process into institutional politics. He mentioned institutional changes come from the friction between institutional capacities and ideational patterns. When the idea an institutional arrangement carries conflict its institutional capacities to achieve these ideas, it leads to the actors' mobilisation.

Policymaking process

Political institutions play a crucial role in structuring political conflicts and thereby produce divergent policy outcomes (Immergut, 1992; Weir and Skocpol, 1985). By providing opportunities and impediments to both politicians and interest groups, political institutions build distinct 'rules of the game' that directly impinge upon the capability of various groups to influence policymaking. Immergut (1992) claims that it is more likely that universal healthcare programme is established when there are few veto players and a strong political leadership. She examines the impact of institutional veto points on health insurance reforms. She explains why Sweden, France, and Switzerland have different healthcare governance systems in spite of the fact that their medical professions are equally strong. The capability of interest groups to influence policy outcomes depends on their access to the political representatives located at points with veto power in the political process. Although the medical profession enjoys similar level of power in the three countries, the Swiss' veto point, such as the referendum, makes the implementation of public healthcare more difficult (Immergut, 1992).

Jeong and Niki (2012) explains these divergent reform outcomes in Japan and Korea by focusing on the different political arrangements. The Korean President is said to have a great deal of power and he or she plays a critical role in public policymaking (Choi, 2010). The authoritarian legacies in Korea have allowed much of presidential power to be left unchecked and negotiations on policies tend to take place by the executive rather than by the legislative. Political parties can maintain strong party discipline among their members because party leaders could exclusively select their candidates for elections. Lawmakers hold strong party loyalty and thus cross-party voting in the National Assembly is not common. Hence, the president tends to have parliamentary support since his or her party usually forms the majority in the parliament.

In contrast to the strong presidency in Korea, the Japanese prime minister had less power until recently (Iio, 2007; Krauss and Pekkanen, 2010). Politicians within the LDP (Liberal Democratic Party) rested on a delicate balance of factional powers within the Policy Affairs Research Council (PARC) playing an important role in pol-

icymaking process. Moreover, state bureaucrats who were influential in setting policy agendas and interest groups that sat in various deliberative councils (*shingikai*) could all exercise veto power (Iio, 2007).

However, this approach has difficulty in explaining two points. First, Prime Minister Koizumi who decided to maintain the fragmented health insurance reform had stronger power than previous Prime Ministers (Iio, 2007; Miura, 2007; Shimizu, 2005; Shinoda, 2007; Uchiyama, 2010; Watanabe, 2012). The prime minister's leadership and the new policymaking process had played a critical role in healthcare reforms, despite the strong opposition from the politically powerful Japan Medical Association and "zoku" politicians⁷, particularly on the issue of medical treatment fee (Ikegami, 2005). Koizumi had replaced bottom-up policymaking process with a top-down one in the so-called "cabinet-directed" (*Kantei shudō*) approach and succeeded in reducing the influence of the factions and the "zoku" politicians from the policymaking process by bypassing the procedure that has been hijacked by various interest groups (Kikuchi, 2010, 220). The Council of Economic and Fiscal Policy (CEFP), a cabinet council, not only infused new ideas into the health system that was previously monopolised by the "zoku" politicians and bureaucracy but also successfully brought in new reform agendas (Iio, 2007). The great victory of the 2005 general election, known as the "postal election"⁸, had also dramatically reduced the influence of "zoku" lawmakers.

Second, while political leadership and policymaking structures might properly explain the pace of policy reforms, they cannot explain major actors' attitudes, preferences and choices in healthcare policy (Béland, 2009, 702). For instance, Japanese and South Korean labour differed widely in their opinions on health reform even though the labour structures in both countries are similar. In addition, the consolidation reform of all health insurance schemes in Korea was driven by mobilisation in rural areas in alliance with workers and intellectuals, not the government (Choi, 2006).

Advocacy coalition framework

⁷ It refers to "parliament members who worked on behalf of special interests and with benefits from their supporters" (Kikuchi, 2010, 221).

⁸ The most controversial issue in this election was the privatisation of postal services.

The “Advocacy Coalition Framework” (ACF) stresses the role of actors’ ideas in forming a long-term policy coalition (Jenkins-Smith and Sabatier, 1994; Sabatier, 1998). Advocacy coalition refers to a band of political actors who seek to achieve their similar policy goals on the basis of shared ideas and beliefs over time (Sabatier, 1988). The policymaking process is characterised by competition between coalitions which advocate different policy approaches in a certain policy subsystem. Advocacy coalitions emerge when they incorporate political actors into a certain policy alternative or platform. According to the ACF, this process is driven by actors’ beliefs rather than their interests. This framework suggests that actors form a coalition based on similar long-term beliefs rather than short-term self-interest (Kübler, 2001, 624). Beliefs bind political actors together within a certain advocacy coalition. The framework also suggests that belief systems consist of three levels. “Deep core beliefs” refer to an actor’s general philosophy and normative values, which are extremely difficult to change. “Policy core beliefs” refer to fundamental policy orientation in a certain policy subsystem. “Secondary aspects” refer to a certain policy goals (Sabatier, 1998, 103-110). Different advocacy coalitions within a specific policy subsystem compete with each other to design or change public policies that closely correspond to their beliefs. Outside of the policy subsystem, there are relatively stable parameters and external subsystem events.

Several studies on the advocacy coalition approach argue that the long-term evolution of the advocacy coalition for equity in the Korean health system is crucial to merging health insurance schemes (Baek, 2010; Kim 2011; Kwon, 2007). Kwon (2007) explains how the reform was consolidated based on institutional strength and the policy rationale of the reformer group. In the late 1990s, the advocacy coalitions in Korea had institutional strength through their access to key institutional locations within the policymaking system. In addition, they developed a clear and coherent policy paradigm (Kwon, 2007, 149). These evolutions had enabled the advocacy coalition to achieve the solidaristic health insurance reform. This approach provides important insights. This framework focuses on coalition as unit of analysis rather than specific interest groups or individuals. It also stresses the importance of shared beliefs among a certain coalition which can make actors hold together.

The ACF, however, has two shortcomings. A first shortcoming is the absence of linkage between institutional arrangements and coalition building (Cairney, 2011, 218-9). According to this framework, institutional arrangements have significant influence on reform outcome only via the decision-making process and do not significantly affect the ideas and beliefs itself behind policy process. Hence, this approach does not adequately explain how different institutional arrangements in the Korean and Japanese health insurance system have shaped actors' interests and ideas about the health care reform. Secondly, the dynamics of policy changes is still insufficiently understood in this approach (Cairney, 2011, 210). Although it suggests various pathways to institutional changes, major changes happen only with external shocks. This is because the framework assumes that members within a certain coalition can hardly change their policy core beliefs voluntarily (Sabatier, 1998, 105; Sabatier and Weible, 2007, 198-199). In contrast to this assumption, this thesis will show that a major change could happen in endogenous process through changing labours' ideas and their orientations.

Kingdon's multiple streams model in policy process studies

Kingdon (1995) seeks to explain the process through which issues become political agenda and allow for meaningful reforms. By analysing transportation policy in the late 1970s, he characterises policy process in three aspects - problematic preferences, unclear technology, and fluid participation. Kingdon states that policies by the national governments are the result of three streams: problems, policies, and politics. The problem stream is the first one in Kingdon's model (Kingdon, 1995, 90). Political actors recognise that there is an existing problem for policy change. Although there are a lot of problems in a society, only some of them can be addressed. Since policy-makers can only deal with a few crucial issues, selecting national agenda is one of the most critical issues in policy process. The second stream is the policy stream (Kingdon, 1995, 116). It is here where solutions and policy alternatives are shaped to tackle visible problems. Policy experts in academia, governmental agencies, interest groups, and think tank shape alternatives and policy proposals. The third stream is the political stream (Kingdon, 1995, 145). It encompasses political environment such as elections, public opinion, and national mood. He notes that

three streams are significantly autonomous. Policy entrepreneurs seek to put together a recognised problem and a policy proposal they favour. When the three streams converge, he notes, the convergence creates a “policy window” for rapid policy change (Kingdon, 1995, 165).

Some studies employ Kingdon’s model of multiple streams in the field of policy process studies in the process of adopting the national health insurance in South Korea (Lee, 2010). When it comes to the problem stream, policy actors recognised the visible problems that the number of insurers recorded deficits. More than 80 percent of municipal health insurance societies were operating in red. As for the policy stream, the integration of all health insurance societies was regarded as the best alternative within reformers. As for the political stream, Kim Dae-jung, who was a long supporter for the integration reform, was elected as new President. As these three streams converged, the merger of the insurers eventually took place.

The Kingdon’s model, however, has three shortcomings. First, his model is highly contingent and policy process is too fluid (Sabatier, 1999). It is quite difficult to predict the timing of conversion in these three streams. He does not elaborate how policy windows are open and close. Birkland (2002, 224) notes that the “opening of window” does not guarantee policy change. Second, his model includes little insight on how to conflate policy ideas within institutional contexts. This is partially because Kingdon restricts himself to the explanation of agenda setting and the specification of alternatives in a particular set of institutions (Zohlnhöfer et al., 2016, 244). This is also partially because his study use institutions just as background information and political opportunities. Third, some critics cast doubts on whether three streams are relatively autonomous (Smith and Larimer, 2009, 112). It is often mentioned that defining the characteristics of a problem is closely associated with finding a solution to the problem. It suggests that problem stream could be significantly connected to policy stream.

2.2 Theoretical framework

Having examined the shortcomings of the relevant literature, this section sets out the theoretical framework for this dissertation’s comparative study. Firstly, it explains the various logics of unions’ preference formation. It then suggests new model

that explains institutional changes based on interactions between self-undermining effects and ideational changes. Finally, it proposes the main hypothesis in this study.

Labour's interests in welfare policy

Trade unions tend to represent the interests of the majority, or protect organisational interests to exerting certain political influences (Anderson, 2001; Davidsson and Emmenegger, 2012; Schmitter and Streeck, 1999). It shows that labour interests are complicated in manifold ways and even competing with each other. Interests of political actors can be contradictory to one another, be it short-term or long-term, economic or political, individual or organisational, and material or ideational. Some actors are more concerned about long-term impacts such as political influences and organisational vitalisation, whereas others instantly respond to short-term incentives from pay-offs (Ebbinghaus and Hassel, 2000; Frege et al, 2004; Kwon, 2012; Ross, 2007).

Political actors' interests in the social health insurance system mirrors this complexity. The fragmented insurance system benefits high skilled workers who enjoy low risk and high income (Jeong and Niki, 2012). In a unified health insurance structure, the "insider" workers would have to pay more to support those at low income and high-risk (Baldwin, 1990; Rehm et al, 2012). Therefore, unions representing employees in large firms tend to oppose the merger of health insurance schemes although it can inhibit solidarity with other groups. The corporate-based health insurance system thus incentivises them to cooperate with employers to block reforms aimed at redistribution and risk pooling in solidarity with other workers.

However, when trade unions seek to uphold solidarity, they can prioritise to implement social reforms in social policy domain. They can transcend short-term interests and embrace broader interests. Confronted by popular demands to restructure their health insurance system, trade unions are faced with difficult choices between promoting members' direct interests for a fragmented health system and adopting a universal single-payer health insurance system⁹ based on the notion of solidarity. In this process, their perceptions on the interests and legitimacy of health

⁹ The single-payer refers to a body for health care in terms of finance and organisation (Hussey and Anderson, 2003, 215)

insurance system, which are crucial to explain their attitudes on the health insurance reform, would be explained by the process in which actors interpret their interests based on the interactions between actors' ideas and institutional practices in a certain policy domain.

Institutional frictions and ideational shifts

A new institutional arrangement creates two competing groups between those who gain benefits from it and incur loss from it, which could be called “winners” and “losers” for an institutional battle. Most of the previous studies which stress institutional stability focus on positive feedback effects which strengthen beneficiaries from the institutional arrangement. Through this process, the winner group can keep taking control of the institution. However, shifts in the balance of power between two competing groups can lead to the institutional change (Thelen, 1999). While some of the “losers” from previous legislative battles sometimes just disappear, other loser groups who mobilise themselves carry out fight for the institutional change and attempt to override the previous winner groups (Thelen, 1999, 385). More importantly, institutional arrangements and ideas can diminish existing policies' bases of political support and expand the opposing coalitions. Part of the groups who were advantaged by a prevailing institutional setting can move to form a policy coalition with loser or reformer groups. The shifts in political coalitions which underpin institutions can result in the change of institutional configurations.

The coalition shifts could begin with institutional tensions. An institution occasionally has certain some built-in components to politically weaken its supporters, to cognitively undermine its legitimacy, and functionally impair its efficiency (Jacobs and Weaver, 2014). An institutional arrangement contains various sub-components such as policy goal, enforcement, monitoring, decision-making, problem-solving, and evaluation (Lowndes and Robert, 2013, 151-3). In addition, an institution contains its underlying ideas since it is the carrier of specific ideas (Rothstein, 2005; Schmidt, 2010). There is no reason to presume that these sub-components are necessarily linked with each other in coherent ways (Lieberman, 2002, 701–702). Some

elements in an institution are sometimes significantly incompatible with others when these elements embody contradictory logics and policy ideas.¹⁰

These mismatched institutional and ideational patterns create frictions for institutional changes and provide the micro-foundation of endogenous institutional changes (Cappocchia, 2016; Lieberman, 2002). It provides space for the political battle among political actors over an existing institution. This discrepancy and incoherence can make the room for ambiguity or plurality of meanings of one institution (Mahoney and Thelen, 2009, 11). When “losers” from a prevailing institution challenge the existing institution, they can use the friction to persuade other political actors and general population to challenge status quo.

This process can be amplified by the transformation of political actors’ fundamental ideas and orientations. Agents are “reflexive” and “sentient” in that they actively reflect the drawbacks of current system and find better solutions (Kwon, 2003, 97-98; Schmitt, 2010, 14). Actors constantly reinterpret the meaning of institution by reshaping their preferences and perceptions of it, rather than simply repeating same actions. When political actors shift their identities and orientations, it will make significant changes of their attitudes and interests in specific policies through their own deliberation over priorities and policy orientations (Frege and Kelly, 2003; Hyman, 2001; Weir, 2006). Political actors can reshape the meaning of an institution and their own interests based on their belief system and main values and thus seek to legitimise their claim for policy change (Béland, 2009, 706-7).

These processes can change the composition of policy coalitions over time when some potential winner groups move to form coalition with the reformers (Béland, 2005, 2009; Cappocchia, 2016). The different types of cross-class coalitions can lead to the divergent reform outcomes. Political parties, trade unions, farmers, and employers’ associations form specific reform coalitions in various ways. When la-

¹⁰ This is because most public policies are the products of political negotiation reflecting various groups’ competing interests and electoral pressures based on politicians’ shorter-term interests (Jacobs and Weaver, 2014, 8; Nordhaus, 1975). There is also critical discrepancy between ‘rule-in-form’ and ‘rules-in-use’ since politically powerful groups seek to bend some components in institutional practices to their priorities and preferences (Leach and Lowndes, 2007, 185). In addition, policy learning from other countries is sensitive to the institutional and political context. Policy makers can deliberately modify some sub-components and practices within a whole institutional setting in the time of policy learning (Rose, 1991, 21–2). Through these processes, some elements in an institution can contradict other elements or their underlying ideas and make frictions for change.

bour forms broad alliances with other sectors, such as the farmers, this leads to inclusive social policies that are based on solidarity (Baldwin, 1990; Esping-Andersen, 1990). In contrast, when labour enters into coalition with businesses, they tend to block reforms that are more egalitarian and redistributive in pursuit of benefits that are exclusive to their specific occupations (Giaino, 2002).

Institutional changes in health insurance reforms

This study focuses on two institutional sub-components or practices that undermine institutional arrangements in the long-run: decision-making processes and credibility on problem solving. The social health insurance system contains the internal tension between solidarity and conservatism, which will be detailed in Chapter 3. Such tension is relieved by several institutional sub-mechanisms such as decision-making processes and credibility on problem solving in some countries. However, other countries under the social insurance system have the defections in these sub-mechanisms and they create potential frictions for institutional changes.

Firstly, decision-making process in health insurance programmes can undermines the institutional arrangement itself through creating two negative effects. Decision-making process could affect the legitimacy of an institutional setting. The social health insurance system is usually fragmented by occupations and this practice is justified by the principle of “self-governance”, which means that insurers govern their health societies themselves independently from the government (Blank and Bura, 2014, 112). A group who shares same occupational identity runs its own health fund. Labour and business equally take part in the administration of their company-based health funds. The self-governance has been regarded as a tool to prompt the liberty in health care policy and strengthen group identity (Giaino, 2002, 92).

This practice has led people to perceive a health insurance society as a substantial unit, which can make meaningful effects on health insurance governance rather than just another form of governmental body. Even though the fragmented health insurance system is supposed to contain some degree of inequality among various occupational groups, the principle of “self-governance” could justify the inequality to some extent. By contrast, when insurers including workers are not allowed to be part of the decision-making, individual health societies are considered as no more

than another form of governmental intervention, which are totally subordinate to the government (Kwon and Reich, 2005, 1107; Lee, 2002, 304). Therefore, such division within health insurance schemes based on occupations are regarded tentative, which can be withdrawn at any time. Moreover, the insurers could cast doubt on the inequality among various occupational health schemes.

The rules for decision-making also affect actors' political capabilities and opportunities. This is because participation in the decision-making process of individual health insurance society can be one of the channels to influence policy making process and thus access to decision-making process becomes political resources for actors. For instance, scholars show that union administration of unemployment benefits, so called the "Ghent system", has constantly increased union strength, as it has allowed them to build large membership bases (Anderson, 2001; Davidsson and Emmenegger, 2012; Rothstein, 1992). By contrast, when trade unions are not able to join the decision-making, they have smaller organisational incentive to protect the fragmented health insurance system.

Secondly, low credibility to solve serious fiscal problems inherent in the fragmented health insurance system could undermine the institutional arrangement itself by creating negative effects, particularly when it contradicts the ideational goal of the institutional arrangement. When a government establishes a universal right to health care for all citizens, for instance, this health care system contains the concept of 'equity' of health care service and governmental responsibility on health care (Blank and Burau, 2014, 110). An institution, however, sometimes could be exposed to critical problems to achieve its goal. The universal health insurance system with multiple insurers has a critical problem to tackle financially distressed health funds. The health funds which mainly cover low-income and high-risk populations are inevitably weak in terms of fiscal capability. Faced with the fiscal problem of these health societies, a government often set up specific problem-solving mechanisms to assist these funds such as governmental subsidy or inter-funds transfer (Buchner and Wasem, 2003; Van de Ven et al, 2007). When these measures can sustain the "fragmented but universal health insurance system" by reducing inequality among health insurance schemes of different occupational groups, the congruence between institutional and ideational mechanisms in the health insurance system make self-reinforcing effects by enhancing the legitimacy of the institution.

By contrast, when these problem-solving rules do not contribute to sustain the operation of fiscally distressed health insurance societies, incongruence between institutional and ideational mechanisms could make self-undermining effects by decreasing the legitimacy of the institution. The problem-solving rules may hold the low level of institutional commitments (Mahoney and Thelen, 2009, 8). When these problem-solving rules are not entrenched by strong commitments, a government or politically stronger groups can exploit the ambiguity in problem-solving rules that, in turn, lead to unfair problem-solving practices (Mahoney and Thelen, 2009, 10). These practices can make cognitive frictions with the ideas of equality and governmental responsibility which are embedded in the universal health insurance system and thus it can lead to challenge the status-quo.

However, these processes through which institutional incongruences between institutional subcomponents and ideational goal make self-undermining effects are not automatic processes. Political actors' ideational reflection crucially affects these processes by re-interpreting the meaning of a prevailing institution. Some beneficiary groups can allow for fundamental changes of the institution by giving up their privileges and adjusting their ideas about the status-quo (Jacobs and Weaver, 2014, 5). This study focuses on the role of labour which can dramatically change their ideas and interests on health insurance policy through shifting union identity. Union members are usually a beneficiary group from the fragmented health insurance system and thus support the system (Giaino, 2002). However, they can move to form a coalition with farmers and other occupational groups. The shift of coalition formation can be one of the main cause of radical health care reforms.

Beyond ideas on specific policy areas, labour movements and unions have their core values and identities; "business unionism", where unions focus narrowly on benefits to their members; "revolutionary unionism or class opposition" where unions seek to politically mobilise their membership for a challenge to the existing social and economic order; and "social movement unionism", where unions attempt to form a coalition with other social actors for social reforms (Connolly and Darlington, 2012; Frege et al, 2004; Hyman, 2001). When trade unions are largely concerned with economic benefits in the labour market, they are more likely to support the fragmented health care system since it provides their members with more benefits in short-term perspectives. When trade unions seek to reorder political economic struc-

ture in a society, they would not be much interested in health care reform. However, trade unions could shift their orientation towards social justice. When trade unions embrace socially oriented labour movement, they are more likely to be positive about the consolidation of health care systems. In this case, unions pursue agendas for social reform, focusing on issues of equity and fairness (Frege and Kelly, 2003; Hyman, 2001). These processes could result in the shifts in the political coalition underlying an institutional setting (Weir, 2006).

However, social movement unionism alone could not account for institutional changes in a specific policy domain. New ideas on the fundamental union orientation needs to interact with institutional arrangements and specific ideas embedded in a certain policy. Firstly, these interactions are involved in agenda-setting process. There are a lot of social reform agendas such as gender equality, education reform, environmental reform, pension reform, tax reform, and health care. Unions have to choose their agendas among them based on their strategic calculation and union orientation. If unions choose a certain issue of reform with low political attention and fewer activists, they will face higher collective action costs to gain sufficient support for policy change. In this regard, unions are more likely to focus on issues which have high salience among population and potential coalition partners (Capoccia, 2016, 1112; Frege et al, 2004, 149). The frictions between ideational goals and institutional capability to achieve them could enhance political salience in a certain policy reform.

Secondly, socially oriented labour movements become more sensitive to the friction between ideational goals and institutional capability. As they changed their orientation, this mismatch became more visible for labour movement and they can more sympathise with members in municipal health schemes and reformers for health insurance reforms. Unions in Korea thought that weak problem-solving practices in Korean health insurance system were against social equity and the government should be more responsible for less fortunate citizens' welfare. In addition, unions in Korea argued that the occupational division within the health insurance system was not based on legitimate grounds and health insurance societies had to be restructured in order to achieve equity.

These micro-foundational processes coupled with institutional frictions and re-interpretation can lead to the coalition shifts in the health care policies. Socially ori-

ented trade unions can form a policy coalition with farmers and civil movement groups upholding solidarity. Such shifts in the political alliance that underpin the health insurance system can result in the reconfiguration of institutional arrangements. In contrast, when labour sustains the policy coalition with business, the coalition can sustain the fragmented health insurance system. While labour and farmers in Korea formed a policy coalition for the integration reform, labour and business in Japan created a coalition for protecting the fragmented health insurance system.

2.3 Arguments

This study put forwards three arguments on the divergent paths to health insurance reforms in Korea and Japan, which are derived from the framework mentioned above. Firstly, the inclusion of labour in the decision-making processes of health insurance at the societal level tends to protect the fragmented health insurance system. In Japan, employees can take part in the decision-making process on company-based health funds. *Rengō* sought to enforce its political influence on welfare and labour reforms through the principle of ‘self-governance’. Trade unions in collaboration with business associations were opposed to radical reforms that would merge all health insurance societies. In contrast, Korean trade unions could have little impact on their health insurance societies because employers did not allow workers’ representatives to participate in the administration of their health insurance societies. In addition, employers regarded the reserve funds in health insurance societies as funds held by their companies. Thus, such institutional arrangement had provided Korean labour with little incentive to oppose the unification of health insurances.

Secondly, the huge gap between the idea of universal health insurance and weak problem-solving mechanism in this system can lead to the integration of all health funds. The Korean government did not confer credible commitments on financing the financially distressed municipal health insurance schemes. This has led to the build-up of less institutionalised problem-solving mechanisms on distressed municipal health insurance schemes. The residence-based health insurance schemes have only begun to receive governmental subsidies at the latter’s discretion and the amount has been changing drastically every year. The Korean government charged high insurance contributions because of the fiscal crisis in the municipal health in-

insurance programme. As there was disparity between the ideas of universal health insurance and actual practices, farmers were mobilised for integration of all health funds as strong commitment for governmental responsibility. This gap also provided the common ground to challenge the status quo between farmers and labour when trade unions focused on the governmental responsibility in the health insurance policy.

By contrast, the health insurance system in Japan carries huge political responsibilities with effective and credible commitments. The central and prefectural government granted half of expenditures of municipal health insurance schemes as public subsidies that are legally binding. The municipal governments have transferred their general budget accounts into municipal health insurance funds to make up for the loss since the Japanese municipal health insurance schemes were directly run by the municipal governments. In addition, inter-fund transfer programmes have transferred a significant proportion of financial resources from corporate-based to residence-based health insurance schemes. Given this as a background, most of the actors thought that it was possible to build a sustainable universal programme under a fragmented system.

Thirdly, when labour movements adopt socially oriented unionism, the reform trial for the integrated health insurance system is more likely to succeed. While labour in Korea has showed little sympathy for farmers at the first stage of reform, the Korean labour movement began to adopt a more socially conscious orientation to pursue broader public interests and to forge closer partnership with the civil movement in the mid-1990s. Even though the core members of labour unions in big businesses were the one who gained short-term benefits from the fragmented health insurance system, the KCTU supported the integration reforms after they had reshaped their orientation towards socially oriented movement. By contrast, as Japanese labour movement adopted more economic orientation, they were resistant to the integration reform. There was a policy network between labour and big businesses in Japanese healthcare, which was consolidated by shared interests in corporate health insurance schemes and cooperative business-labour relationship (Kume, 1998). They were more interested in protecting short-term economic benefits.

2.4 Conclusion

This chapter has discussed the shortcomings of existing studies in relation to the health insurance reform in Korea and Japan and set out the theoretical framework for the dissertation. Theories such as professional dominance theory and multiple streams model do not provide an adequate explanation of variation in the health insurance reforms in the two countries.

This study instead focuses on the role of trade unions since they can shift their ideas and interests in health insurance policies and thus lead to the coalition shifts. This study also seeks to specify the condition under which institutional self-undermining effects and ideas are intertwined and these interactions can give rise to shift of coalition formation. It is claimed that decision making process and credibility on problem-solving rules have potential to result in institutional change. It is also claimed that when actors change their broad orientations, these institutional features can help them change their specific ideas on the social policy. Based on the interaction, the political actors can challenge an existing institutional arrangement.

Chapter 3 The politics of health care reforms

This chapter analyses the distinct political dynamics of the health care reform. Firstly, it examines why and how health care makes the unique dynamics of political conflicts. Secondly, it reviews the typology of health care systems and examines the main characteristics of the social health insurance system, or Bismarckian health care system, as the health care systems of Japan and Korea fall into this category. Lastly, it explores recent debates about the merger of health insurance schemes under the social insurance system.

3.1 The distinctiveness of health care service and its politics

Health care service has several peculiar characteristics compared to other goods and these features shape the unique dynamics of health care politics. First, health care is regarded as a 'merit good' (Musgrave, 1957), which is to be distributed among the population by the principle of need rather than financial ability to pay. Since healthy life is regarded as minimum standard of civic life, governments have the duty to provide the basic health care service regardless of its citizen's financial capability.

Second, there is significant information gap between providers and consumers of health care services. Consumers have limited information on their health conditions and treatments, and consumption of health care services is largely dependent on doctors' recommendation. As a result, doctors have an incentive to encourage their patients to demand more medical services than a Pareto-efficient level, and -it sometimes leads to an oversupply of medical services. The phenomenon in medical service market is called 'supplier-induced demand' (Evans, 1984; Rice and Labelle, 1989). The regulatory actions are justified to correct this problem by changing incentive structure of medical providers.

Third, health care service creates significant 'external effects' (Coase, 1960). When consumption or production of a commodity makes external cost or benefit to a third party, who is not involved in this process, it creates negative or positive externalities. Some health care services, particularly those concerned with communicable

diseases, generate external benefits. If some people get vaccinated against whooping cough, for instance, it enables to reduce the probability of others getting the disease. The concepts of sanitation, vaccination, and quarantine in modern history show the importance of external effects in health care services (Porter, 1999).

Lastly, the co-evolution of professions and state licensure is also important in shaping health care politics (Abbott, 1988; Carpenter, 2012; Starr, 1982). In most societies, governments have endowed legitimated experts with particular legal authority to deliver medical services. Officially legitimated physicians from government alone are able to prescribe and deliver medical procedures to citizens. They are able to effectively mobilise themselves in order to enhance their collective status ranging from a price of their medical services to a control of supply on physicians (Alford, 1975; Freidson, 1970). Based on strong organisational capacity, they have acted as a ‘veto group’ on the development of health care policy (Freeman and Rothgang, 2010, 369). Although other policy experts in economic, security, and environmental policy also play critical roles in their fields, the organisational and institutional power of medical profession is hardly matched.

3.2 Typology of the health care systems

There are huge variations in how different countries deliver and finance their health services. Scholars have attempted to put these variations in health care policy into several regime types. A starting point for a typology of health care systems can be also found in Esping-Andersen (1990)’s concept of welfare regimes. His pioneering study seeks to identify the three patterns of welfare regimes. He presents a typology of welfare states based respectively upon the operationalisation of three principles: de-commodification (which examines the extent to which an individual’s welfare rely on market force), levels of social stratification (which examines the role of welfare programmes in sustaining social stratification) and the private–public mix (which examines relative proportion of state, family, and market in the provision of welfare benefits). He categorises welfare states into three distinctive regime types; Liberal (US, UK, and Ireland, for example), Conservative (Germany, Austria, France, and Belgium, for example), and Social Democratic (Sweden, Norway, Denmark, and Finland, for example). However, the ‘three worlds of welfare states’ do not fit well

into health care services (Bambra, 2005). For instance, Britain, Canada, and New Zealand, which are regarded as liberal welfare states, have more similarities with the social democratic model than the liberal model in the health care system. It is because his typology is largely based on cash benefit programmes such as pensions, sickness, and unemployment benefits whereas it neglects to examine services programmes such as education, health care, and other social services (Kautto, 2002, 54).

The most frequently used division of health care services is that between National Health Service (NHS) model, social insurance model, and private model by exploring the dimensions of financing, provision, governance, and regulation of healthcare (Blank and Burau, 2014; Carpenter, 2012; Castles, 1998; Freeman and Rothgang, 2010; Immergut, 1992). The NHS used in the UK, Sweden, and Canada is characterised by universal coverage funded out of general taxation. For example, more than 80 percent of financial resources of health care came from public one in 2010 in the UK and most of them came from general tax (Blank and Burau, 2014, 82). Only 9.6 percent of funding came from co-payments by patients and private insurance accounted for just 3 percent of total health expenditures in the UK. It ensures free access to health care services for all citizens and thus it guarantees universal medical services (Hassenteufel and Palier, 2007, 576). Although private health care is allowed in the UK, its practice by private doctors is highly restricted and marginalised (Jordan, 2010, 869). In the national health system, delivery is also unique. Most of the hospitals are public owned. Doctor's income is not determined by the market competition. In the UK, general practitioners in the ambulatory sector are paid mainly on the basis of a capitation while doctors in hospital are salaried.

This system is often known as the Beveridgean model, named after the "Beverage report" which contained the core principle of this system. According to this report, all citizens are endowed with socio-economic rights, irrespective of class or market position, as much as political rights. The Beveridgean idea assumes that a state provides services as a matter of right to all citizens to guarantee basic necessities such as health, knowledge, food, and shelter by offsetting some basic social risks such as invalidity, old age, unemployment, illness, and maternity. In this regard, the system seeks to promote the equal benefits.

The social insurance system or Bismarckian system used in countries such as France, Germany, and the Netherlands provides its citizen with health care benefits

through health insurance societies. They are to be para-public and non-profit, which are operated under public law. The system is mainly financed by social contributions. Health insurance is funded by social contributions of employees and employers as a fixed percentage of their monthly incomes. Other sources of funding are co-payment from patients and governmental subsidy. When people visit a doctor, they are supposed to pay at some proportion of medical fee on the emphasis of individual responsibility. Governments also provide subsidies for vulnerable groups who have difficulty paying their contributions and co-payment. The freedom of medical services in this system is much higher than in the national health system. A patient is able to choose providers. The supply of health care is mixed; partially private (most of the primary or ambulatory health care), and partially public (in substantive proportion of hospital services). Physicians in the ambulatory sector are mainly paid on the basis of the fee-for-service system.¹¹

The social insurance system is based on the mixed ideas such as conservatism and social solidarity. As for the principle of social solidarity, contribution is paid in proportion to one's salary rather than one's health risk, which represents a redistributive feature in terms of risk and income. At the same time, it contains the conservatism. Originally, social health insurance was designed for protecting high-skilled employees and offers protection against catastrophic medical expense and income loss. For this reason, social insurance schemes are usually fragmented by various occupation-based schemes. The levels and scopes of benefits among them are usually quite different.

The private insurance system, used in countries such as Switzerland and the United States, is characterised by the market-driven approach and the dominant roles of private actors (Hassenteufel and Palier, 2007, 577). It is based on the belief that the less state involvement in health care service is the more efficient system and the funding and provision of health care should be left to market principal (Blank and Bureau, 2014, 84-6). The system is featured by various private health insurance contracts and employers or individuals pay for them. Individuals voluntarily make their contracts with insurance providers and the level of premium is linked to the level of individual health risk rather than income. Patients are required to pay co-payment or deductibles to cover all or part of the costs of their health care services. Companies

¹¹ The FFS is a system under which providers are paid for each service individually.

sell various private health insurance contracts and their premiums are usually contingent on individual health status and coverage boundary. Public insurance programmes in the US only cover certain groups of their citizens. Medicaid works for the poor and Medicare covers the elderly and disabled. Service delivery is mainly performed by private providers. In the private health care system, health care is provided by hospitals and doctors operating as entrepreneurs. This system allows consumers to freely choose their providers. Doctors gain remuneration based on the fee-for-service system.

3.3 Reforms in the Bismarckian healthcare system

There are some common problems and conflicts inherent in the Bismarckian healthcare system. As Blank and Burau (2014, 108-10) points out, the three health care regimes face a trilemma in healthcare policy between quality, equity, and cost containment. In many advanced countries, their health care systems are threatened by uncontrolled upward trend in health expenditures. At the same time, as health care attracts considerable political attention, governments have to maintain the quality and equality of health care service. The NHS system is geared to pursuit equality and cost containment at the expenses of its quality. The private health insurance system is supposed to emphasise quality over other two values. The social insurance system is designed for the quality and, to a lesser extent, equality at the expense of cost containment.

Cost containment

Health care policy in many advanced countries has been dominated by the pursuit of reforms for the last two decades (Saltman and Figueras, 1997). Most of the health care reforms were directed at cost control and improvement of efficiency. It is well known that the Bismarckian health care regime is much more vulnerable to cost explosion than the National Health System (Hassenteufel and Palier, 2007, 576). In the NHS, it was relatively easy for governments to control their health care expenditures by freezing their budgets and thus this system ensures relatively low levels of health care expenditure. Instead, the NHS in the UK offers a low quality of treatment,

which is well represented by long waiting lists for the access to specialist care. In sacrifice of service quality, the NHS has achieved the control of health care expenditure.

In the social insurance system, by contrast, it has a different combination among various goals of health care services. It usually provides higher quality of health service than the National Health Service (Hassenteufel and Palier, 2007, 576). However, the social insurance system tends to result in higher health expenditures. The government in this system is not able to directly control health care expenditures since the system guarantees reimbursing significant part of medical expenses incurred by insured person. This system has suffered a significant rise in health expenditures. Therefore, deficits in health insurance schemes and cost containment have been put on the top of the agenda of health care reforms (Blank and Burau, 2014, 125). Since the 1970s, health care spending in Germany, France, and the Netherlands swelled much faster than their economy grew (Hassenteufel and Palier, 2007, 582). While they opt for raising contributions in the 1980s in response to the fiscal problem, high contributions led to high labour costs. Employers in Germany claimed high contributions made German industry less competitive in the global economy and inhibited the growth of employment (Giaino and Manow, 1999, 977). In this regard, health care reforms in most of the European social insurance countries shifted from raising contributions towards limiting the growth of health care expenditure. They have attempted to introduce the variety of cost containment measures such as budget cap for health spending, comprehensive payment methods, and higher co-payment (Blank and Burau, 2014, 128; Schut and Van de Ven, 2005, 62).

Solidarity and conservatism

The Bismarckian health care system contains the tension between the ideas of solidarity and conservatism and governments seek to balance them. Theoretically, there are two competing principles underlying the social insurance system - the logic of social security and the logic of insurance (Blank and Burau, 2014; Kurata, 2009). On the one hand, “the logic of social security” emphasises solidarity among different groups. This logic supports the idea that all citizens have a right to acquire similar level of health care benefits regardless of their occupations. The benefits are sup-

posed to be equally distributed by needs and citizenship. In this regard, social insurance programme acts as not just insurance but also redistribution measure. On the other hand, “the logic of insurance” stresses the budget balance in the social insurance scheme since it is a kind of insurance. Benefits are supposed to be closely linked to contributions and, in turn, the insured person is to be conscious of costs as well as benefits. In addition, the principle presumes that redistribution through health insurance programme does not fit well with its goal and it should be marginalised. “The logic of insurance” also emphasises the self-governance in the social insurance scheme, which is run by the insured. The boundary of insurance had to be limited to similar occupational group members since the social insurance schemes were organised by strong group identity. It also implies that non-members including government could not strongly intervene in the insurance scheme for common goods. In this regard, this logic is used to justify different levels of contributions and benefits in various health insurances societies.

The two competing ideas make the political dynamics of solidarity in the social insurance system. Solidarity is often defined as “a general readiness to help those who are in need” (Ullrich, 2002, 124). Correspondingly, welfare state is regarded as an institutionalised form of solidarity (Cramme and Diamond, 2009, 178). Health care politics in the social insurance system includes the multi-dimensional meanings of solidarity (Maarse, 2003; Van de Veen, 2012). “Risk solidarity” means that premium the insured person pays is not related to the level of one’s health risk. Risk solidarity is a redistributive arrangement by redistributing individual person’s medical care costs across all members in a group. Risk solidarity implies redistribution from the healthy to the (potentially) sick. Risk solidarity contrasts with “actuarial fairness”, the principle underlying private health insurance schemes. The actuarial fairness principle means that a person with higher health risk is supposed to pay higher premium and this way to pay one’s premium is fair. The second dimension is “income solidarity”, which means contribution level is related to one’s ability to pay. In other words, contribution is determined by the subscribers’ incomes. Income solidarity implies redistribution from the rich to the poor. By contrast, there is usually no link between a person’s income and premium in private health insurance.

Risk	Low-risk group	High-risk group
Income		
High-income group	support the fragmented health insurance system	-
Low-income group	-	Support the integrated health insurance system

Table 3.1 Incentive structures on health insurance reforms on the basis of the level of risk and income

Source: Based on Baldwin, 1990; Rehm et al, 2012

Baldwin (1990, 20-28) shows how the levels of risk and income shape actors' interests on public insurance programmes, as shown in Table 3.1. Based on their economic incentives, a group with lower risk and higher income is more likely support the "insurance principle" while a group with higher risk and lower income is more supportive of "solidaristic principle." This is because when insurance pool is more integrated, financial resources move from the wealthy and secure to the disadvantaged and insecure.

The Bismarckian health regime is based on the occupational origin in Germany. The social policy programmes in the system are split along occupational lines and solidarity was limited in the demarcation of labour market. To some extent, it has contained inequality within different occupational health insurance funds. In this regard, governments in this regime attempted to balance between two principles by introducing several measures to enhance equity such as risk-adjustment scheme (van de Ven et al, 2007, 163).

3.4 The Debate between the single payer and multi-payer system

Many countries in the social health insurance system confront the choice between a single-payer and multi-payer systems.¹² Under the single-payer system, a single body controls the system of health care service and finance (Hussey and Anderson, 2003, 215). Under the single-payer system, one organisation - usually gov-

¹² A single payer system includes the nationalised healthcare system like in the UK, Canada and so on, but in this section, it means a single insurance scheme under the social health insurance system (Hussey and Anderson, 2003, 215).

ernment - collects revenues and purchases health services for the entire population. Under the multi-payer system, several insurance bodies carry out these services for certain groups of people. The social insurance system started with the multi-payer system while the NHS started with the single-payer system.

The countries which adopt the social health insurance system have sought to offer effective health care services without sacrificing solidarity. In this process, the integration of separate insurance programmes emerged after the end of the Second World War (Baldwin, 1990, 100-104). France and Germany attempted to establish comprehensive and solidaristic social insurance schemes through consolidating different occupational insurance programmes. This reform proposal was attractive for the governments because it would enable governments to operate their social insurance schemes with few subsidies and reduce inequality across different occupational insurance programmes, at the same time. In some East Asian countries such as Japan, Korea, and Taiwan, the consolidation of multi-payer health insurance system was taken into seriously after the late 1980s. Some advocate groups claimed that it would enhance not only equality but also efficiency of the health care system. After Taiwan established a single payer system in 1995, this idea was given more attention from scholars and politicians in this region.

In general, the debates between these two models focus on efficiency and solidarity (Hussey and Anderson, 2003; Oliver, 2009; Tuohy, 2009). The first topic is whether the integration reform increases the efficiency of health insurance administration and achieves cost containment in response to the trend in increasing total health spending. The supporters of a single-payer system claim that it has an advantage over a multi-payer system in overall cost control. Firstly, a single payer system can use financial resources more effectively through the implicit transfer mechanism from a wealthy and healthy section of population towards a less fortune section. In a multi-payer system, on the other hand, the transfer between different health insurance schemes is fairly restricted. Therefore, it occasionally happens under a multi-payer system that some heavily deficit-ridden funds coexist with other health funds with a large amount of reserves.

Secondly, a single-payer system has the advantage on the size of risk pooling and its effect. The 'law of large numbers' indicates that risks become more predictable as the size of the pool grows. Health care costs for a small group are less predict-

able than a large group. In a multi payer system, there are many different sizes of health funds. Some of them are occasionally too small to efficiently pool their members' health risks. Tiny health funds are fairly vulnerable to a surge in insurance claims and it would lead to a fiscal catastrophe. If risk pool becomes larger, it would be easier to predict potential risk levels and less vulnerable to this kind of shocks.

Third, under a single payer system, it is much easier to reduce administrative cost. Under a multi-payer system, an individual insurer possesses its own monitoring, information, and payment system. By contrast, a single-payer system is to build a single administrative body, which means to reduce overlapping administration fee. Moreover, a single payer may have greater bargaining power against providers since it could monopoly the purchase of medical service and hold a strong control on services and goods.

By contrast, those in favour of the multi-payer system claim decentralising health care administration is easier to control moral hazards and governmental burden. Firstly, the consolidation of health insurance schemes in the social insurance system leads to dramatic rise in health spending due to highly politicised health care policy. As Pierson (1994) claims, sophisticated tactics to hide the responsibility and visibility of welfare policies are more likely to cut off the welfare spending. When health policy making is centralised, however, it is much easier to track the responsibility of welfare retrench. The integration of all health insurance bodies means that government is fully responsible for the finance of the public health insurance system (Kwon, 2007, 153). It would lead to a greater political determination of total health expenditure levels and most politicians are reluctant to support unpopular policy to raise the contributions or cut off the benefits.

Moreover, a single payer system would face serious moral hazard problems. Under a multi-payer system, each health society is responsible for its own fiscal balance, including collecting revenue and controlling expense. Since the fiscal outcome in a health society affects the levels of contributions, the insured person becomes more conscious of the financial status of its insurance fund. They have an incentive not to overuse medical services since excessive utilisation may increase their insurance contributions. By contrast, patients in a single-payer system may take less trouble to minimise their health care expenditures. In addition, the collection of contribu-

tions would not be done actively under the single-payer system.¹³ Lastly, those in favour of the multi-payer system argue that it is not clear whether government as a single insurer are really willing to use its power against the providers.

The other main topic is the solidarity and redistribution in health insurance. Those in favour of the integration reform argue that the reform would lead to the moral sense of equity and solidarity by achieving vertical and horizontal equity. Due to the quite different financial conditions of health funds, the insured are supposed to pay different contribution fees for the similar benefits in a multi-payer system. However, in a single-payer system, it is much easier to equalise contribution rates across subscribers with similar income, which is the concept of ‘horizontal equity’. In addition, a single-payer system is usually progressively financed¹⁴ and it helps to promote greater financial redistribution between different income groups, achieving ‘vertical equity’. If health societies are merged, it can redistribute financial resources across different groups. Moreover, a single-payer system is able to maximise the redistributive effect through comprising whole population. By contrast, a multi-payer system is able to share the risk and revenue only within specific groups because it is divided by workplaces or regions. It often happens that those with higher income pay less contribution than those with less income under a multi-payer system.

The champions of the multi-payer system, however, claim the integration reform ironically undermines fairness. The income structures between the self-employed and salaried workers are different since incomes of the self-employed fluctuate and are difficult to objectively assess (Bärnighausen and Sauerborn, 2002, 1568). Some countries have difficulties in calculating contributions and collecting revenues from them due to widespread tax evasion, large informal economy, and limited capacity of tax administration. If a government consolidates all health schemes regardless of different income structures, it would hurt the fair charging mechanism in its health insurance system. For these reasons, solidarity should be mainly applied into a homogenous group.

Moreover, a multi-payer system is also able to redistribute its financial resource through a variety of subsidies and transfers. Government provides subsidies for cer-

¹³ It falls into the collection of the self-employed contribution since employees’ contributions are automatically deducted under a single insurance fund.

¹⁴ Progressive financing arrangement means that a proportion of contribution rises in accordance with income level.

tain groups in need of assistance such as the elderly or the unemployed. In addition, there are financial transfers from richer health fund to poor health funds in some multi-payer countries. For example, in Germany, there are inter-pool transfers between different health funds in accordance with different levels of risk and income (van de Ven et al, 2007).¹⁵

3.5 Conclusion

In this chapter, the first section has examined the distinctiveness of health care service and its politics, followed by the description of the three main types of the health care system. Japan and Korea falls into the social insurance system, which relies on the occupational demarcation and social insurance contributions. The following section has explained the general problems inherent in the social insurance system. This system has been more vulnerable to cost explosion than the National Health Service. It has also contained the tension between social solidarity and conservatism. The last section has summarised the debates between the single-payer and multi-payer system in terms of efficiency and equality. Based on the general explanations on health care systems and reforms developed in this chapter, the next chapter will examine the features of Korean health insurance system and its reform goals in the 1980s and 1990s.

¹⁵ A risk-adjustment scheme in Germany seeks to equalise differences of risk level in the sickness funds' membership based on age, income, sex, and number of dependents. They provide subsidies for sickness funds which account for more high-risk people. This system is geared to improve efficiency and solidarity.

Chapter 4 Political context of the health insurance reform in South Korea

This chapter examines the historical and political background of the health insurance reform in South Korea. In the first section, it reviews the historical development of health care policy in Korea. This section provides a systematic analysis of the origin and evolution of the Korean health insurance system from the 1960s to the 1980s. In the second section, it examines the main features of the Korean health care system. In the third section, it investigates the problems inherent in the healthcare system in Korea. The institutional features under the fragmented system coupled with the upward trend of health care spending resulted in the serious fiscal crisis in municipal health insurance schemes. These schemes, which consisted of the relatively older and poor insured persons, were in an adverse financial position. In the following section, it explains how the idea for the integration of all health insurance schemes was raised in South Korea. Lastly, it identifies major actors in health care policy in Korea and analyses the actors' stances on the health insurance reform drawing from institutional arrangements and incentive structures.

4.1 Historical development of health insurance in South Korea

The Korean health insurance system has undergone several transformations in response to changing social and economic conditions. Korea built up its social health insurance system to protect skilled workers and acquire the legitimacy of political regime in 1963 and it actually began to work in 1976. The health insurance benefits were gradually extended into employees in small firms and their family and then the Korean health insurance system achieved the universalisation of health insurance in 1989. In 2003, the Korean health insurance system integrated all health funds.

The origin of health insurance

The origin of social health insurance in South Korea could be traced back to the early 1960s (Kwon, 2007; Wong, 2004). Following the military coup d'état in 1961, the government in South Korea announced to introduce a series of social policies

including public health insurance in January 1962. In July 1962, the military coup leader, Park Chung-Hee, issued a memorandum to the “Supreme Council for National Reconstruction” (SCNR) calling for the implementation of social policies. The Ministry of Health and Social Affairs (MOHSA) set up the “Committee for Social Security” (CSS) to tackle these tasks. The CSS put forth a proposal on the introduction of several welfare programmes such as health insurance. When the Medical Insurance Act was enacted in December 1963, the SCNR made public health insurance not compulsory but voluntary, considering the weak economy and meagre medical resources in South Korea. For this reason, most of the companies did not take part in the programme and thus the public health insurance covered only 0.46% of the population in 1976 (Federation of Korean Medical Insurance Societies, 1997, 61).

The Medical Insurance Act in Korea was substantially revised in December 1976 and came into effect in 1977. The 1976 Medical Insurance Act made it mandatory for all firms with 500 plus workers to build up health insurance societies. The bill was highly influenced by the Japanese health insurance system. When the bill was being drafted, Korean legislators invited Japanese physicians and scholars to learn the Japanese model (McGuire, 2010, 224). The Korean health insurance system emulated the basic structures of the Japanese system as it was divided between salaried workers and the self-employed.

Despite the revision of the Medical Insurance Act, the health insurance schemes which covered employees in small companies and the self-employed were still voluntary. In 1979, the company-based health plans were extended into corporations with more than 300 employees. It was extended into companies with over 100 employees in 1981, over 16 employees in 1983, and over 5 employees in 1986 (Kwon, 2007, 65). In 1979, another health insurance programme for government employees and private school teachers came into effect. The medical assistance programme for the destitute was also introduced in the same year.

Democratisation and universal coverage of health insurance in the 1980s

South Korea finally achieved the universal health insurance that covered the entire population in 1989 by extending its health insurance coverage. After the announcement about the universalisation of health insurance coverage, debates on the

health insurance governance occurred. Some lawmakers and academics proposed a single insurance body for the universal health care, claiming that it would solve the potential fiscal problem in municipal health insurance. However, the government chose to keep a multi-payer health insurance system, arguing the merger of health insurance schemes would increase the burden of the government.

As shown in Table 4.1, 138 municipal insurance societies in rural areas began to operate in January 1988, which meant that approximately 70 percent of the population were covered by public health insurance. As 117 urban municipal insurance societies began to work in July 1989, public health insurance became available to the entire population. Both political and economic factors led to the rapid achievement of universal health care (Kwon, 2007, 69). Firstly, the economic boom in the late 1980s substantially increased the financial ability of the self-employed to pay for social insurance contributions. Secondly, as a political factor, President Chun and the ruling party attempted to retain their political base in rural areas by proposing universal health insurance coverage. The 1987 democratic transition in Korea also made the government more responsive to the mass public.

Year	1977	1980	1985	1987	1988	1989
Coverage rate (%)	8.8	24.2	44.1	51.1	68.9	94.2*

Table 4.1. Health insurance coverage from 1977 to 1989

Source: Kim, 2012, 116

Note: The others were covered by the medical aid programme in 1989.

4.2 The Structure of health insurance system in South Korea before reform

This section examines the structural features of the Korean health care system before the integration reform in terms of organisation, financing, and delivery. While it shared the critical features in the Bismarckian health care system, there were some crucial differences between Korean and typical social insurance system (Hwang, 2008).

Organisational structure

Health insurance programmes in Korea were fragmented by occupation and labour market status. Before the integration reform of the health insurance schemes in 2000-3, the national health insurance system in Korea was made up of more than 300 non-profit health insurance societies. As shown in Table 4.2, there were three types of health insurance programmes in Korea; first was one for employees in private companies, second for public officers, and the last for the self-employed organised at the municipal level (Kwon, 2003, 76).

Programme	Occupation	Number of the insurers	Proportion of those covered
Corporate health insurance programme	Employees in large companies	150	37.2%
Health insurance programme for public workers	Public workers	1	10.6%
Municipal health insurance programme	Self-employed and others	266	45.6%
Medical aid*	The destitute	-	6.6%
Total	-	417	100%

Table 4.2 The structure of health insurance programmes in Korea (As of December 1991)

Source: Hoffmeyer et al, 1994, 30

Note: The Medical aid programme was legally independent from health insurance schemes.

The health insurance programme for employees in private companies was established on the basis of enterprise or industrial district. A company whose employees were more than six thousand was able to build its own health insurance scheme (Federation of Korean Medical Insurance Societies, 1997, 265). In an industrial district, small companies could put together to build a health insurance scheme. Most of the *Chaebol* companies, large family-owned business conglomerates in South Korea, built up their common health insurance schemes. For instance, companies in Samsung built up the “Samsung General Health Insurance Scheme”. Each health insurance society was legally autonomous although it was operated under the direct supervision of the Ministry of Health and Social Affairs. All insurance societies joined

the Federation of Korean Medical Insurance Societies. In July 1977, 481 health insurance societies began to operate based on the 1976 Health Insurance Act, which covered approximately 3 million populations (Maeilgyöngje, 1977). A second category was for government employees and private school teachers. The civil servants, private school teachers, and soldiers were covered by an independent medical insurance scheme, the Korean Medical Insurance Corporation (KMIC).

The municipal health insurance programme covered those who were not entitled to join these two employment-based health programmes, such as the self-employed, unemployed, retired, and farmers. It was constructed mainly on the basis of residence under Article 6 of the 1976 Medical Insurance Act. The programme was mainly organised at the municipal government level. 266 municipal health insurance societies were organised as of December 1991.

Financial structure

There were three main sources of health care financing in Korea: contributions, government subsidy, and co-payment. The first source of health care financing was contributions by the insured persons, which comprised around 30 percent of total health spending in 1990 (Jeong, 2011, 141). The contributions of the employment based-health insurance schemes were designed to be equally shared between employers and employees. Employees paid their contributions as a fixed percentage of their monthly incomes. The contribution rate was decided by individual health societies within legal framework, between 3 and 8 percent of their wages in the early 1990s.

Health insurance societies for the self-employed collected contributions from the insured and they were responsible for paying their entire contributions. Since it was fairly difficult to assess their incomes, the schemes charged contributions in a different way compared to salaried workers. As shown in Figure 4.1, the contributions for the self-employed comprised two parts: basic and capability part (Federation of Korean Medical Insurance Societies, 1997, 361-88). The basic part was not proportional to subscriber's capability to pay contributions while the capability part reflected the subscribers' abilities to pay contributions. The basic part consisted of two components. The "basic contribution per household" was a fixed amount per

household and “basic contribution per person” was commensurate with the number of family members. The capability part consisted of two components, the earnings-related contribution and the assets-related contribution, which was linked to subscribers’ income and asset respectively.

However, there was widespread discontent over the fee system among farmers. The basic part was proportional to the number of persons, characterised as capitation fee. In capability part, farmers also had significant disadvantages compared to salaried workers since land, a basic production means of agricultural industry, also was regarded as asset. As consequence, average monthly contribution for rural health societies was 6,096 Korean Won (KRW), which was higher than that for corporate health societies (5,787 KRW) and that for public workers (4,510 KRW) (*Maeilgyǒngje*, 1988).

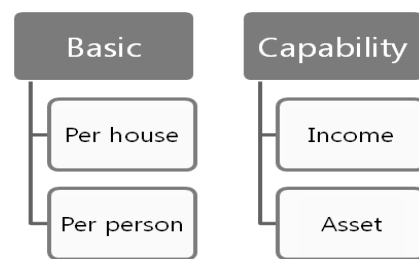


Figure 4.1. The basic structure of premium in municipal health insurance schemes

Source: Federation of Korean Medical Insurance Societies, 1997, 470

The second source of financing was government subsidy. In the 1990s, it accounted for less than 10 percent of total health spending (Jeong, 2011, 141). As Kwon (1998, 66-67) called the role of the government in welfare policy as “regulator” not “provider”, the government was reluctant to take the responsibility of financing. The government supported the health plans for the self-employed, providing subsidies between 20 and 50 percent of benefit expenses. The size of tax-financed subsidy towards these health funds was subject to change depending on the political and economic circumstances.

The third main source of financing was co-payment. The patients had to pay a considerable amount of money for health care services from their pockets. It accounted for more than 60 percent of total health spending in the early 1990s (Jeong, 2011, 141). Patients were supposed to pay between 30 and 55 percent of co-payment

for covered outpatient healthcare services and 20 percent for inpatient treatment. Beneficiaries in Korea had to bear the heavy burden of out-of-pocket payments due to the large scopes of uncovered services. Although the government attempted to gradually enlarge the boundary of covered services, the pace of expansion was quite slow (Jeong, 2011, 6).

Lastly, there were few structural mechanisms for financial transfers among the different types of health insurance funds within the national health insurance system. In 1991, the risk adjustment programme for highly expensive medical services started and it was extended into the expenses on the elderly care in 1995. The health insurance funds paid the fixed proportion of money for these transfers, and then re-shuffled the financial resources according to the rules on these schemes. However, these transfers were not helpful to solve fiscal crisis in the municipal health funds since they were quite limited.

Benefits coverage

The health insurance system in South Korea offered universal but limited benefits packages strongly controlled by the government. In principle, health care benefits packages were identical across various medical insurance programmes. Benefits packages covered not only outpatient costs but also prescription drugs, dental care, and hospital stay. However, there were a wide range of non-covered services. When patients use non-covered services, they had to pay in full for these services. The scopes of covered services were quite narrow. Several important medical services such as CT (Computer-aided Tomography) and MRI (Magnetic Resonance Imaging) were not covered by the public insurance until the mid-1990s. The public insurance covered provided the maximum 180 days of benefits for one's treatment and, in turn, chronic disease patients received limited benefits from it.¹⁶ If the treatment was over the period, a patient had to pay. However, the medical costs of serious illness often exceeded a middle-class family's financial capacity due to a wide range of non-covered services.

¹⁶ It was extended into 210 days a year in 1995.

Provider and reimbursement

Physician entrepreneurship was a strong element in the organisation of health care in Korea, where most clinics and small hospitals were private. The health care sector was exposed to competition among private-sector providers. The privately-owned hospitals and clinics account for 96 per cent of total numbers of medical institutes. More than 90% of physicians were hired in private medical institutes (Jones, 2010, 9). Basically, private physicians were reimbursed by patients and insurers through fee-for-service (FFS) mechanism. The FFS is a system under which providers are paid for each service individually. Patients were to pay for fixed proportion of co-payment for medical services and the remainder was reimbursed by health insurance societies. The MOHSA identified the 762 kinds of different medical services when the mandatory health insurance programme began in 1977. Each medical service had a specific point and medical providers were reimbursed by the amount of points.

The government exercised strong control over the negotiation on national fee level with medical providers. The government introduced the “official notification system” on medical fees in 1977. The MOHSA could unilaterally set up the price on health care services. Instead, medical institutes could opt out for the national health insurance system. At the moment, 30 percent of clinics and 15 percent of small hospital did not take part in the public health insurance because the official fee level of the national health insurance was much lower than market level. In response to the low level of physicians’ participation in the national health insurance system, the authoritarian government made it mandatory for all medical institutes to be included into the public health insurance system in 1979¹⁷. The physicians were strongly dissatisfied with significantly low fee level in the national health insurance. Doctors’ response to the low fee levels was to provide more services. By increasing the volume of their services and shortening a consulting time with a patient, they made up for the low levels of medical service fees. In addition, they encouraged patients to take uncovered medical services, which were free from the governmental regulations.

¹⁷ It stipulates that “*Medical care institutions may not refuse to provide medical care benefits without any justifiable ground*”.

Regulation and decision-making

Before the integration reform in 2000-3, there were more than 300 non-profit health insurance societies. The administrative structures of health insurance societies were para-public emulating the German and Japanese health insurance system. However, self-governance in health insurance societies was hardly realised in Korea. There were huge gaps between “rule-in-form” and “rules-in-use” in the decision-making process in the individual company-based health insurance societies (Leach and Lowndes, 2007, 185). According to the official regulations, subscribers were able to take part in the decision making in their insurance societies. For instance, Article 19 of the 1988 Presidential Decree under the 1987 Medical Insurance Act stipulates that “*the employers appoint half of the steering committee members and the employees elect half of the members (Presidential Decree No. 12481, 1987).*” The steering committee members could select directors based on Article 25. One of the directors became the head of directors, who would be legally in charge of the administration of the health insurance society based on Article 26. However, labour was hardly able to join the steering committee and board of director in their health insurance schemes in real practice. Business often appointed human resources personnel as the representative of subscribers (Han’györe, 1998a). In addition, big business unilaterally used the reserved funds in corporate health insurance societies.

The citizen in municipal health insurance had no channel to express their voice in one’s health scheme. Municipal health insurance programme had more authoritarian regulations on the decision-making process. The official regulations granted few opportunities for members to participate in the decision making at the municipal health insurance scheme level. Article 29 of the 1994 Presidential Decree under the *Medical Insurance Act* stipulates “*The body entrusted by a local medical association would recommend its steering committee.*” Moreover, the municipal health insurance schemes were managed by revolving door personnel from the government or the military. Most of the directors in these schemes were appointed with the political connection to the ruling party and high-level bureaucrats and they monopolised the decision-making process (Han’györe, 1989).

At the national level, bureaucrats had great influences on health insurance societies. Health insurance societies were also subject to strict regulations imposed by

the government. All insurers offered the identical statutory benefit packages and the insured person had no freedom to choose their insurance societies. Various health insurance societies did not compete with each other in order to attract the insured person (Chun et al, 2009, 114).

4.3 Major problems in the health insurance system

Although the Korean health insurance system successfully provided health services for the whole population, the insurance programme confronted critical challenges. There was an uncontrolled upward trend in health care expenditures. Moreover, the weak gate-keeping system and fee-for-service reimbursement system resulted in patients' frequent visits to doctors and longer stay in hospital compared to other countries. In addition, the mechanisms to support the residence-based health funds were fairly weak.

Cost explosion

The health care expenditure in South Korea has increased more rapidly than its economic growth as shown in Table 4.3. For example, South Korea's health spending grew by 7.5% between 1990 and 2001 while the GDP rose by 5.2% (OECD, 2003, 29). There were several factors for the rise in health care expenditures. Firstly, as health care benefits extended into more people, they increase the visit for medical institutions.

Year Type	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Health spending per capita	73	94	121	121	137	147	157	181	219	248

Table 4.3. The trend of health care spending in South Korea

Unit: US dollars per capita¹⁸

Source: OECD 2015

¹⁸ Health care spending refers to the amount of the final consumption of health goods and services. This indicator includes public and private spending. It includes long-term care, pharmaceuticals, prevention programmes, and health care administration costs. This indicator is measured in USD per capita (using PPP).

The second is a demographic factor, the ageing of the population. The increasing longevity, coupled with decline of birth rates, is producing increasingly the proportion of the elderly. South Korea has increased its life span from 65.9 year in 1980 to 80.3 year in 2009 (OECD, 2011, 79). The longer human life means more needs for medical care services for the elderly. Thirdly, the technical innovations of health care have contributed to significant increase in health care costs (Freeman and Rothgang, 2010, 372). To satisfy public demands for ever expanding services, the state-of-art facilities such as CT and MRI were more often used.

What was worse, the health care system in Korea had few tools to constrain its health expenditure. It adopted the fee-for-service (FFS) system, which can cause the over-supply of medical services (Bodenheimer and Grumbach, 2009, 33). The FFS system encourages providers to supply more medical services for their profits. As Table 4.4 shows, the number of consultations per capita per year in South Korea was much higher than the OECD average and patients in Korea tended to stay longer in acute care beds than other countries.

	Korea	OECD average
Number of doctor consultations (in 1999)	8.8	6.9
Average length of stay in acute care beds (In 1998)	10.6	7.5

Table 4.4 Estimates of the volume of health care in the late 1990s

Source: Colombo and Hurst, 2003, 41-43

Unit: per capita, days

In addition, medical technologies had also inflated the health expenditure in Korea by providing incentives for frequent use of high-tech medical measures. As Table 4.5 shows, Korea more often accessed to high-tech medical equipment than other OECD countries.

In many countries, general practitioners (GP), who provides primary care, play a role of gatekeepers.¹⁹ With limited choice of medical service, GP refers patients to specialists' out- and inpatient service in hospitals. Some empirical studies show countries with GP gatekeepers have lower per capita health spending (Gerdtham and

¹⁹ Gatekeepers refer to primary care physicians who coordinate overall patient care and control access to higher level of medical service through referring patients to physicians.

Jönsson, 2000). However, South Korea had weak gate-keep functions, leaving patients free to consult any medical provider. Some patients visited several doctors for a treatment. The introduction of the strong gatekeeper system was refused by large hospitals, which successfully attracted many patients to their out-patient departments. These factors contributed to more outpatient contacts per capita in South Korea than other countries (Chun et al, 2009, 167).

	1990	2000	2005
MRIs	1.4	5.5	12.1
CT Scanners	12.2	28.4	32.2

Table 4.5 Diffusion of medical technology in South Korea

Source: OECD, 2003, 94; OECD, 2008, 85

Unit: times per million populations

Inherent inequality in health insurance system

Although the Korean health care system extended its coverage into the entire population in 1989, it still contained the serious inequality. First of all, the contribution of health insurance was regressive, which meant that lower-income group tended to pay a larger proportion of income for insurance contribution than higher-income group. In terms of occupational equity, those who were enrolled in municipal health insurance suffered a relatively high contribution. Their insurance contributions were higher on average than employed workers although farmers' average income was lower than that of waged workers. At that time, wage earners paid 1.19 percent of their income for contribution and public officers paid 1.68 percent on average. By contrast, an enrollee in a rural municipal health insurance scheme paid 2.36 percent and an enrollee in an urban municipal health insurance scheme paid 2.04 percent of their income (Tongailbo, 1990).²⁰ As remarked earlier, this kind of regressive system in Korea came from the special criteria to calculate the insurance contribution in municipal health insurance schemes. While employment-based health in-

²⁰ The source of data was the Korean Consumer Council, which investigated more than 600 households on the health insurance system.

insurance schemes charged the contribution solely based on insurers' income, residence-based health societies charged the contribution based on property, family size, and income.

Fiscal crisis in municipal health insurance schemes

Year		1992	1993	1994	1995	1996	1997
		Type					
Corporate-based insurance schemes	Reserves	1,618	1,274	2,259	2,450	2,607	2,503
	Reserve ratio	117.8	119.4	128.7	116.3	103.7	91.0
Residence-based insurance schemes	Reserves	549	762	943	942	786	815
	Reserve ratio	48.1	55.8	59.9	46.5	30.9	27.8

Table 4.6. The financial gap between employment-based and residence-based health insurance societies

Source: Federation of Korean Medical Insurance Societies, 1997, 606

Unit: Billion Korean won, (%)

Note: Reserve ratio = Reserves / Insurance benefits costs for this year

The public health insurance system in Korea had the inefficient financing structure. First, there was a significant disparity between employment and residence-based health societies in terms of members' risks and incomes. Those who were insured in municipal health funds were older than those in employment-based funds. Whilst the elderly over 60 years old comprised only 9 percent of company-based health plans' members, they comprised 15 percent of municipal health plans' members in rural areas (Choi, 2003, 28). The subscribers of municipal health societies earned smaller income than those of company-based health societies. In addition, the municipal health societies had difficulty in collecting contributions. They were able to collect between 80 and 90 percent of revenues while the contributions of employment-based health plans were automatically deducted from employees' wages.

Table 4.6 gives more detailed information about a financial gap between residence and employment-based health plans. The health societies for employees in

private firms stocked their reserves equivalent to one year's benefit costs. For example, in 1995, these health societies had 2.45 trillion won as reserves, which accounted for 116 percent of their annual medical expenditures. However, municipal health plans had only less than half year costs.

Secondly, some municipal health funds were too small to efficiently pool their members' risks. There were five municipal health societies to cover even less than 5,000 populations (Jo, 1998, 268). Most of the tiny health funds were quite vulnerable to huge insurance claims by insured persons who suffered from serious diseases. In this case, they usually relied on the steep rise in contribution.

Third, the small size of municipal health schemes led to "diseconomies of scale" and high management costs (Sin, 2004). Small health societies spent a significant proportion of their expenditures on administrative costs. On average, municipal health funds in rural areas paid 15.6 percent of their total spending for administrative cost while company-based health funds 8.6 percent and health fund for public servants 6.7 percent (Tongailbo, 1994). The five health insurance schemes with less than 5,000 insured persons spent 30 percent of total cost on managerial cost (Jo, 1998, 268). In 1996, 24 health societies spent more than half of total expenditures on the costs.

	1988	1989	1990
Number of municipal health societies in red	18	118	228
Number of total municipal health societies	140	254	254
Proportion (%)	13	46	90

Table 4.7. The proportion of municipal health societies in red

Source: Federation of Korean Medical Insurance Societies 1997, 586

For these reasons, municipal health insurance societies had difficulty in tackling their fiscal deficits. As shown in Table 4.7, 90 percent of schemes in this category recorded deficits in 1990. There were also six municipal health societies which had no reserved fund at all, as of the end of 1996 (Jo, 1998, 268). Although the government had to increase the subsidy for them to offset this deficit, the proportion of governmental subsidies in their expenditures was decreasing.

Weak institutional commitment of financial support

There was the commitment problem of financial support in municipal health insurance programme in South Korea. When the health plans for the self-employed were launched, the government assured them that the programme would be subsidised to a large extent. The government guaranteed it would share the half of contributions for the self-employed as Japan did for its municipal health insurance schemes. However, it turned out that the government did not keep the promise after launching municipal health insurance schemes in 1988. The financial resources for subsidising municipal health plans largely exceeded the government's initial expectation of how much funding was required because of the steep rise in health expenditures.

In addition, there were more crucial features of financial structures in the Korean health insurance system than rapid growth of health spending itself. The central and local government showed weak commitment to support financially distressed municipal health societies. Firstly, the financial support for municipal health insurance schemes was not legally binding strongly. The Medical Insurance Act in Korea made financial aid for municipal health insurance schemes arbitrary. Article 48 of the 1987 Medical Insurance Act stipulates that "*the government could support the part of expenses for the health insurance schemes.*" In addition, Article 36 of its 1988 Presidential Decree mentions that "*The part of the expenses to be borne by the national treasury (....) shall be determined annually by the Minister of Health and Welfare within the limits of the budget.*" The size of subsidy towards these health funds in Korea was subject to change depending on political and economic circumstances.

Secondly, a municipal health society in South Korea was not legally related to its local government. A municipal government in Korea did not take any responsibility for a local health society in its jurisdiction in contrast to the Japanese case. In this regard, while local governments in Japan transferred its general account budget into its health insurance fund to make up a deficit, those in Korea did not make fiscal contributions to the municipal health societies. It also weakened institutional commitment to solve the fiscal problem in the Korean municipal health societies.

4.4 Major actors related to the health insurance system

The previous section analysed the problems in the Korean health insurance system. This section describes main actors' roles in health care policy and incentives on the health care reforms. Bureaucrats, doctors, labour unions, business, farmers, civil movement, and the associations of health insurances were main actors in the process of the health insurance reform. This section elaborates how these actors shaped their policy preferences on the health care reform.

Bureaucrats

Welfare bureaucrats in South Korea historically played a key role in shaping the health insurance system. Given weak demands from society, government elites took responsibility to set up the health insurance system. In general, the Ministry of Health and Social Affairs (MOHSA, later became Ministry of Health and Welfare) was the advocate of the universal health insurance system in the 1980s because it would bring to enhance their organisational capability. However, its political will often was limited by the political processes in the Blue House and cabinet meeting. This was because economic bureaucrats who held stronger power to control policy agendas did not support a rapid expansion of social welfare benefits. The economic bureaucrats controlled welfare expansion that may put significant financial burdens on the government (Kwon, 2011, 654). They were more interested in using social policy as a tool of industrialisation. In this regard, they preferred to gradually expand health insurance coverage.

The idea of integrating all health insurance funds was raised by some of officials in the MOHSA in the early 1980s for the fast achievement of the universal health care. They claimed that financially strong company-based health insurance schemes could support the relatively unstable self-employed group. The Korea Development Institute (KDI), one of the most influential governmental think-tanks on economic policy, backed up the idea of merger since it would utilise the financial resources more efficiently (Maeilgyōngje, 1980). By contrast, other high-level officials in the Blue House were opposed to this proposal, claiming the integration of all

health funds would lead to the escalation of governmental subsidy. Moreover, a fragmented health insurance system provided bureaucrats with job opportunities as managers of municipal insurance societies, which was often called “revolving doors”. For example, more than one hundred governmental officials were appointed as the director of health insurance societies in 1988.

Political parties

There were different opinions on the health insurance reform inside the ruling party. On the one hand, the leaders were opposed to the integration reform. Since the ruling party stressed overall economic performance over welfare policy, the party was worried about the burden of massive subsidy which might slow the pace of economic development. They also considered the opposition of business associations on the reform. On the other hand, individual lawmakers in the ruling party were interested in a rise in the subsidy for health insurance schemes, which was directly linked to their electorates’ needs. Especially, the parliamentary members representing rural constituencies had an incentive to support the integration of all health funds based on constituents’ voices. In this regard, the ruling party’s position was subject to change depending on the electoral circumstances and the level of party discipline. When the party lost its popularity, they could lean towards the increase in the subsidy for rural residents’ health schemes. And when party discipline in the ruling party became loose, more lawmakers in the ruling party could support the subsidisation or integration of the health insurance system.

The two centre-left opposition parties, the Peace and Democratic Party and the Reunification Democratic Party, were quite interested in the health insurance reform. Health insurance was the only universal welfare programme in the late 1980s. They fought against the legacy of the authoritarian system and thus it made them attempt to be framed as reformists in the institutionalised political arena. They showed sympathy with rural residents and reflected the electorates’ request for the integration reform. At the same time, liberal parties may seek to balance between economic growth and social welfare expansion in order to appeal to the middle class of the electorate. In this regard, the integration of health insurance schemes would be an

attractive option for them because they thought the reform would bring the equal health care with small amount of the governmental subsidies.

Medical providers

The associations of medical providers in South Korea have been strongly involved in health care and insurance policies. While the Korean Hospital Association (KHA) represented large medical institutes, the Korean Medical Association (KMA) mostly represented physician in primary care sector. These organisations protected medical professions' interests in health policy. They had a strong organisational power on the basis of cohesive interests and were dedicated to protecting their social and economic interests. The introduction and expansion of health insurance in the 1970s made them much more active in the political process of health policy.

They put their priority on the reimbursement such as fee schedules and payment methods in health insurance system. In these issues, they confronted the government that tried to save the expenditures on health care with strong control of fee schedule. The health-care providers insisted that they were underpaid due to low medical fees. Doctors' associations claimed it was impossible to sustain their business under quite low fee schedule and low fee for medical service inevitably led to low quality of medical service. They have threatened to strike over low fee level several times. After democratic transition in South Korea, they claimed that the unilateral decision of medical fee level by the government was not democratic and it had to be autonomously negotiated with providers and insurers (Kyŏnghyang Shinmun, 1987). Moreover, they argued the review of reimbursement claims had to be handled by an independent body, not the government. They also exerted their power to block the reform of the payment system. In response to cost explosion, for example, the pilot programme for the Diagnostic-Related Group (DRG)²¹ payment method system started in 1997. In spite of the favourable outcome of the project, the introduction of the DRG system was rejected by physicians, who were strongly hostile to moving away from the fee-for-service system.

In contrast, they were not dedicated to contributing their resources to the single-

²¹ Diagnosis-related group (DRG) is a system to classify hospital cases into one of several groups. Under the DRG payment system, the reimbursement is made on the basis of the DRG grouping not the aggregation of total treatments (Bodenheimer and Grumbach, 2009, 39).

payer reform. The representatives of doctor's associations paid little attention to this issue when the health policy committee in the MOHSA was organised in 1988. The representative of physicians in the committee said that they were not much concerned about whether health insurance schemes were merged or not so long as the reimbursement for providers would work (Han'györe, 1988a). Furthermore, the provider groups' positions regarding health insurance integration were often inconsistent and ambiguous. On the one hand, some of the medical providers announced the support for the merger reform, claiming it was more convenient to be rewarded for medical fee from various insurance schemes. In addition, some of health insurance schemes, particularly in rural areas, had difficulty in rewarding physicians for covered medical services and often delayed the reimbursement for medical institutes. The integration reform was to help to solve this problem. On the other hand, there was a serious concern over insurance fund integration, worrying the monopoly of the government in healthcare policy. The physicians were worried about whether the integration reform could significantly enhance the power of the government over them by creating a single payer in the health care system.

Business

Employer organisations such as the Federation of Korean Industries (FKI) and the Korean Employers Federation (KEF) played key roles in health insurance policy. Without their consent, it was impossible for the government to launch health insurance programmes. They were supposed to pay half of contributions on behalf of their employees. In fact, employers had negative preference on health insurance at the first time. In this regard, it was not mandatory for companies to join health insurance societies in the 1960s. It was critical for the origin of health insurance that employers changed their preference on health insurance in the late 1970s. The big business in Korea already had provided health care benefits with its employees. After the 1970s, there was a shift towards heavy and chemical industrialisation in the Korean Economy. They needed to protect skilled workers and a stable relationship with labour that were required for new industrial structure. Besides, if health insurance system was legalised, they could gain the tax relief for contribution on health insurance. The business groups have been willing to provide the generous welfare programs in order

to encourage workers to develop firm specific skills but the boundary was strictly limited to regular workers.

The business groups had been most vocal in opposing the proposed consolidation. When the idea of insurance merger was discussed within policy making process, they fiercely counterattacked the idea. Firstly, employers were unwilling to discard their financial advantages arising from the employment-based health insurance system. In South Korea, the employers in big business had *de facto* right of management on the accumulated surplus in health insurance funds (Kim, 1996, 199). For example, the Samsung health fund had about 96 billion Korean Won as reserves and the LG health fund had around 41 billion Won in 1995 (Kim, 1996, 199). They could take out a loan from a bank with quite low interest based on their reserves (Kim, 1996, 200). And employers could also have a room to move under the fragmented system by delaying the payment of their contributions depending on their financial conditions.

Secondly, they were worried about the hike in contributions, which meant higher labour costs. Employment-based insurance scheme in big business was designed for the exclusive benefit at company level. It consisted of relatively lower risk and better-off members than municipal health schemes and thus the fragmented system would provide health insurance with lower price for them than the integrated system. If health insurance societies were integrated with rural health funds, they would not only lose massive reserves but also pay extra contribution for other members. In this regard, big business was strongly opposed to the consolidation proposal.

Trade unions

Workers had significantly complicated interests on the health care reform. Unions' preferences can also be formed in several different logics. According to the logic of representational interests, trade unions prefer low contribution rate and broad coverage of benefits. The integration reform had serious disadvantages for the employee in big corporations. The contribution would rise sharply to support the low-income self-employed. When some of welfare bureaucrats suggested the merger of health insurance schemes in the early 1980s, the Federation of Korean Trade Unions (FKTU) supported the partial integration only among workers' health insurance

schemes. It claimed that current company-based schemes used higher administration fee, than a single insurance body for public workers. The company-based schemes used 7.4 % of total revenues as managerial cost while the insurance for public officers only spent 4.4 %. However, the organisation did not agree on the idea of integration of all health insurances because it would increase members' contribution rate. During the second debate on the integration in 1988-9, they announced to take a stand against the integration with self-employed. It expected to increase their contribution by 50 percent (Maeilgyöngje, 1986). They were worried that the evasion of income and difficulty of income assessment of self-employed workers would result in a greater economic burden on them.

Unions' preferences can also be formed in order to protect organisational interests and exert political influence. Health insurance reform became a politically salient issue among the farmers and civil activists in the late 1980s. If labour is more willing to cooperate with other social movement groups in the issue, trade unions would gain their political partners.

Rural residents

The farmers in Korea were a less fortunate and relatively old group. Korean farmers usually had small size of their own farm due to land reform in the end of 1940s. About 89 percent of the farms had less than two hectares in size (Powelson and Stock, 1987, 181). Farmers would be benefited from the single-payer reform through the redistribution of healthcare resources. There was a serious shortage of medical institutes in rural areas and the rural residents had difficulty in access to medical institutes. Considering a high level of geographical inequalities between urban and rural areas in healthcare service, the nationalisation of healthcare would be the best option for them. It is often said that remote rural communities are more likely to be under-supplied by medical personnel and facilities in health care system (Blank and Burau, 2014, 94). In Korea, there were a few private and public health facilities in rural areas while most of the health providers were located in urban areas. Given the geographical imbalances of physicians, their low incomes, and high health risks, the farmers had a strong incentive to support the National Health Service

(NHS), which were used in countries such as the UK. However, it was hardly possible to implement it, considering weak political left.

A selective subsidy for rural residents would benefit them, too. Japanese government, for instance, provided around half of expenditure of municipal health insurance and local governments transferred their general account budgets into municipal health insurance funds to make up for recorded deficits. In Germany, the government provided the subsidy for farmers' health funds and the Farmers' Cooperation Foundation in Taiwan played a similar role in reducing farmers' burden on health insurance premiums. However, there was the credibility problem underlying in targeted subsidy policy, as mentioned above.

In this regard, farmers had the perception that the politically feasible commitment to rectify inequality in health insurance was the merger reform. The integration reform of health insurance schemes would also be beneficial for them. Although it was not able to significantly improve access to medical care, it would reduce quite heavy contributions for them by promoting the transfer between different income groups and risk groups. At the same time, it could be a substantially strong commitment to correct inequality in the national health insurance system because the government would hold direct responsibility for the fiscal problem of healthcare system.

Civil organisations

The political attention on the healthcare and health insurance system in the late 1980s could provide a crucial opportunity for civil organisations to present their blueprint of welfare state. Most of the progressive civil activists preferred universal and large welfare states and linked the health insurance reform to welfare expansion. The government contributed less than 10 percent of the national health spending in 1988 and patients bore huge health care costs (Jeong, 2011, 138).

NGOs and civic groups in Korea had the potential to play critical roles in health care reforms. First of all, they were able to provide the political base where different groups were united. Korean civic groups were organised through democratic movement under authoritarian regime and led by activists for democratic transition and progressive academics. The democratisation in South Korea led to the mobilisation of NGOs, which heightened the political awareness of social policy. They included

diverse groups and could form a broad political coalition for policy changes. Secondly, NGOs had close connections with progressive academics and thus provided reformist groups with a theoretical rationale for the health insurance reform. Those who were discontented with the current health insurance system lacked the policy expertise and it effectively discouraged them from participating in policy debate and discussion. The health care is a fairly technical issue and a relatively new issue in the reformer group. NGO which were linked to progressive academics generated solid arguments against the business groups and conservative media. They also contributed to the diffusion of their policy rationales into grassroots activists through organising a series of lectures and publishing booklets.

4.5 Conclusion

This chapter has examined the historical and political background of health reform in South Korea. The health insurance system in Korea has dramatically developed over the last four decades. It began in the 1960s but came into effect in 1977 based on employees in large companies. The coverage of the national health insurance continually expanded into other occupational groups such as government employees, workers in small firms and the self-employed.

In spite of the rapid expansion of the health insurance system in Korea, it had several significant problems, demanding immediate solutions. There was the upward trend of health care spending. The fragmented system, comprising more than 400 different health insurance societies, made it worse since there was a serious gap of financial capability between residence-based and employment-based health insurance schemes. The health insurances for the residents in rural areas covered relatively old and poor insured persons than employment-based insurance funds. In this regard, municipal health insurance funds struggled to tackle their deficits from onset.

Faced with the critical challenges in the national health insurance system, main actors who were involved in health policy had different opinions for health insurance reform. The farmers and progressive civil movement groups strongly supported the integration of all health insurances into a single body, claiming that it could solve the fiscal problem in rural health insurance through massive reserves in company-based health funds. Furthermore, the reform would make the system not just more equal

but also more efficient through the transfer of financial resources and the reduction of administrative costs. By contrast, the business groups and government economic officials were strongly opposed to the merger proposal, claiming that the move would increase employers' contributions and governmental subsidy. Moreover, they were worried that it would bring inefficiency into social insurance system and increase the total health spending. The medical providers set their priorities on reimbursement for them but did not have strong incentives to make collective actions on the administrative structure reform. The labour union also took an ambiguous position at the beginning.

Chapter 5 Political context of the health insurance reform in Japan

This chapter examines the political background of the health insurance reform in Japan. The chapter begins with an overview of the historical development of the Japanese health insurance system. The subsequent section examines the problems inherited in the Japanese health insurance system in order to explain why the proposal for the integration of all health insurance schemes was raised in Japan. Lastly, the chapter analyses main actors' interests and ideas on the health care policy and the health insurance reform. It elaborates how actors shaped their policy preferences based on the incentive structures and their ideas.

5.1 Historical development of health insurance in Japan

There are three phases of development of social health insurance in Japan. The first phase is between its onset and the Second World War. After the late nineteenth century, there was the demand for health insurance system in Japan in response to economic transformations and industrialisation. Japan built up the social health insurance in 1927 to protect skilled workers and prevent labour unrest. The second phase is between 1945 and the 1970s, characterised by the universalisation of the health insurance system. The Japanese health insurance system expanded into the whole population in 1961, and the dramatic change was the move towards free health care for elderly the in the 1960s and 70s. The third phase is after the 1980s, when health care policy was moved in the opposite direction for retrenchment. With the economic downturn and cost explosion of health expenditures, Japan was struggling to streamline its welfare payments including health care expenditures.

The introduction of statutory health insurance between 1920s and 1945

The public health insurance system in Japan could trace back to the 1890s, when medical insurance was firstly proposed by the Central Hygiene Committee. It proposed that a workplace with 100 or more workers would set up its statutory health fund and yet the proposal was turned down. After a while, some of the volun-

tary health insurance schemes such as railroad workers' mutual aid fund were built up. The Ministry of Agriculture and Commerce drafted the first bill on the statutory health insurance programme in 1922. It was enacted in 1923 and came into effect in 1927. The first health insurance programme was for manual employers just as the German social health insurance model (Shimazaki, 2005, 3-4). Business with over 10 employees was required to offer health insurance benefits to their employees in this bill (Yoshihara and Wada, 2008, 44-6). When it came into effect, some of the manual workers in limited sectors could receive health insurance coverage, which accounted for 3% of the whole population in 1927. The employment-based health programme expanded its coverage into small-scale manufacturing employees in workplaces with more than five workers in 1934 and then white-collar employees in 1937.²²

The Citizen Health Insurance programme (CHI)²³ was proposed to cater for farmers and other occupational groups in the 1930s. The Great Depression and the following Showa Depression in the late 1920s damaged living conditions in farming villages. The average income of farming households had halved from 1929 to 1931. In response to the economic crisis, voluntary and community-led movements were organised to provide health care services in rural areas. Moreover, as Japan entered into the stage of total war in 1937, it was requested to supply a "healthy military and labour force" (Takaoka, 2011). For these reasons, the government enacted the 1938 Citizen Health Insurance Act.

Universalisation and benefit expansion between 1945 and 1970s

The effort to expand health insurance coverage reached its peak in 1943, around 70% of the population. However, health insurance schemes were crumbling in war-time and post-war time chaos. After the Second World War, almost half of the municipal health insurance societies did not work and health insurance coverage rate fell to around 50 percent of the whole population (Reich et al, 2011, 1108). The gov-

²² The regulations of the mandatory health insurance schemes in the first stage were quite complicated depending on the sectors and size of business. It is well described in Yoshihara and Wada (2008, 44-6).

²³ The Japanese translation of this programme is close to the National Health Insurance(NHI). But the NHI is often used to refer to the whole public health insurance system. In this regard, this thesis call this programme as Citizen Health Insurance.

ernment set out the rebuilding of the CHI schemes by revising the Citizen Health Insurance Act (Ishioka, 2014, 5).

In the mid-1950s, the “Seven Committee” and “Committee for Social Security” recommended that the government should universalise health insurance coverage (JMA, 1997, 46). At that moment, both right- and left-wing parties pledged to achieve the “health insurance for all” and the 1958 Citizen Health Insurance Act was passed, which would extend coverage into the whole population. As all local governments built up their municipal health insurance schemes, Japan achieved the universal health coverage in April 1961. After the universalisation of health insurance, the elderly medical care became a main political issue in election campaigns. In 1969, several local governments including the Tokyo Metropolitan Government and Akita prefecture began to provide free medical services for the elderly. It was widely spread across the nation amid high-speed economic growth. In this background, the 1972 Elderly’s Welfare Act was passed to guarantee free access to medical care for the elderly across the nation.

Moreover, in this period, the Japanese health insurance system became more generous to all citizens. A ceiling of patients’ cost-sharing was introduced in 1973 to relieve their burdens of serious disease. When a monthly out-of-pocket payment exceeded a ceiling, insurance fund paid back the excess amount to the patient. In this regard, 1973 is often regarded as an “epoch-making move towards a welfare state (*Fukushi gan'nen*)” (Tsuchida, 2011, 251).

The efforts towards cost-containment in the 1980s

The Japanese welfare state took some measures for retrenchment in the 1980s. Unfavourable economic conditions and rising health-care costs created the new political environments for welfare reforms in the 1980s. The elimination of co-payment for the elderly resulted in the excessive demands for health care and thus the national health expenditures had increased from 250 billion yen in 1970 to 1.1 trillion yen in 1979. Moreover, the Japanese yen significantly appreciated against the US dollar and oil crisis also hit the Japanese economy in the 1970s. As the government accumulated a budget deficit in the 1980s, it attempted to cut welfare spending (Tsuchida, 2011, 250-1). The burgeoning health care expenditures became one of the main targets for

streamlining the public expenditures. To advance the major “administrative reform” (*Gyosei Kaikaku* or *Gyokaku*), Prime Minister Nakasone established the Second Provisional Administrative Reform Commission under the banner of ‘fiscal reconstruction without tax increase’. The government also initiated a policy discourse about a “Japanese-style welfare society” to justify welfare retrenchment. They reconfigured not only national economic frameworks but also a cultural ethos which rewarded traditional values of ‘self-help’ (*jijo*). It sought to assign the responsibility of basic welfare into individual, family, and community rather than the government.

Based on the new policy orientation, the government embarked on attempts for the retrenchment of health care services. The ‘health care system for the elderly’ (*Rōjin Hoken Seido* or *Rōken*) was designed to constrain the growing health expenditures by re-introducing elderly patients’ co-payment and sharing the elderly care costs with public health insurance programmes (Graig, 1999, 106-7).

Searching a new era in the 1990s

In the 1990s, there were more complicated policy features in Japanese health care policies. The government sought further cuts in health care expenditure. However, the government wanted to make some measure to tackle aging society and burgeoning elderly care costs at the same time (Izuhara, 2003, 396). In Japan, the elderly had been reliant more on hospitals for long-term care than social services. This practice resulted in the large number of hospitals beds and the long average stay in Japan (Jones, 2009, 13). A significant proportion of acute care beds were used for the long-term care function for the elderly, the phenomenon known as “social hospitalisation” (Imai, 2002, 7).

In this background, “*kaigo hoken*” (long-term care insurance, LTCI) was introduced in the process of several steps. First, in 1989, the Ministry of Welfare published the *Ten-Year Strategic Plan for Health and Welfare Services for the Elderly*, known as the *Gold Plan*. It focused on the expansion of care services for the frail elderly. In 1994, all municipal governments had to initiate their plans for “Health and Welfare Plan for the Elderly”. The Long-term Care Insurance Act was passed in 1997 and the Long-term Care Insurance took effect in April 2000. It offered institutional or domiciliary services for people aged 65 or over (category I) and some peo-

ple aged 40–64 with specific disabilities (category II).

5.2 The Structure of Japanese health insurance before reform

This section examines the structural features of the organisation, financing, and delivery of the Japanese health insurance system in the 1990s. The goal of this section is to analyse the pre-condition of the health insurance reform. `

Organisational structure of health insurance system

The Japanese health insurance system was fragmented on the basis of occupation and labour market status. There were four different types of health insurance programmes in Japan. First, the SMHI (Society-Managed Health Insurance) or “*Kempo*” was for the employees in large firms. The SMHI covered 32.5 million, about 26 percent of the population in 1999. This programme made its own association, National Federation of Health Insurance Societies, much well known as “*Kenporen*”. Second tier was the programme for employees in small and medium-sized corporations and their dependants, called “Government-Managed Health Insurance” (GMHI, *Seifu kanshō kenkōhoken*). When Japan began its health insurance programme, some of the companies were too small to organise their own health societies. The government decided to directly provide their employees with health insurance coverage. This programme evolved into the GMHI. The GMHI plans covered 30.7 percent of the population in 1997. It was a single body managed directly by the Social Insurance Agency. Third type was the mutual aid funds for public workers. These three programmes were for the employees.

The last programme was the Citizen Health Insurance (CHI, *Kokumin kenkōhoken* or *Kokuho*). It was designed for those who were not covered by any types of the employment-based health insurance schemes and thus covered various groups such as farmers, the self-employed, the retired, and the unemployed. As shown in Table 5.1, there were more than three thousand municipal plans and 166 CHI plans for the self-employed associations in 1999. The CHI societies built up their association, the “All-Japan Federation of National Health Insurance Organisations” (*Kokumin kenkō hoken chūōkai*).

Type	Insurer	Number of insurer	Number of insured (thousand person)	Occupation
SMHI	Health insurance societies	1,794	32,578	Employee in large company
GMHI	Government	1	37,575	Employee in SME
Sailors' health insurance	Government	1	259	Sailor
MAI ²⁴	Mutual aid funds	79	10,139	Public workers
CHI	Local government	3,249	41,021	Farmers, fisherman, self-employed, unemployed, and retired
	Special CHI funds	166	4,433	craftsman
	Total	3,415	45,454	-

Table 5.1 the structure of health insurance system in Japan (As of March 1999)

Source: Ministry of Health and Welfare, 2001

Financial structure

There were three main sources to finance health care in Japan: contributions, government subsidies, and co-payments by patients. Firstly, insurance premiums were the largest source of financing health care, which accounted for around half of total health expenditures. In employment-based health plans, employees and employers contributed a premium together. The legal premium rate of the insurance societies varied from 3 percent to 10 percent of wages. The average contribution rate was 8.5 percent of employees' wages in 1997. A large proportion of employers paid more than half of workers' contributions in Japan.²⁵ The GMHI scheme set up flat contribution rate at 8.5 percent of monthly gross salary in 1999, which was equally shared by employers and employees. The CHI schemes had a more complicated sys-

²⁴ There are mutual aid funds organised for employees in central and local government and teachers including their dependants. The operation is similar to other company-based health insurance.

²⁵ On average, employers in the society-managed paid around 55 percent of the total contributions and employees paid 45 percent. Big companies often pay more than half of total contribution and sometimes up to 80 percent of the contribution.

tem for the calculation of subscribers' contributions. The insurance premium per household was calculated by the basic premium, the earnings-related insurance premium, and the assets-related insurance premium, similar to the Korean case.

Source \ Year		1955	1965	1975	1985	1995	2005
Tax	Total	15.9	25.9	33.5	33.4	31.7	36.4
	Central government	11.6	22.1	28.9	26.2	24.2	25.1
	Local governments	4.2	3.9	4.6	6.8	7.5	11.4
Premium		45.5	53.2	53.5	54.3	56.4	49.2
Patients' co-payment		38.7	20.6	13.0	12.3	11.9	14.4

Table 5.2 Financial source of national health spending (%), 1955–2005

Source: Tatara and Okamoto, 2009, 61

Secondly, as shown in Table 5.2, over one third of the national health spending came from general tax. It was fairly higher than other Bismarckian healthcare states in Europe. While providing only limited subsidy for administrative expenses to the SMHI schemes (Fukawa, 2002, 5), the government provided 796 billion yen for GMHI, which counted for 13 percent of its total costs, and provided 3,192 billion yen for the CHI schemes in 2005.

The CHI members' capability to pay contribution was limited with absence of employer. The central and local governments paid around half of the total costs in CHI plans. Municipal governments which were responsible for managing their municipal health plans allocated significant extra funds to cover deficits in the CHI funds (Tatara and Okamoto, 2009, 38).

Lastly, the proportion of health care cost borne by patients was lower than other financial sources. Users were supposed to pay small parts of money for health service from their pockets, ranging between 10 and 30 percent of co-payments, depending on age and health insurance programmes.

There were special mechanisms of risk pooling and redistribution of financial resources in the Japanese health insurance system. The fragmented health insurance system chronically suffered fiscal crisis due to the discrepancy of the elderly enrol-

ment between residence-based and employment-based health insurance schemes. To cope with the rising health care costs and unequal burden for the elderly, the risk-adjustment mechanisms²⁶ that transferred revenues from employment-based schemes to municipal health schemes were created in the early 1980s. In 2005, the SMHI programme paid 1.2 trillion yen for the elderly health programme, which accounted for about 30 percent of its premium revenue.

Benefit coverage

The health insurance system in Japan offered comprehensive and universal coverage and the benefits packages were strongly controlled by the government (Tatara and Okamoto, 2009, 56). Benefits packages covered outpatient cost, prescription drugs, dental care, and hospital stay. While they were roughly identical across various health insurance schemes, company-based plans provided favourable extra benefits for their members (Fukawa, 2002, 6).

Patients paid directly out-of-pocket for some portion of their health care. The enrollees in the employment-based health plans paid 10 percent co-payment for medical care while their dependents paid 30 percent for outpatient care and 20 percent for inpatient care in the mid-1990s. The enrollees in the CHI plans paid 30 percent co-payment. The old who joined the elderly health programme paid 10 percent in general.

There has been a ceiling for the out-of-pocket cost since 1973. Because the medical costs of serious illness or injury sometimes could far exceed an individual's saving, the government set up the maximum out-of-pocket ceiling of medical costs. If the amount of out-of-pocket payment was larger than the ceiling, a patient could pay back the gap from one's insurance fund.

Provider and reimbursement

In general, the Japanese health insurance system paid both physicians and hos-

²⁶ The risk-adjustment mechanism in the social insurance system refers to compensating for differences in risk profiles between various funds by shuffling financial resource between different health plans based on unequal distribution of high risk groups in health insurance schemes (Schut and van Doorslaer, 1999).

pitals on a fee-for-service (FFS). The fee schedule played a crucial role in the delivery and finance of the health insurance system. It was one of the most important policy tools in health care policy. This was because it not only determined the doctors' incomes but also shaped the incentive structure of whole health care industry through price setting. To operate the FFS payment method under the public health insurance system, the government offered the official table for medical fee points. The fee schedule in Japan revised every two years. The Central Social Insurance Medical Council including providers, insurers, and consumers was involved in this process. In practice, a negotiation between the Japan Medical Association (JMA) and the government was the most important factor to determine national fee level (Ikegami and Campbell, 1999, 63). All covered medical services were paid by third parties, health insurance schemes. After providers claimed their medical services, these schemes were supposed to review these claims and paid back to physicians. Since the screening process was quite technical, special bodies were in charge of the reimbursement process on behalf of individual health societies.

Regulation and decision-making

Health insurance societies in Japan have been subject to strict regulations by the government. In the Japanese system, consumers had no right to choose their health insurer and insurance schemes could not choose their consumers. Enrolment in the public health insurance programmes was mandatory and whole population was registered in one specific insurance society according to their employment status or residence (Imai, 2002, 5). In this regard, there was no competition among health insurance schemes for the attraction of consumers. Instead, the health system in Japan allowed consumers' freedom to choose medical providers.

At the individual health society level, there were strict rules on decision making.²⁷ There were two main bodies of decision making at company-based health insurance society level; the Society Committee and the Board of Directors (Kenporen, 2014, 15). The Society Committee was the place to make important decisions on budget, rule changes and annual business plans. Employers would nominate their

²⁷ This part is written on the basis of the interview with one executive of a company-based health society and one official in a municipal health society.

appointed members of the society committee and employees (the insured) would elect their committee members. The management and the insured would have the same number of committee members. The board of directors would be in charge of executing the operation of its health insurance scheme. The board of directors would be made up of directors representing business and workers. The managers would nominate the appointed directors among its committee members and the insured would elect their directors among their committee members.²⁸ Besides two committees, there would be audits members to oversee a health insurance society. The health insurance scheme's assets would be kept apart from the corporation's and could be used only for the health insurance scheme (Interview with an Executive of a Company Health Insurance Society, Tokyo, December 2014). Previously, some of the health societies invested their reserved funds into risky assets. However, the Ministry of Health and Welfare began to regulate the risky investment. Recently, most of the company-based health societies invest their reserves into low risk assets such as central and local government bonds (Interview with an Executive of a Company Health Insurance Society, Tokyo, December 2014).

In the CHI schemes, there would be several institutional arenas for citizens to take part in their health societies. The "operation council" would be an advisory institution in a municipal health insurance scheme. This council would decide the contribution rate, contribution levy method, and the scope of benefits. The operation council of the Kunitachi City²⁹ health insurance society I interviewed was composed of the 14 representatives: four representatives of subscribers, four representatives of providers (including pharmacists), four representatives of public interests, and two representatives of company-based insurance schemes in its jurisdiction (Interview with a public officer in Municipal Health Insurance Division of Kunitachi City, Tokyo, January 2015). When a CHI health scheme attempts to initiate significant changes on its rules, it often opened the public hearings on these issues. The citizens were able to participate in public hearings. Moreover, the municipal council monitored its health insurance society on the budget and business plans.

²⁸ The company health society I interviewed was made up of 259 thousand members in 2014. There were 46 members in society committee and equally allocated for the business and labour (Interview with an Executive of a Company Health Insurance Society, Tokyo, Dec 2014).

²⁹ It is a city located in the western part of the Tokyo metropolitan area.

5.3 Major problems in the health insurance system

The Japanese health insurance system was challenged by several problems. The main problem was a sharp rise in health care costs. In addition, the weak gate-keeping function and fee-for-service reimburse method resulted in more frequent visiting outpatient clinic and longer stay in hospital. Too much fragmented health insurance system led municipal health insurance schemes to record chronic budget deficits, too.

Cost explosion and aging population

There was an increasing concern on how to control health expenditures in a sustainable manner. As shown in Figure 5.1, since the early 1970s, the health spending in Japan had dramatically increased. The national health expenditures had skyrocketed from 2.5 trillion yen in 1970 to 11 trillion yen in 1979. The concern over increasing health care costs was burgeoning in the mid-1990s, as Japan entered into long economic recession. The pace of the rise in the national health care spending was faster than that that of the GDP. For example, from 1990 to 2001, Japan's health spending had grown at 3.8 percent while overall GDP growth was just 2.3 percent (OECD, 2003).

Some institutional features of the Japanese health care system were responsible for the steep rise in the health expenditures. Firstly, a fairly generous elderly health care programme caused excessive use of medical services, as mentioned above. Secondly, the Japan's primary care system contributed to the cost explosion due to its weak gate-keeping function. This system guaranteed access to treatment at higher specialist medical institutions. A patient was able to go directly to highly specialised hospital without primary care physician's referral although they were supposed to pay more than usual fee (Tatara and Okamoto, 2009, 42). This feature led to more visits to specialists in Japan. Thirdly, the Japanese health care system mainly used a fee-for-service system in a wide range of medical services while other OECD countries widely introduced the package reimbursement system. It is often said that the fee-for-service system tends to increase the health spending since it gives providers an incentive to provide more services.

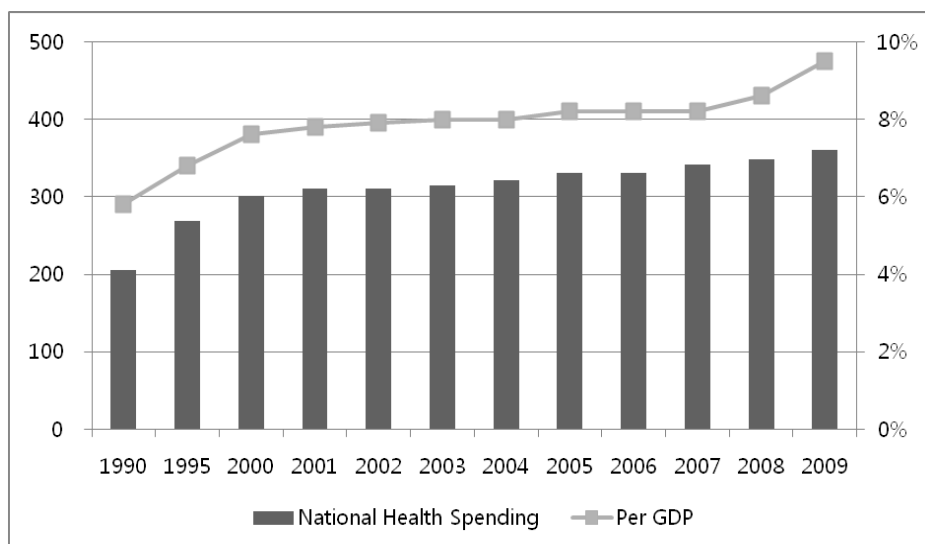


Figure 5.1 The trend of the national health expenditure per GDP in Japan, 1990-2009³⁰

Source: MHLW 2013

Unit: Trillion Yen, %

As shown in Table 5.3, in outpatient care, patients in Japan tended to more frequently visit doctors than other countries. The number of consultations per capita per year was more than twice the OECD average in 1998 (Jeong and Hurst, 2001, 30). Moreover, the average length of stay in hospitals was about four times more than the OECD average in 1998, which was the longest record among the OECD countries (Jones, 2009, 12). When it comes to drug consumption, Japan showed the third highest consumption level. In addition, Japan ranked high on most of the indicators as shown in Table 5.4. One million people accessed the MRI around 40 times and used the CT scanners around 90 times in 2005, which was the most frequent access among the OECD countries.

The trend was also closely related with an aging population in Japan. This is because the elderly tend to spend much more health expenditures than others. For example, those aged 85 or over in Japan were 957,000 yen per person in 2007 while the age group 15 to 19 spent only 57,000 yen per person as shown in Figure 5.2

³⁰ The ‘national health spending’ is larger than as total health expenditure calculated by the OECD. The indicator of the OECD excludes maternity, childbirth expenses, preventative medical care, and non-prescription drugs (Imai, 2002). However, the Japanese government prefers to publish documents based on the ‘national health spending’ since it is better to show the total health expenditures including health insurance costs.

(Reich et al, 2011, 1110). With a plummeting birth rate and the long life expectancy, Japan's population was aging faster than that of other developed nations. According to the OECD health care data (OECD, 2010), Japan's life expectancy had increased from 76.1 year in 1980 to 83 year in 2010. The proportion of people aged 65 years or over in Japan had nearly doubled in the past two decades, growing from 9.1 percent in 1980 to 17.3 percent in 2000.

	Japan	OECD average
Number of doctor consultations	16	6.6
Average length of stay in acute care beds	31.5	8.2
Drug expenditures	301	259

Table 5.3 Estimates of the volume of health care in 1998

Source: Jeong and Hurst, 2001, 40-45

Unit: per capita, day, per capita US\$ in PPP's

Note: For several countries data are for either 1996 or 1997

	MRIs	CT Scanners	Lithotripters
Japan	40.1	92.6	7.1
Germany	7.1	16.2	3.7
Canada	5.7	11.5	0.5
OECD average	9.5	21.5	2.9

Table 5.4 Access to medical technology in the Japan and OECD in 2005

Unit: times per million populations

Source: OECD, 2008

In addition, the demographics change in Japan stressed the health care financing system that relied on payroll taxes. Consequently, the proportion of the elderly compared to working generation has sharply increased. There is the index of "old age support rate", which refers to how many people in working generation support one elderly. It is measured by the ratio of the population who are more likely to be economically active - aged 20 to 64 - to older people who are more likely to be economically inactive - aged 65 or over (OECD, 2011). While ten working generation peo-

ple supported one elderly in 1950, as shown in Figure 5.3, only 3.6 people in working generation supported one elderly in 2000. Because the capability of working generation to support the elderly was quite limited, an aging population posed a serious threat to the whole Japanese welfare system.

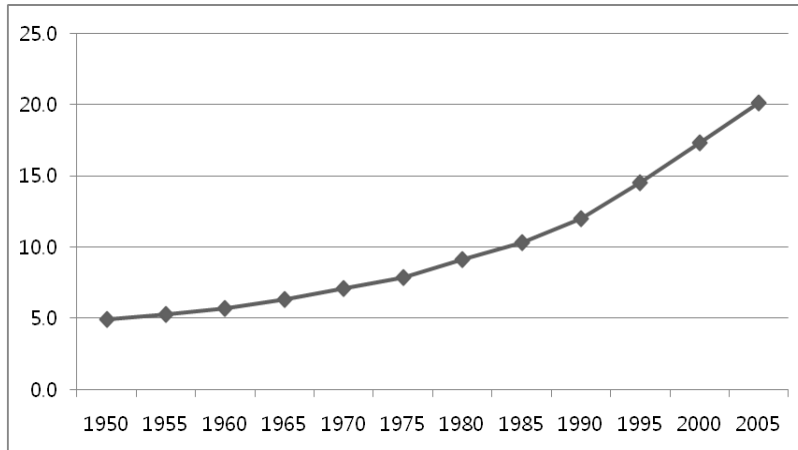


Figure 5.2 The trend of an ageing population in Japan*

Unit: %

Source: MHLW, 2008

Note: It refers to the proportion of people aged 65 or over among total population

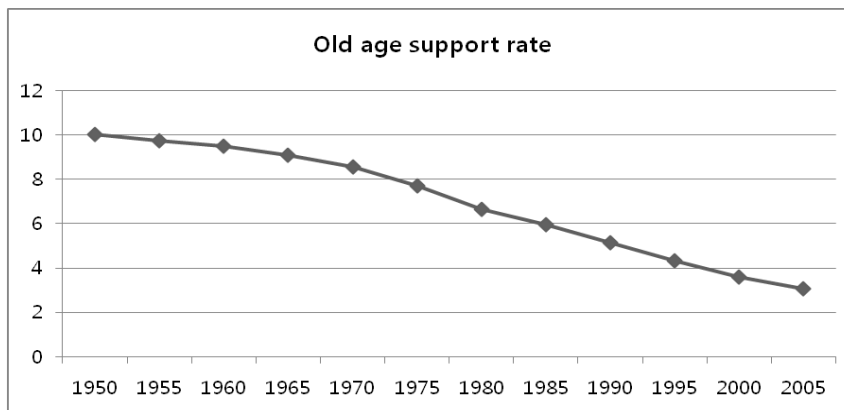


Figure 5.3 The old age support rate in Japan, 1950-2005

Unit: people

Source: OECD, 2011

Note: The old age support rate refers to number of people of working age (20-64) per person of pension age (65+)

Financial crisis in the Citizen Health Insurance (CHI)

Increasing cost pressures were evident in the fact that about two-thirds of the municipal health insurance societies suffered losses in 1996 as shown in Figure 5.4. The cost explosion in health care expenditures led to the financial problem in municipal health insurance societies, which were much more vulnerable health programme than the others. In order to make up the deficits in these societies, around 331 billion yen was transferred from the general account of local governments into local health plans in 1998 and around 387 billion yen in 2003.

There were some structural problems in municipal health insurance schemes. Firstly, its financial condition had been threatened by aging structure. The proportion of the elderly in the CHI was much higher than employment-based health plans. The total insured in the programme was 51.6 million in 2004 and there were 20.7 million aged 65 years or over among them, which was 40.1 percent of the total insured (MHLW, 2006). The SMHI schemes consisted of only 3.9 percent of those aged 65 years or over. These aged 75 and over accounted for only 0.2% in the SMHI plans. The average age of insured persons in the CHI schemes was 53.7 year olds while that of SMHI schemes was 34.2 year olds in 2004. Higher proportion of the elderly in the CHI schemes led to higher health spending per person in these schemes. While 3.2 young people supported an old person in overall health insurance programmes in 2004, only 1.2 young people in municipal health insurance supported an old person (MHLW, 2006). Figure 5.4 shows the proportion of the CHI members among the whole Japanese population by age groups. While one in four was the CHI member among those aged 20s-50s, three in four were the CHI member among those aged 65 or over.

Moreover, the CHI plans suffered their small revenues. As the proportion of the unemployed and low-income in these plans had risen, the CHI plans were on the verge of the collapse. It was related to the shift of industrial structure. While two-fifths in the CHI schemes worked for farming and fishery in 1965, these industries made up only 5 percent in 2002 as shown in Table 5.5 (MHLW, 2003). Instead, the number of households with no job has sharply increased. The half head of the households in these schemes had no job in 2002.

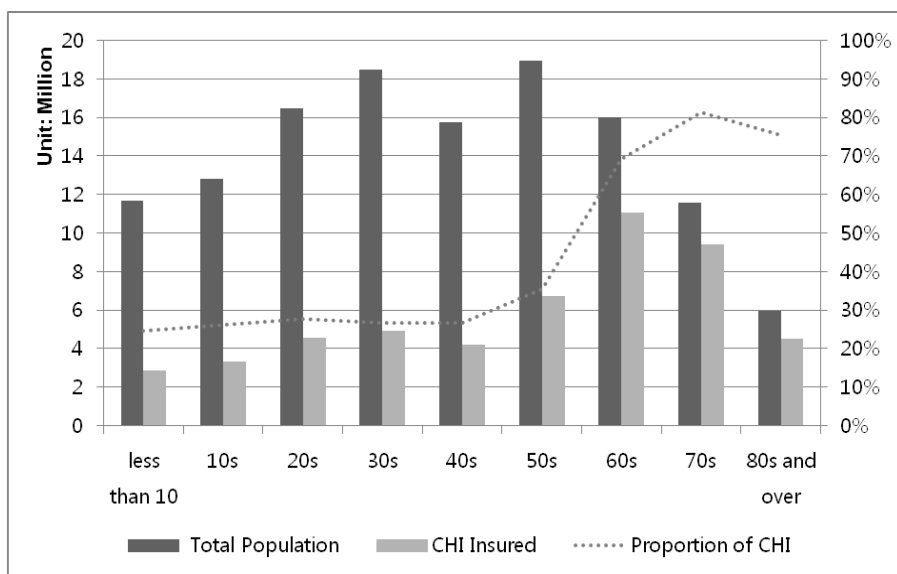


Figure 5.4 The number and proportion of the CHI members by age groups in 2004

Source: MHLW, 2006

	Number of municipal insurers	Insurers in red	Proportion in red (%)
1996	3,249	2,117	65%
1997	3,249	1,543	47%
1998	3,249	1,817	56%
1999	3,245	1,967	61%
2000	3,242	1,722	53%
2001	3,235	2,012	62%
2003	3,144	2,289	73%

Table 5.5 The proportion of municipal insurers in red, 1996-2001

Source: MWHL, 2003

Note: Municipal insurers mean the CHI schemes excluding special craftsmen's health insurance schemes.

Moreover, one quarter of households earned income below the taxation threshold (MHLW, 2003). This change led to the dramatic decrease in members' average income in the CHI schemes, as shown in Table 5.6. While the average income of household in these schemes was 1.975 million yen in 1998, it was 1.65 million yen in 2004. The members' average income in these schemes - 1.8 million yen - is less

than half that of employment-based health plans - 3.8 million yen in 2004. This change undermined the financial base of the municipal health insurance programme.

Year		1965	1983	2002
Head of household occupation	Farming· Fishery	42.1	13.6	4.9
	No job	9.4	23.7*	51.0
Proportion of no income household		-	15.1	26.6
Proportion of the elderly*		5.0	11.7	26.6
Proportion of small insurer with less than 3,000 members		10.0	25.7	34.7
Collection rate (%)				90.4

Table 5.6 The structural change of the Citizen Health Insurance

Source: Shimazaki, 2005, 20

Unit: %

Note: The elderly means over 70 in 1965 and then those who obtain the subsidy based on the elderly health programme in 1983 and 2002.

In this regard, premium revenue was decreasing even though premium rate increased. Average premium rate had increased from 6.68 percent in 1995 to 8.63 percent in 2004. However, the premium revenue had decreased from 154,000 yen in 1995 to 142,000 yen in 2004. This was because the average income of insured persons in the CHI had much sharply decreased than rise in premium rate. These schemes also encountered the problem in collecting contributions. While they collected about 96 percent of total expected premiums in 1974, they did only 90 percent in 2004 (MHLW, 2009).

Lastly, the small size of insurance societies made the crisis more serious. For example, 35 percent of these schemes had less than 3,000 members in 2002 while only 10 percent had less than 3,000 members in 1965. It is important for insurers to adequately gauge the hazards of a risk. Some small health societies had a serious fiscal problem because it failed to diffuse risks. It also caused the inefficient administration of the health insurance societies. Small health societies put more proportion of money into administration fee than those in larger size.

Inherent inequality in the health insurance system

Although the Japanese health insurance system showed the strong equity, there were some factors that contained the inequality between different health insurance schemes. Firstly, the co-payment rate was different depending on the health insurance scheme to which people belonged. While those who were covered by employees' health plans only paid 10 percent of co-payment, the insured persons covered by Citizen Health Insurance had to pay 30 percent of co-payment. Although the scope of official benefits was the same across different programmes, company-based health plans provided favourable extra benefits compared to municipal health insurance schemes.

Secondly, the payment of health insurance system was regressive. The insured in company-based health insurance scheme made higher income than those in municipal health insurance schemes. However, subscribers of municipal health insurance programme paid 8.3 percent of their income as insurance fee while those of company-based health insurance programme only paid 3.3 percent, as shown in Table 5.7.

	CHI	SMHI	GMHI
Average age of insured (year old)	53.7	40.9	43.1
Proportion of over 65-year-old (%)	40.1	3.9	8.0
Average income of insured (thousand yen)	1,650	5,462	3,832
Average real premium rate (%)	8.63	3.34	4.10

Table 5.7 The comparison of different health insurance programmes in 2004

Source: MHLW, 2004

Unit: thousand yen

5.4 Major actors related to the health insurance system

This sub-section analyses the roles of main actors related to the health insurance system in Japan. It also examines the institutional framework of health care policy making processes. It is often said that the health care policy in Japan has been mainly

determined by the negotiations between the government and medical professionals. However, other important actors were also deeply involved in the maintenance and operation of the health insurance system. These main actors included bureaucrats, medical providers, business, labour unions, local governments, and associations of health insurance societies.

Bureaucrats

The Ministry of Health, Labour, and Welfare (MHLW) became the primary governmental body in charge of the health policy in Japan, as a result of the merger between the Ministry of Health and Welfare (MHW) and the Ministry of Labour in 2001. The MHW was originally built up in 1938 in response to the need for healthy soldiers and workers, and it had played a key role in shaping the Japanese health care system since then. The MHW inclined to take full control of health care policy based on the concept of public health paradigm, an ideal of good health care across all the population by the public bodies (Campbell and Ikegami, 1998, 27). During the Second World War, the government took almost entire initiatives for health care policy in hands. This practice left important policy legacies in the Japanese health care policy and the health insurance system was regarded as a crucial tool to achieve this goal (Ikegami and Campbell, 2004, 32). There had been a long sharp conflict between the MHW and the doctors' associations. Welfare bureaucrats were in an effort to hold down the rise in medical service fee. In the 1980s, "the project for stabilisation of health cost" was launched by the ministry. It was a crucial turning point to take an initiative in health care policy against the doctors' associations (Yuki, 2004, 39). They had complicated incentives on the integration of all health funds. On the one hand, it could reduce the administration fee and enhance the equity. On the other hand, it could make the whole health insurance system less efficient.

Bureaucrats in the Ministry of Finance (MOF) affected health care policies by controlling the national budget. In addition, the Council on Economic and Fiscal Policy and the Regulation Reform Council had a significant power to propose policies at macro level (Tatara and Okamoto, 2009, 35). Firstly, economic bureaucrats pursued cost containment measures in health care policy. They were concerned about the financial integrity in Japan. They called for increasing co-payment to curb the national

health spending and the introduction of target for financial limits for health insurance expenditure.³¹ For cost containment, on the one hand, they occasionally fought against welfare bureaucrats who were reluctant to take these measures. On the other hand, they backed up welfare bureaucrats in their struggle against medical profession with regard to the level of the medical fee schedule. Secondly, economic bureaucrats attempted to lessen the scope of governmental involvement in health care policy. They sought to get rid of rigid regulations in healthcare service such as “mixed treatment”³² and the ban on investor-owned hospitals (Ikegami and Campbell, 2004, 32). Lastly, economic bureaucrats preferred to the fragmented health insurance system rather than the integrated system. They supported to strengthen the competition among insurers in a fragmented system like the Dutch and German health insurance system. In this regard, they were opposed to a merger between employment-based and residence-based health plans, which would get away with the competition between health insurance schemes.

Political parties

It is often said that political parties in Japan, including the LDP, are reactive actors in health care policy. Health reforms driven by the party leadership were often frustrated by particular interest groups. The policy making process in the LDP left little room for the prime minister's initiatives in health care policy (Leduc and Leduc, 2003). Before the 2000s, party leaders' political support was vacillating between bureaucrats and medical providers and usually failed to take an initiative in health care reforms. There were some reasons why political parties, especially the long ruling party, left the health policy in control of bureaucrats and medical providers.

First, the LDP had a strong connection with medical providers' associations for the sake of campaign contributions. The Japanese Medical Association (JMA) was a key constituency for the party (Campbell and Ikegami, 1998, 32). They provided substantial campaign funds for the party. For instance, the JMA donated around 305

³¹ If the total cost of health spending exceeded the target, the fee schedule would be automatically decreased next year.

³² “Mixed medical care” refers to the provision of uninsured and insured medical services at the same time. In principle, the mixed treatment of uninsured and insured service could not be covered by public health insurance.

million yen to the LDP in 1998 (Leduc, 2002, 68). The organisation was also a crucial source of votes by mobilising votes for the party at the local level.

Second, the decision-making process in the LDP had allowed particularistic interest groups to have significant influences on policy decisions (Krauss and Pekkanen, 2010). All proposed legislations and policies adopted by the party should be examined and approved by the Policy Affairs Research Council (PARC) in the party and then send it to Cabinet and Diet (Martin and Stronach, 1992, 244–47). The PARC was divided into several sections and the “Social Affairs Division” and the “Medical Care Committee” deal with health policy. This Committee was usually dominated by policy tribes who acquired expertise in specific areas, so-called “*zoku*” politicians. In the health policy, the welfare-related group of Diet members had been closely linked to the medical associations, highly influencing the decision making in the PARC. The Committee in the LDP was used to defend the interests of medical professionals.

On the health insurance governance, the LDP was opposed to the integration reform. They were worried about the moral hazard from the single-payer system. They claimed the proposal would reduce the efficiency of the health insurance system. While an individual insurer would do its utmost to control medical costs under the multiple insurer system, it would be not easy for a single insurer to control medical costs. Instead, they supported the creation of a new health insurance programme for the elderly. They claimed that such a programme would be helpful to curb the health care spending.

Medical providers

The associations of medical providers in Japan had long been involved in health policy. There were several medical associations but the Japanese Medical Association (JMA) had a pivotal role in health policy making (Mano, 2012; Somae, 2012; Yūki, 2004). It was founded in 1916 based on private primary care sector and re-established in 1947. The core interest of medical profession was its reward for their work and professional autonomy. The association was successful in prompting and protecting its interests based on substantial resources.

They had a strong organisational power on the basis of high density. While 60

percent of doctors joined the JMA on average, most of the private-practice physicians joined this association (JMA, 2010). Since their organisational power was strong, the consent from the JMA was fairly crucial to operate the public health insurance system. For example, in February 1961, at the eve of launching the universal health insurance system, physicians took a strike action calling for increasing fee level and in September they announced to withdraw from the health insurance system (JMA, 1997, 77). In addition, they had created strong connections with the ruling party, as explained above.

With regard to the health insurance system, the priority of this organisation was reimbursement such as fee level and payment methods (Somae, 2012, 126). In this issue, they made confrontation with the government which attempted to save the health care expenditures. They also exerted their power to block the introduction of the comprehensive payment system. Secondly, physicians advocated the autonomy of medical profession, which was often threatened by the government. The government sought to interfere with physicians through standard guideline of healthcare. However, physicians requested the right to choose the best treatment themselves based on high ethical standards and professional skills. Thirdly, physicians favoured generous health service covered by massive subsidies (Somae, 2012, 126). When the government sought to grapple with cost containment in health care, physicians were against this measure. If the public health insurance system reduced its scope of coverage or increased co-payment for patients, people would reduce the visit of medical institutes. Later, the physicians proposed the tax-based independent ‘medical care scheme for the senior elderly’, which would be financed by general tax.

However, the medical profession in Japan was not much interested in the reforms of health insurance governance. Although the JMA was in favour of the health insurance integration in the 1980s under the president Takemi’s leadership (Arioka, 1997), this organisation was not dedicated to changing the health insurance governance (Jeong and Niki, 2012; Yoshihara and Wada, 2008). This was because it did not directly affect physicians’ income and working conditions.

Business

The Japan Federation of Economic Organizations (*Keidanren*) and Japan Federation of Employers' Associations (*Nikkeiren*) had been involved in the health care policy.³³ The business groups in Japan were worried about the increase of health cost. The burden of contributions for the elderly coupled with long-term care insurance payments placed the employment-based health insurance societies under financial pressure. The increase in health insurance premiums would result in the hike in labour cost and the loss of competitiveness in international market. Instead, they had an incentive to support the measures to control health care expenditures and the transition into tax-based system. Later, business suggested it seemed more appropriate that government would finance health expenditure through consumption taxation rather than payroll taxes.

In addition to the control of health care expenditure, business groups had strong incentives to resist the consolidation of all health insurance funds. The integration reform means pooling high risk group with low risk group, financially healthy funds with deficit-ridden funds, and the wealthier with the poorer. If company-based health insurance societies were integrated with municipal health funds, business would pay extra finance for other health insurance societies as a sort of cross-subsidy. Moreover, company-based health funds could be used as a tool to provide their employees with exclusive benefits.

Trade unions

The Japanese Trade Union Confederation (*Rengō*) had been involved in the health care policy. Trade unions had strong incentives to be opposed to the integration reform. There were some reasons why labour supported the fragmented health insurance system in Japan. Firstly, the prevailing system provided an economic advantage for members in employment-based health schemes. In practice, most large firms paid more than half of employees' premiums, around 60 percent on average as shown in Table 5.8. Furthermore, the company-based health schemes provided more generous benefits than other health schemes. In the mid-1990s, society-managed

³³ In 2002, *Keidanren* and *Nikkeiren* merged into the Japan Business Federation (*Keidanren*).

health insurance schemes (SMHI) provided the health care benefits with only 10 per cent of co-payment while municipal health plans with 30 percent.

If all health insurance schemes were integrated into a single health insurance scheme, high income workers' premiums would significantly increase and health care benefits for them would be cut. It was expected that the enlargement of the risk-adjustment programme put additional burden on the SMHI programme, which was 0.3 trillion yen in total and 110,000 yen per person (Asahi Shimbun, 2002a).

	employer	employee	total
NEC Health Insurance society	4.2%	2.8%	7%
Kawasaki Steel Health Insurance society	5.6%	3.2%	8.8%

Table 5.8 The rate of premiums shared between employer and employee in 1990

Source: Graig, 1999, 102-3

Secondly, the prevailing system strengthened labour's influence on healthcare policy through the co-administration of company-level health insurance schemes. It is often said that the labour in corporatism occupies an important governance role on the social insurance side of business, which is commonly the case in Continental Europe (Giaimo, 2002). For example, in Germany, the sickness funds managed by both unions and employers allow organised labour and capital a voice in the health care administration (Manow, 1997). Under this system, organised labour could play two roles as payer and insurer. As major financial contributors, the employees would pay a substantial proportion of the premium revenues in the public health insurance system. At the same time, they occupy the role as insurers, which means that they are directly involved in the administration of health insurance schemes at company level. Combining these two roles gave labour greater leverage in the health care policy.

Local governments

In Japan, a local government has a considerable fiscal responsibility to its municipal health plan. Faced with post-war chaos, the 1948 revision of National Health Insurance Act stipulate that a municipal government would directly operate its local

health insurance programme. The role of local governments on health policy had become increasingly important in providing and organising health care and social services. However, they had difficulty due to on-going deficits in their municipal health insurance schemes. In this regard, the municipal governments had strong incentives to support the integration of the health insurance system. If all health funds were merged, it was more likely that the health insurance system would be controlled by the central government or an independent administrative body.

5.5 Conclusion

This chapter has analysed the background of the health insurance reform in Japan. The first section has provided a systematic analysis of the origins and evolution of Japanese health insurance system from the 1920s through the late 1990s, along with subsequent policy initiatives. The following section has provided an analysis of the health insurance system in terms of organisation, finance, benefits, and regulations.

The third section has examined why the reform of the health insurance system emerged as a critical issue in welfare policy. The upward trend of health spending exacerbated by demographic change pressured the Japanese economy. Moreover, there was a serious gap between company-based insurance and self-employed insurance. The health insurances for the unemployed, the self-employed and so on covered older and poorer people compared to employed-based health insurance plans. The municipal health insurance funds and local government had struggled to tackle their fiscal problems.

The last section has analysed the position of main actors in the health care reform drawing on the institutional arrangements and incentive structures. Faced with the critical challenges in the health insurance system, political actors who were involved in health policy had totally different opinions. On the one side, the local governments and municipal health insurance schemes had incentives to support the integration of various health plans into a single body, arguing the fiscal problem in municipal health insurance schemes could be solved only by this reform. On the other side, business, labour, and company-based health insurance schemes had incentives

to support the status quo in the health insurance system, worrying that they would bear more costs for other groups after the integration reform.

Chapter 6 The political dynamics of health insurance reform in South Korea

This chapter analyses the political dynamics behind the health insurance reform in South Korea between the late 1980s and the early 2000s. South Korea integrated its multiple health insurers into a single national health insurance between 2000 and 2003. The first section examines the unsuccessful reform trial in the late 1980s. In 1989, Korea achieved a universal health insurance system but one which was divided by workplaces and regions. Farmers protested that their health insurance system was unequal and ill-managed. An integration bill on the health insurance system was passed in the National Assembly, which was led by liberal opposition parties. However, President exerted his veto power to scrap the merger reform. Absence of labour in a coalition for the health care reform contributed to its failure. The second section explains the process of coalition formation for the health insurance reform. Frustrated by failed militant strategies, labour sought to change its identity and orientation towards embracing social reforms and other progressive issues. The farmers, labour, and civic movement groups organised the “Coalition for the Integration of the NHI”, a crucial organisation for the health insurance reform. The broader coalition led to the partial integration reform between the health insurance societies for public officers and the self-employed on the eve of the 1997 presidential election. The third section explains how the reformers achieved the full-scale health insurance merger under the Kim Dae-jung administration. This section provides an analysis on how solidarity between farmers and labour and new president’s strong leadership overcame the persistent obstruction by a conservative party and its followers.

6.1 Reform attempt after democratisation between 1987 and 1989

This section explains why the trial of health insurance reform led by opposition parties, farmers, and progressive civil movement ended up with failure in 1989. In 1988, the Korean health insurance system extended its coverage into rural residents under the fragmented system. However, the Korean health insurance system had the defects of inequality and inefficiency, as mentioned in Chapter 4. The organisational

differentiation of health insurance societies along labour market status produced serious inequalities among the insured persons since the municipal health funds in Korea covered a disproportionate share of poorer and sicker segment of the population. The rural population were frustrated by not only unequal but also poorly-managed health insurance system. They organised themselves in defence of equal right of social protection.

6.1.1. Passage of reform bill in the National Assembly

An emerging idea for the integration reform

In response to the serious fiscal problem in the municipal health societies, some called for the integration of all health insurance schemes. Initially, the idea of integrating all health insurance funds had been raised by some of the high officials in the Ministry of Health and Social Affairs (MOHSA) in the early 1980s. They argued that it would enhance the efficiency of the health insurance system by streamlining its managerial bodies (Won, 2006, 162). Although Minister Chun Meoyng-gi was in support of this idea, President Chun Doo-whan did not approve of the proposal, worrying about a heightened political responsibility for the health insurance system after the integration reform. The dispute on the integration reform ended up dismissing the high-level bureaucrats in the MOHSA who were in favour of the reform in 1983. After that event, the integration idea had lost the political base inside the government and bureaucrats moved to lean towards the fragmented system.

The second debate on the merger reform was mainly triggered by the government's announcement of the universal health care in the 1986. When the government released the plan on the extension of health insurance coverage into the self-employed, it did not have a clear idea on financing this new programme (Yu and Anderson, 1992, 295). Some scholars claimed the integration of all health insurance schemes could effectively finance the universal health insurance through the mechanism of internal transfers from the wealthy and healthy section to the poor and unhealthy section of population (Won, 2006, 167).

Mobilisation of frustrated farmers

When the health insurance schemes for the self-employed in rural areas began in 1988, it turned out that the rural population was frustrated by not only unequal but also poorly-managed health insurance system. When farmers received the first bill for their insurance contributions in January 1988, they began to organise the protests against high contributions. They returned the bill to their health insurance associations and refused to pay contributions as means of protests. In addition, they signed the petition calling to redress the major problems in their health insurance schemes. The outcry over poorly-managed health insurance programme sparked the community-wide protests, so called “Health Insurance Rectification Movement”. The protests on the health insurance reform in rural areas began in Gui-San, Chung-Nam Province and quickly spread across the nation. The number and intensity of collective actions in local areas were proportional to the organisational power of local farmers’ associations to a large extent (Kyŏngnyang Shinmun, 1988). The Rectification Movement became a main vehicle for farmers and protesters to attempt to raise the political awareness of healthcare issues among mass public.

The fact that farmers successfully mobilised in the health insurance reform could be explained by the gap between farmers’ expectation and reality. The gap between the idea of social welfare and institutional incapability in Korea led to farmers’ mobilisation as Lieberman (2002) mentions institutional changes come from the friction between institutional capacities and ideational patterns. Institutions themselves are not neutral structures of incentives but, rather, the carriers of specific ideas (Rothstein, 2005; Schmidt, 2010). Before the introduction of the health insurance programme for the self-employed and farmers, the certificate of public health insurance was conceived as a symbol of the privilege for public officers and employees in large corporations. The population had the idea that the health care benefits were their exclusive rewards based on their social status. The introduction of a universal health insurance system, however, had changed the public attitudes and ideas on healthcare by bringing the idea of social inclusion and governmental responsibility for healthcare in the Korean society. They realised that all citizens were entitled to acquire the basic right of healthcare. The ideational shift generated a high level of political awareness of inequality among different health insurance programmes. As mentioned in Chapter 4, there were some critical problems to sustain the municipal

health insurance programme. The ideas and discourses carried by the universalisation of healthcare had made frictions with its poor institutional capacity to achieve its ideal goal.

Mobilisation of civil society

After well-organised farmers took lead in protests, progressive civil movements were joined to achieve health insurance reforms. There were progressive civil movement groups in South Korea as a legacy of the democratisation movement and they pointed out serious defects in the health insurance system. There was inequality between corporate and municipal health insurance plans and civil activists were sympathetic to disadvantaged agrarians. In addition, they criticised the government for not being responsible for municipal health insurance schemes. The two grassroots movements such as farmers and civic associations spontaneously joined forces to fight for better healthcare services. At first, their demands were fairly broad and vague. They called for a rise in subsidy to sustain municipal health insurance schemes, discount on insurance contribution, and the modification of current contribution formula which was disadvantageous to the farmers. In addition, they called for delaying the payment of their contributions until harvest. However, their demands became more directed towards the consolidation of all health schemes. The Catholic Farmers' Council, Christian Farmers' Council, National Farmers' Association, and other 48 organisations built up the "National Committee for Medical Insurance Integration (NCMII)" in June 1988, calling for the integration of all health insurance funds (Han'györe, 1988b). The incorporation of civic associations into the reform coalition provided the rationale for health insurance reform because civic movements had strong connections with several influential progressive academics on healthcare policy.

The supporters for the health insurance reform in Korea tailored their tactics, reflecting the institutional commitments and political possibility. There were several reasons why reformers in the healthcare arena opted for the consolidation of all health funds as their policy alternative. First, there was the low level of institutional and political commitments on the subsidisation for the municipal health insurance societies. While the subsidisation was considered as an option by farmers at first, they had

realised that it would hardly be possible that their health funds could receive massive governmental subsidies. While the government pledged to raise the financial supports for health insurance schemes in rural areas, it did not keep the promise. Since the subsidy for health insurance programmes had a critical problem of commitments, the farmer and civil activists thought the integration of all insurance societies could be a politically feasible and strong commitment to rectify inequality in the health insurance system.

Secondly, the reformers also considered a winning reform coalition on the health insurance reform in political arena. Since their political power was not strong, they needed to appeal to liberal opposition parties. At that time, there was no left-wing party in the National Assembly. Instead, the two liberal opposition parties - the “Party for Peace and Democracy” and “Reunification Democratic Party”- were available political partners to support the health insurance reform. These opposition parties fought against the legacies of the preceding authoritarian regime, identifying themselves as “reformists” in the mainstream political arena. Based on their reformist image and the electorates’ demands to amend the health insurance system, they were deeply involved in the reform. However, these parties as liberals sought to balance the economic growth and the expansion of social welfare. They were reluctant to sharply increase welfare spending, which may slow the growth of the national economy. In this regard, the integration proposal had the crucial advantages compared to other reform ideas. It could enhance the quality of the health insurance system within constrained budget since it would contain the financial transfers between different sections of population. It could also lower the managerial costs of the health insurance schemes by the reduction of overlapping administrative activities. For these reasons, the reformers thought that the integration proposal could obtain the support from the liberal parties.

In the same vein, the reformers ruled out the radical transition towards the National Health Service. There were small groups such as the “Humanitarian Doctors’ Association”, which advocated the tax-based nationalised health care service (Han’györe, 1988c). Nonetheless, most reformers dismissed the proposal for the NHS. In Korea, most of the medical institutes were private and doctors hardly agreed the transition towards this system. In addition, most of the politicians regarded it as a communist idea (Interview with a Deputy Director of Human Resources Department

in National Health Insurance Corporation, Seoul, May 2015). In this regard, the reformers spontaneously ruled out the proposal for the NHS.

Reform bills by liberal opposition parties

The 13th general election in April 1988 gave a big boost to the health insurance reform. The ruling party did not obtain a majority in the National Assembly. The two liberal opposition parties formed a policy alliance for political and social reforms against the legacies of previous authoritarian regimes. The agrarian uprising for health care reforms gave these liberal parties a political opportunity to represent farmers' interests. The civil movement groups drafted their own health insurance reform bill. In September 1988, the "National Committee for Medical Insurance Integration (NCMII)" drafted the new National Medical Security Act which called on the government to introduce the integration of all health schemes (Federation of Korean Medical Insurance Societies, 1997, 521). Two liberal parties also prepared the revision on the Medical Insurance Act reflecting the voice for the integration reform. At the end of 1988, the two opposition parties submitted their own health insurance reform bills respectively, embracing the integration of different health funds. Later, the New Democratic Republic Party, a relatively conservative opposition party, also shifted its position to support the integration reform and these three opposition parties made a single reform bill including the integration of all health funds. In contrast to the bill proposed by the opposition parties, the government made a counter-proposal for the partial merger of 254 municipal health societies into sixteen societies at the greater local government level. The governmental proposal did not tackle company-based health societies and public officers' health society.

The ruling party was opposed to the integration reform but it did not vote against the bill proposed by the opposition parties. The ruling party could not block the bill since the three opposition parties in favour of the reform held majority in the National Assembly (Sin, 2010, 173). Instead, the ruling party attempted to partially revise some clauses such as contracts with medical providers and patients' co-payment in order to reduce additional burdens on the government. In March 1989, the National Assembly passed a bill for the merger of health insurance societies.

Reactions of interest groups

The Federation of Korea Trade Unions (FKTU), which had been co-opted by the authoritarian regimes, expressed the opposition to the integration bill although it admitted the long-term merits of the plan. The organisation said they could accept the bill only when the government would implement two prerequisites (Welfare and Society Committee, 1989, 37). They called for increased governmental subsidy for the public health insurance programme since otherwise the reform may shift the burden to salaried workers. In addition, they called to return the reserves in company-based health funds to workers. This was because the reserves were solely contributed by salaried workers' efforts to save medical expenditures (Welfare and Society Committee, 1989, 39).

The medical providers were in favour of the integration reform and made the petition for it in November 1988. This was because the municipal health insurance schemes were financially weak and thus had difficulty in reimbursing physicians (Sin, 2010, 173). However, it should be noted that medical providers were not committed to the integration reform and their support for the reform was instrumental (Han'györe, 1988a). They did not agree the core ideas conveyed by reformers such as equality and solidarity in health care policy. The physicians regarded the reform as a political opportunity to increase their economic incomes and their professional autonomy. They called for rise in the level of medical fee and freedom to opt out of the public health insurance system.

6.1.2. Coalition without labour

Labour in Korea did not show solidarity with health care reform groups in the late 1980s, which made a sharp contrast with its vigorous mobilisation after the mid-1990s. At that moment, the labour movements reflected more particularistic interests such as working conditions and wages rather than social policies (Mo, 1996; Wong, 2004). To answer the question of why labour did not support the grassroots demands for the better health insurance system, we need to delve into the Korean labour

movement in the late 1980s, which was the era of successful mobilisation by “militant unionism”.³⁴

1987 Great Workers' Struggle and the 1987 Labour System

Democratisation in 1987 opened up a new political arena for labour who were dissatisfied with authoritarian regimes. In the aftermath of the democratic transition, workers massively mobilised themselves during the “1987 Great Workers' Struggle” in July-September of 1987. Outbursts of labour movements occurred when the government relaxed labour control. The 1987 Great Workers' Struggle started in the large factories of export-led industries and soon expanded into other industrial sectors including white collar workers. Workers' revolts were focused on immediate grievances over their salaries and working conditions. There were huge gaps of salary and status between white collar and blue collar workers in the same companies. Moreover, workers had to tolerate the harsh labour discipline in factories unilaterally imposed by managers (Koo, 2001, 64). They also sought to establish their “democratic” trade unions, independent from the previous co-opted ones, to achieve these goals. Faced with workers' uprisings, managers were reluctant to negotiate with workers at first because they did not regard labour as an equal partner for a long time. Instead, managers attempted to disrupt the construction of democratic trade unions in their firms. In response to the suppression, workers mainly relied on the repeated mobilisations such as strike actions and protests in defence of workers' rights.

As shown in Table 6.1, the Great Workers' Struggle in 1987 was, to a large extent, successful in advancing workers' rights and invigorating union organisations. Firstly, they organised more than 3,000 strikes in the period and 1.3 million workers participated in these industrial actions. Secondly, it brought about the creation of new trade unions at 1,131 firms with 363,760 new union members (KLI, 2002, 135). The proportion of organised workers increased from 12.3 in 1986 to 17.8 percent in 1988 (Pae, 2008, 28). Based on the experience of victory during the Great Workers' Struggle, newly emerging trade unions established a loose consultation body of the

³⁴ Kelly (1996) suggests militant unions are defined by a willingness to engage in industrial action and have an ideology of conflicting interests. See Connolly and Darlington 2012 and Murillo 2001.

democratic unions at the national level, National Confederation of Trade Unions (NCTU, *Chunnohyup*) in January 1990. Thirdly, in terms of workers' economic benefits, there was a significant rise in wages. Real wages rose by 7 percent in 1987 while it rose by 5 percent in 1986 (KLI, 2002, 12). Lastly, the Great Workers' Struggle contributed to the construction of "labour class" in Korea. The nascent labour movements in the period boosted workers' confidence, collective identity, and class consciousness (Koo, 2001, 153).

	1986	1987	1988	1989
GDP growth (%)	11.0	11.0	10.5	6.1
Increase of Consumer Price Index (%)	2.8	3.1	7.1	5.7
Real wage Increase (%)	5.3	6.9	7.8	14.6
Union Density (%)	12.3	13.8	17.8	18.6
Labour Disputes (Number)	276	3,749	1,873	1,616

Table 6.1. The index related with labour movement in South Korea, 1986-1989

Source: Pae, 2008, 28

The two events held in 1987 - democratic transition and the Great Workers' Struggle - shaped a new labour system, which is often called "the 1987 labour system" (Yun, 2008, 278-81). First, it was shaped by democratic politics in contrast to the preceding authoritarian system. The government had to discard previous labour policy of state-sponsored unionism. In spite of continuing illiberal labour practices, Korean workers could enjoy legal rights as a citizen. Secondly, however, the 1987 labour system had continued labour exclusion from the official policymaking process. Labour was not invited in policy concertation in governmental councils nor inter-linked to political parties. It meant Korean workers could not enjoy political rights as a collective group. The final characteristic of the 1987 labour system was the containment of labour movements at the enterprise level. Without effective linkage to political parties, trade unions concentrated on the struggle for wage increases. It was not allowed for unions to fight for political issues. The legal and political limitations deterred the labour movements from going beyond the enterprise level.

Labour position on the health insurance reform

Although workers were united for enhancing their political and social influence during the Great Workers' Struggle, most of them were less sympathetic to grass-roots demands for health care reforms (Wong, 2004, 147). Only the employees in the municipal health insurance schemes were aligned with the health reform groups (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). For several reasons, the “democratic union movement” not interested in allying with farmers and progressive civic groups to create the solidaristic health insurance system in the late 1980s. First, the fragmented health insurance system was beneficial for employees in large firms and thus union leaders were not able to find the common interests with the reformers for health insurance consolidation at that time. Second, labour movements were more preoccupied with wages and working conditions. They were eager to organise workers and enhance incomes and working conditions. They thought that struggles for other issues would diminish the power of trade unions and distract workers’ attention (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015; Interview with a Senior Director of Policy Division in the KCTU, Seoul, April 2015). The union movements heavily relied on the mobilisation of union members and bargaining at individual company level.

Component	Militancy
Goals	Ambitious demands with few concessions
Membership resources	Strong reliance on mobilisation of union membership
Institutional resources	Exclusive reliance on collective bargaining
Methods	Frequent threat or use of industrial action
Ideology	Ideology of conflicting interests

Table 6.2 Components of militant strategy in the union movements

Source: Kelly, 1998, 60

Third, Korean labour movements adopted “militant unionism”. Their combative stance is often characterised by the concept of militant unionism, as shown in Table 6.2. Most of the union leaders embraced left-wing ideological opposition against the government and business. They were more preoccupied with radical transformation of the political order rather than gradual social reforms (Interview with a Senior Director of Policy Division in the KCTU, Seoul, April 2015). They regarded industrial relations as zero-sum games between labour and business and thus radical industrial actions were justified by the logic of class struggle. In this regard, the Korean labour movements did not adopt the health insurance reform as their policy goal.

6.1.3 Presidential veto and failed reform

The bill for the integration of the health insurance system in the late 1980s was overridden by President Roh Tae-woo. On 16 March 1989, the Cabinet Council recommended that the President veto the bill on the health insurance merger and he exercised the constitutional power of presidential veto, returning the bill to the National Assembly on 24 March.³⁵ The President mentioned the bill should be re-voted in the National Assembly since it was against constitutional rules. Firstly, it was against the principle of equality since the contribution of the insurers in corporate health insurance would be used for the non-contributors. Secondly, it also violated the property right since the reserves in corporate health insurance schemes had to move to a new insurance body although the reserves were the property of the subscribers in the company-based health societies (Sin, 2004, 116).

In addition to the constitutional rows, there were political reasons behind the presidential veto. First of all, there was a strong lobby to scrap the bill from business (Kwon, 2007, 157; Wong, 2001, 335). Second, most of the workers did not support the integration bill at that moment, as mentioned. The conservative media also repeatedly asserted that the integration reform would increase the burden of employees and it affected the citizens’ attitudes towards the integration reform (Interview with a Deputy Director of Human Resources Department in National Health Insurance Cor-

³⁵ According to the Ninth Amendment of Constitution in Republic of Korea, any bill vetoed by the President is sent back to National Assembly. Unless it gains votes from the two thirds of the members who are present in the same assembly period, the legislation would be aborted.

poration, Seoul, May 2015). Third, most government officials in the Blue House and the MOHSA were opposed to the reform. They thought the integration reform might aggravate a fiscal problem in the public health insurance system and over-politicise health care policies (Wong, 2001, 334).

6.2 Labour, the reshaping of a coalition, and the introduction of a partial reform between 1990 and 1997

This section explains the process of forming a broader coalition for the health insurance reform in South Korea that resulted in the partial integration reform between the health insurance programme for the self-employed and public officers just before the presidential election in 1997. Labour changed its identity and orientation towards embracing social reforms, and the broad coalition sparked fierce debates and mobilised the political campaign for the reform.

6.2.1. Political condition for the redirection of labour

The democratic labour movement in Korea became more sympathetic to the health care issue and willing to build up a broad coalition with civil society in the 1990s. It was remarkable since labour movements could dilute its revolutionary orientation and accept the rise in their insurance contributions. To explain this shift, this sub-section traces back to the failure of militant tactics between the late 1980s and the early 1990s.

The crisis of labour movement

In light of meagre political resources and isolation in public arena, the failure of the General Strike in 1991-2 created a sense of crisis in labour movement. While unions' strike mobilizations were successful in obtaining bargaining gains in the late 1980s, the effectiveness of combative strategy was declining. The trade unions took offensive posture at spring fights in 1990 and 1991, organising the first general strike since the Korean War. However, the government effectively lashed back the general strikes through physical violence and appeal to public opinion. Middle class also

quickly took back their supports on radical labour movements, worrying that militant labour movements could negatively affect the national economy.

After the defeats in the early 1990s, the democratic labour movement did not have sufficient resources to fight against business and government. First of all, in terms of union membership, as shown in Table 6.3, the proportion of organised workers in Korea peaked at 19 percent in 1989 but fell back to about 15 percent in 1992. Secondly, trade unions in Korea were unsuccessful in cultivating connections with political parties in contrast to European trade unions (Anderson and Meyer, 2003, 30; Lee, 2006, 734). No left-wing party acquired a single seat in the National Assembly until 2002.³⁶ The majority electoral system with limited proportional representative (PR) and region-based voting behaviour in Korea had strong negative effects on third parties (Mo, 1996). In addition, trade unions denied the role of construction of left-wing party because they were more interested in organising workers at the workplace level. Aside from a left-wing party, there was little possibility of coalition between labour movements and liberal progressive parties (Lee, 2006, 736). The liberal parties were reluctant to fully embrace labour movements, worrying about their radical image. The labour movements did not trust liberal progressive parties, which focused on the gradual modification of society rather than radical formation of economic order.

	1986	1987	1988	1989	1990	1991	1992
Union Density	12.3	13.8	17.8	18.6	17.2	15.8	14.9
Labour Disputes	276	3,749	1,873	1,616	322	234	235

Table 6.3 Union density and labour dispute in South Korea, 1986-1992

Source: Pae, 2008, 32

Unit: %, Number of case

Thirdly, it was hardly possible for labour to participate in official institutional bodies which would decide social, economic, and labour policy in Korea (Lee, 2011; Yun, 2008). One of the main characteristics of the 1987 labour system was to contain

³⁶ The “Democratic Party of One Nation” (*Han’györeminjungdang*) won one district in the 1988 general election in the midst of disqualification of a liberal candidate in this district. However, the only lawmaker left the let-wing party just after the election.

labour collective actions at factory level (Yun, 2008, 295). Basically, labour related laws did not allow unions to carry out centralised bargaining beyond individual company-level. Moreover, the government and business did not regard labour as an equal partner and instead repressed labour movements through physical intervention. In this regard, the Korean labour movement had excluded labour from the policy-making process. Lastly, the labour movement was isolated from other social groups. The middle-class had gradually shifted to a hostile posture towards labour movements (Wong, 2005, 102). They thought continuing unions' industrial actions would deteriorate national economic conditions and competitiveness in the international market.

The debate on new direction of labour movement in 1992-94

The limited political resources and failed mobilisation of labour pushed it to search for new partners. Some scholars claim that it is more likely that unions engage in a coalition when they face a serious crisis (Frege et al, 2004, 145). The failure of the militant labour movement in the early 1990s gave rise to internal and external debates on new orientation and strategy for the labour movement (Gray, 2007, 70). Some of the union activists and scholars raised the question over whether mass mobilisation strategy including repetitive strike actions had really promoted workers' industrial rights and political influence. They claimed that the Korean labour movement had to adopt a more socially conscious orientation, pursuing the wider public interest and proposing a closer partnership between labour and civil movements. In contrast to militant unionism, this new orientation was called as "social unionism" or "social movement unionism". Social movement unionism refers to the orientation that "*unions act in concert with other progressive social forces and particularly the new social movements, grounded in the politics of social identity, the environment, and globalisation*" (Frege et al, 2004, 137).

The argument for a new direction of labour movement rested on the ineffectiveness of unions' militant strategy. They argued the Korean labour movement was stuck in a serious crisis, caused by not only government repression but also union militancy (Choi, 1992; Kim, 1992). The repeated mobilisations of union members through strike actions undermined the base of the labour movement, rather than

strengthening the organisational capacity of trade unions due to high risks and costs. Workers may lose their wage for a strike period and unions may lose its members (Golden, 1997, 16). Militant actions could weaken unions' organisational capacities through undermining their membership and rationale (Connolly and Darlington, 2012, 245). Particularly, a significant proportion of collective actions were outlawed in Korea at that moment and, in turn, the cost of illegal actions was quite high. Moreover, militant unionism would be markedly vulnerable to counter-attack from employer, government, and public opinion (Gray, 2007, 71-3; Kelly, 1998).³⁷ Repetitive strike actions may lead to the erosion of the legitimacy of trade unions and this kind of backfire happened in South Korea. Most newspapers blamed trade unions for posing potential threats to Korea's economy.

The new orientation of the labour movement put more emphasis on new agendas and partners with social movement groups. Militant labour movement focused on narrow scopes of interests of male regular workers in the manufacturing industries (Chun, 2009; Rowley and Yoo, 2008). New thinkers thought that militant tactics and worker-centred demands isolated the labour movement from society and mass public support (Kim, 1992; Park, 1992). Instead, they urged to embrace a wide range of agendas such as the environment, gender equality, consumer, and peace movement by upholding solidarity with other progressive civil actors. They argued that the formation of coalitions with progressive civic movements could fortify the legitimacy of trade unions and their activities (Choi, 2006; Kim, 1992).

It should be mentioned that the social movement unionism in "democratic labour movement" was different from the orientation of the FKTU, former official partner of the authoritarian regime (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). Although the FKTU was more willing to accept social dialogues with the government and business, it rather put emphasis on economic interests for its members. The organisation hardly paid attention to the social movement agendas. In addition, the FKTU had few networks with civil activists while the KCTU had dense network with them. Most of civil activists thought the FKTU could not be their partner for

³⁷ For instance, there were commuters' backlashes against some workers' strike actions such as New Year's Eve strikes at the London Underground. These industrial actions also provoked employers' counter-mobilisation (Connolly and Darlington, 2012, 245)

social movement since the organisation was just ‘interest group’ (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers’ Union, Seoul, May 2015).

In contrast to new thinkers who embraced social movement orientation, other union activists were opposed to the transition of the labour movement for some reasons. They cast doubt on whether social movement unionism could fit into the Korean situation (Noh, 2008). According to them, the Korean government brutally repressed labour movements and thus they should be militant in defence of workers’ rights (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015). The militant approach adopted by the democratic union movement had efficiently improved wages and other benefits for workers. Moreover, they argued that social unionism would dilute class consciousness in the labour movement (Kim, 2002).

The debate on the new labour movement lasted quite long time. There was roughly equal power balance between two competing groups of labour unions (Interview with a Senior Director of Policy Division in the KCTU, Seoul, April 2015). The new thinkers were not strong enough to override the others but were strong enough to provide new impetus for the directions of labour movements and expansion of the workers’ concerns beyond workplaces (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015; Interview with a Senior Director of Policy Division in the KCTU, Seoul, April 2015). In this regard, the partial shift of the labour movement opened the opportunity to form the coalition between workers, farmers, and civic activists for the health insurance reform.

As shown in Table 6.4, in June 1993, the “democratic labour movement” put together various democratic trade unions into one body, the “Korean Council of Trade Union Representatives” (KCTUR, *Chōnnotae*), at the national level. While it was a loose consultative body, it included all democratic unions and thus promoted the unity of the democratic labour movement (Rowley and Yoo, 2008, 48). In November 1994, democratic unions established the Preparatory Committee for the Korean Confederation of Trade Unions (KCTU).³⁸ In November 1995, they founded the KCTU (*Minjunoch’ong*) and applied to the Ministry of Labour for acquisition of legality with 862 enterprise unions. At that moment, the moderate groups took control

³⁸ The Committee's main task was to prepare and facilitate the reorganization of individual unions into various industrial federations and the formation of the Confederation.

of several important workplaces such as the Hyundai Automobile, a symbolic workplace in the Korean labour movement. At the national level, Kwon Young-Gil, the first leader of the KCTU, was also significantly influenced by social unionism and coined the slogan, “labour movement with citizen” (Kim, 1998).³⁹

Time	Event
Fall of 1987	Great Workers Struggle
January 1990	Foundation of National Confederation of Trade Unions (NCTU, <i>Chŏnnohyŏp</i>)
October 1991	Foundation of “Joint Emergency Committee for ILO Treaty Ratification and Revision of Labour Law”
June 1993	Foundation of “Korean Council of Trade Union Representatives” (KCTUR, <i>Chŏnnotae</i>)
November 1994	Preparatory Committee for Korean Confederation of Trade Unions
Spring of 1995	Social reform fight led by Preparatory Committee for KCTU
November 1995	Foundation of “Korean Confederation of Trade Unions” (KCTU, <i>Minchunoch'ong</i>)

Table 6.4 Timeline of major events in Korean labour movement

Source: Gray, 2007, 152

6.2.2 The cross-class coalition for health insurance reform

In 1993, the “democratic labour movement” began to support the integration of the health insurance system. The leaders in the democratic labour movement thought that the formation of a policy coalition for health insurance integration would open up new opportunities for increasing the influences of the labour movement even though their core members bore more burdens from the consolidated health insurance system.

Rules and practices in the health insurance system and their effects

³⁹ Kim Yu-sun (1998), a former head of Policy Division of the KCTU, has claimed that the first stage of the KCTU leadership leaned towards social unionism.

As Korean labour movements moved towards the socially oriented stance, labour unions re-interpreted the meaning of the prevailing health insurance system and, in turn, reconstructed their interests in the health insurance policy. Trade unions reinterpreted the institutional arrangements in the health insurance system and this made self-undermining feedback mechanisms by diminishing the bases of political support for the prevailing institutional arrangement and expanding reformers' political power.

Firstly, the specific problem-solving practices for fiscal crisis fostered an interpretive effect that the government should be more responsible for less fortunate citizens' welfare. The Korean health insurance system showed substantially low political responsibility and weak commitments on financial support for the municipal health insurance programme, as mentioned in Chapter 4. The municipal health societies sharply increased insurance premiums with governmental approval in response to their fiscal problems (Han'györe, 1996). The financial condition of municipal health insurance schemes seriously deteriorated in 1995, when the maximum day for covered treatment was significantly extended (Federation of Korean Medical Insurance Societies, 1997, 572). As shown in Table 6.5, around half of municipal health insurance funds recorded deficits in 1995. The amount of reimbursement for medical institutes was increased by 29 percent while the governmental subsidy was increased by only 8 percent. The imbalance of accounts resulted in the steep rise in contributions of municipal health insurance schemes. As shown in Table 6.6, the contribution was increased by 15 percent in 1996 and 26 percent in 1997.⁴⁰ The hike in premiums was widely reported in the press. As the government depended on the repeated increases in the contribution rates of municipal health insurance schemes, the reformers thought that it presented the structural vulnerability of the fragmented health insurance system in Korea.

In addition to rise in contributions, the Korean government constrained the expansion of the scope of medical services in face of chronic fiscal problems in municipal health insurance schemes (Han'györe, 1994). For instance, the introduction of some high-tech facilities such as CT and MRI into health insurance coverage suggested by the "First Health Care Reform Committee" ended up with failure at the end of 1994. In Korea, the scope of covered medical service was almost uniform

⁴⁰ The rise in premiums varied depending on the condition of health insurance schemes. Increasing premiums by more than 20 percent was not uncommon in 1996 (Han'györe, 1996).

across all different health insurance schemes. Although some financially strong insurance schemes afforded to increase the scope of covered benefits, it was barred from the governmental intervention (Hoffmeyer et al, 1994, 30-2). This was because the expansion of covered medical services would aggravate the financial problems of municipal health insurance societies. In this regard, the government was reluctant to vastly and promptly enlarge insurance coverage and, in turn, the coverage of medical services in Korea remained quite narrow.

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Revenue	215	531	994	1,495	1,667	1,862	2,068	2,377	2,831	3,472
Expenditure	173	434	1,008	1,130	1,314	1,542	1,760	2,238	2,866	3,349
Proportion of local health societies in red (%)	13	46	90	0	3	6	12	50	65	81

Table 6.5. The financial trend of the municipal health societies

Source: Federation of Korean Medical Insurance Societies, 1997, 574

Unit: billion won, %

Year	1994	1995	1996	1997
Health insurance fee* (billion won)	1182	1324	1576	2023
Number of Household	6766	7088	7320	7508
Average fee per household	146	156	179	225
Increasing rate (%) **	5.0	6.8	14.7	25.7

Table 6.6. The premiums in the municipal health insurance schemes

Source: Kim, 2000,114

Note1: Health insurance fee means the amount of premiums imposed by the municipal health insurance schemes not actual fee revenue.

Note2: Increasing rate is calculated based on the number of household not total subscriber.

The advocates for the integration reform claimed that the failure of introduction of high tech facilities in 1994 showed the weakness of the fragmented health insurance system. The reformers linked this episode into the institutional defects in the fragmented health insurance system. According to them, it was almost impossible to achieve generous health care benefits under the fragmented health insurance system

(Han'györe, 1994). In this sense, it was widely believed, particularly in pro-welfare groups, the unification of health insurance societies would inevitably bring about a more expansionary and generous welfare program (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015).

Secondly, the employees in Korea could not join the decision making and administration of their health insurance societies, as mentioned in Chapter 4. This practice in the Korean health insurance governance had significantly undermined the legitimacy of its fragmented health insurance system, reducing the meaning of health insurance society to just an “administrative unit” rather than a “substantial unit”. A company-based health insurance society did not play meaningful roles in health care policy. Its main roles were to collect premiums and control its membership on behalf of the government. In these regards, whether the government or individual health schemes would manage the public health insurance did not make difference (Lee, 2002). There was no special reason that individual corporations should build their own health schemes.

A Senior Director of Policy Division of the KCTU mentioned that most workers regarded a company-based health insurance society just as an automatic mechanism to deduct money from their salaries in exchange for healthcare benefits (Interview with a Senior Director of Policy Division in the KCTU, Seoul, April 2015). A former leader of civil activists, mentioned that most of the activists thought that the multiple health insurance system would be able to be merged into a single insurance scheme since an individual insurer was a just instrument for the health insurance system (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). Furthermore, union leaders realised the unilateral management of company-based health societies by business was against the law. The company-base health scheme began in the 1970s, the era of authoritarian labour control, and such administration of the schemes was incompatible with democratic principle. The socially oriented labour movement became more sensitive to the democratic process of administrations in their health schemes (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015).

Interactions among actors and their deliberations

The democratic labour movements began to embrace the health care reform based on their ideational changes. The labour movement adopted a more socially conscious orientation, promoting the pursuit of the wider public interest and proposing a closer partnership between labour and civil movement. This shift was identified at various levels. At the first level, the new national centre of trade unions itself attempted to pay more attention to social policy reforms through the reflection on its orientation. There were strong opinions inside the democratic labour movements that the national centre had to put more emphasis on social policies (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). The democratic labour movements began to embrace social reforms such as tax, pension, education, and healthcare as one of their goals.

At the second level, there were significant interactions between labour and health reform groups in this period (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015; Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). The Korean health reformers were seeking their policy partners after previous attempts to integrate all health insurance plans ended up with failure by presidential veto. They contacted union leaders based on the perception that the previous reform attempt in the late 1980s failed due to the absence of workers' consents (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). The conservative media repeatedly asserted that the integration of all health funds would increase the burden of employees and it undermined the political base of reformers. Some key activists for the health insurance reform visited major workplaces and persuaded workers to join forces with the reform. Professor Kim Yong-ik at Seoul National University contacted several crucial labour leaders such as the association of Hyundai labour unions (*Hyŏnch'onglyŏn*), the council of Daewoo labour unions (*Taeno hyŏp*), the general association of white-collar employees (*Ŏpchonghoeŭi*), and white-collar employees (*Chŏnnotae*). It was possible because the health reform groups had strong connections with labour movements (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015).

The reformers asserted the health insurance reform was beneficial for workers as well as farmers. First, the integration reform could enhance healthcare benefits for employees. It was quite difficult to achieve generous health insurance system under the fragmented system because the national benefits level was determined by the fiscal balance of municipal health insurance societies. Second, they underlined the life span perspective in healthcare policy (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). In Korea, a retired worker was supposed to move from a company-based into a residence-based health insurance scheme. In this sense, the crisis of the municipal health insurance schemes was closely linked to salaried workers. Third, the reformers emphasised redistribution across various income groups through the integrated health insurance system (Kwon, 2007, 156). The reformers framed the health insurance reform as a form of ‘solidarity’, claiming that social welfare had to include the function of redistribution (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015).

At the third level, some parts of the trade unions such as workers in charge of municipal health insurance schemes directly called new national centre to embrace health insurance reform as its main goal (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015; Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). When the KCTU, new national centre of labour unions, was being constructed, labour unions from various industrial sectors put forward their own agendas. The trade unions of employees in municipal health insurance schemes had called for integration reform since 1988. Their demands for the health insurance reform were conveying into top-leaders at the national centre through leaders in the white-collar workers’ association (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015).

Coalition for the Integration of the NHI

Several studies in welfare state stress the importance of coalition building since the success of a welfare reform highly depends on the formation of a large coalition for policy changes (Häusermann, 2010; Sabatier and Jenkins-Smith, 1993). The

farmers, democratic labour movement, civil groups, and progressive academia in social policy organised the crucial organisation for the health policy coalition, the “Solidarity for the Integration of the Health Insurance” (*Ŭipoyŏntae*) in 1994. Putting failure of integration reform in 1989 behind it, the establishment of the coalition re-sparked a heated debate on the consolidation of all health insurance entities.

Compared to the first reform attempt, the boundary of coalition for policy change was expanded. Whereas the reformers at the previous stage only included some progressive NGOs and farmers, it newly recruited labour movements and other NGOs in economic and social policy areas (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). While the consolidation reform itself was definitely disadvantaged for regular workers in large enterprises, their organisational goal made them transform their strategies and preferences. In return, workers could get broader support from farmers, liberal parties, and civil activists as a sort of political exchange (Wong, 2001). The reformers also obtained the support of prestigious civic organisations such as the People’s Solidarity for Participatory Democracy (PSPD or *Ch’amyŏyŏn-tae*) and the Citizens’ Coalition for Economic Justice (CCEJ or *Kyŏngsillyŏn*). These two civil associations were regarded as reformative and rational ones rather than radical and ideological ones and their images were helpful to enlarge the supporters for the reform (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015).

The formation of the large coalition strengthened the political power of reformers. Firstly, the coalition attempted to gain access to political arena. They had strong connections with a liberal opposition party, which was a strong supporter of the integration reform. In November 1994, the “Solidarity for the Integration of the Health Insurance” filed a petition calling for health insurance merger to the National Assembly through an opposition lawmaker. Secondly, the coalition opened discussion tables in big corporations several times to persuade workers to support the health insurance reform. Two key civil activists in health care policy such as Professor Kim Yong-ik and Professor Jo Hong-jun and Heo Young-gu, Vice Chairperson of the KTCU, visited several workplaces to persuade leaders in enterprise unions to take part in the merger reform. They stressed the common interests between labour and farmers in terms of social welfare as well as progressive blueprints.

Thirdly, the KCTU made a strategy to link the health insurance reform into collective wage bargaining at company level under the banner of “fight for social reform”.⁴¹ This strategy was successful in re-sparking political campaigns for the merger reform and raising the agenda in civil society (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015). Heo commented on the “fight for social reform” led by the KCTU that,

“The KCTU was a just loose alliance mainly based on enterprise unions. It tended to evade complicated problems on which various members had diverse and competing preferences. This was because they were worried about deep division of the new organisation. Most of the KCTU members in large corporations would pay more contributions if all health insurance societies would be merged. Professor Kim Yong-ik, Professor Jo Hong-June, and I visited several large workplaces to make speeches on this issue. The union leaders at factories were fairly sympathetic to farmers and low-income self-employed. They roughly recognised that redistribution through a social insurance system would be required. I thought it was a miracle to lead workers in large firms to overcome their self-interests in this issue. (Park and Heo, 2001, 69)”

It should be noteworthy that the KCTU was not committed to implement other social reform such as tax and education although the organisation officially announced that it would challenge the existing policies in these policy domains. Unions tend to be involved in an issue which has high political salience among population (Capoccia, 2016, 1112). This was because the organisation would have had difficulty in obtaining sufficient supports for policy change in these issues due to the low level of political attention and mobilisation (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015). There are a lot of studies to demonstrate the relationship between the broad coalition formation and success of the health insurance reform in South Korea (Baek, 2010; Kwon, 2007; Lim, 2010; Wong, 2004). However, most of them assumed that labour and progress civil movement were supposed to support the

⁴¹ There were five categories in the KCTU’s social reforms; tax, pension, education, healthcare and corporate governance reform.

integrated health insurance system. As mentioned earlier, however, labour's support for solidaristic welfare programme was contingent on political contexts and their orientations.

6.2.3 Debate on merger and institutional framing effects

Launching the coalition in 1994 and the fights for social reform raised by the KCTU in 1995 sparked the debates on the effective and equal health insurance system again. The outline of debates between the single-payer system and multi-payer system was already mentioned in Chapter 3. This part focuses on the peculiar perspectives of the debates on the health insurance reform in Korea.

Accountability

Those who supported the integration reform understood accountability of the health insurance system in terms of governmental responsibility. They claimed that the government should take more responsibility for the municipal public health insurance schemes. People held their government responsible for the social welfare of their citizens. They assumed that governments would be supposed to take significant responsibility for the public health insurance schemes since it was part of the public welfare system (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers' Union, May 2015). They thought that all citizens had a right to obtain equal and effective health care services. The public health insurance system was a tool to achieve this goal and thus the government should provide equal and well-managed health insurance programmes for its citizens. In addition, they claimed that the financial vulnerability of municipal health insurance schemes largely stemmed from the structural problems rather than their own faults. The municipal schemes relied on relatively weaker financial foundation and in turn it led to the financial problems and inequality. In this regard, people who were dissatisfied with the health insurance system called for the merger of health insurance schemes, which was regarded as a firm commitment to rectify these problems (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers' Union, May 2015).

Those who opposed the integration reform understood accountability of the health insurance system as the principle of “self-governance”. The self-governance was a strong rule in the social insurance system. A subscriber of insurance could have a sense of belonging in a multi-payer system since health insurance schemes were organised based on their identity, workplace, and residence. If a subscriber over-uses insurance claims, it would return the increase in insurance contributions. In this regard, the member of a health insurance society should take responsibility for management and financial outcome of one’s insurance scheme. They claimed the proposal for the integration was inappropriate since the reformers completely misunderstood the health insurance system. The reformers wrongly regarded it a mere tool to dispense welfare benefits instead of insurance (Federation of Korean Medical Insurance Societies, 1997, 572).

Comparing two arguments, the Korean context diminished the legitimacy of a fragmented health insurance system. Firstly, self-governance could not be strong grounds to defend the fragmented system in the Korean context, where representatives of labour were not able to join managerial meeting of health insurance schemes. Secondly, the government did not pay much attention to the structural weakness of municipal health insurance schemes, which consisted of lower income and higher risk groups. It looked impossible that fragmented health insurance system in South Korea would be able to provide the universal and decent health insurance system for all the population.

Neither central nor local governments had direct responsibility for finance and management of municipal health societies because they were autonomous legal bodies in official logic. Low political accountability of health insurance societies also contributed to poor management performance of them. The central government held most of the authorities in handling health care policy due to a highly centralised political system. The ministry provided the guidelines on administration for individual health society. The politicians who supported the consolidation of health insurance schemes believed that full-scale unification would bring the advantages such as wide risk pooling, more equal contribution rate between rural and urban area, and lower administrative costs. It also affected the strategies of social actors who supported welfare expansion. They thought that unification of health care insurance, which

meant more direct responsibility of government for health insurance funds, would bring a more generous welfare program.

Fairness of health insurance

Those who were in favour of the integration reform in Korea understood the fairness of health insurance as the moral sense of “indiscrimination and solidarity”. Their first basic idea was that people should not be discriminated against in healthcare policy on the ground of their occupations. The level of benefits and contributions was largely determined by the types of health insurance schemes one joined. Those insured by municipal health insurance plans were treated less favourably just because they were non-employees. Those who were in favour of integration reform contended that the discrimination between different occupational groups should be removed and that integration could ensure equality in the health insurance system.

The second axiom was that public insurance system was supposed to pursue redistribution within different income groups. The principle of solidarity led to a significant level of redistribution between the healthier and the less healthy, the affluent and the impoverished, and the younger and the older (Maarse, 2003). Most of the municipal health societies consisted of relatively low-income, older, and high risk members while most of the health insurance societies in big corporations consisted of affluent, younger, and healthier subscribers. The defenders of the single-payer reform called for the fundamental redistribution between two different groups through the integration of all health funds (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers’ Union, May 2015). The single-payer system was able to maximise the re-distributional effect through comprising the whole population. The multi-payer system, by contrast, shared the risk and revenue only within specific groups because it was divided by workplaces or local community.

In contrast, those who supported the multi-payer system in Korea understood the fairness of health insurance as procedural justice and entitlement to claim. They claimed that the existing three different types of health insurance programmes were reflecting differences in income structures and occupational features among different

groups. They also claimed that the reformers should respect this historical configurations and different ordering principles of corporate health insurance schemes. The third argument was that financial resources should be distributed by ‘entitlement’ rather than ‘need’. Individual health insurance schemes were supposed to manage their own finance in the social health insurance system. If one health scheme accumulates the reserves, the members in this scheme have the strongest right to claim the benefits from the surplus rather than subscribers in other health schemes.

Related with these claims, there were two practical and controversial issues. The most crucial issue of equity in the argument was “fair taxation” under the different income structures among several occupational groups. Countries with well-functioning taxation infrastructure are able to fairly and effectively collect health insurance premium (Hussey and Anderson, 2003, 216). If there was widespread tax evasion in some part of business, usually small business and unofficial economy, however, other groups such as wage workers should pay more. There were only limited capabilities to collect tax and premium in South Korea at that moment. The government obtained only around a quarter of taxation source data on the self-employed in the mid-1990s (Wong, 2001). The opponents argued that a single-payer insurance system would shift its financial responsibility onto salaried workers since their actual income levels were completely exposed. It is also related with different concepts of vertical equity between supporters of integration reform and defenders of a multi payer system (Kwon, 2007). The next overriding issue on equity for them was the reserve funds in corporate health insurance societies. The corporate health insurance societies accumulated massive reserves. The opponents claimed these funds had been contributed solely by the members of corporate health insurance societies (*Han'györe*, 1994). They argued the massive reserves accumulated in company-based health societies were attributed in frugality embedded in a fragmented system. Under the system, members attempted to save their financial resources since otherwise their premiums would increase directly. In this account, non-member who had not contributed to the reserve funds at all was not entitled to claim sharing of the funds.

Judging from these competing arguments in the Korean context, we can understand the farmers’ moral appeal for equal treatment was fairly strong. This was because health insurance schemes were regarded as just ‘managerial units’ rather than

‘substantial units’. In Korea, labour did not equally take part in the decision-making process of company-based health insurance schemes and the government significantly restricted the autonomy of individual health insurance schemes. The MOHSA decided most fundamental factors in the governance of health insurance schemes such as reimbursement and benefits level (Hoffmeyer et al, 1994). These practices undermined the legitimacy of the fragmented health insurance system and insurance schemes remained plain managerial units in charge of the collection and payment of insurance finance. Even several scholars who opposed the integration reform mentioned that there would be little differences in the health insurance system after the consolidation reform because prevailing health insurance societies did not play meaningful roles (Choi, 2014; Lee, 2002). If a company-based health insurance scheme was just an administrative unit, it was difficult to justify the huge gap of fee levels across different insurance schemes. In this context, the Korean Constitutional Court also dismissed the challenge that the reserved funds should not be shared with other members in June 2000, claiming it should belong to the whole social insurance system rather than private insurance funds.

Efficiency

The health reformers stressed the ‘economies of scale’ as mentioned in Chapter 3 while opposition groups highlighted the ‘diseconomies of scale’. There would be the economies of scale in integration reform to reduce the management costs of health insurance schemes and the instability in small health insurance schemes by enlarging risk pools. By contrast, the diseconomies of scale such as moral hazard of insurance members and red tape in bureaucracy would emerge.

The reformers for integration in South Korea underlined the efficiency of an integrated system at macro-level. Those who supported the idea of integration contended that full-scale unification would bring advantages such as wider risk pooling and the lower administrative costs. They made a strong argument that the integration would increase the efficiency of the Korean health insurance system on the basis of transfers among different risk and income groups. The idea of integration was attractive since it would enable the health insurance system to self-sustain with no additional funding (Baldwin, 1990). The National Conference for New Politics (NCNP),

a major liberal opposition party, claimed financial resources saved by the integration reform would be used to stimulate research and development (R&D) and industrial restructuring. In addition, there were huge reserves in corporate health insurance schemes. In 1995, the amount of reserves in corporate health insurance societies reached around 2.5 trillion won, the equivalent of 14 months' payments for insurance claims from their members (Federation of Korean Medical Insurance Societies, 1997, 605). Using the reserves, they could solve the fiscal problem in the Korean health insurance funds (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers' Union, May 2015).

Those who were against the integration reform understood the term of efficiency at micro-level, emphasising moral hazard problems stemming from the integration. There would be a stronger financial incentive for subscribers in a multi-payer system to refrain from overusing medical insurance benefits than a single-payer system. This was because high medical expenditures would directly affect the fiscal condition of their health insurance schemes and, in turn, may lead to rise in contributions under a multi-payer system. They claimed, if all health insurance schemes were merged, the reserves in corporate health insurance societies would be depleted quickly because patients would overuse medical services due to little incentive to save financial resources. In this regard, self-governance in a health insurance society could enhance the efficiency of the whole public health insurance system.

Comparing two claims in the Korean context, the reform group put forward more tangible benefits such as sharing reserves and decreasing personnel in the health insurance schemes through the integration reform. In contrast, the benefit of a fragmented system was quite uncertain. This was linked to the peculiar practices in the Korean health insurance system. The corporate health insurance societies in Korea had only limited functions as insurers while their counterparts in Germany and Japan, to some extent, had wider functions such as setting up the rules on benefits and health promotion since the government took strong control of these regulations (Choi, 2014; Lee, 2002). The corporate health insurance societies in Korea played a limited role in improving members' physical condition while it was quite common in Japanese counterparts. Those who supported the fragmented system in Japan successfully demonstrated how a company-based health insurance society could enhance the efficiency of health insurance system through the discourse of strengthen-

ing ‘insurer functions’. In contrast, the health insurance societies in Korea failed to demonstrate how they could contribute to the improvement of the efficiency of health insurance system and healthcare service.

6.2.4 Partial reform bill under the conservative government

After the healthcare reformers in Korea formed a broader coalition, not only a liberal opposition party but also the conservative ruling party paid more attention to the health care policy. The 1997 presidential election reshaped the political environment in favour of the health insurance merger. Some of the lawmakers in the ruling party were supportive of the merger reform. The National Assembly, in these circumstances, passed the partial reform bill in November 1997, which stipulated that 227 municipal health insurance societies for the self-employed would be merged into an insurance body.

Policy recommendations from governmental committees

The government set up the “Development Committee for Farming and Fishing Villages” to investigate how to improve the overall welfare system for rural residents after closing the Uruguay Round, one of the GATT Rounds which agreed to open world agricultural market. The committee released the report in May 1994, proposing the consolidation of all health insurance schemes and the shift of contribution charging method in municipal health societies. Nonetheless, government officials in healthcare policy dismissed the suggestions, claiming that the report solely reflected farmers’ voices and most of the committee members were not experts in the healthcare field.

Instead, the government set up a specialised committee for healthcare and health insurance reform. The government also set up the “First Healthcare Reform Committee” in January 1994 and “Second Healthcare Reform Committee” in 1996, (Sin, 2004, 152). These committees released the policy reports, both recommending the consolidation of the 227 community-based health societies into 16 societies at the great local government level. They claimed this measure would improve the or-

organisational efficiency and enlarge the scope of risk pooling. The government put forward it as the counter-proposal against the full-scale integration plan.

Gradual integration bill

There was a stand-off between reform groups and opposition groups until 1997, when the presidential election took place. Although opposition party submitted a reform bill for the integration of the whole health insurance schemes in 1996, it was not reviewed in the National Assembly without the consent of majority ruling party. However, there was a significant shift in the stance of the ruling party on the health insurance reform in 1997. A lawmaker in the conservative ruling party Hwang Seong-kyun proposed the three staged-reform plan in August 1997 (Sin, 2004, 157). In the first step, the municipal health programme and public officers' health programme would be merged into a single body. In the next step, various corporate health societies would be absorbed into the single-payer in terms of organisation but their fiscal accounts would be still kept separated from the others' accounts. In the final stage, the fiscal structures of all health funds would be also integrated. He proposed the bill stipulated that the health insurance programme for the self-employed and public officers would be merged into a single insurance carrier, which was the first stage of his three-step merger plan.

The shift in party position could be understood in terms of the upcoming presidential election held in December 1997 and weak party discipline. Most of the lawmakers in the ruling party from rural constituencies were supportive of Hwang's idea since they could obtain political gain by supporting the health reform bill. In response to the pressures from rural areas for improved health insurance governance, ruling party lawmakers pushed their party leaders to pledge to reform the health insurance system in the presidential campaigns. Lee Hoe-chang, the presidential candidate of the ruling Grand National Party (GNP), pledged to carry out the gradual integration of health insurance schemes in September 1997 (Kim, 1997). Just before the next presidential election, an incumbent president's influence on the ruling party was marginalised due to a serious economic downturn and political scandals. The presidential secretary and party leaders usually took control of lawmakers under strong party discipline. However, at that moment, presidential secretary could not

play an important role in mediating between the ruling party and the government. While the government attempted to keep the fragmented system, it could not have a significant influence on ruling party lawmakers.

Against this background, major political parties reached a compromise on the partial integration bill and it was passed in November 1997. President Kim Young-sam did not exert veto power. The Korean government had already applied for the International Monetary Fund (IMF) bailout package and was not willing to fight against major political parties on health insurance reform amid an escalating financial crisis. Moreover, since the partial reform bill did make no change in the enterprise-based health insurance societies, business was not opposed to the Act. On the grounds of the 1997 National Health Insurance Act, the first step of full integration of all health funds took place in October 1998 under the next government.

6.3. Large-scale health insurance reform between 1997 and 2003

A new political resolve to implement the health care reform came up after the regime change at the end of 1997. President Kim Dae-jung embarked in a new direction with expansion of the welfare state driven by serious economic crisis and regime change. The health care reform might inflict the pain of adjustment on the corporate actors. Although the conservatives and some waged workers attempted to thwart the government's intention and then restore fragmented health insurance system, the coalition between farmers, labour, civic activists, and the new ruling party led the legislature to integrate all health insurances.

6.3.1 Regime change in 1997 and the Tripartite Commission

Asian Financial Crisis and regime change

The 1997 Asian Financial Crisis opened new political arena and opportunity. The financial crisis hit Southeast Asia in the summer of 1997 and soon spread into South Korea. On November 21, the government announced the formal request for the International Monetary Fund (IMF) intervention to restore investors' confidence and stabilise the national economy. The agreement between the Korean government

and the IMF, including a \$57 billion bailout, was signed on December 3. It was obvious that the 1997 Asian Financial Crisis during the last months of Kim Young-sam's tenure played an important role in the regime shift in South Korea. The crisis was the most intense economic panic that Korea had faced since the onset of its rapid economic development in the 1960s.⁴² The Asian Financial Crisis discredited the prevailing government because not only policy failure but also corruption in the ruling elite had contributed to the economic catastrophe. Furthermore, the signing of the IMF bailout agreement was regarded as “semi-colonisation”. Just one month after the onset of the financial crisis a new presidential election occurred. The presidential election in December 1997 had brought the Kim Dae-jung government to office, which was the first regime change by election in South Korea.

There is a lot of literature that emphasises external shocks such as war and economic crisis to explain institutional changes (Ikenberry, 2001; Krasner, 1984). However, the crisis had brought only limited effects on actors' positions on the health insurance reform. One of the crucial actors, labour, changed its preferences and goals on health insurance policy in the mid-1990s even in absence of exogenous shocks. Although the Asian Financial Crisis helped implement the health insurance reform by weakening the opponent groups, it could not account for the dynamic process of reshaping actors' attitudes on the health insurance reform.

Political and partisan effects of the new government

President Kim Dae-jung was inaugurated on 25 February 1998. The regime change contributed to the integration reform in several ways. First of all, it helped the integration reform move on the policy agenda. To enter the official policy agenda, policy makers should perceive a policy issue as a serious problem. Key actors in policy-making process attempted to construct the problems and put them on the table of policy agenda (Kingdon, 1995). In this regard, the regime change helped to construct the health reform agenda. The integration reform was one of his pledges during the presidential campaign. Soon after he won the presidential election, he put the reform on the top of social security reform.

⁴² The unemployment rate in Korea had risen from 2.1 percent in October 1997 to 8.7 percent in February 1999 (Haggard, 2000, 197).

Secondly, the regime change empowered the advocacy coalition for the health insurance reform since the reformers held strong control over the government and cabinet (Kwon, 2007, 158). The President Kim himself had supported the integration reform and was willing to push the health insurance reform. President Kim appointed Cha Heung-bong as Minister of Health and Welfare. He was also a staunch supporter of integration, who was a former high-level officer in the Ministry of Health and Society Affairs and yet fired by authoritarian government because of taking side with the consolidation reform. In this regard, appointing Cha Heung-bong as Minister was itself remarkably symbolic (Kwon, 2011, 662). In addition, the progressive NGO activists and academics such as Lee Sang-Yi joined the governmental bodies and ruling party in social policy division in order to map out the reform proposal. Instead, Kim Jong-dae, one of the main staunch opponents among high-level officers, was sacked. Most of the members in the governmental committee of health insurance reform, which was leading the reform, were in favour of the health insurance reform.

Thirdly, the regime change made strong partisan effects on welfare policy since the progressive government brought new ideas into the governmental bodies. President Kim was much more interested in welfare expansion than the Conservative candidate (Kwon and Reich, 2005, 1004). While conservative elites in Korea had solely stressed economic development over social security and thus welfare system was highly under-developed, the new president took a more positive posture on solidaristic welfare policy. The Kim Dae-jung government sought to reform or expand the major social-insurance programs such as health insurance, pensions, and unemployment insurance. In addition, the government established the Minimum Living Standard Guarantee for the poor. These initiatives reflected a new direction in the development of social welfare under the Kim Dae-jung administration (Haggard and Kaufman, 2008, 250).

Tripartite Commission and partial integration

To overcome the economic crisis, president-elect Kim Dae-jung brokered the social pact among the government, business, and labour. The Korean Tripartite Commission made up of government, business, and labour representatives in January 1998, negotiated crucial economic and labour reforms. The establishment of the Tri-

partite Commission was a historic event in Korea because there was no meaningful social dialogue institution beyond the firm level (Haggard and Kaufman, 2008; Kwon, 2011). In addition to regime change, the 1997 Asian Financial Crisis also made a totally different policy environment. When a country was stuck in a deep crisis that led to high unemployment and painful adjustment, there were powerful incentives for bargaining and cooperation to recover international competitiveness (Avdagic, 2010; Hassel, 2003). In the Tripartite Commission, the government persuaded trade unions to accept labour market flexibility, in return for the expansion of welfare programmes for the unemployed (Shin, 2003, 191).

The talk bore fruit with so-called the “Great Compromise” in February 1998. They reached the “Tripartite Accord for Overcoming the Economic Crisis”, which was a political exchange between labour and business. Labour accepted the legalisation of layoffs in return for the expansion of labour rights and welfare programmes (Haggard, 2000, 211). The firms with an urgent managerial difficulty could use redundancy lay-offs. Labour instead secured the package including the expansion of basic rights for labour,⁴³ recognition of a teachers’ union, the medical insurance reform, and the rights of laid off workers to join enterprise-level unions (Ha and Lee, 2007).

The agreement among three parties also led to a series of reforms in social policy area such as health care, pension, and unemployment benefits (Gray, 2014, 490). The Korean Tripartite Commission agreed the legislation for the full-scale merger of health insurance schemes by the end of 1998, adding it to the “100 national policies list for the new government” to be pursued by the Kim Dae-jung administration. It made the integration of all health insurance schemes much easier than the previous attempts which faced strong veto groups such as business (Kwon, 2011, 661). At that moment, the priority of big businesses was protecting their *Chaebol*⁴⁴ corporate governances given their weak financial condition. As the government attempted to overhaul the *Chaebol* governance by enhancing internal transparency, business was willing to negotiate with other actors on the health insurance reform (Kwon, 2011, 660).

43 Public officers could create their consultative organisation and trade union could be involved in various political activities.

44 The *Chaebol* is large conglomerates and the group of affiliated companies based on cross-ownership linkages of business family in Korea.

6.3.2 Advocacy groups' positions

Reformer groups

In this period, there were four major ways in which the reformers reinforced their ideas for the integration reform. Firstly, reformers including the KCTU had framed the fragmented health insurance system as a by-product of the *Chaebol* governance, which was blamed as one of the main culprits in the current economic crisis (Interview with a former Vice Chairperson of the KCTU, Seoul, May 2015). The corporate governance was closely linked to the health insurance governance and the latter was a reproduction of the former. The corporations in *Chaebol* governance formed their joint health insurance schemes on the basis of their enterprise conglomerates. For instance, the corporations in Samsung conglomerate established the Samsung Joint Health Insurance Scheme. They accumulated 96 billion Korean Won as reserves and the LG Joint Health Insurance Scheme had around 41 billion Won as reserves at the end of 1995 (Federation of Korean Medical Insurance Societies, 1997). Just as the *Chaebol* governance monopolised national economic power, the reserves in company-based health schemes were used for business without labour's monitoring. These health schemes had accumulated massive reserves but they did not allow labour to join their decision-making process. Based on these circumstances, the reformers claimed that labour and citizen had to obtain more control on health care policy through the consolidated health insurance system.

Secondly, the rivalry between the KCTU and the FKTU was generating their identity-building (Choi, 2006, 64). The former sought to taint the latter's image as exclusive economic bigots. The FKTU joined forces to fight against the full-scale merger of the health insurance system, claiming the integration would lead to increase workers' contributions. The FKTU sought to identify the KCTU as a radical and militant group, framing themselves as a gradual reform group (Interview with a Senior Director of Strategy and Planning in Korea Health and Medical Workers' Union, Seoul, May 2015). The two national centres clashed with each other in the street, the National Assembly, and televised debates on the consolidation reform. The

KCTU framed its rival as a narrow interest-driven organisation while framing itself as an encompassing progressive group.

Third, new problem-solving practices on fiscal crisis in the new health insurance scheme arising from the partial integration between the health insurance programme for the self-employed and public officers generated a positive feedback to strengthen the idea for the integration reform. The balance of the health insurance system recoded a historical deficit in 1999, just after the partial integration of health insurance plans. The government took immediate action to redress it by increasing the governmental subsidies for the health fund. The government introduced tobacco tax in order to offset the deficits in the health fund. The new problem-solving practice strengthened the reformers' idea that the integration reform would increase the responsibility of the government for the Korean health insurance system.

Lastly, labour reforms between 1996 and 1999 gave insight into the importance of a broad political coalition. At the end of 1996, the ruling party passed a bill on the labour market to ease the strain of layoffs. Labour organised large-scale strikes between December 1996 and March 1997 against more flexible labour market policy. At that moment, the progressive civic groups were willing to embrace labour issues and uphold solidarity with labour. Faced with the strong opposition, President Kim Young-Sam had to cancel the revision of the Trade Union Act and thus the strike was often said to be the most successful one in the 1990s. In addition, the Asian Financial Crisis posed a serious threat to trade unions and the KCTU had to rely on a coalition with other civic groups in pursuit of employment protection and its legal recognition (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015).⁴⁵

Opposition groups

The health insurance policy in Korea was highly politicised after the government pushed the merger of health insurance societies. In response to the plan, there was a massive counter-mobilisation. There were three major concerns regarding the implementation of full merger among different occupational health insurance pro-

⁴⁵ The KCTU did not gain legal recognition until 1999. This was because labour related law did not allow multiple trade unions.

grammes. First, while wage earners' incomes were completely exposed to tax authorities, the self-employed in South Korea usually underreported their income (Kwon, 2011, 661). The opponent groups resented the fact that they would bear more contributions for the self-employed who insufficiently contributed to the public health insurance after the integration reform. Second, the government failed to construct the fair contribution system to impose contributions among different occupational groups (Kwon, 2007, 158). Third, there was a constitutional controversy over the integration of all health insurance schemes (The Korea Times, 1999). Some scholars and lawmakers argued the bill was against the constitution because it would forfeit the reserves in corporate health insurance schemes. Since the reserves in corporate health insurance schemes were only contributed by their members rather than whole citizens, the funds should be regarded as exclusive assets for the subscribers in these schemes.

There were three main opposition groups including workers in corporate health insurance schemes, Grand National Party (GNP), and some wage earners. The strongest opposition group against the health insurance integration was the employees in corporate insurance schemes. They were concerned about job losses, which may happen if employment-based health insurance societies were dissolved. In response to the threat of massive layoffs and job displacement, they set up their labour unions at the national level in July 1998. They also provided theoretical rationale to oppose integration plan based on empirical data. In addition to theoretical opposition, the association of corporate health insurances sabotaged the integration by refusing to provide practical materials to implement the integration of all health insurance schemes (The Korea Times, 2000).

The GNP, a major opposition party, joined forces to resist the full-scale merger of the health insurance system by shifting its position on the reform. During last presidential campaigns, the GNP supported the integration of health insurance system, considering the voter from rural areas and some lawmakers from rural constituency had supported integration. However, the party changed its position, which was undoubtedly influenced by mobilisation of opposition groups (Won, 2006, 172-3). In addition to the lobby, faced with the financial crisis of the partially integrated medical insurance system, the GNP sought to criticise the incumbent government for incompetence. They expected it would lead to widespread discontent with the ruling

party (Wong, 2004, 109). In this regard, the opposition party blamed the government and ruling party for giving “blind support” of the full-scale merger, calling the President an idealist.

The third main actor in the opposition groups was the Federation of Korea Trade Unions (FKTU). The FKTU joined forces to fight against full-scale merger of health insurance, claiming the integration would increase workers’ contributions. They also felt concerned about the unfair distribution of additional burdens because of the wide tax-evasion of the self-employed (The Korea Times, 1999). In addition, as the association of corporate health insurances joined the FKTU in 1998, the latter had a strong incentive to protect their new members (Choi, 2006, 65). The FKTU threatened the government that they would refuse to pay health insurance and pension contributions unless the government deferred the integration of the health insurance scheme for more than two years.

However, it is noteworthy that the debate in this period focused on the pacing and sequencing of integration process and opposition groups hardly disagreed with the integration reform itself (Wong, 2004, 109). The opposition groups called for deferring the full-scale integration of all health funds, pointing out its practical problems. In response to the criticism, the government and reformers accommodated their concerns by taking some measures enhancing transparency and stability of the health insurance system.

6.3.3 Political process of the health insurance reform

Integration of health insurance programmes

The government took a first step on merger, integrating the health societies for public officers and local residents based on the partial integration bill. In October 1998, 227 local health insurance societies and a health fund for public workers were subsumed into a single “National Health Insurance Corporation” (NHIC). Meanwhile, for the full-scale integration of all health insurance programmes, President Kim Dae-jung ordered the establishment of the “Special Committee for Social Reform” and the Ministry of Health and Welfare build up the task force for the health insurance integration in March 1998. A significant proportion of scholars who de-

fended the integration plan joined the committee. After they undertook research on the effective structure of the integrated health insurance system, they released the guidelines on the health insurance integration in July 1998. The government proposed the bill to unite the organisation of all health insurance schemes in December 1998. It stipulated that all organisations of medical insurance plans would be merged in January 2000 while the financial resources would keep being separated for two more years. It also mentioned that insurance contributions for all subscribers would be imposed based on a single method. The standing committee on Health and Welfare endorsed the bill in December 1998. The plenary session formally endorsed the National Health Insurance Act in January 1999 amid a walkout by opposition lawmakers (Sin, 2004).

Reform outcome

However, the full-scale integration was disrupted by the major opposition party (Korea Times, 1999a). The GNP resisted the planned financial consolidation of the health insurance system by proposing an alternative bill which would keep disintegrating the health insurance funds for wage workers and the others. The ruling party and major opposition party reached the agreement to hold off the financial integration for one year and a half (The Korea Herald, 2001). As shown in Table 6.7, the revised bill on delaying financial merger until July 2003 was passed in January 2002 with consent of both parties. As the consolidation of the health insurance system would take place in the next government, the GNP gained an opportunity to scrap the integration reform. Since the next presidential election was scheduled to be held in December 2002, it could be a crucial political momentum to push or thwart the financial consolidation of health insurance funds.

In December 2002, the ruling party candidate Roh Moo-hyun won the presidential race by a narrow margin. Although it seemed that the ruling party had the mandate on the health insurance reform, the GNP still took the majority in the National Assembly. In April 2003, the GNP submitted the bill on the separation of fiscal accounts in the health insurance schemes between salaried workers and the self-employed. The opposition party called for a two-year delay of the financial merger and the establishment of special committee to discuss further health insurance reform.

Time	Contents
November 1997	Partial integration bill between health insurance for public officers and self-employed was passed
December 1997	Kim Dae-jung won the presidential election (Regime change)
February 1998	Social pact in the Tripartite Commission
October 1998	Partial integration bill between health insurance was implemented (1 st step of reform)
December 1999	The bill on deferment of financial merger by the ruling party lawmakers was passed
July 2000	Organisation integration was implemented (2 nd step of reform)
January 2002	A bill on deferment of financial merger proposed by the opposition party was passed
December 2002	The ruling party candidate, Roh Moo-Hyun, won the presidential election
June 2003	A bill on deferment of financial merger by the opposition party lawmakers was rejected
July 2003	Financial integration was implemented (3 rd and final step of reform)

Table 6.7 Timeline of major events on the health insurance reform between 1997 and 2003

Source: Kim, 2012, 55

However, the opposition groups were isolated from mass public. Through two consecutive presidential elections, the reformers gained the approval of the population on this issue. In addition to shift in mass opinion, the opposition party's final trial to obstruct the complete integration plan was frustrated by two lawmakers' defection. In the GNP, two lawmakers in the Committee for Health and Welfare defied the party line on the vote, criticising the party leadership for being in a bigoted position on the health insurance reform.⁴⁶ The party's discipline on the reform was not strong at that moment because the supportive opinion on the integration was overriding the opposition one. Even quite many opposition lawmakers also backed up the integration bill, claiming the ruling party obtained the mandate on the health insur-

⁴⁶ Among 15 members in the welfare committee of the National Assembly, the GNP had 9 lawmakers and had a majority. However, two rebels in the party voted against their party's plan.

ance reform by the presidential election (Interview with a Deputy Director of Human Resources Department in National Health Insurance Corporation, Seoul, May 2015). In this regard, as shown in Table 6.8, the whole process of the health insurance integration was completed in July 2003 when the merger of financial structures was finally fulfilled.

Level	Types of the health insurance schemes	As of September 1998	As of October 1998	As of July 2000	As of July 2003
Organisational structure	Municipal	227	1	1	1
	Public officer	1			
	Corporate	142	142		
Financial structure	Municipal	227	1	1	1
	Public officer	1	1	1	
	Corporate	142	142		

Table 6.8 The process of the integration of the health insurance schemes

Unit: number of insurance schemes

Source: Kim, 2012, 85

6.4 Conclusion

This chapter has analysed the political dynamics underlying the health insurance reform in South Korea. It has presented how the institutional features in the Korean health insurance system such as decision-making and problem-solving practices had influences on the path of the health insurance reform by shaping main actors' attitudes and strategies. In the Korean health insurance system, there were two remarkably distinct features which resulted in the different institutional effects on the health insurance reform. The first characteristic of unique aspects was the absence of self-governance. Labour was usually unable to take part in the administration of health insurance schemes. This practice in the Korean health insurance governance significantly undermined the legitimacy of the fragmented health insurance system, reducing an individual health insurance society to just an "administrational unit". The second characteristic of unique aspects was the substantially low political re-

sponsibility for the health insurance system, particularly municipal health insurance schemes, which were financially weaker than corporate health insurance schemes. The central and local government also conferred weak commitments to aid financially weak municipal health societies. It also fostered the interpretive effects that the fragmented health insurance system itself lacked public responsibility for rural residents. The reformers claimed that a single-payer system could enhance the governmental responsibility on health care policy.

The ideational shift of the KCTU towards social movement unionism and dense network between labour and health reformers in Korea was also crucial for the reform outcome by reshaping trade unions' interests on health insurance policies and reinterpreting the meaning of a prevailing health insurance system. The democratic union movements shifted their stances on the integration reform in the mid-1990s while they were not fully supportive of the reform in the 1980s. The social movement unionism contributed to redirecting labour towards embracing social issues. The reshaping of labour's position in the mid-1990s had brought about the broad coalition between farmers, labour, and civic associations.

Chapter 7 The political dynamics of health insurance reform in Japan

This chapter explores the political dynamics behind the health insurance reform in Japan between the late 1990s and the early 2010s. The first section will explain the launch of the health insurance reform between 1997 and 2001. As mentioned in Chapter 5, the municipal health insurance programme was financially more distressed than other health programmes. It resulted from the disproportionate share of the elderly in this programme. The idea that all health insurance schemes would be integrated into one came from the municipal health insurance schemes and municipal governments. They claimed that the integration plan could solve increasing disparity among subscribers in different health insurance programmes. However, actors who were involved in the corporate health insurance schemes favoured the fragmented health insurance system and business and labour formed the policy alliance for the fragmented health insurance system. Moreover, the government were not able to adjust the contending interests among major actors in health care policy because of the lack of political leadership.

The second section will explain the decision to maintain the fragmented health insurance system under the Koizumi administration. While Health Minister Sakaguchi was in favour of a more solidaristic reform proposal than the current system, the opponents were opposed to it. Those in favour of the fragmented health insurance system created a new policy discourse centred on strengthening the roles of individual health insurance societies. It successfully showed how autonomous and decentralised health insurance bodies could increase the efficiency of the whole health insurance system. To protect the fragmented system favoured by corporate actors, the government introduced the independent health insurance schemes for the late elderly on the basis of the cabinet-oriented policy making process.

The third section will explain the unsuccessful reform trial under the government of the Democratic Party of Japan (DPJ) between 2009 and 2012. The DPJ made the pledge to integrate all health insurance plans and reverse the unpopular health insurance schemes designed by the Koizumi government in its manifesto. However, *Rengō* were still opposed to the integration reform, being worried about

rise in high-income workers' burdens. Moreover, the DPJ was divided on the tax hike issue after the Kan administration. In the end, the party leaders gave up the health insurance reform.

7.1 Health insurance reform trial in the 1990s

Medical expenses for the elderly in Japan has accounted for the lion's share of the total health expenditure in response to their ageing society. The nation's medical expenditures for the fiscal year⁴⁷ 1995 reached 27 trillion yen, representing an increase of 5.3 percent from the previous year (The Daily Yomiuri, 1996). Japan had suffered the increase in health spending for the elderly, which accounted for half of the national health spending (The Daily Yomiuri, 1996). In addition, political concern on increasing health care costs was burgeoning in the mid-1990s as the Japanese economy entered into a long recession. In response to these problems, the government began to investigate how to restructure its health insurance system.

7.1.1 An emerging idea for the integration reform

At that moment, new policy idea for the integration of all health funds, so called "*ipponka*", emerged from municipal health insurance societies, local governments, and scholars in response to the serious fiscal problem in the municipal health schemes (Shimazaki, 2009, 13). The idea of a full-scale integration of health insurance schemes can be traced back to 1947 (Jeong and Niki, 2012, 59). The General Headquarter proposed the "Measure for the Reconstruction of the Municipal Health Insurance". It considered merging multiple health insurance schemes at the municipal government level. The Ikeda government also considered a merger between the employment-based and residence-based schemes just after achieving the universal health care in 1961 (Yoshihara and Wada, 2008, 188). In response to the retrenchment of the health care benefits in the 1980s, the medical professionals called for the integration of the health insurance system. In August 1984, the Japanese Medical Association (JMA) and Liberal Democratic Party (LDP) signed a memorandum on

⁴⁷ Fiscal year begins April 1 and end March 31 next year.

the integration of the health insurance system, stipulating a full scale merger of health schemes (JMA, 1997, 181; Yoshihara and Wada, 2008, 608). However, neither the LDP nor the Ministry of Health and Welfare were fully supportive of the integration reform. In 1989, the committee of social security concluded that “*While it was ideal to integrate health insurance schemes, such a goal would be pursued through the health care programme for the elderly for the time being*” (JMA, 1997, 199).

As the problems in the Japanese health care system became pronounced, this idea of the integration came up again in the 1990s. The municipal health societies were grappling with their serious fiscal crisis (Shimazaki, 2009, 13). In June 1996, the subcommittee of the Council on Health Insurance released a report on various health care reforms such as healthcare delivery, health insurance, and reimbursement. In 1996, the LDP and other two ruling parties - the Social Democratic Party (SDP, *Shamintō*) and *Sakigake* (Harbinger) Party - started to build up the health insurance reform council to review the healthcare and insurance system. The Council on Elderly Health and Welfare (*Rōjin Hoken Fukushi Shingikai*) also released a policy report on the reforms for elderly care in December 1996, putting forward four different ideas⁴⁸, which had provided the base for future health insurance reform for over a decade. The integration of all health schemes was included in this report.

Demand for integration

The municipal health insurance programme had been financially more distressed than the corporate health insurance programme because the former covered a large number of low-income elderly. In 1996, around 65 percent of the municipal health societies went into deficit (MHLW, 2003). They claimed the problems in these societies mainly came from a disparity of the elderly members and shift of industrial patterns rather than their managerial problems. The government, in turn, had to find the solution through structural reforms. The “National Association of Towns and Villages”, “Japan Association of City Mayors”, and the “All Japan Federation of

⁴⁸ This report parallelised four competing reform options: integrating all health societies, widening risk adjustment, creating new independent health plans for the elderly, and introducing a two-track option. These ideas had provided the base for future health insurance reform for over a decade.

National Health Insurance Organisations⁴⁹ issued a policy report on health care reforms in December 1999. What it proposed was the merger of all health insurance schemes. They suggested taking immediate action leading to the integration of financial structures before the full-scale integration. They thought that the unification of the employment and residence-based health plans could also fundamentally solve the fiscal crisis plaguing municipal health insurance schemes by merging all health insurance funds between fiscally healthy and unhealthy funds (*Kokumin Kenkōhoken Chūōkai*, 1998). Moreover, it could lead to the equalisation of benefits and burdens to all insured persons, as the subscribers of the municipal health insurance programme had to bear higher contributions than those in other programmes. The integration reform would rectify inequality in the health insurance system (Reich et al, 2011, 1120).

The municipal governments also became strong supporters of the integration reform. This was because they were responsible for not only managing but also financing their municipal health insurance societies on the basis of the 1948 Citizen Health Insurance Act. As such, they had to put their financial resources into their health insurance societies. It was not easy for municipal governments to increase contribution rates for municipal health insurance schemes since it was unpopular policy for elected local governors and civil council members (Interview with a public officer in Municipal Health Insurance Division of Kunitachi City, Tokyo, January 2015). Moreover, it was politically difficult to substantially increase the level of cross-subsidisation because the employee health insurance schemes were strongly opposed to the measure.

In addition, there were some serious concerns about the consolidation reform. Firstly, it was difficult to find an accurate method which would ensure to charge equal contributions between salaried workers and the self-employed (Asahi Shimbun, 1998; Kenporen, 2008, 5; Shimazaki, 2009, 25; Tsuchida, 2011, 241; Yoshioka, 2009, 91). The income transparency of the self-employer in Japan was still significantly low. It would be almost impossible to create common criteria for levying insurance premiums between the two groups (Reich et al, 2011, 1113).

⁴⁹ As mentioned above, the ‘All-Japan Federation of National Health Insurance Organizations’ (*Kokumin Kenkōhoken Chūōkai*) was a national association for Citizen Health Insurance societies.

The other problem was found from a political perspective (Reich et al, 2011, 1331; Jeong and Niki, 2012, 61-2). Business and labour were strongly opposed to the integration reform for two reasons. The integration reform would merge between employment-based and residence-based health funds and thus health scheme at the individual company would vanish. In addition, the winners and losers of this reform were too obvious. This reform would lead salaried workers to pay more contributions for others compared to the current system.

Moreover, the integrated health insurance system may introduce a moral hazard in the health care system (Asahi Shimbun, 1998; Rengō, 1997). Notably, it could blur the responsibility of the health insurance schemes. Each health society was responsible for its own financial outcomes including collecting revenues and the insured persons would have incentives to reduce their health care utilization under the fragmented health insurance system. If the insured persons in a separate insurance pool reduce the cost of their insurance claims, their health insurance carrier could provide more benefits with lower contributions. However, after the merger of segmented health insurance funds, people may care less about minimising their health expenditures.

Merit and demerit of risk structure adjustment plan

A less radical reform proposal existed that focused on improving solidarity within a fragmented system (Asahi Shimbun, 1998; Nishimura, 1999). It was to strengthen the risk structure adjustment programme while maintaining the basic framework of the current health insurance system. The health insurance schemes under a fragmented system contained a number of diverse enrollees. The members' differences in income and health status would have a strong impact on the financial situation of the health insurance schemes (Buchner and Wasem, 2003). In the public health insurance system, a health insurance scheme which covers higher proportion of those considered high risk or poor usually has difficulty in balancing its budget. The risk-adjusted programme seeks to equalise the disparity of risk factors such as age, gender, and disability among subscribers in different health plans by cross-subsidising (Izumi, 2010; Van de Ven, 2007).

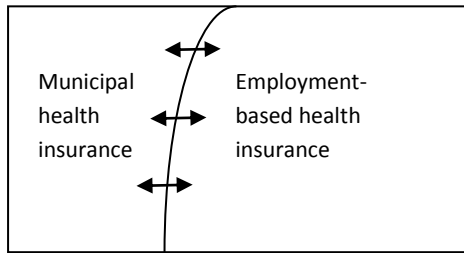


Figure 7.1 The structure of risk structure adjustment

Source: Nishimura, 1999, 9

Japan already introduced the basic risk-adjustment mechanism in 1982. The ‘health care services for the elderly’ was generated in 1982 as an effort to rectify imbalance in elderly enrolment, particularly between health insurance for the employees and self-employed (Tatara and Okamoto, 2009, 135; Tsuchida, 2011, 238). It adjusted the imbalance of risk levels among different schemes by the proportion of elderly people over the age of 70. The new proposal would strengthen the cross-subsidisation by introducing other factors to measure inequality between various health funds, as shown in Figure 7.1. While the existing programme had only two age groups, those over the aged 70 and those who were not, new proposal for risk-adjustment would proceed to divide the age group more specifically. For each age group, there was the standard level of medical expenditures. The risk-adjustment programme would adjust the imbalance of risk between schemes based on differences in the age structure of each insurer (Shimazaki, 2009, 27).

It was fascinating that there would be an achievement of equality without the need to abolish the self-governed health insurance schemes. However, corporate health insurance schemes and their political allies were also hostile to the enlargement of the risk adjustment schemes because of the rise in their contributions (Kenporen 1999, 33; Shimazaki, 2009, 27).

7.1.2 Coalition for the fragmented system

The fragmented health insurance system was sustained and supported by advocacy groups such as employers and employees in big business. Their responses to the consolidation proposal was decidedly negative (Asahi Shimbun, 1998; Rengō, 1997).

This was because the young and high income enrolees in company-based health insurance schemes were more likely to bear more contributions after the integration reform.

Institutional arrangements

There were some institutional mechanisms to sustain the fragmented health insurance system in Japan. First, this system provided economic advantages for the insured persons in the employment-based health schemes. Most of the large corporations paid more than half of employees' contributions, around 60 percent on average as shown in Table 7.1. Moreover, they tended to provide a variety of extra benefits (Interview with an Assistant Director in Welfare Policy Division of Rengō, Tokyo, December 2014). For example, a company health insurance scheme had three luxury resorts found in areas popular for tourists. Although these facilities were officially for those recuperating, in reality, it was for all enrolees in the scheme (Interview with an Executive of a Company Health Insurance Society, Tokyo, December 2014). If all health insurance schemes were integrated into a single national health insurance scheme, the contributions of high income workers would significantly increase and health insurance benefits would be reduced.

	employee	employer	total
Panasonic Health Insurance society	39%	61%	100%
Nissan Health Insurance society	42%	58%	100%
Hitachi Health Insurance society	43%	57%	100%

Table 7.1. The rate of premiums shared between employer and employee in 2014

Source: Each health insurance society webpage

It was expected that the enlargement of the risk-adjustment programmes put a huge burden on the Society-Managed Health Insurance programme, as an enrolee in this programme would pay additional 110,000 yen per annum for one's contribution (Asahi Shimbun, 2002a). Although it was quite difficult to exactly anticipate the amount of hike in contributions paid by employees due to the integration reform, the

additional burdens borne by an enrollee in this programme would be higher than the cost from the enlargement of the risk-adjustment programmes.

Secondly, the fragmented health insurance system strengthened the influence of trade unions on health care policy through co-management of the company-level health insurance societies. It is often said that workers in corporatism occupy an important governance role on the social insurance system, which is commonly the case in Continental Europe (Giaino, 2002). For example, sickness funds managed by both unions and employers allow organised labour and capital a voice in the health care administration in Germany (Manow, 1997). Under this system, organised labour and capital could play two roles as payers and insurers simultaneously. As major financial contributors, employees and employers would pay a substantial proportion of the contributions for the public health insurance system. At the same time, they occupied a role as insurers, which meant that they were directly involved in the administration of health insurance schemes at the company level. Combining these two roles gave them greater leverage in the health care policy. In addition, most of the important issues in the Japanese health care policies were addressed in the Ministry of Health and Welfare (MHW) advisory councils, “*shingikai*”. Trade unions could have an influence in this arena to some extent since they were members of the *shingikai* and were involved in policy deliberation on company-based health insurance societies (Interview with an Assistant Director in Welfare Policy Division of Rengō, Tokyo, December 2014).

Building a coalition in health care policy

In addition to economic and institutional incentives, the cooperative labour-management relationship in Japan helped employers and employees to form a policy alliance in the health care field. The cooperative labour-management relationship had become dominant since the mid-1970s, which was mainly cultivated in the private sector (Hirokuni, 1997; Kume, 1998; Suzuki, 2007). Japanese labour relations were largely established from the enterprise union system. From 1945 to the 1960s, the labour movement had been quite militant in its tactics and goals. A series of brutal defeats such as coal miners’ strike at the Miike mine in 1959-60 and increasing exposure to the international market pushed the Japanese trade unions towards a

more co-operative strategy. Large enterprise unions in the private sector led by the International Metalworkers Federation- Japan Council (IMF-JC) fostered this trend during the oil crises in the 1970s. Faced with the economic crisis, union leaders decided to cooperate to restrain wages, hold inflation, and maintain full employment (Kume, 1988). Instead, the management and government allowed unions to join policy consultations at the firm and national level.

Labour and business shared policy goals in the healthcare arena. Firstly, faced with discussion on the health insurance reform in the 1990s, they had been quite vocal in opposing the consolidation of all health insurance programmes. They claimed that a rise in insurance premiums would not only increase the burden on salaried workers but also reduce their international competitiveness in the global market (Keidanren, 2001). They also attempted to protect their company-based health insurance schemes because it could preserve their political influences on the health care policy. Since unions were keen to pursue an insider-oriented economic policy, the burdens on workers in large corporations were critical issues for the Japanese trade unions (Song, 2012, 416; Yun, 2008, 147).

Secondly, labour and business attempted to protect their interests as payers against medical providers (Campbell and Ikegami, 1998, 22; Mano, 2012, 188). In health care policy area, they had long cultivated a cooperative relationship against medical providers. As the “profession dominance theory” implies, there were power imbalances in health care policy between providers and consumers. The providers’ political sway in Japan was enhanced by their connections to the ruling party and strong organisational power (Leduc, 2002, 46). Undeterred by strong medical professionals, labour and business attempted to protect their interests in the employment-based health insurance schemes. The trade unions, business groups, and the corporate health insurance associations built a strong coalition against medical providers in the healthcare related governmental committees.

Thirdly, they also protected the interests of corporate actors against the farmers and self-employed in health policy. The government and LDP had provided large-scale government aids and protections of farming imports for the farmers. Small business had gained several benefits such as budget subsidies, tax forbearance, and regulatory protection, too (Rosenbluth and Thies, 2010, 54). In the health care field, the health insurance funds for the self-employed obtained the significant governmen-

tal subsidies and the transfer of financial resources from the company-based health funds. In this regard, the corporate actors called for the reduction of cross-funds subsidy from employment-based to residence-based health funds.

Lastly, they protected the interests of the working generation against the elderly (Kenporen, 1999, 2002). The elderly had obtained quite generous healthcare services since the 1970s. Although the ageing society and burgeoning healthcare expenditure put heavy burdens on the working generation, politicians who were concerned about old voters were reluctant to reduce the benefits. The corporate actors called for a balance of the burdens between different age groups. In sum, labour and business shared these goals in health care policy and developed a policy coalition for their common interests.

Penetration formula (Two-track formula)

The corporate actors' ideas on the health insurance reform were embedded in two policy proposals - penetration formula (also known as two-track formula or "*Tsukinuke hōshiki*" in Japanese) and independent health insurance for the elderly. Some organisations involved in the corporate health insurance programme made a proposal that would strengthen the occupational distinction. The National Federation of Health Insurance Societies (*Kenporen*), the Japan Federation of Employers' Associations (*Nikkeiren*), and the Japanese Trade Union Confederation (*Rengō*) argued that individual health insurance associations would introduce the penetration formula and keep maintaining membership for the coverage for those who retired from the company. At that time, as workers retired, they were to automatically move from corporate health societies to municipal health societies. In contrast to the prevailing system, the penetration formula would make it possible for an enrollee to stay in the company-based health insurance programme for life. As shown in Figure 7.2, the employment-based health societies would continue to provide a medical insurance coverage for the retired who were enrolled in employment-based health societies for more than 25 years. This proposal would be beneficial for company-based health funds because it would scrap or reduce cross-subsidies from employee-based to residence-based health insurance schemes. This proposal could also reduce the conflict between generations because the working generation who were involved in compa-

ny-based health funds would support those who were enrolled in company-based health funds for a long time, not all elderly people in the country.

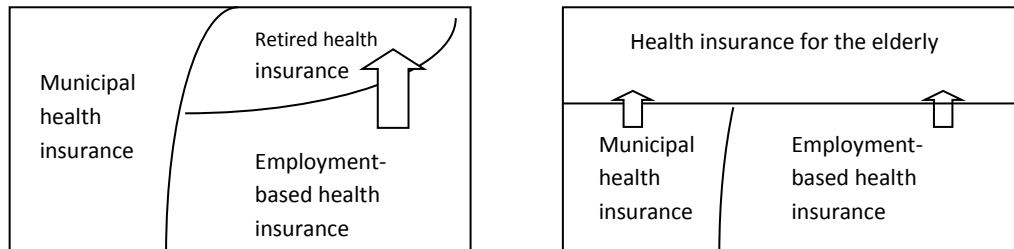


Figure 7.2. The penetration formula structure (left) and Independent health insurance scheme for the elderly (right)

Note: The arrows refer to the flow of financial supports.

Source: Shimazaki, 2009, 15

However, there were some concerns that this proposed programme could make a strong demarcation between employee-based and residence-based health insurance schemes and, in turn, it would prompt inequality among various types of the health insurance programmes (Shimazaki, 2009, 26). Since the eligibility of the penetration formula was strongly connected to the labour market status and long-term contributions, it would be an exclusive benefit for those who worked in large corporations as regular workers. In this regard, some people criticised the two-track system for contradicting the principle of social solidarity embedded in the universal health insurance system.

In addition, the two-track system would aggravate financial distress of the municipal health insurance schemes. This plan would increase the burdens of the Citizen Health Insurance programme because it assumed the removal of the cross-funds subsidy between employee-based and residence-based health societies (Asahi Shimbun, 1998). If the two-track reform was put in place, it was expected that the contribution of those enrolled in Citizen Health Insurance schemes would increase by about 19,000 yen per person (MHLW, 2001).

Lastly, it was claimed that this proposal would conflict with the flexibility of employment practice. The pattern of employment became more dynamic and flexible (Hori, 2009, 185). It seemed that more people would cross the line between employ-

ee-based and residence-based health insurance schemes than before. In this regard, this proposal could not reflect the change in employment structures.

Independent health insurance scheme for the elderly

Other proponents of the fragmented health insurance system suggested introducing a separated health insurance programme for the elderly. As shown in Figure 7.2, this proposal suggested separating the elderly from younger generations. Some argued that there was a need for the separate health insurance programme for the elderly considering some features of this age group. Seniors were generally more susceptible to the disease and thus tended to use medical institutions more frequently compared to other age groups (Reich et al, 2011, 1111). Moreover, this age group was more likely to be part of low income groups.

In addition, this proposal was based on the existing medical programme for the elderly. The previous health insurance system already had the division between old and young generations. The 1972 Elderly's Welfare Act provided free access to medical care for the elderly and then it was replaced by the 'health care system for the elderly' in 1982 (*Rōjin Hoken Seido or Rōken*). The elderly who joined this programme paid 10 percent of co-payments and the health insurance programmes which covered the small proportion of the elderly directly provided the subsidies for the elderly care. These practices of age division in the current health insurance system led to the discussion on the independent health insurance scheme for the elderly.

As shown in Table 7.2, the Japan Medical Association (JMA) and the Japan Federation of Economic Organisations (*Keidanren*) supported this proposal to create the independent health insurance programme for the elderly (Asahi Shimbun, 2001a; Konuma, 2003, 24). These two organisations regarded the proposed system as the transition into the tax-based health care system for the elderly care. They called for huge subsidies for the elderly health care, which could cover 90 percent of medical expenditure for the elderly. According to them, this subsidy would be funded by general tax since the elderly were not suitable to be handled by the contribution-based social insurance system (Izumi, 2010, 59).

Proposal	Main framework	Supporting bodies
Integration	Integrating all health insurance schemes into one insurer	Citizen Health Insurance Association and municipal governments
Risk adjustment	Strengthening risk adjustment based on age, sex and other risk factors	-
Two-track system	Keeping maintaining membership after retirement	<i>Kenporen, Nikkeiren, and Rengō</i>
Independent health insurance schemes for elderly	Separating independent scheme for the elderly from other schemes	<i>Kaidanren and JMA</i>

Table 7.2 Various health insurance reform proposals

Source: Konuma, 2003; *Asahi Shimbun*, 2001a

There were some advantages for this proposal. Firstly, it clarified the rule of benefits and burdens among the different generations (Izumi, 2010, 62). Although the existing medical programme for the elderly (*Rōken*) was run by municipal governments, there was no body which held the legal and fiscal responsibility for the programme. Secondly, it could restrain an increase in medical costs for the elderly. The new proposal could pose barriers to the access of the medical service by putting a heavier financial burden on the elderly than before. Thirdly, it could solve the uneven distribution of the elderly between employment-based and residence-based health insurance schemes. Regardless of employment status, those who were over 75 should move to a special health insurance schemes, according to this proposal.

Nonetheless, there was criticism of the new proposal. Firstly, there may not be enough risk pooling for the elderly (Yoshioka, 2009, 84). A social insurance system is supposed to enlarge a risk pool by aggregating enrolees with a different risk level. Considering insurance theory, it is not an effective insurance programme because the elderly health scheme seeks to separate high risk groups from low risk groups (Kokuho Shimbun, 1997). Secondly, since the elderly as a group could pay only a limited portion of their health expenditures, it was inevitable that the elderly health insurance scheme would record massive deficits (Ikegami and Campbell, 1999, 68). The other insurance carriers and government may be obliged to bear the significant

burden of health care for the elderly otherwise and it was not much different from the status quo.

Thirdly, another concern was that the health insurance programme targeting the elderly would trigger serious conflicts between generations (Asahi Shimbun, 1998). The reason was that a new health scheme would require financial support from the younger generation, which would be taken from tax or other such contributions (Nishimura, 1999, 12). Lastly, there was a concern for the possible deterioration of medical service quality for the elderly (Ikegami, 2005, 132-133). The government may decrease the quality of health care service for the elderly in order to constrain health expenditures. Since the proposed plan separated the elderly from others, it would be much easier for the government to give physicians economic incentives to provide poor service for the old.

7.1.3. Political process and negotiations

The proposal from the Ministry of Health and Welfare

In the Ministry of Health and Welfare (MHW), officials and policy experts sought to carry out health insurance reforms. The ministry released the reform headline, “the Health Insurance System of the 21st Century” (*21 Seiki no Iryōhōken Seido*) in August 1997, which contained two options on the health insurance governance. The first option was the integration of all health insurances by merging employment-based and residence-based health insurance schemes. The other option was to build up the independent insurance scheme(s) for the elderly with maintaining the fragmented health insurance system. These two proposals from the health ministry brought important debates in the health policy community. The ruling parties supported the independent health plan for the elderly (Konuma, 2003; The Daily Yomiuri, 1997). In August 1997, the LDP, the Social Democratic Party and New Party *Sakigake*⁵⁰ agreed in principle to create a new health insurance system solely for people who were 70 or older. Facing an ageing society, the government sought to relieve the heavy burden on the working generation by imposing more burdens of

⁵⁰ These two parties were non-Cabinet allies with the LDP. But they left the coalition in August 1998.

social security on the elderly. They were also able to broadly agree that the drugs pricing system needed reforming (The Japan times, 1997; The Ruling Parties' Medical Insurance Reform Council, 1998).

Failure to reform the prescription pricing system and revolt of Kenporen

The government and ruling parties faced a tough test of leadership when they pursued the pharmaceutical reform. Physicians and hospitals in Japan could directly dispense drugs, contrary to most Western European countries. For Japan, it was one of the main sources of profits for physicians and hospitals (Ikegami and Campbell, 1999, 63; Leduc, 2002, 162). While the government set up an officially listed price for each drug, pharmaceuticals could sell drugs to the hospitals at comparatively lower prices. The gap between the wholesale price and fee-schedule price was called "R-zone" (Talcott, 1999, 16). Doctors and hospitals were able to make profits through this difference. Meanwhile, it had led to the higher consumption of drugs, so called "intoxicated Japan". Japan had the highest per capita consumption of drugs in the world in 1996 and over-prescription led to inflate the medical spending in Japan (Ikegami and Campbell, 1999, 74).⁵¹

An advisory panel to the Health and Welfare Minister proposed the introduction of a "reference price system"⁵² in January 1999, aiming at reducing drug costs (Ikegami and Campbell, 1999, 69). However, the introduction of the reference pricing system faced high hurdles from interest groups (Asahi Shimbun, 1999c). The Japan Medical Association was strongly opposed to the proposal, claiming that it would just put more burdens on patients while drug prices would not necessarily drop. Welfare-related *zoku* (policy tribe) politicians in the LDP were concerned that it could ruin the relationship between the party and doctors' association. Due to staunch opposition from physicians and lawmakers, pharmaceutical reform ended up with failure in April 1999 (Leduc and Leduc, 2003, 570; The Daily Yomiuri, 1999).

After the announcement of delaying for the pharmaceutical reform, the corporate insurance schemes complained the LDP continued to protect the doctors' inter-

⁵¹ The prescription cost was around 7.4 trillion yen a year, more than a quarter of the national health spending (The Daily Yomiuri, 1999).

⁵² It is a system that "establishes a common reimbursement level or reference price for a group of interchangeable medicine" (Dylst et al, 2012, 128).

ests and that the party was shifting the burden onto them. In July 1999, the National Federation of Health Insurance Societies (*Kenporen*) denied to pay its cross-subsidy for the elderly health care, blaming the government for imposing heavy burden for the elderly health care on company-based health insurance schemes (Asahi Shimbun, 1999a, 1999b). *Kenporen* successfully mobilised its members to temporarily freeze payments for the inter-fund transfers. 1,793 health insurance schemes, which amounted to 97 percent of the total company-based insurance schemes, joined this collective action. They delayed paying subsidy (152 billion Yen) for the elderly health care. Labour and business also joined the movement, calling for the abolishment of the risk-sharing schemes. Ninomura, a vice president of *Kenporen*, said that it was successful in drawing public attention to the problem of cross-subsidy for elderly healthcare (Asahi Shimbun, 1999c).

7.1.4. Reform outcomes

The first reform trial in the late 1990s ended up in failure due to weak political leadership. At that time, the “*shingikai*”, an affiliated ministerial consultative council, played an important role in shaping the reform path (Campbell and Ikegami, 1998; Iwabuchi, 2013; Talcott, 2001; Yuki, 2004). When bureaucrats in Japan raised a major reform issue, the ordinary procedure of introducing new policy or changing policy began by putting the reform agenda on the *shingikai*. It consisted of representatives from core interest groups for a specific public policy area. The healthcare and health insurance related consultative councils were typically composed of the representatives from the JMA, *Kenporen*, business groups, labour unions, and academics.

In the healthcare policy council, there was a clash of the interest groups in health reforms and they failed to adopt one of proposals as the future reform plan (Asahi Shimbun, 1999f). The organisations related to Citizen Health Insurance programme called for the integration of all health insurance schemes. *Kenporen* and *Rengō* claimed that each health insurance association should cover its members in their whole life. The Japan Medical Association insisted on separating the medical insurance program for the elderly from other health insurance programmes, providing huge subsidy for new programme. The policy council submitted the policy report to the Minister in August 1999, showing all four policy alternatives.

Politicians were unsuccessful in coordinating the various interests of related actors. In the aftermath of the failure of medicine reform and *Kenporen's* revolt, the government leadership to push healthcare reform was seriously weakened (Asahi Shimbun, 1999d, 1999f). In addition, after *Sakigake Party* and Social Democratic Party left the coalition in August 1998, the discussion for healthcare reform was subsiding. In November 1999, in the Committee on Health and Welfare in the House of Representatives, Minister Niwa said that it was almost impossible to achieve the medical insurance system for the elderly before 2000 (Asahi Shimbun, 1999e). No final agreement emerged by the end of 2000 and the health insurance reform was postponed to the next government.

7.2 Koizumi era reforms

The healthcare system in Japan hinged on a fundamental review of medical spending for the elderly. Although medical insurance schemes were on the verge of collapse due to ballooning medical expenses, the health care and insurance reform attempt was not successful in the 1990s. It was largely explained by the lack of political leadership in the previous government. Against this background, when Prime Minister Koizumi took office in April 2001, he announced that he would push for structural reforms in order to revitalise the moribund economy and health insurance reforms to enhance the efficiency of health care financing.

7.2.1. Reshaping reform ideas in the Koizumi administration

The Koizumi administration fostered the favourable environment for health insurance reforms in the early stage. Although Minister Sakaguchi made a solidaristic reform proposal, the coalition of the fragmented health insurance system resisted the idea. Instead, the coalition sought to support their ideas by a new policy idea which strengthened the insurers' role under the fragmented health insurance system.

Demand for integration of all health insurance societies

As the health care reforms in the 1990s ended up in a failure, the Koizumi cabinet needed to take the political initiatives to push the reforms. Prime Minister Koizumi and Health and Welfare Minister Sakaguchi showed political will to lead the health insurance reform.⁵³ The MHLW set up the Committee on Health Insurance Reform in September 2001, inviting the JMA, *Kenporen*, *Keidanren*, *Rengō*, representative of local governments and municipal health insurance scheme, and related scholars as its members. We representatives of municipal health insurance schemes and local governments called for the integration of all health insurance societies in order to solve their fiscal problem. Nishimura, a health economist at the University of Kyoto, supported their idea on the reform.

Meanwhile, Minister Sakaguchi proposed the enlargement of the risk-sharing programme into all age groups in September 2001. He said that he preferred integrating the health insurance system and risk-sharing programme could be a stepping stone for the integration of all health societies (Kokuho Shimbun, 2001b). He pursued the partial integration as a short-term goal. Firstly, municipal insurance societies would be merged into a single prefectural insurance society at the prefecture level and occupational insurance societies would be merged into an occupational insurance at the prefecture level. In the next step, the government would seek to integrate the residence-based insurance and occupation-based insurance scheme at the prefecture level. The local governments and the association of the municipal health insurance programme hailed the Minister's proposal amid the hope that the proposed risk adjustment scheme would ease their burdens for the elderly care. Moreover, it could be an intermediate step towards the consolidation of all health insurance societies (Kokuho Shimbun, 2001b; Asahi Shimbun, 2002a).

Lesson drawing from Korean experience

As Korea achieved the integration of health insurance system at that time, Japanese policy actors in health care domain were interested in the experiment of the Korean health insurance system. A policy implemented in a place might provide lessons for governments and policy actors in other places, conceptualised as “lesson-

⁵³ They criticised the committee politics in *shingikai* in the 1990s of being inefficient to reach a decision and conciliate the conflicts of interests among main actors related to health policy.

drawing” in policy studies (Rose, 1991). However, opinions on the Korean case were divided in Japan. This was partly because the contexts in which policy was created and implanted were complex and thus the causal effect was often unclear. This was also partly because actors sought to interpret the outcome and evaluation of the cases according to their interests. Actors within municipal health insurance societies claimed that Korea achieved the more equal and efficient health insurance system due to the consolidation reform.

However, actors within employment-based health scheme had opposite ideas. They drew ‘negative lesson’ from the Korean experience of the achievement of the integration reform. Especially, *Kenporen* took intensive research on the Korean experience and its lessons (Kenporen, 2002). They pointed out the demarcation between salaried workers and the self-employed still existed in the Korean health insurance system despite the integration of all health insurance schemes. These two groups in Korea paid their premiums in different ways and the self-employment income report was still not transparent (Kenporen, 2002, 82-84). The integration also led to increase in governmental subsidies for the health insurance programme since the reform aggravated the fiscal condition of the health insurance system in Korea. Moreover, a single insurer was controlled by politicians and public officers and thus lost its autonomy. The research of *Kenporen* only mentioned that the integration reform led to the declining managerial cost arising from reducing the number of staffs and the progress of IT system for collecting and managing data (Kenporen, 2002, 96). In sum, two competing groups sought to draw different lessons from Korean experience based on their stances.

New discourse on insurers’ roles

Meanwhile, the political debates on the integration of the health insurance system kept going. Those who were in favour of a fragmented system created a new policy discourse,⁵⁴ “vitalisation of insurer functions” (*Hoken-sha Kinō-ron*) and they used it as the crucial weapon to attack the logic of integration reform (Abe, 2004;

⁵⁴ The discourse of “vitalisation of insurer functions” refers to “both a set of policy ideas and values and an interactive process of policy construction and communication.” (Schmidt, 2002, 210). The discourse is more than one policy idea since it intertwines several ideas such as insurer autonomy, competition-based health care, and consumer sovereignty in health care policy.

Ogata, 2005, 245-7; Tajika and Kikuchi, 2003; Tsushima, 2003; Yamasaki and Ogata, 2003). It was influenced by the concept of “managed competition” (Enthoven, 1988) and experience of the health insurance reform in several Continent European countries. The managed competition is an idea that providers and insurers compete on the quality and price of medical care and the government set up the rules of competition to guarantee certain public goals such as solidarity and universality (van Kleef, 2012, 171). In the Dutch and German health insurance reforms, it was shown that managed competition could provide the universal access to good-quality health care and the strong incentives for efficiency at the same time. In Japan, some academics modified the concept of managed competition to some extent, stressing the active roles of insurers (Tajika and Kikuchi, 2003; Yamasaki and Ogata, 2003).

Traditionally, there was limited room for autonomy of the insurers in Japan compared to the German and other European social health insurance systems (Ogata, 2005, 245-7). Most of the important decisions in health care policy were made by the government in Japan. Individual health insurance schemes were restricted by uniform rules set by the government. For example, the benefits for the insured were almost the same across different health insurance schemes. In this regard, the main roles of health insurance schemes in Japan were limited to the administration of the health insurance system such as management of their membership, collection of premiums, provision of the benefits, and reward for medical providers.

However, the discourse of “vitalisation of insurer functions” put emphasis on self-governing capabilities of individual health insurance schemes. It was claimed that autonomous insurers could improve the efficiency of the social health insurance system and empower their consumers in several ways. Firstly, insurers would set up its own rules on the level and scope of their insurance benefits. Secondly, as contracting parties, insurers would make contracts with medical providers. If a health insurance society could directly contract with providers, insurers could lower the price for medical services than before and be more responsible for their payments for insurance claims. Thirdly, an autonomous health insurance society could contribute to the improvement of its members’ health conditions. It could provide regular health check-up, medical consultations, and health promotion programmes such as anti-smoking campaigns. Fourthly, insurers would provide information on the quality of health care services for patients. Patients in Japan usually had little information on

medical institutes and largely left major decisions on medical services to doctors. If health insurance schemes accumulate data on healthcare services, then the patients could use it as important sources of information on health care (Tatara and Okamoto, 2009, 62). In addition, insurers could measure the quality of hospitals based on the guideline, common index, and consumers' survey.

The new discourse on insurers' roles could spread widely based on the several features in the Japanese health insurance system. The market-friendly Koizumi reform fit well into this discourse, which stressed the competition among various insurance societies. In addition, there was a long tradition that employees and employers took decisions on individual health insurance schemes together. This practice made the perception that company-based health insurance schemes were a kind of self-governing bodies. The new discourse on insurers' functions fundamentally changed the frame of debates on health insurance reforms by reinforcing the logic of a fragmented system (Mano, 2012, 206). The advocate for the multi-insurers system argued that the government had to allow insurers to play wider roles in health care and insurance policy by easing the complicated regulations. Based on the idea, the government also considered to grant more autonomy to each health insurance society.

This new discourse was adopted by the supporter for the two-track system and independent elderly insurance system. First, *Rengō*, which backed up the two-track system in the health insurance reform, attempted to strengthen its proposal through the discourse on the "vitalisation of insurer roles". The two-track system would provide strong incentives to seek to improve members' health status for health insurance schemes. This was because a member of a company-based health plan could keep staying in the same type of health insurance programmes for life. *Rengō* stressed the importance of continuous health promotion from the young generation (Social Security Advisory Council's Subcommittee on Medical Insurance, 8th Meeting Minutes, 2004).

Second, the advocates for the independent health insurance programme claimed that health insurance schemes could be actively competing for better service and lower price if the elderly was separated from other age groups. As mentioned above, they pointed that the elderly was a special age group and thus they did not fit well into the social insurance system. The proportion of the elderly in individual health insurance schemes could distort their outcomes. In this regard, they claimed that the

elderly insurance programme would lead insurers to make more efforts to enhance the efficiency of their health schemes. In sum, the new discourse on insurers' functions backed up the legitimacy and efficiency of a fragmented insurance system.

Unions' efforts for revitalisation

The Japanese labour unions suffered declining organisational power at that time. Firstly, the union density in Japan had decreased from 25.2 percent in 1990 to 21.5 percent in 2000. While *Rengō* had around eight million members in 1989 at the time of its foundation, the number of its members decreased to seven million in 2001 (Watanabe, 2015b, 516). As Korpi (1983) mentioned, union density is closely related to the unions' organisational and financial strength and, in turn, decreasing members led to the retrenchment of workers' political power. Secondly, labour's institutional channels to take part in the policy making process were also weakened. The political influence of labour union was undermined by the Koizumi reforms. *Rengō* was denied access to the policymaking process in cabinet committees on the labour market deregulation by the Koizumi government (Miura, 2007; Watanabe, 2012).

Thirdly, the political reform in the 1990s undermined the connections between trade unions and political parties (Nakakita, 2009). When *Rengō* was established in 1989, it attempted to use the connections with the Japan Socialist Party (JSP, *Nihon Shakaitō*) and the Democratic Socialist Party (DSP, *Minshatō*) to have influences on institutional political arenas. However, as the party reform within the JSP was unsuccessful, *Rengō* decided to loosen the connection with this party and joined the anti-LDP coalition in the early 1990s. Although *Rengō* got aligned with the Democratic Party of Japan (DPJ) later, the relation with the DPJ was not as strong as its previous relation with the JSP. Although *Rengō* and the DPJ attempted to coordinate labour and welfare policy in the elections, the DPJ leaders occasionally kept the distance from trade unions when organised workers were criticised for protecting their vested interests (Nakakita, 2009, 26-8).

Faced with the deep crisis of the labour movement, *Rengō* attempted to organise non-regular workers in small and mid-sized enterprises (SMEs) to achieve its revitalisation (Watanabe, 2015b). The new leadership declared the "New *Rengō*" in 2001 and released the "Union Organising Action Plan 21" to organise them. In 2003,

Rengō adopted another action policy to reinvigorate it at its regular convention. Traditionally, Japanese labour unions were not active in organising part-time workers and employees in SMEs. Only 1.3 percent of workers in companies with less than 100 employees joined trade unions in 2003 (Hanami, 2004, 12). As trade unions suffered weakening political influence and declining union density, however, union leaders put more emphasis on organising non-regular workers. Moreover, increasing social inequality pushed trade unions to make counter-actions against such a trend. After the 2001 “*Shuntō*” (spring labour offensive), *Rengō* campaigned for higher wages of part-time workers, claiming the reduction of the gap between regular and non-regular workers. The organisation accused Prime Minister Koizumi of widening social divide stemming from his market-oriented reforms. *Rengō* mentioned that it would give priority to narrowing social disparity by supporting part-time workers and regular workers in SMEs (The Japan Times, 2005). In this regard, trade unions’ stances on health insurance policies were slowly moving towards embracing non-regular and SMEs workers’ needs.

Rengō’s partial shift on the health insurance reform

According to two-track system proposed by *Rengō*, labour market insiders could be involved in the favourable company-based health insurance programme for their whole life while labour market outsiders could not to join this programme. The eligibility for the benefits of this programme depend upon labour market participation and employment status, and most part-time workers could not join the company-based health insurance programme at that moment. This was because only workers who worked more than 30 hours per week were eligible for the membership of the corporate health insurance schemes. In addition, entitlement to a full membership of the retirement health insurance programme for the retired required a contribution record of twenty-five years (Rengō, 2002, 46). The long-required contribution period became another obstacle for labour market outsiders to join this health insurance programme (Häusermann, 2010). Because of these features, the two-track system was criticised for promoting inequality in the health insurance system.

In response to such criticism and increasing non-regular workers, *Rengō* began to call for the expansion of coverage of employees’ health insurance schemes to in-

clude non-regular workers. Although they kept claiming the strong division between employment-based and residence-based health insurance schemes, its meaning was changed. While previously the two-track system was exclusively favourable for regular workers in large firms, new demand attempted to enhance the equity between labour market insiders and outsiders.

However, *Rengō* still resisted the implementation of the integration of all health funds. Firstly, the organisation recognised the importance of company-based health scheme as a tool to influence health care policy since workers took part in its decision-making process (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014). Secondly, the organisation was worried that the solidaristic health insurance reform could be a mere mechanism of cost shift onto high-income salaried workers (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014). The organisation thought that since the highly-institutionalised transfer system from company-based health schemes to residence-based health schemes could support the municipal health schemes, it did not need to bring more solidaristic health insurance reform. Thirdly, union leaders and staff in *Rengō* were influenced by the discourse of insurers' roles. They thought that the fragmented system would be more efficient than the unified system just as what the discourse of insurers' roles claimed. An official in *Rengō* criticised the municipal health schemes "for solely relying on the governmental subsidy and cross-transfer system, rather than streamlining their fiscal management" (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014). Lastly, *Rengō*'s new stance towards social movement unionism should not be exaggerated. As Watanabe (2015b) points, the organisation was still more concerned about the vested interests of well-organised regular employees in big corporations. In addition, unions' efforts to organise non-regular workers and regular workers in small companies were not sufficient. In this regard, staff in *Rengō* were reluctant to accept the integration reform, which might increase the burden of contributions on regular employees in large corporations.

7.2.2. Debates on health insurance reform and insurer functions

As the government stepped up the health insurance reform, the actors in health care policy attempted to increase their political influences. In health policy committees of the Ministry of Health, Labour, and Welfare (MHLW)⁵⁵, major actors debated the health insurance reform. As the debates became intense, clashes on the path of the health insurance reforms narrowed down the conflicts for and against the integration of health insurance schemes. These two sides had shaped the different meanings of fairness, responsibility, and efficiency of health insurance schemes through ongoing debates.

Fairness

Those who supported a single-payer system stressed “solidarity” and “indiscrimination as fairness” (Hori, 2009, 197). This meant that all people should not be discriminated on the ground of their health insurance programmes. Under a multi-payer system, the insured persons of municipal health insurance societies were treated less favourably than those of employment-based health societies. Those who supported the integration reform claimed that the discrimination among different occupational health insurance schemes was unfair. They maintained that the burden of insurance premiums should be proportional to the financial capability just like taxation. In this sense, they claimed that the unification between the employees and self-employed insurance schemes would be necessary in order to achieve fair burden (Reich et al, 2011). The idea was based on the concept that the health insurance should be a tool to achieve a solidaristic health insurance system.

In contrast, those in favour of a multi-payer system stressed “insurance principle and self-governance”. They described the fairness of health insurance as a fair burden among different insurance programmes (Kenporen, 2008; Kurata, 2009). Their argument was that the different treatment among different groups could be justified. That was because the different types of health insurance programmes were reflecting the different income structures and occupational features among different groups. There were considerable differences in income structures and transparency among several occupational groups (Reich et al, 2011, 1113; Shimazaki, 2009, 25;

⁵⁵ There was the merger between the ‘Ministry of Health and Welfare’ and the ‘Ministry of Labour’ in 2001.

Izumi, 2010, 77). The *raison d'être* of organising health insurance societies at the company level was based on the uniformity of its members and thus solidarity should be limited within homogeneous groups at the workplace level (Tsutsumi, 2008).

The key point underlying the debates on fairness was whether an individual insurance scheme was a subordinate or substantial unit. If an individual insurance scheme was just subordinate to the public health insurance system, on the one hand, the government could impose and adjust the burdens on a section of populations for the management of the whole health insurance schemes. Since the burdens would be proportional to their economic conditions, the high contributions of company-based health insurance schemes could be justified. If an individual insurance scheme was essentially a substantial unit under the public health insurance system, on the other hand, the government should respect the difference among various health insurance programmes.

In the Japanese context, where labour and business equally took part in the decision-making process of company-based health insurance schemes, there had been a strong sentiment of legitimacy of a self-governed health insurance society. The health insurance schemes were recognised as substantial and autonomous units. The company-based health insurance schemes had been long embedded in the Japanese tradition of industrial relation and social welfare. An official in *Rengō* mentioned the autonomy of company-based health insurance schemes should be respected within the boundary of the public insurance system (Interview with an Assistant Director in Welfare Policy Division of Rengō, Tokyo, December 2014). This principle was mentioned several times in the official documents in health care reform as the guideline. For instance, the “Outline of the Health Care Reform” made by the MHLW (2001) mentioned the independence and autonomy of the employment-based health insurance schemes should be respected. In addition, the discourse of insurers’ roles strengthened the perception that individual insurance societies would be a substantial and autonomous unit to increase the efficiency of the whole health insurance system. Based on this perception, inequality among different insurance schemes could be justified to a large extent.

Responsibility

There had been the debates on responsibility of the fiscal crisis in the health insurance schemes. Those who supported the integration reform claimed the structural vulnerability in municipal health insurance programmes led to the financial problem and it could be only solved by the integration reform (Interview with a Head of Health Centre in Machida City). Since the Citizen Health Insurance (CHI) schemes consisted of the self-employed, unemployed, retired, and elderly, they had the relatively weak financial foundation. The difference in participants' age structures and income levels within the medical insurance system led to heavy burden on the CHI schemes.

Furthermore, those who supported the integration reform stressed the governmental responsibility for protecting the universal public health insurance system. They argued that the government should take more responsibility for financial difficulty in the municipal health schemes since this health insurance programme sustained the most vulnerable sections of the universal health insurance system (Interview with a public officer in Municipal Health Insurance Division of Kunitachi City, Tokyo, January 2015). These health plans had encompassed those who were not entitled to join the employment-based health insurance plans. In this regard, the municipal health programme was the last resort of the universal health insurance system (Saguchi, 1995, 202; Shimazaki, 2005, 217). Recently, these health schemes were at the verge of collapsing due to structural changes in Japanese society and economy. Considering these circumstances, they claimed that the government should integrate all health insurance plans into one plan in order to sustain the universal health insurance system (Interview with a public officer in Municipal Health Insurance Division of Kunitachi City, Tokyo, January 2015).

In contrast, those who were opposed to the integration reform stressed the principle of "self-governance" of the health insurance schemes (Kenporen, 2008; Rengō, 2005). One of the crucial characteristic features of the Bismarckian welfare system is a partial decentralisation of authority to quasi-public administrative bodies, which is often co-managed by labour and business representatives (Häusermann, 2010, 20). The health insurance society has the responsibility for operating its fund, ranging from collecting revenues to managing the balance of its account (Kurata, 2009, 202-4). If an insurance scheme streamlines its management, then the good results of managerial performance would be attributed to its members. Although employment-

based health insurance schemes could provide financial transfers to municipal health insurance to some extent, such transfers had to be controlled under the self-governance principle.

The key point of the debates on responsibility was whether it was possible that a fragmented health insurance system would be able to provide the universal and decent health insurance benefits for all population. In practice, a multi-payer insurance system in Japan had redistributed financial resources through a variety of subsidies, which made it possible to build the sustainable universal health insurance system (Hussey and Anderson, 2003, 217). The unique aspect of Japanese health insurance system was a substantially high political responsibility for fiscally distressed health insurance schemes. As mentioned, this was because the central and local governments had a high legal responsibility for the health insurance system and risk-adjustment programmes were well developed in order to support the municipal health societies. These practices had fostered the interpretive effects that it might be possible to balance the principle of solidarity and self-governance under the current health insurance system and thus destroying this balance would result in worse outcomes than the current health insurance system.

Efficiency

Those in favour of the integration reform believed that the unification had the advantages such as wider risk pooling and lower administrative costs. A single-payer reform could substantially reduce the excessive administrative costs arising from managing thousands of the fragmented health insurance societies. There were more than 5,000 individual health insurance schemes and it cost enormously to operate these numerous and diverse programs (The Japan times, 2003). However, the integration reformers were not successful in making solid arguments on enhancing efficiency in the health insurance system.

In contrast, advocates of the fragmented system well demonstrated how the vitalisation of insurer's roles could enhance the efficiency of the whole national health insurance system, as mentioned above. They argued these roles would be more efficient at the individual health insurance plan level rather than the national level (Rengō, 2005, 19; Tsushima, 2003, 197). In addition, those who claimed the mainte-

nance of corporate health insurance schemes argued that they should have more autonomy to operate themselves (Tsushima, 2003). In Japan, the autonomy of health insurance schemes was quite limited. It was hardly possible for those in a health insurance scheme to make a direct contract with doctors and assess the claim made by providers. They argued that enlargement of insurers' autonomy could improve the efficiency of healthcare system. In addition, they criticised a single-payer system for bringing a moral hazard problem in the whole public health insurance system (Rengō, 2002, 49). There would be few financial incentives for managers and members to save their resources under a single-payer system (Interview with an Executive of a Company Health Insurance Society, Tokyo, December 2014). Furthermore, those in favour of the fragmented health insurance system framed the integrated health insurance system as an inefficient "state-controlled mechanism" (Kenporen, 2005, 9; Social Security Advisory Council's Subcommittee, 7th Meeting Minutes 2004).

7.2.3. Political process and negotiations

After the submission of a set of bills aimed at cutting the national medical spending in March 2002, the MHLW moved to focus on the reform of the health insurance governance. They stepped up the reform, calling for the fundamental changes in the health insurance governance in order to cope with rapidly ageing society.

Responses from the coalition for the prevailing system

As mentioned above, Minister Sakaguchi called for the enlargement of the risk-sharing programme in September 2001. However, the coalition in the employment-based health insurance schemes including *Kenporen*, *Keidanren*, and *Rengō* was strongly opposed to it. In the Committee on Health Insurance Reform, Murakai, representative of *Rengō*, claimed that the single-payer system would be less efficient than the current one similar to the government-insurance programme for small company workers, which suffered serious deficits. Simomura, representative of *Rengō*, argued that the single-payer system was supposed to be a government-operated health care system, which would be odd with the principle of the social insurance system (Kokuho Shimbun, 2001b).

In addition to trade unions, most of the LDP lawmakers were opposed to the integration reform. The Committee on Basic Medical Problems in the LDP set up its own working group for health insurance reforms. Most of the committee members supported the independent health insurance programme for the elderly based on the fragmented system. The chairperson of the committee Niwa expressed the concerns about the full-scale integration and risk-structure adjustment plan, claiming these ideas would impair the autonomy of the health insurance societies and eventually ruin the social security system (Asahi Shimbun, 2002a).

In November 2002, the working group in the LDP released its reform proposal, proposing the establishment of new independent health insurance for those aged over 75. Although the medical professions also supported this plan for the elderly, they favoured a far more generous health insurance programme for the elderly than the LDP's plan. The JMA called the government to increase the subsidy rate of the elderly's insurance contributions to 90 percent in order to stabilise elderly people's healthcare programme. It would guarantee more stable incomes to the doctors since elderly people could visit hospitals and clinics more often (Yomiuri Shimbun, 2002).

At that moment, welfare bureaucrats took ambiguous stances on the reform of health insurance governance. Their main concern was to manage the financial problem of the municipal health insurance and to curb public subsidy for health care (Ito, 2008). The manager of the Municipal Health Insurance Division in the MHLW said, "*The independent elderly health insurance scheme and two-track programme would make the fiscal condition of municipal health insurance schemes much worse than the current system. Moreover, the two-track system is hardly acceptable since it contradicts the principle of social solidarity too much* (Kokuho Shinbun, 2001a)." Moreover, the health insurance programme for elderly people would result in the large-scale subsidies for them if the new programme minimised the cross-subsidisation transfers. It would increase the subsidy by 10.8 trillion Yen by 2025, according to the outcome of the simulation conducted by the MHLW (Asahi Shimbun, 2002a).

The 2002 MHLW proposal and 2003 Cabinet's basic guideline

These two policy ideas raised by the LDP and Minister Sakaguchi were both included in the 2002 MHLW proposals. In December 2002, the MHLW released the draft on health insurance reforms, including two plans. The first plan (plan A) adopted the ‘risk structural adjustment formula’, calling for the enlargement of the cross-subsidisation among different health insurance programmes to adjust different enrollees’ risk level in the age and income structure. It was similar to Minister Sakaguchi’s proposal and could attenuate the heavy burden of the elderly care on the CHI schemes. The plan B adopted the ‘creation of a new insurance scheme for those aged 75 and over’, based on the LDP’s proposal. The late elderly would be separated from the previous system, focusing their high demands on medical service. Local governments would be in charge of the new health insurance for elderly people. Elderly people would bear more contributions than under the current system for equality of medical fees among different generations (Ikegami and Campbell, 2004, 30-1).

The *Kenporen* was strongly objected to the risk adjustment plan, saying there was no room to negotiate on the plan. The risk-adjustment scheme was designed to transfer money from low-risk to high-risk group, as shown in Table 7.3. It would largely increase the amount of financial transfers from corporate to municipal health insurance programme. The *Kenporen* (2002:5) said that “*The financial transfer for the elderly health care is out of control and it has brought the crisis of the health insurance system by undermining the self-governance. It makes no sense to increase the controversial cross-subsidisation in spite of this circumstance. We call to scrap the cross-subsidisation scheme.*”

Reform option		CHI	SMHI
Risk-adjustment scheme	total	-	+300 billion Yen
	Per person	-	+11,000 Yen
Independent health insurance for elderly people	total	+600 billion Yen	+200 billion Yen
	Per person	+17,000 Yen	+9,000 Yen

Table 7.3 Expected increasing burden incurred by health insurance reforms

Source: *Asahi Shimbun*, 2002b

The government sought to find the common ground where all major stakeholders could compromise (Yomiuri Shimbun, 2003). The government decided to combine plans A and B in the 2002 MHLW draft. The cabinet made the decision on health insurance reforms, so-called the “Basic Direction on the Health Care Reform” in March 2003. New insurance schemes for the late elderly would be created and the risk adjustment system for those aged between 65 and 74 would be introduced. The compromise suggestion had some advantages compared to the initial proposals. It could make the balance of additional burdens among major actors. Moreover, this proposal could curb the increase in public expenditures for the elderly care through the transfer from the company-based health insurance programme to the elderly care.

7.2.4. Reform outcomes

The landslide victory in the 2005 general election following rejecting the bill to privatise the national postal service promoted the health insurance reform (Asahi Shimbun, 2005; Izumi, 2010, 76). The MHLW released a proposal, the “Structural Reform of the Healthcare” (*Iryō seido kōzō kaikaku shian*) in October 2005 (MHLW, 2005b). In June 2006, the Diet passed a law which introduced new insurance schemes to cover people aged 75 or older. It was called the “Health Insurance Scheme for the Late Elderly” (*Kōkikōreisha Iryōhoken*). Firstly, the new health insurance programme for people aged 75 or older would be established, as shown in Figure 7.3. Elderly people would pay for some portion of their premiums, which would account for 10 percent of the total costs of the programme. Secondly, risk adjustment system for those aged between 65 and 74 would be introduced (See Izumi, 2010, 62-4; Shimazaki, 2009, 5).

Although the solidaristic health insurance reform was supported by municipal health insurance societies, the Health Minister, and some scholars, the reform was thwarted by the coalition between business, labour, and conservative politicians. In addition to the balance of power among policy coalitions, this issue had quite low salience among mass population. When a certain issue gained low political attention, it was much easier to defend the status quo (Cappoccia, 2016, 1112). The integration of health insurance was dealt only within health care policy community. Therefore,

institutional incumbents easily resisted the policy change by mobilising their voices in institutionalised policy arena.

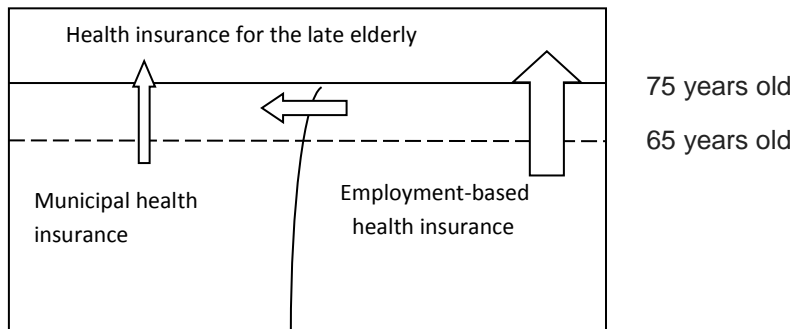


Figure 7.3 The structure of new health insurance for elderly people

Note: Arrows in the figure mean the flow of financial Transfer

Source: MHLW, 2008

7.3. The DPJ's failed reforms

The late elderly health insurance programme started in April 2008. After the launch of the new health insurance programme, however, this programme backfired due to several serious problems such as administrative errors and high contributions. Although the LDP and the MHLW made minor revisions on the programme, the new insurance scheme was unpopular. In 2009, the newly-elected Democratic Party of Japan (DPJ) government vowed to abolish this scheme and integrate all health insurance schemes at the prefectural level. The DPJ's historical victory and expression of mass grievance on the new health insurance system opened the opportunities for another health insurance reform.

7.3.1. Power transition in 2009

Manifesto election in 2009 and the re-emergence of integration plan

The Democratic Party of Japan (DPJ), the leading opposition party at that time, swept to a landslide victory in the House of Representatives election held in August 2009. The party gained overwhelming 308 seats among the 480-member House of

Representatives. The party took advantage of the growing discontent at the widened inequality stemming from the Koizumi reforms. The party presented its policies as clearly different from the LDP's reform agenda. The DPJ coined the new slogan, "People's Lives Come First", by forming new party identity. The party campaign called for the expansion of welfare safety net in response to increasing unemployment and inequality (Rosenbluth and Thies, 2010, 191). Several key interest groups such as the JMA and agricultural cooperative associations eschewed the endorsement of the LDP candidates and declared free vote in the general election in 2009. The JMA had been one of the major supporters for the LDP but the organisation was annoyed when the Koizumi administration cut the level of the national medical fee schedule twice to curb the increasing national health expenditures.

The DPJ launched its manifesto for the 2009 general election, which focused on boosting social security funding. The party vowed to block the welfare budget cut suggested by the previous LDP government. Instead, the DPJ laid out the expansion of social welfare programmes. The party outlined its key demands; the reconstruction of the pension system including a minimum 70,000 Yen monthly pension, the provision of income supports for households in the agricultural sector, the removal of the high school fees, and the provision of increasing child allowance. In addition, the party said that these promises would be achieved without tax increase.

In health care policy, the DPJ (2009, 18) vowed to abolish the new health insurance scheme for the late elderly because it discriminated elderly people, bearing more burdens of medical services on them. Moreover, the DPJ's manifesto suggested gradually integrating all health insurance schemes. It was said in the manifesto that the inequality of benefits among diverse health insurance plans would be reduced. To rectify the inequality, the party proposed the integration of all health funds as a long-term goal. The health care reforms would be implemented in two stages. At the first stage, the government would scrap the special health insurance scheme for the late elderly and establish a transitional programme. At the next stage, the government would implement the consolidation of all health funds at the prefecture level.

Structural shifts in welfare policy under the DPJ government

The DPJ pursued equity in welfare policy in terms of age and gender. They pledged to introduce universal child benefit and strengthen the measures to support child care. The party also attempted to put more emphasis on activation such as investment in skill training. It has been often said that Japan was one of the most elderly-oriented welfare states in comparative welfare state studies (Lynch, 2006, 8). Most of the benefits were concentrated on elderly people while the spending for mothers and children was under-developed. (Osawa, 2007). For instance, 69 percent of public welfare spending was devoted to elderly people in 2001 (Chopel et al, 2005, 22). In addition, Japan had shown the strong features of “male-breadwinner welfare system”⁵⁶, which was based on the idea of separate gender role that a man works full-time and a woman dedicates herself to housework. Under this system, the eligibility of welfare benefits was usually connected to the long-term labour market participation and contribution. Women were usually covered through derived rights from their husbands. Child care service remained substantially unpaid and performed inside home. It led to low female labour market participation because woman tended to exit labour market for child care (Häusermann, 2010).

7.3.2. Labour’s position under the DPJ government

Rengō’s call for welfare expansion and transformation

Rengō exercised strong influences on the DPJ’s social and welfare policies as one of the party’s key interest groups. Under the DPJ government, *Rengō* called for a transformation of welfare policy. According to the “*New Vision for Social Security in the 21st Century*” (*Rengō*, 2011), there were three main proposals that would transform welfare policies. Firstly, it sought to change welfare policies from elderly people-oriented to the age-neutral social policy (*Rengō*, 2011, 13). *Rengō* blamed the current welfare system for being biased towards elderly people (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014). Instead, the organisation proposed to increase social spending for the working gener-

⁵⁶ According to Pascall (2010), “*the male breadwinner model is an ideal of the family in which men earn a family wage and provision while wives do domestic labour and care for family members*”.

ation, who would support elderly people by paying tax and social insurance contributions. Secondly, *Rengō* highlighted the transition from the “safety net for poor relief” towards “active policy for promoting work continuity” (*Rengō*, 2011, 12). The organisation stressed the social investments in education and skill training. Thirdly, it stressed the transition from the “state-led” towards “self-governed” welfare programmes (*Rengō*, 2011, 14). The unions proposed to establish the “Social Security Fund”, which labour, business, and other insurance subscribers would equally take part in with regards to the administration of social security programmes.

As mentioned earlier, *Rengō* called for including non-regular workers as the beneficiaries of employees’ health insurance schemes. While the proportion of part-time and temporary workers was on the rise, the social security system was not geared to coping with these new forms of employment. Most non-regular workers were not able to be enrolled in the social insurance programmes provided by their firms. For instance, 24 percent of the subscribers in the municipal health societies were non-regular workers who could not join the health societies in their companies in 2005 (MHLW, 2005a). *Rengō* claimed that those who worked more than 20 hours in a week would be the beneficiaries of the employment-based health insurance and pension programme.⁵⁷ Furthermore, the organisation argued the proposal would relieve the heavy burdens on municipal health insurance schemes (*Rengō*, 2010, 27-30). The crisis of the municipal health insurance programme was partly caused by the increase in low-income non-regular workers. Although they were employees in company, they could not join the company-based health programme. If some part of the non-regular workers and their family members moved to the corporate health insurance schemes, the burdens on the municipal health insurance programme would be reduced (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014).

In addition, *Rengō* called on the government to introduce the “taxpayer identification number” to identify an individual for tax and social security system. The organisation claimed the underreporting of income was still widespread, mainly by the self-employed. This practice undermined the fairness of social security system. The tax payer number system could make tracking down of the income record much eas-

⁵⁷ With strong support from the DPJ lawmakers, a bill which expanded the coverage of the employment-based social insurance programmes was passed in 2012.

ier and thus it could contribute to enhance the transparency of taxation of the self-employed (Rengō, 2010, 32).

Rengō's responses to the health insurance proposals

Rengō was not satisfied with the special health insurance programme for the late elderly, which was implemented by the Koizumi administration. Firstly, it was not sustainable to introduce insurance only for elderly people since they were a fairly high risk group. Secondly, the financial transfer from company-based health insurance schemes to elderly people health insurance was complicated. Thirdly, it may lower the quality of the elderly medical care. Lastly, all elderly people paid their premiums under the present system whereas elderly people who were dependents of company workers were exempted from payment under the previous system.

Although the welfare policy orientations of the DPJ and *Rengō* were similar, the latter was opposed to the integration reform supported by the former. *Rengō's* health care policies were still influenced by the corporate coalition with business. According to an Assistant Director in Welfare Policy Division of *Rengō*, although *Rengō* collided with business on labour market reform issues after the Koizumi administration, we had maintained a cooperative relationship in the health care policy (Interview with an Assistant Director in Welfare Policy Division of *Rengō*, Tokyo, December 2014). Firstly, the organisation was still against the integration reform proposed by the new ruling party. If all health insurance schemes were integrated into a single scheme, premiums of employees and employers would rise. The organisation mentioned that the integration plan was at odd with the goals to control the medical care expenditures and vitalise the role of insurance schemes (The Daily Yomiuri, 2009).

In addition, the decision to increase insurers' roles in the health care policy under the DPJ government bolstered the coalition between labour and business for the fragmented system. The company-based health insurance societies played more important roles in health promotion on their members than before. The company-based health insurance societies put forward the "Data Health Plan", which prompted efficient and effective health promotion activities of individual health insurance societies based on the analysis of related data. The employees' health insurance societies

would collect and analyse their members' medical reimbursement statements and diagnostic data. This information would be used to maintain insurance subscribers' health condition. A trade union official mentioned company-based health societies do their best to streamline the health costs in the long-term perspectives through activating the plan (Interview with an Assistant Director in Welfare Policy Division of Rengō, Tokyo, December 2014).

The municipal health insurance, the late elderly health insurance, and the health insurance for the employees of small companies recorded massive deficits and thus they needed rise in contribution rates. Faced with the problems, the government chose to increase the burdens on the health insurance societies for the large corporations as new problem-solving practices in 2009. First, the government provided around 45 million Yen as special subsidy for municipal health insurance societies, which was 12,000 Yen per household. Second, the government increased the subsidy for health insurance for the employees of small and midsize companies. It was expected that the scheme had to increase the rate from 8.2% to 9.9% of members' salaries. However, the government increased the subsidy rates from 13% to 16.4% of their health expenditures instead of allowing rise in health insurance contributions. Third, the government increased the subsidy for health insurance for the late elderly health insurance to prevent steep rises in the contributions of elderly people. It was expected that the government had to increase the contribution rate by 14.2%. However, it only increased by 2.1% since the government paid the gap as special governmental subsidy to stabilise the fiscal condition of the late elderly health insurance programme.

In contrast, the government decided to put more burdens of health insurance costs in the health insurance societies of large corporations. Their burdens increased by 50 billion yen since the government made a change in the rule of the calculation of the cross-subsidy for the late elderly health insurance programme. The Diet revised the National Health Insurance Act, which stipulated that the rule of cross-subsidy for the late elderly health insurance would be based on total salary including bonus while the previous rule for cross-subsidy was based on subscribers' basic salary.

In response to the change in the rule of burden sharing, the actors in company-based health insurance societies were strongly opposed to this measure, criticising it

for being unfair. As the government implemented this change, they thought that the government was more interested in the protection of the elderly and self-employed at the expense of salaried workers. These problem-solving practices strengthened the perception of the actors in company-based health insurance societies that solidaristic health insurance reforms would shift the fiscal responsibility of health care costs onto them. An official in Economic Policy Bureau of Keidanren mentioned that “municipal health insurance societies in metropolitan areas have a large room to collect more contributions from the rich subscribers but they do not attempt. That is because they just rely on subsidies from the government and company-based societies. In this regard, it is quite unfair system” (Interview an officer in Economic Policy Bureau of Keidanren, 2014). An official in Head of Planning Department of Kenporen also mentioned that the government put more burdens on the company-based health societies in order to control the health care spending from the government (Interview with a Head of Planning Department in Kenporen, Tokyo, 2014).

7.3.3 Political process and negotiations

In September 2009, the DPJ and its two coalition partners, Social Democratic Party and People's New Party, signed the agreement to underpin their coalition government, which included the abolition of the special health insurance programme for the late elderly. The DPJ lawmakers were eager to scrap this programme built by the LDP. As people's dissatisfaction with this late elderly health insurance programme contributed to the DPJ's victory, the removal of the plan was considered a symbolic action. They thought that it would bring a favourable public opinion about power transition. A senior DPJ member said that scrapping the scheme would be a litmus test of the policy credibility of the new government (Yomiuri Shimbun, 2009). Health, Labour, and Welfare Minister Nagatsuma announced that the government would scrap this unpopular health scheme just after he took up his post.

However, it was unclear which programme would replace the new health insurance system (The Japan Times, 2009). Minister Nagatsuma decided to postpone the abolishment of the new health insurance programme for the late elderly until the end of 2010. He set up “the Council for the Reform of Health Care Services for the Elderly” (*Kōreisha Iryōseido Kaikaku Kaigi*) in order to investigate new health insur-

ance system. The health insurance reform under the new government was guided by the principles suggested by the Minister: abolishing the health insurance plan for the late elderly, creating a new insurance programme on the basis of wider regional integration, not dividing subscribers by their age, financially supporting the municipal health schemes, and not causing inequity in the health care system.

Doctors' proposal for integration

After the political regime change, the JMA changed its position on the integration reform. The JMA (2010) released a report, "Medical Insurance System to Promise Peace of Mind" and proposed a step-by-step reform. In the first step, the government would abolish the health insurance programme for the late elderly. The second step was to merge the CHI schemes at the prefectural level. At the same time, the government would integrate the scheme for public servants and one for employees in small firms. Third step was to merge all SMHI schemes. Lastly, all health plans would be integrated into a single body.

There were some reasons why doctors turned to support for the consolidation of health insurance programmes. A linkage between the new president of the JMA and the DPJ contributed to the shift of its position on the integration reform, too (Asahi Shimbun, 2010a). In April 2010, the JMA elected Katsuyuki Haranaka as new president, who backed up the party. He moved the organisation close to the ruling party on the health care policies. In addition, the serious financial crisis in municipal health insurance schemes led to a rise in the patients' out-of-pocket payments. It was often said that there would be a negative relation between burdens on the patients and demands for the medical service. For instance, when the government increased the co-payment in the late 1990s and early 2000s, patients tended to refrain from visiting medical institutes.

Competing reform ideas in the Council

In the Council for the Reform of Health Care Services for the Elderly, there were the four different ideas on the health insurance reform, which were similar to previous reform debates from the late 1990s to the mid-2000s. Firstly, Ikegami, Pro-

fessor at Keio University, advocated the integration of all health insurance programmes at the prefectural level. He claimed that it could maintain equitable and universal coverage in response to the ageing society and changes in employment patterns. Secondly, the president of the *Kenporen* Tsushima favoured the minor revision of the current system, supporting the independent health insurance for elderly people. He suggested expanding the boundary of beneficiaries for the elderly health insurance programme from aged 75 to aged 65. Thirdly, the representative of *Rengō* in the council, Kojima, backed up the two-track system, calling for the special health insurance for the retired workers who were enrolled in the employment-based health societies for more than 25 years. Lastly, Miyatake, Professor at the Mejiro University, proposed to integrate the elderly health insurance scheme into the municipal health insurance programme. As the special health insurance for the late elderly would be absorbed into the municipal health insurance schemes, this idea could bypass the ageism. The plan also maintained the divided health insurance system based on the occupations.

The Council for the Reform of Health Care Services for the Elderly released an interim report calling for abolition of the health insurance for the advanced elderly based on the professor Miyatake's idea. The prefectures would run the whole part of municipal health insurance plans, including elderly people. In contrast to his idea, however, the report suggested that elderly people who were employees or dependents of employees could move into the corporate health insurance plans. The Elderly Health Care Reform Committee (2010) submitted the final report on the elderly health insurance reform in 2010. The basic structure of health insurance reform was same as the interim report (Shimazaki, 2011, 112).

The comprehensive review of social welfare and tax system

During the election campaign in the House of Councillors in 2010, the LDP proposed the increase in consumption tax. It was expected that the government social welfare spending would reach about 60 trillion Yen in 2025 (The Japan Times, 2011). Faced with the financial problem of the growing social security spending, some DPJ politicians considered the consumption tax hike. Especially, Prime Minister Kan took the lead in the discussion of the rise in consumption tax although it deviated

from the 2009 DPJ manifesto (Lee, 2012, 1). In response to the agenda on tax hike, the division within the new ruling party emerged. As the party pledged to improve social welfare benefits without additional taxation in the 2009 DPJ Manifesto, tax hike would undermine its political responsibility. Particularly, DPJ Secretary General Ozawa was strongly opposed to the consumption tax hike.

These circumstances created issue linkages between social welfare reforms and tax hike, deterring the ruling party from submitting the health insurance bill in December 2010. The cabinet endorsed the “Outline of the Integrated Reform on the Social Security and Tax” in February 2012. There was a political negotiation between competing groups on tax increase, which allowed the implementation of pension and health insurance reforms posted in the 2009 DPJ manifesto in exchange for approving the consumption tax hike.⁵⁸ In April, the Diet began to review the outline of the integrated reform proposed by the DPJ. The government and the ruling party were planning to submit a bill to abolish the contentious health insurance scheme for elderly people in the Diet session.

However, the LDP was strongly opposed to these moves which would scrap the elderly health insurance schemes. The party, which designed and implemented this health insurance schemes, claimed that the current system made a significant advance in the Japanese health insurance system and it should be maintained (The Daily Yomiuri, 2012a). The LDP said, if the DPJ simply returned to the previous health insurance system for the old, it would repeat the same problems. Moreover, interest groups such as *Kenporen* and *Rengō* strongly opposed the integration of the health insurance system.

7.3.4 Reform outcomes

As the ruling and opposition parties reached the gridlock on social security reforms, the review on the health insurance reform bill was also halted. The LDP attempted to dissuade the ruling party from implementing the social welfare reforms presented in its manifesto. The LDP released a counter proposal on social security reforms in May 2012 and mentioned that the abandonment of these “radical” social

⁵⁸ The pension reform included introducing a guaranteed minimum pension and the health insurance reform contained abolishing special health insurance for the elderly.

policy reforms was the precondition for final agreement on the consumption tax hike. The cooperation from opposition parties was indispensable for the DPJ because the ruling party lost the majority in the House of Councillors in 2010, which was the less powerful Upper House but a majority approval was still necessary for any bill to pass.

Finally, the DPJ, the LDP, and New *Komeito* reached the basic agreement to pass several bills on the reforms of tax systems and social security on 15 June 2012. These three parties agreed to raise the consumption tax rate to 8 percent in April 2014 and then to 10 percent in October 2015. Instead, the implementation of the controversial proposals on welfare reforms such as abolishing the health insurance scheme for the late elderly and creating a minimum guaranteed pension would be dealt with in the “National Conference on Social Security”, which would be established under the Prime Minister to discuss the whole social welfare reforms (The Daily Yomiuri, 2012b).

However, some DPJ members were furious about the three parties’ agreement, which would break the crucial pledges in the manifesto of their party. The DPJ faced a huge internal revolt. 57 DPJ lawmakers voted against the bill for the rise in consumption tax in the Lower House on June 26, 2012. 57 other ruling party lawmakers who were opposed to their party orientation split to form a new party after the passage of this bill. They criticised Prime Minister Noda for breaking the DPJ’s election manifesto and fundamental party identity. Based on the three parties’ agreement, the discussion on these reform agendas such as health insurance reform and pension reform moved into the “National Conference on Social Security”. However, the discussion on these reforms was halted after the collapse of the DPJ government. In December 2012, the DPJ fell from power as a result of the stunning landslide loss to the LDP and thus the health insurance reform led by the DPJ was totally stopped.

As shown in this period, while the government partisanship can be important, it cannot explain the reform outcome. The DPJ government in Japan was a strong supporter of the integration reform. However, it failed to obtain the supports from trade unions and mass population. In this regard, the integration reform ended up with failure due to strong opposition from the coalition for the fragmented system between business and labour.

7.4 Conclusion

This chapter has analysed the political dynamics underlying the health insurance reform in Japan between the late 1990s and the early 2000s. Japan had over 3,000 public health insurance schemes, broadly divided into employment-based and residence-based programme. However, the ageing population and changes in working patterns had eroded the fiscal basis of municipal health insurance schemes. The residence-based health insurance schemes particularly had suffered a serious fiscal problem because they covered relatively lower-income and older people compared to the employment-based health insurance schemes. To solve the fiscal problem in the municipal health schemes, local governments and some scholars proposed the integration of all health insurance schemes. However, the idea was rejected by the stakeholders of the employee health insurance programme. Labour and business built up a policy coalition for protecting the occupation-based health system.

This chapter has presented how two crucial institutional features in Japanese health insurance system affected the path of health insurance reforms by shaping the main actors' attitude and strategies. The first characteristic of unique aspects was the self-governance and workers' participation in the management of the corporate health insurance schemes, which increased the political base, legitimacy, and efficiency of the fragmented health insurance system. The second characteristic was the high political responsibility for the health insurance system. That was because municipal health insurance schemes were directly run by the local governments. It also fostered specific problem-solving mechanisms through which the central government, local governments, and corporate health insurance fought for subsidy or cross-subsidy.

The ideas of labour unions and the network between labour and business were crucial in explaining the reform outcome by reshaping their interests and interpreting the meaning of a prevailing health insurance system. The strong network between labour and business had long existed in the health care policy. They attempted to protect the corporate actors' interests in the health care system. The cooperative labour movement in Japan also contributed to this coalition. The coalition thought a fragmented health insurance system as a tool to protect their common interests in the whole health care system.

Chapter 8 Comparative politics of health insurance reform in Korea and Japan

Based on the findings in the previous two chapters, this chapter conducts a comparative analysis of the politics of the health care reform in Korea and Japan. Firstly, this chapter examines the different aspects of the health insurance reforms in these two countries. Secondly, this chapter examines main actors' stances on the health insurance reform, investigating how these positions shape various policy coalitions. This chapter specifies the different institutional practices and unions' orientations in these two countries and then analyses how the interactions between distinct institutional practices and unions' orientations had affected the divergence of the health care reforms in the two countries.

8.1 Comparison of Korean and Japanese health insurance reform

Korea and Japan had the fragmented health insurance systems, which were broadly divided into employment- and residence-based health insurance schemes. In these two countries, the ageing population and changes in working patterns had eroded the fiscal basis of municipal health insurance schemes. The residence-based health insurance programme particularly had suffered serious fiscal problems because it covered relatively lower-income and older people compared to the employment-based health insurance schemes. In addition to the fiscal difficulty, there was inequality among various occupational health societies. Contribution rates in employees in large corporations were substantially lower than others. To solve the problems, some of the actors in the municipal health insurance schemes and scholars proposed the integration of all health insurance schemes. However, Korea and Japan chose the different reform paths. While the Japan government maintained its fragmented health insurance system, Korean counterpart implemented to integrate all health schemes into the not-for-profit National Health Insurance Corporation, which could be regarded as more solidaristic health insurance reform in terms of risk pooling in health care finance.

The integration of all health schemes was successfully implemented in South

Korea in the early 2000s. In the mid-1990s, labour sought to change its identity and orientation towards embracing social solidarity with other progressive groups. Korean workers led by the KCTU formed a coalition with farmers and civil activists to challenge the current system. The trade unions, farmers, and civic movements established the “Coalition for the Integration of the NHI”. As democratic labour movement joined the forces for the health insurance reform, it could make the expansion of reformers’ political influences on the reform. The labour movement leaders underscored the common interests between labour and farmers. The Korean trade unions attempted to link the bargaining with employers at the company level into the health insurance reform at the national level. This organisation held social solidarity in terms of risk and income since the reform would create the ‘single-payer system’. When it comes to the risk pooling in health insurance finance, the unitary risk pool Korea adopted held the strongest solidarity than other systems since the revenues were placed in a single central pool that attempted to cover a set of public health care services.

In Japan, by contrast, the reform was denied by the coalition between labour and business. Some proposed the consolidation of all health insurance schemes in Japan to sustain the universal health insurance and solve the fiscal problem in the municipal health schemes. The 1997 health insurance reform proposal made by the Ministry of Health and Welfare partially accepted this idea. It suggested two options including the integration of all health funds and independent health scheme for the elderly. In the early 2000s, Health, Labour and Welfare minister Sakaguchi was also interested in the solidaristic health insurance reform. He proposed the extension of inter-fund transfers, which was regarded as a stepping stone for the consolidation of all health funds.

However, this idea was rejected by the coalition between labour and business because these proposals would increase the burdens of employees and employers on health insurance contributions. They made a strong policy coalition to protect their corporate health insurance schemes and lobbied the government. In this regard, the Koizumi administration decided to protect the fragmented system favoured by corporate actors. The government decided to introduce new insurance scheme for people aged 75 years and older in 2005, maintaining the employment-based health insurance schemes. When it comes to the risk pooling in health insurance finance, Japan main-

tained the ‘partially integrated risk pools.’ Although the institutional arrangement contained financial transfers among various risk pool to some extent, it had significant limitation since it was based on the fragmented risk pool.

8.2 Labour’s significant role in the health insurance reform

In the health insurance reform in Korea and Japan, the positions of one political actor (labour) were significantly different. While business opposed and actors involved in the municipal health insurance societies supported the health insurance reform in both countries, the attitudes of physicians were ambivalent in both countries. Although government partisanship and welfare orientation explains their positions on health insurance reform, the reform outcomes in Japan cannot be explained by this factor. It was labour’s identity and incentives that had crucial impact on the reform outcomes in these two countries.

Firstly, business in the two countries was strongly opposed to the integration reform. This was because the reform would increase the burden of large corporations. When all health societies were merged, those who had high incomes and low risks would bear more contributions for those who had low incomes and high risks. In addition, the integration reform would get rid of the company-based health societies, which had strong relation with their companies. The company-based health societies provided exclusive benefits for their employees and they were regarded as one of the company-based welfare programmes.

Secondly, actors who were involved in the municipal health insurance societies in the two countries were supportive of the integration of health insurance societies. The residence-based municipal health insurance societies in the two countries had suffered serious fiscal problem because they covered relatively lower-income and older people compared to the employment-based health insurance schemes. To remedy the fiscal failure in these schemes, the integration of all health insurance schemes was proposed. The integration reform could solve the fiscal difficulty in municipal health insurance societies as well as enhance equity among various occupational groups. The movement for health insurance consolidation was ignited by the

local governments and municipal health societies in Japan and it was led by the farmers in South Korea.

Thirdly, physicians in both countries were largely indifferent to the integration reform, taking ambiguous stances (Jeong and Niki, 2012; Kwon and Reich, 2005, 1016). In Korea, while they were supportive of the reform at the early stage, they turned to the opposition. In Japan, while they were supportive of the reform, they suggested the different reform idea at some points. More importantly, physicians in both countries were not committed to implementing the reform of health insurance governance since they were not directly affected by the outcomes of the integration reform. Instead, they focused on the negotiation on the fee schedule and the reforms on the payment system.

Fourthly, governments in both countries changed their stances based on leaders' ideas and partisanship of governments. The Korean government was opposed to integration reform between 1987 and 1997. Under the conservative governments, the Korean government was opposed to the integration reform. They were worried that the integration of all health schemes could increase the governmental subsidy for health insurance system. However, the government shifted its stance after Kim Dae-jung won the presidential election in 1997. It supported the integration reform and built the special committee which handled the reform process.

In Japan, the government took ambiguous stances at the first stage of the reform. Although the Ministry of Health and Welfare (The Ministry of Health, Labour and Welfare later) was not a staunch supporter of the integration reform, the ministry did not exclude the integration reform from policy alternatives. The 1997 health insurance reform proposal made by the Ministry of Health and Welfare partially accepted this idea. It suggested two options including the integration of all health funds and independent health scheme for the elderly. In the early 2000s, Health, Labour, and Welfare minister Sakaguchi proposed the solidaristic health insurance reform, too. He proposed the extension of inter-fund transfers, which was regarded as a stepping stone for the consolidation of all health funds. Moreover, the Democratic Party of Japan (DPJ) which proposed the integration of all health insurance societies during 2009 became the supporter of the reform. The DPJ government was fully supportive of the integration reform based on its 2009 General Election Manifesto. However, while government partisanship looks important in explaining the Korean case, it

cannot properly explain the reform outcome in the Japanese case. Although the DPJ government was a strong supporter of the integration reform, the reform trial ended up with failure due to strong opposition from the coalition for the fragmented system between business and labour.

This leaves only labour as a political actor that might have affected reform outcomes in different ways in Korea and Japan. In fact, labour in both countries took totally different stances. In Korea, trade unions shifted their attitudes towards the health insurance reform in the mid-1990s when they adopted more socially oriented unionism with the emergence of the Korean Confederation of Trade Unions (KCTU). The Korean labour movements became “active supporters” for the integration of health insurance schemes. The union leaders stressed the importance of redistribution across different income groups through the consolidation of the health insurance system. To increase the political salience of the health insurance reform, the KCTU linked the health insurance reform into wage bargaining. The KCTU generated the new strategy that linked the health insurance integration into national wage bargaining process, which was called “fight for social reform”. It expanded reformers’ political influences and finally led to the integration of all health insurance schemes under the Kim Dae-jung government.

As mentioned Chapter 3, the Bismarckian health care system holds the tension between the ideas of solidarity and conservatism. In the mid-1990s, the union leaders in the Korea Confederation of Trade Unions (KCTU) stressed the redistribution and solidarity across different income groups rather than occupational differences. Though this transformation, the KCTU accepted the integration reform as its policy alternative in the health insurance reform. The “solidarity” among labour, farmers, and civil movements could break down occupational barriers among various social groups. This organisation held strong social solidarity in terms of risk and income since the reform would create the single-payer system, as mentioned above.

In contrast, Japanese unions were not supportive of the consolidation of all health funds. The Japanese trade unions had incentives to maintain the separate system. If all health insurance schemes were integrated, workers’ contributions would significantly increase and health care benefits for them would be reduced. In addition, the current system strengthened workers’ influence on health policy through the co-administration of company-level health insurance schemes. Furthermore, *Rengō* at-

tempted to fortify the demarcation between their members and the others, claiming that each health insurance association had to maintain membership for the coverage for those who have retired from the company, which was based on the prevailing fragmented insurance system. It would construct a more strongly divided system between employee-based and residence-based health insurance schemes penetrating all aged group. Labour in Japan embraced ‘conservatism’ rather than ‘social solidarity’, which meant that they sought to protect occupational barriers among various social groups. When it comes to the risk and income solidarity, the organisation wanted to reduce the sharing of risks and revenues with other groups. They stressed the self-governance in the social insurance scheme. According to them, the boundary of an insurance scheme had to be limited to a similar occupational group since the health insurance schemes had to be organised by strong group identities and similar income structures.

In this regard, this study has focused on the roles of labour which can dramatically change their ideas and interests on health insurance policy through shifting union identity. Unions’ stances on the integration of health insurance schemes were quite crucial to account for the different reform outcomes in the two countries since they had shaped the different social coalitions underpinning the health insurance systems.

8.3 Ideational and Institutional differences in Korea and Japan

The different levels of solidarity in the labour movements and formations of policy coalitions in Korea and Japan would be explained by the process in which trade unions (re)interpreted their interests based on the interactions between ideas and institutional practices. Therefore, this section compares the ideational differences in the Korean and Japanese trade unions and the institutional differences in the Korean and Japanese health insurance system.

Ideational orientation of trade unions

The Korean trade unions made ideational shift towards social movement unionism while Japanese trade unions took more economic orientation. The Korean labour

movements adopted the militant position at the first stage of the reform. They were more concerned with members' economic conditions and attempted to improve them by militant industrial actions. However, faced with serious threat from inside and outside, progressive labour unions led by the KCTU undercut narrow group identities and created a broad coalition in favour of egalitarian social policy. In the early 1990s, the general strikes and other mobilisations ended up in failure due to not only the brutal government repression but also the cynical middle-class attitude towards the labour movements. Frustrated by the failed militant strategy, labour sought to change its identity embracing social reform and other progressive issues. The KCTU adopted a more socially conscious orientation in the mid-1990s, pursuing the wider public interest and proposed a closer partnership with civil movement. The fierce debates on unions' orientation and dense networks between labour and reformers such as farmers and civic activists also was credited with the position change of labour through intensive policy learning.

In Japanese case, trade unions sought economic objectives. There was a trend of the pursuit of economic goals such as job security, increased wages and improved working conditions through collective bargaining. As Mouer (1989: 120) mentioned, Japanese "unions have shifted their attention from the distributive or egalitarian interests of individual workers to administering personnel policies on behalf of management in the name of higher incomes and a larger pie for all workers". Moreover, the Japanese labour movement was fairly keen on the insider-oriented economic struggles (Song, 2012, 416; Yun, 2008, 147). In addition, there were strong policy networks in health care policy domain between trade unions and big businesses. These policy networks were built up by cooperative business-labour relationship (Kume, 1998). This relationship has existed since the mid-1970s and it was mainly cultivated by export-oriented private sectors (Suzuki, 2007).

Decision-making processes

In Korea and Japan, the decision-making processes at the individual health insurance society level were entirely different. A health insurance society is responsible for its management and financial outcome and managers and insured people join the decision-making process together, called as "self-governance" principle (Giaino,

2002). While Korean labour could not join the decision-making processes at their employment-based health schemes, Japanese counterpart could join the processes. The self-governance principle was rarely realised in Korea (Kwon and Reich, 2005, 1006). Contrary to the official regulation that guaranteed equal participation between employers and employees, workers were hardly able to take part in the administration of their health insurance societies. Only 10 percent of corporate health insurance schemes allowed labour to join managerial meeting of their health insurance schemes and the other corporate insurance societies were operated solely by managers. In addition, most of the corporate health insurance societies allowed their managers to use the reserved funds without the permission of the insured.

Employees in Japan, by contrast, had taken part in the decision-making processes at their employment-based health schemes. Two main bodies existed for decision making at company-based health insurance level; the Society Committee and the Board of Directors (Kenporen, 2014). In these bodies, employers and employees shared equal portion of the committee members and directors. Trade unions could be involved in important decisions such as budget, rule changes, and annual business plan as representative of the insured. In addition, they could take control of the reserved funds in their corporate health insurance societies with employers.

Problem-solving practices

The second institutional difference in the health insurance systems between these two countries was the levels of political responsibility and commitments on the problem-solving mechanisms in the health insurance systems. In Korea, the government showed weak commitments to back up financially distressed municipal health societies. Firstly, the number of subsidies for municipal health schemes was left to the discretion of the government. When municipal health schemes began in 1988, the government assured the insured that they would be significantly subsidised. However, this promise was not strongly institutionalised in the 1988 Medical Insurance Act. The government had the discretion to manipulate the size of subsidy and, thus, it was subject to change depending on various political and economic circumstances (Kim, 2012, 102). Secondly, a municipal health society had no legal relation with its local government, which was opposite to the Japanese regulation. As a consequence, a

municipal government did not need to put its budget into a health insurance society in its jurisdiction. Lastly, the municipal health insurance societies relied on a steep rise in contributions in response to the serious fiscal crisis and huge deficits (Federation of Korean Medical Insurance Societies, 1997, 570).

The Japanese health insurance system, by contrast, showed high political responsibility. The municipal health insurance schemes have been directly run by local governments. The municipal governments have managed their local health insurance programs on the basis of the 1948 Citizen Health Insurance Act (Iwabuchi, 2013; Shimazaki, 2005). It had also fostered specific problem-solving mechanisms in which central government, local government, and corporate health insurance decided the rules of subsidy and cross-subsidy. Firstly, central government had provided around half of expenditures of municipal health insurance schemes with strong legal binding (Campbell and Ikegami, 1998). Secondly, municipal governments spent considerable amount of their budgets in general accounts in making up for the deficits of their health insurance societies. Municipal governments spent around 10 percent of their annual spending on balancing the budgets of their health insurance societies (Kokumin Kenkōhoken Chūōkai, 2012, 7). Third, risk-adjustment programmes transferred a significant proportion of financial resources from employment-based to residence-based health insurance societies.

8.4 Interactions between ideational and institutional factors and reinterpretations of institutional meanings

This interaction between actors' ideas and institutional practices in the health insurance system made political actors (re)interpret the meaning of the institution. When these orientations of trade unions in Korea and Japan interacted with specific institutional practices mentioned above, they led to the divergent political dynamics by making different interpretations and interests on the fragmented health insurance system.

Interactions between union orientations and decision-making process

The different decision-making processes in Korea and Japan mentioned above

had shaped and actors' interests and interpretations on the health insurance system by interacting with unions' ideational orientations. First, the different decision-making processes in these countries affected to shape the 'interests' of trade unions. Korean trade unions had fewer institutional incentives to support the fragmented health insurance system than the Japanese counterpart. Although core members enjoyed economic benefits from the fragmented insurance system, their organisational benefits from the fragmented insurance system were narrow due to the exclusion from the company-based health insurance schemes. It made them shift their stances on the health insurance reform in the mid-1990s much easier when the Korean labour movements adopted social-movement orientation. They thought long-term organisational incentives would be larger than short-term economic interests if they joined forces on the health insurance reform.

When the presence of self-governance in the health insurance societies interacted with economic orientation of the labour movements in Japan, by contrast, this interaction strengthened the perception that the current system could serve unions' interests. The priority of trade unions on health insurance policy was the economic benefits for their core members. In Japan, trade unions saw the health insurance system as benefits for their members based on their labour market status. The fragmented health insurance system provided health care benefits at low price and thus trade unions supported this system. In this background, trade unions had regarded corporate health insurance schemes as effective tools to protect their interests in health insurance policy. At the individual health society level, labour could have a huge influence on its administration through self-governance body. In addition to its prominent role in health insurance administration, labour enjoyed official status in policy forum. The government consulted *Rengō* and *Kenporen* on major policy proposals and changes at the national level. The administrative role in managing the social insurance systems gave them an institutional channel to affect health insurance policies based on their own interests (Clegg and van Wijnbergen, 2011).

The differences in the decision-making processes also fostered the different interpretations of the fragmented health insurance system, which could affect the 'legitimacy' of the prevailing system. The absence of self-governance principle in Korean had significantly undermined the legitimacy of a fragmented system. In the mid-1990s, labour began to criticise that the previous management of the health in-

insurance societies skewed towards business. More importantly, this feature reduced the meaning of an individual health insurance society to no more than a governmental body to collect contributions. The occupational divisions in the health insurance system had not special meaning. This perception of health insurance programmes helped the Korean labour movements change its position on health insurance reform after they adopted the social movement orientation. They thought company-based health insurance schemes were able to be merged into other schemes. .

In Japan, by contrast, the presence of self-governance led that people perceive a health insurance society as a substantial unit. A company-based health insurance scheme was recognised as a basic unit embedded in the long history of industrial relation. The government and other major actors involved in health care domain respected the tradition of the self-governed corporate health insurance schemes. The occupational divisions in the health insurance system had special meanings to sustain democratic governance and increase micro-efficiency in the Japanese health insurance system. This perception strengthened the legitimacy of the fragmented health insurance system. In this background, *Rengō* effectively used the codetermination between managers and workers as a tool to protect their interests in health insurance policy.

Interactions between union orientations and problem-solving practices

The divergent problem-solving practices in Japan and Korea mentioned above made significant effects on the health insurance reform in two ways. First, these differences led to contrasting interpretations on governmental responsibility for the health insurance system. When the low credibility of problem-solving practices were combined with social-movement orientation in the Korean labour movements, it made the change in the meaning of the fragmented health insurance system. When the universal public health insurance system is initiated, people have an expectation that their government holds responsibility to provide health care for all citizen. Based on this expectation, the notion of fairness in the universal public health insurance system is created. However, when the actual governance of the insurance system by their government collide with this expectation to large extend, people may delegitimise the institutional configuration. In these backgrounds, when the KCTU

embraced the social movement orientation, its leaders thought trade unions had to be involved in this issue to strengthen their political influence and moral grounds. While union leaders regarded the health insurance system as mere economic benefits for workers in the 1980s, it was seen as symbol of “social exclusion of the disadvantaged” and “malfunctioned social policy” stemmed from the irresponsible government in the 1990s. They thought that their government was rarely concerned about less fortunate citizens’ welfare and failed to establish a fair and trustful health insurance governance. They also shared the idea with farmers and civil activists that the integration reform was the only possible and fundamental solution in Korea because of weak commitments on financial aid for municipal health societies.

In Japan, by contrast, the credible problem-solving practices interacted with economic orientation in the Japanese labour movements. This interaction fortified the notion that it did not need to adopt more solidaristic reform because the Japanese health insurance system had already established a systematic support for the fiscally distressed municipal health societies. Trade unions thought that the government provided significant protections for the municipal health insurance schemes and this well organised support for the municipal health societies provided the foundation for the self-governance of individual health insurance societies. In this regard, trade unions stressed the financial responsibility for individual health insurance societies rather than social solidarity among a variety of the health insurance societies. Furthermore, they regarded the excessive amount of cross-subsidisation programme among various insurance schemes just as a tool which was geared to shift the health care costs onto them.

Second, these problem-solving practices also created different political dynamics of the reform in Korea and Japan, which affected the organisational incentives to take part in new policy coalitions. As mentioned above, the problem-solving practices in Korea contradicted the rural residents’ expectations towards the universal health insurance system, which was based on the equity and government’s responsibility. The mismatch between ideas underlying the public health insurance system and its weak institutional capability made the friction. The insured in the municipal health societies were outraged by the broken pledge to support their health insurance schemes. The farmers who were the main subscribers to the municipal health insurance schemes became strong proponents of this reform. The massive mobilisation

based on rural areas raised public awareness of the health insurance reform. It provided the political opportunity to form an alliance between farmers and labour. When Korean trade unions called for solidarity with other civic groups, they had to find the critical issues to be involved. Due to the lack of organisational capability, they could not get involved in all social movement agendas. While Korean trade unions raised a variety of the social reform agendas such as education, judicial process, and media related reform, their organisational capability was limited. Since there was high public awareness in the health insurance reform, trade unions chose to join this reform issue. In addition, when the KCTU mobilised their members in this issue, the organisation framed the health insurance reform as the most critical problem among the Korean social reforms based on these problem-solving practices.

In Japan, by contrast, problem-solving practices did not make serious friction among mass population. Instead, municipal governments and managers in municipal health schemes became the strong advocates of the integration reform while the farmers were not active in this movement. This was because farmers obtained the significant level of protection on their health insurance schemes whereas local governments in charge of their municipal health schemes put a lot of financial resources for them. In this regard, the debates on the health insurance merger in Japan were confined in the boundary of the health care policy community and public attention on the health insurance reform was fairly low. *Rengō* could not find organisational incentives to support the integration reform.

8.5 Conclusion

This chapter has compared the politics of the health insurance reform in Korea and Japan from the 1990s. This chapter has examined the main actors' stances on the integration reform and identified that the positions of labour on the reform and different policy coalitions were crucial to account for the different reform outcomes in these two countries. This chapter has also compared institutional factors related to policy making and problem-solving mechanisms, and the identities and orientations of labour movements in the two countries. The interactions between these institutional practices and workers' ideas made the totally different cognitive and incentive mechanisms of labour movements in these two countries, which led to forming vari-

ous policy coalitions for the health insurance reform and the diverging outcomes of health insurance reforms.

Chapter 9 Conclusion

This thesis has sought to analyse the question on why and how Korea chose to integrate all health insurance societies while Japan chose to keep its fragmented health insurance system. The health insurance systems in Korea and Japan were divided on the basis of occupation and labour market status. In the 1990s, there were more than 400 different health insurance societies in Korea and more than 3,000 health insurance societies in Japan. However, these two countries have taken fairly different reform paths on health insurance reform. Korea implemented the integration of all different health funds in the early 2000s. In contrast, Japan chose to keep its occupation-based health insurance system in the mid-2000s. This thesis has emphasised the role of labour and cross-class coalition in the health insurance reform in these two countries. This final chapter discusses this study's theoretical contributions to the literature on institutional change and ideational shift. The chapter then considers the implications of this thesis's findings for the solidarity in labour and welfare politics.

9.1 Theoretical contributions

This thesis contributes to the literature on the political economy of institutional changes and preference formation processes, especially in relation to labour and welfare politics. The first contribution is to the literature on institutional change. The thesis has demonstrated that some potential winner groups could form a coalition with the loser or reformer groups and achieve a policy change, by combining the micro and macro process. This thesis has explained institutional changes through interactions between political actors' ideas and institutional practices by bridging micro and macro foundations. At the micro-level, some institutional practices conflict with ideas embedded in the current health insurance system. This incongruence in the current institutional practices provides the room for institutional change by giving rise to the mass mobilisation of disadvantaged groups from the existing institutional setting. At the macro-level, the transformation of major political actors' orientation can lead to their shifts in stances on the specific policy reforms by forming a broad cross-

class coalition. Ideas act as cognitive filter through which actors perceive the environment and their interests. In the ideational process, political actors reinterpret the meaning of institutions by reshaping their own preferences and perceptions about it, rather than simply repeating the same actions. This process of institutional changes is much more likely to successfully work when institutional conflicts provide micro-foundations for them. Furthermore, when actors' ideas on their broad orientation interact with institutional incongruence, it could create the specific policy ideas which challenge the prevailing institution.

Secondly, this study contributes to the debate on the roles of ideas in institutional accounts. There are continued debates among scholars about the role and relative importance of ideas in institutional explanations (Berman, 1998). Traditional historical institutionalism has the structural-materialist core to analyse the origin, evolution, and transformation of institutions (Skocpol, 1995, 105; Thelen, 1999). Many sceptics argue that "ideas" are not independent but rather epiphenomenal to material factors (Hansen and King, 2001, 258). By contrast, other scholars argue that institutionally critical choices are shaped by the ideas actors have and debate with others (Béland and Cox, 2011, 12). By reconciling ideas and institutions, this study suggests that ideational and material analysis of institutions must be integrated in order to gain greater understanding of the complicated realities. This study shows how ideas exert their own influences on the mechanism of institutional change and interact with other contextual and institutional factors (Parsons, 2016). Actors make political actions through interpreting their world through specific ideational elements. At the same time, such interpretation which bring to an institutional change could happen when it was based on corresponding institutional configurations.

Thirdly, this thesis explains the importance of the role of labour and cross-class coalitions in welfare reforms. Korean trade unions embraced the solidaristic health insurance system and it led to the success of the reform. In contrast, Japanese trade unions cultivated the cooperative relationship with business and attempted to protect their company-based health insurance schemes. This thesis has demonstrated that workers' different stances on the health insurance system and cross-class coalitions for the welfare policy reform explain the crucial diversion of health insurance reforms in the two countries. In addition, this thesis develops the account for workers' attitude towards solidaristic welfare reforms. Worker's solidaristic support for

welfare development cannot be taken for granted as the labour class is often divided when facing specific welfare issues (Nijhuis, 2009; Rueda, 2007). Actors can shape their preferences by re-interpreting the meaning of institutional arrangements. The shift in attitude towards the prevailing institutions can be explained by the interactions between ideas and institutional arrangements and practices.

Lastly, the thesis contributes to our understanding about East Asian welfare states by conducting a systematic comparative analysis. Most studies on the welfare system in this region understood the consolidation reform of health insurance programme in Korea and its absence in Japan solely based on single case studies. For example, single case studies on the Korean health insurance reform have tended to regard the multi-payer system as a legacy of the authoritarian state. However, this is the case only in the Korean context. In addition, single case studies on the Japanese health insurance reform have tended to underestimate the non-providers' roles, particularly business and labour, in the reform process. This thesis has shown how political dynamics including labour and business as political actors could explain the specific aspects of the health insurance reforms in the two countries.

9.2 Political implications

This thesis's empirical study of Korean and Japanese health insurance reforms could be extended into the trajectories of health insurance reforms in other countries. Firstly, solidaristic social policy reform could be possible even under neoliberal globalisation, as seen in South Korea. Labour's position on the reform is fairly crucial to explain reform outcomes, and workers' positions on health insurance reforms are various depending on their conditions and ideas. Ironically, some trade unions have taken more solidaristic stances on social reform in the era of neo-liberalism since neoliberal reform faced with reducing their political power. For example, trade unions that attempted to revitalise their organisation in the US embraced the solidaristic health care reform and other social movements (Weir, 2006).

Secondly, political activists and policy entrepreneurs could use multiple and ambiguous meanings of specific features in their health insurance system to challenge the previous one (Béland, 2009; Béland and Cox, 2016). This thesis has shown the institutional arrangements of public health insurance in South Korea and Japan

had various meanings and interpretations. In a similar way, the public health insurance systems in the Continental European countries may have various goals and meanings as they contain social solidarity and occupational division at the same time. In this regard, policy entrepreneurs who want to challenge the status quo of institutional arrangements may attempt to frame the relevant health insurance system in different meanings. In this regard, framing on policy reforms are also crucial to explain the outcome of health care and insurance reforms. For example, the Dekker Commission in the Netherlands diffused some crucial policy ideas such as ‘managed competition’ and ‘internal market’ to implement comprehensive health care reform. As also seen in Korea and Japan, political actors use policy ideas and framing on related ideas to persuade populations and various interest groups to support or oppose specific reform proposals (Van Kleef, 2012).

9.3 Closing remarks

After the 1990s, the health insurance system in Korea and Japan had struggle to cope with the fiscal problems and inequality among different occupational schemes. In response to these problems, two countries chose different reform paths in spite of certain similarities. This question is fairly intriguing due to the trade unions’ positions. Labour in these two countries had taken totally different stances on this issue. However, the most common explanatory approaches such as power resources, pluralism, and rigid institutionalism had difficulty in explaining the divergence. Particularly, against social democratic assumption, this thesis has pointed out that labour’s support for solidaristic welfare programme was contingent on political contexts and their orientations. The thesis has found out the conditions under which trade unions in both countries shaped different policy interests.

As the Korean experience has shown, the institutional shift is possible in a highly path dependent policy area such as health insurance. The institutional arrangements of welfare policy are not as resistant to reform as has often been suggested. The analysis of the political processes surrounding health insurance reforms corroborates the basic assumptions laid out in the theoretical framework about the underlying institutional features and ideas in health politics.

Therefore, the adoption of certain reforms in the area of health care policy will be affected by the policy coalitions. As the Korean experience has shown, a broad cross-class alliance may be able to implement very comprehensive changes to the status quo of health insurance policy. By contrast, as the Japanese experience has shown, privileged groups could effectively block the reform. The privileged groups are committed to organising their political resources. In addition, they could invent policy discourses and logics which are used to defend the status quo. In addition, we can analyse complex interactions of numerous individual and corporate actors with specific capabilities, perceptions, and preferences under certain institutional setting. We must take into account the specific internal structures and ideational aspects of corporate actors in order to account for variations in their stances on health reforms. In these backgrounds, it remains to be seen whether these countries will also be able to implement reforms in health insurance policy to ensure the fiscal sustainability and social solidarity of their arrangements in the context of an ageing society at the same time.

Bibliography

- Abbott, A. D. (1988) *The System of Professions: An Essay on the Division of Expert Labor*. Chicago, IL: University of Chicago Press.
- Abe, T. (2004) Tsuyoi hoken-sha ga ninau shakai hoken no manejimento [Strong insurer will handle social insurance]. *Nissei kiso-ken REPORT [NLI Research Institute Report]*, 11(3) 1–4.
- Alesina, A. and Rodrik, D. (1994) Distributive Politics and Economic Growth. *The Quarterly Journal of Economics*, 109(2) 465–490.
- Alford, R. R. (1975) *Health Care Politics: Ideological and Interest Groups Barriers to Reform*. Chicago, IL: University of Chicago Press.
- Anderson, K. M. (2001) The Politics of Retrenchment in a Social Democratic Welfare State: Reform of Swedish Pensions and Unemployment Insurance. *Comparative Political Studies*, 34(9) 1063–1091.
- Anderson, K. M. and Meyer, T. (2003) Social Democracy, Unions, and Pension Politics in Germany and Sweden. *Journal of Public Policy*, 23(1) 23–54.
- Arioka, J. (1997) *Sengo Iryō No GojūNen: Iryō Hoken Seido No Butaiura [50 Years of Post-War]*. Tokyo: Nihon Iji Shinpōsha.
- Arthur, W. B. (1994) *Increasing Returns and Path Dependence in the Economy*. Ann Arbor, MI: The University of Michigan Press.
- Asahi Shimbun (1998) Sedai Sabetsu Nai Seido O Kōseishō No Kōrei-Sha Iryō Kaikaku [For Age Equal Health Care System]. Asahi Shimbun, 6 November, 4.
- Asahi Shimbun (1999a) Kenpokumiai 'Mō Genkai' 'Fubarai Undō' Kentō [Health Insurance Societies Consider Non-Payment Campaign]. Asahi Shimbun, 31 May, 1.
- Asahi Shimbun (1999b) Kenporen, Rōjin Iryō-Hi No Kyoshutsu-Kin O En'Nō, Hōkenseido Kaikaku Unagasu [Kenporen Delays the Payment of The Contributions of the Elderly Health Care Costs to Prompt Insurance Reform]. Asahi Shimbun, 11 June, 3.
- Asahi Shimbun (1999c) Iryō Hoken Ashibumi Shakai Hoshō Kaikaku [Pending Health Insurance Reform] Asahi Shimbun, 14 July, 6.
- Asahi Shimbun (1999d) Kokumin Hoken Jūbyō, Shujutsu Isoge Tsuyoi Fukōhei-Kan [National Health Insurance in Danger and It Needs Radical Reform]. Asahi Shimbun, 11 October, 3.
- Asahi Shimbun (1999e) Kōrei-Sha Iryō No Kaikaku, Rainen 4 Tsuki Wa Fukanō, Niwa Yūya Kōshō [Welfare Minister Niwa Says the Elderly Health Care Reform Would Be Delaying]. Asahi Shimbun, 11 November 3.

- Asahi Shimbun (1999f) Seido Kaikaku, Rongi Susumazu Kōrei-Sha Iryō [Elderly Health Care Reform Does Not Proceed]. Asahi Shimbun, 26 December, 3.
- Asahi Shimbun (2001a) Jisshitsu Rongi Ni Fumidase Iryō Kaikaku [Substantial Discussion on Health Care Reform Begins.]. Asahi Shimbun, 5 May, 2.
- Asahi Shimbun (2002a) Ugokidasu Kōrei-Sha Iryō Kaikaku `Nenrei Shotoku De Futan Chōsei' No Atsu Rōshō Kōsō [Minister Sakaguchi Proposes to Enlarge The Risk-Sharing Programme]. Asahi Shimbun, 18 September, 15.
- Asahi Shimbun (2002b) `Chōsei-Gata'wa Kenpo Futan-Zō Kōrei-Sha Iryō Kaikaku, Kōrōshō No 2 Shian [The Ministry Drafts Two Proposals on the Elderly Healthcare Reform]. Asahi Shimbun, 18 December, 2.
- Asahi Shimbun (2005) `Tatakidai' Yukuwa Arashi Iryō Seido Kaikaku, Kōrōshō Ga Shian [The Ministry Drafts the Health Care Reform Proposal]. Asahi Shimbun, 20 October, 2.
- Asahi Shimbun (2010a) Nichii, Minshu No Kōreishairyōseido-An Yōnin E Jikō Hanare Senmei Shinryō Hōshū Kaitei O Hikae Sekkin [JMA Moves to DPJ]. Asahi Shimbun, 10 November, 4.
- Avdagic, S. (2010) When Are Concerted Reforms Feasible? Explaining the Emergence of Social Pacts in Western Europe. *Comparative Political Studies*, 43(5) 628–657.
- Baek, S. (2001) Ŭilyopohōmt'onghapilwōnhwa Chōngch'aekkyōlchōngkwachōng Punsōk [A Study on the Policy-Making Process of the Integration of Health Insurance]. *Han'guksahoegwahak [Korean Social Science]*, 23(2) 151–169.
- Baldwin, P. (1990) *The politics of social solidarity: class bases of the European welfare state, 1875-1975*. New York: Cambridge University Press.
- Bambra, C. (2005) Cash versus Services: 'Worlds of Welfare' and the Decommodification of Cash Benefits and Health Care Services. *Journal of Social Policy*, 34(2) 195–213.
- Barakso, M., Sabet, D., and Schaffner, F. (2014) *Understanding political science research methods: the challenge of inference*. New York, NY: Routledge.
- Baumgartner, F. R. and Jones, B. D. (2002) Positive and Negative Feedback in Politics. In: Frank R. Baumgartner and Bryan D. Jones (eds.) *Policy dynamics*. Chicago, IL: University of Chicago Press, 3–28.
- Bärnighausen, T. and Sauerborn, R. (2002) One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries? *Social Science & Medicine*, 54(10) 1559–1587.
- Béland, D. (2005) Ideas and Social Policy: An Institutional Perspective. *Social Policy and Administration*, 39(1) 1–18.

- Béland, D. (2009) Ideas, Institutions, and Policy Change. *Journal of European Public Policy*, 16(5) 701-718.
- Béland, D. and Cox, R. (2011) *Ideas and Politics in Social Science Research*. New York, NY: Oxford University Press.
- Béland, D. and Cox, R. (2016) Ideas as Coalition Magnets: Coalition Building, Policy Entrepreneurs, and Power Relations, *Journal of European Public Policy*, 23(3) 428-445.
- Berman, S. (1998) *The Social Democratic Moment: Ideas and Politics in the Making of Interwar Europe*. Cambridge, MA: Harvard University Press.
- Birkland, J. (2002) *Design for Sustainability: A Sourcebook of Integrated, Ecological Solutions*. London: Earthscan.
- Blank, R. H. and Burau, V. (2014) *Comparative Health Policy*. 4th edition. Basingstoke: Palgrave Macmillan.
- Blyth, M. (2002) *Great Transformations: Economic Ideas and Institutional Change in the Twentieth Century*. Cambridge, United Kingdom: Cambridge University Press.
- Bodenheimer, T. and Grumbach, K. (2009) *Understanding Health Policy: A Clinical Approach*. 5th edition. New York, NY: McGraw-Hill Medical.
- Bradley, D., Huber, E., Moller, S., Nielsen, F., and Stephens, J. D. (2003) Distribution and Redistribution in Postindustrial Democracies. *World Politics*, 55(2) 193–228.
- Buchner, F. and Wasem, J. (2003) Needs for Further Improvement: Risk Adjustment in the German Health Insurance System. *Health Policy*, 65(1) 21–35.
- Cairney, P. (2011) *Understanding Public Policy: Theories and Issues*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan.
- Campbell, J. C. and Ikegami, N. (1998) *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System*. Cambridge, MA: Cambridge University Press.
- Capoccia, G. (2016) When Do Institutions Bite? Historical Institutionalism and the Politics of Institutional Change. *Comparative Political Studies*, 49(8) 1095-1127.
- Carey, G. (2002) *Human Genetics for the Social Sciences*. Thousand Oaks, CA: Sage.
- Carnes, M. and Mares, I. (2007) The Welfare State in Global Perspective. In: Carles Boix and Susan C. Stokes (eds.) *The Oxford Handbook of Comparative Politics*. 1st edition. New York, NY: Oxford University Press, 868–885.

- Carpenter, D. (2002) Groups, the Media, Agency Waiting Costs, and FDA Drug Approval. *American Journal of Political Science*, 46(3) 490–505.
- Carpenter, D. (2012) Is Health Politics Different? *Annual Review of Political Science*, 15(1) 287–311.
- Castles, F. G. (1998) *Comparative Public Policy: Patterns of Post-War Transformation*. Northampton, MA: Edward Elgar Publishing.
- Choi, B. (2014) *Pokchitamlon [Welfare Discourse]*. Seoul: Imijibuk.
- Choi, J. (1992) Saeroun Nodongdongŭi Panghyang Mosaegŭl Wuihayo [For the Search for A New Direction of The Labour Movement], *Sahoepyongnon [Social Review]*, June 232–246.
- Choi, J. (2010) *Minjuhwa Ihu Ŭi Minjujuŭi: Han 'guk Minjujuŭi Ŭi Posujŏk Kiwŏn Kwa Wigi [Democracy after Democratization]*. 2nd edition. Sŏul T'ŭkpyŏlsi: Humanit'asŭ.
- Choi, S. (2006) Minchuhwawa Chetochŏk Yusan Kŭliko Pokchichŏngch'I - Ŭilyopohŏm Kaehyŏkuntong, 1980~2003 [Democratization, Institutional Legacies and the Welfare Politics: The Reform Movement of the Korean National Health Insurance, 1980-2003]. *Sahoeyŏn 'gu [Social Studies]*, 7(2) 39–76.
- Chopel, A., Kuo, N., and Steinmo, S. (2005) Social Security, Taxation, and Redistribution in Japan. *Public Budgeting and Finance*, 25(4) 20–43.
- Chun, C., Kim, S., Lee, J., and Lee, S. (2009) Republic of Korea: Health system review. *Health Systems in Transition*, 11(7) 1–184.
- Chun, J. J. (2009) *Organizing at the Margins: The Symbolic Politics of Labor in South Korea and the United States*. United States: ILR Press.
- Clegg, D. and van Wijnbergen, C. (2011) Welfare Institutions and the Mobilization of Consent: Union Responses to Labour Market Activation Policies in France and the Netherlands. *European Journal of Industrial Relations*, 17(4) 333–348
- Coase, R. H. (1960) The Problem of Social Cost. *Journal of Law and Economics*, 3(1) 1–44.
- Colombo, F. and Hurst, J. (2003) *OECD Reviews of Health Care Systems Korea*. Paris: OECD.
- Connolly, H. and Darlington, R. (2012) Radical Political Unionism in France and Britain: A Comparative Study of SUD-Rail and the RMT. *European Journal of Industrial Relations*, 18(3) 235–250.
- Cramme, O. and Diamond, P. (2009) *Social Justice in the global age*. London: Polity.

- Dahl, R. A. (1958) A Critique of the Ruling Elite Model. *The American Political Science Review*, 52(2) 463–469.
- Davidsson, J. B. and Emmenegger, P. (2012) Defending the organisation, not the members: Unions and the reform of job security legislation in Western Europe. *European Journal of Political Research*, 52(3) 339–363.
- Deeg, R. (2005) Change from Within: German and Italian Finance in the 1990s. In: Wolfgang Streeck and Kathleen Thelen (eds.) *Beyond Continuity: Institutional Change in Advanced Political Economies*. New York, NY: Oxford University Press, 167–202.
- Democratic Party of Japan (2009) *Minshutō No Seiken Seisaku [Manifesto]*. Tokyo: DPJ.
- Dylst, P., Vulto, A., and Simoens, S. (2012) Reference pricing systems in Europe: Characteristics and Consequences. *Generics and Biosimilars Initiative Journal*, 1(3-4) 127–131.
- Ebbinghaus, B. and Hassel, A. (2000) Striking Deals: Concertation in the Reform of Continental European Welfare States. *Journal of European Public Policy*, 7(1) 44–62.
- Elderly Health Care Reform Committee (2010) *Kōrei-Sha No Tame No Aratana Iryō Seido-Tō Ni Tsuite: Saishū Torimatome [Final Report on the Elderly Health Insurance Reform]*. Tokyo: Elderly health care reform committee.
- Elman, C. (2005) Explanatory Typologies in Qualitative Studies of International Politics. *International Organization*, 59(2) 293–326.
- Enthoven, A. C. (1988) *Theory and Practice of Managed Competition in Health Care Finance*. New York, NY: Elsevier Science Pub. Co.
- Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*. Cambridge, UK: Polity Press.
- Estevez-Abe, M. (2008) *Welfare and Capitalism in Postwar Japan: Party, Bureaucracy, and Business*. United Kingdom: Cambridge University Press.
- Estevez-Abe, M., Iversen, T., and Soskice, D. (2001) Social Protection and the Formation of Skills: A Reinterpretation of the Welfare State. In: Peter A. Hall and David Soskice (eds.) *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*. United Kingdom: Oxford University Press, 145–183.
- Evans, R. G. (1984) *Strained Mercy: The Economics of Canadian Health Care*. Toronto: Butterworth-Heinemann.
- Federation of Korean Medical Insurance Societies. (1997) *Ŭilyopohōmūi Palchach'Wi [The Course of Health Insurance]*. Seoul: Federation of Korean Medical Insurance Societies.

- Feltenius, D. (2007) Client Organizations in a Corporatist Country: Pensioners' Organizations and Pension Policy in Sweden. *Journal of European Social Policy*, 17(2) 139–151.
- Flyvbjerg, B. (2001). *Making Social Science Matter*. Cambridge University Press.
- Freeman, R. (2000) *The Politics of Health in Europe*. Manchester: Manchester University Press.
- Freeman, R. and Rothgang, H. (2010) Health. In: Francis G. Castles Stephan Leibfried and Jane Lewis (eds.) *The Oxford Handbook of the Welfare State*. 1st edition. Oxford, UK: Oxford University Press, 367–377.
- Frege, C., Heery, E., and Turner, L. (2004) The New Solidarity? Trade Unions and Coalition Building in Five Countries. In: John Kelly and Carola M. Frege (eds.) *Varieties of Unionism: Strategies for Union Revitalization in a Globalizing Economy*. New York: Oxford University Press, 137–58.
- Frege, C. M. and Kelly, J. (2003) Introduction: Union Revitalization Strategies in Comparative Perspective. *European Journal of Industrial Relations*, 9(1) 7–24.
- Freidson, E. (1970) *Professional Dominance: The Social Structure of Medical Care*. 4th edition. Chicago, IL: Aldine Publishing.
- Fukawa, T. (2002) *Public Health Insurance in Japan*. Washington, D.C: The World Bank
- George, A. L. and Bennett, A. (2005) *Case Studies and Theory Development in the Social Sciences*. Cambridge, MA: MIT Press.
- Gerdtham, U.G. and Jönsson, B. (2000) International Comparisons of Health Expenditure: Theory, Data and Econometric Analysis. In: A. J. Culyer and J. P. Newhouse (eds.) *Handbook of Health Economics*. Amsterdam: Elsevier BV, 11–53.
- Giaimo, S. (2002) *Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States*. Ann Arbor, MI: The University of Michigan Press.
- Giaimo, S. and Manow, P. (1999) Adapting the Welfare State: The Case of Health Care Reform in Britain, Germany, and the United States. *Comparative Political Studies*, 32(8) 967–1000.
- Golden, M. A. (1997) *Heroic Defeats: The Politics of Job Loss*. Cambridge: Cambridge University Press.
- Goodman, R., Kwon, H., and White, G. (eds.) (1998) *The East Asian Welfare Model: Welfare Orientalism and the State*. 1st edition. New York: Taylor & Francis.

- Graig, L. A. (1999) *Health of Nations: An International Perspective on U.S. Health Care Reform*. 3rd edition. Washington, D.C.: Congressional Quarterly Books.
- Gray, K. (2007) *Korean Workers and Neoliberal Globalization*. 1st edition. New York, NY: Routledge.
- Gray, K. (2014) The Global Uprising of Labour? The Korean Labour Movement and Neoliberal Social Corporatism, *Globalizations*, 5(3) 483-499.
- Greif, A. and Laitin, D. (2004) A Theory of Endogenous Institutional Change. *American Political Science Review*, 98(4) 633–652.
- Ha, Y. and Lee, W. (2007) The Politics of Economic Reform in South Korea: Crony Capitalism after Ten Years. *Asian Survey*, 47(6) 894–914.
- Hacker, J. S. (2004) Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States. *American Political Science Review*, 98(2) 57–130.
- Haggard, S. (2000) *The Political Economy of the Asian Financial Crisis*. United States: Institute for International Economics.
- Haggard, S. and Kaufman, R. R. (2008) *Development, democracy, and welfare states: Latin America, East Asia, and Eastern Europe*. Princeton, NJ: Princeton University Press.
- Hall, P. A. (1993) Policy Paradigms, Social Learning and the State: The Case of Economic Policymaking in Britain. *Comparative Politics*, 25(1) 275–296.
- Hall, P. A. and Soskice, D. (2001) An Introduction to Varieties of Capitalism. In: Peter A. Hall and David Soskice (eds.) *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*. 1st edition. Oxford: Oxford University Press, 1–68.
- Hanami, T. (2004) The Changing Labor Market, Industrial Relations and Labor policy. *Japan Labor Review*, 1(1) 4–16.
- Han'györe (1988a) Kukmintaep'Yo lmyöngto Öpsi Üilyochöngch'aek Simüi'wenmal' [Health Policies Deliberation without Subscribers' Representatives]. Han'györe, 19 June, 3.
- Han'györe (1988b) Üilyopohöm Pinkonch'Üngi Tö Pulli [The Poor Is More Disadvantaged in Health Insurance]. Han'györe, 30 June, 6.
- Han'györe (1988c) Chilpyöngpalsaengüi Sahoechök Yoin Ch'Upang Ap'chang [Humanitarian Doctors' Association Will Take Action for Healthy Society]. Han'györe, 6 December, 8.
- Han'györe (1989) Chiyöküipo Taep'Yoisa Ch'inyöinsa Tokchöm [Directors of Municipal Health Insurance Are Becoming the Spoils]. Han'györe, 21 November, 10.

- Han'györe (1994) Üipot'onghap Sötullöya Hanta [We Need to Integrate All Health Insurance Schemes], Han'györe, 31 Oct, 16
- Han'györe (1996) Chiyöküipolyo 24% Olla [Municipal Health Plans Increase Their Premiums By 24%]. Han'györe, 14 October, 2.
- Han'györe (1998a) Chikchangüipo, Notongcha Sooe [Labour Is Denied To Access To The Decision Making In Company-Based Health Societies]. Han'györe, 16 November, 22.
- Hansen, R. and King, D. (2001) Eugenec Ideas, Political Interests, and Policy Variance: Immigration and Sterilization Policy in Britain and the U.S. *World Poltics*, 53(1) 237-263.
- Hassel, A. (2003) The Politics of Social Pacts. *British Journal of Industrial Relations*, 41(4) 707–726.
- Hassenteufel, P. and Palier, B. (2007) Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems. *Social Policy & Administration*, 41(6) 574–596.
- Häusermann, S. (2010) *The Politics of Welfare State Reform in Continental Europe: Modernization in Hard Times*. New York, NY: Cambridge University Press.
- Hirokuni, T. (1997) Industrial Relations and the Union Movement. In: Junji Banno (ed.) *The Political Economy of Japanese Society: Volume 1: The State or the Market?* New York, NY: Oxford University Press, 85–109.
- Hoffmeyer, U., Rowlatt, P. and Lloyd, A. (1994) *The reform of health insurance in Korea: The NERA report*. New York: National Economic Research Associates.
- Hori, K. (2009) *Shakai Hoshō Shakai Fukushi No Genri-Hō Seisaku [Principle, Law and Policy of Social Security and Social Welfare]*. Tokyo: Mineruvu Ashobō.
- Hussey, P. and Anderson, G. (2003) A comparison of single- and multi-payer health insurance systems and options for reform. *Health Policy*, 66(3) 215–228.
- Hwang, G. (2008) Going Separate Ways? The Reform of Health Insurance Funds in Germany, Japan and South Korea. *Policy Studies*, 29(4) 421–435.
- Hyman, R. (2001) *Understanding European Trade Unionism: Between Market, Class, and Society*, London: Sage.
- Iio, J. (2007) *Nihon No Tōchi Kōzō: Kanryō Naikakusei Kara Giin Naikakusei E [Japan's Governance Structure: From Bureaucratic Cabinet System to the Parliamentary Cabinet System]*. Tōkyō: Chū Ō Kō Ron Shinsha.
- Ikegami, N. (2005) Japan. In: Robin Gauld (ed.) *Comparative Health Policy in the Asia Pacific*. 1st edition. New York, NY: Open University Press, 122-145.

- Ikegami, N. (2006) *Bēshikku iryō mondai [Health issues]*. 3rd edition. Tōkyō: Nihon Keizai Shinbunsha.
- Ikegami, N. and Campbell, J. C. (1999) Health Care Reform in Japan: The Virtues of Muddling Through. *Health Affairs*, 18(3) 56-75.
- Ikegami, N. and Campbell, J. C. (2004) Japan's Health Care System: Containing Costs and Attempting Reform. *Health Affairs*, 23(3) 26–36.
- Ikenberry, J. G. (2001) *After Victory: Institutions, Strategic Restraint and the Rebuilding of Order after Major Wars*. Princeton, NJ: Princeton University Press.
- Imai, Y. (2002) *Health Care Reform in Japan*. Paris: OECD.
- Immergut, E. M. (1992) *Health Politics: Interests and Institutions in Western Europe*. New York, NY, USA: Cambridge University Press.
- Ishioka, T. (2014) Sengonihon Ni Okeru Shakai Hoken Chūshin Shugi No Seiritsu Katei Ni Kansuru Kenkyū [A Study on the Policy Formation of Social Insurance Model of the Social Security System after the World War II in Japan]. *Bukkyōdaigaku daigakuin kiyō shakai fukushi-gaku kenkyū-ka-hen*, 42(1) 1–15.
- Ito, S. (2008) *Kōki Kōreisha Iryō Seido: Kōreisha Kara Hajimaru Shakai Hoshō No Hōkai [Health Insurance for the Late Elderly: The Collapse of the Social Security Starting from The Elderly]*. Tōkyō: Heibonsha.
- Iwabuchi, Y. (2013) *Nihon No Iryō Seisaku: Naritachi to Shikumi O Manabu [Japan's Health Policy: Establishment and Its Mechanisms]*. Tokyo: Chuohokishuppan.
- Izuhara, M. (2003) Social Inequality under a New Social Contract: Long-term Care in Japan. *Social Policy and Administration*, 37(4) 395-410.
- Izumi, M. (2010) Kōreishairyōseido No Gaiyō To Kore Made No Ikisatsu: Zaisei Chōsei O Chūshin Ni [Overview and History of the Elderly Health Care System: Focusing on Risk Adjustment]. *Refarensu [Reference]*, 709(1) 55–79.
- Jacobs, A. M. and Weaver, R. K. (2014) When Policies Undo Themselves: Self-Undermining Feedback as a Source of Policy Change. *Governance*, 28(4) 441–457.
- Japan Association of City Mayors, National Association of Towns and Villages, And All Japan Federation of National Health Insurance Organizations (2005) *Kōsei Rōdōshō Iryō Seido Kōzō Kaikaku Shian Ni Tsuite [On the Ministry'S Health Insurance Proposal]*. Available from http://www.mayors.or.jp/p_opinion/o_teigen/2005/10/h171026iken.php [accessed 1 October 2014]

- Japan Medical Association (1997) *Nihon'ishikai Sōritsu Kinen-Shi — Sengo Go Jū-Nen No Ayumi [Celebrating the Fiftieth Anniversary of JMA Foundation: The Course of Post-War 50 Years]*. Tokyo: Japan Medical Association.
- Japan Medical Association (2010) *Kokumin No Anshin O Yakusoku Suru Iryō Hōkenseido [Medical Insurance System Which Promises the Peace of Mind]*. Tokyo: Japan Medical Association.
- Jenkins, C. (1983) Resource Mobilization Theory and the Study of Social Movements. *Annual Review of Sociology*, 9(1) 527-554.
- Jenkins-Smith, H. C. and Sabatier, P. A. (1994) Evaluating the Advocacy Coalition Framework. *Journal of Public Policy*, 14(2) 175–203.
- Jeong, H. (2011) Korea's National Health Insurance: Lessons from the Past Three Decades. *Health Affairs*, 30(1) 136–144.
- Jeong, H. and Niki, R. (2012) Divergence in the development of public health insurance in Japan and the Republic of Korea: A multiple-payer versus a single-payer system. *International Social Security Review*, 65(2) 51–73.
- Jo, W (1998) Sinchōngpuūi Ūilyopohōm Chōngch'aekkwache: Ūilyopohōm Ilwōnhwa Ch'uchinpanganūl Chungsimūlo [Health Insurance Reform under the New Government]. *Sahoebokchijōngch'aek [Social Welfare Policy]*, 6(1) 260-284.
- Jo, Y. (2008) Hankukpokchichōngch'aekkwachōngūi T'ūksōnge Kwanhan Yōnku [A Study on the Characteristics of Welfare Policy Process in Korea: The Case of Health Insurance]. *Han'gukchōngch'ihak'oebo [Journal of Korean Political Science Association]*, 42(1) 71–91.
- Jones, R. S. (2010) *Health-Care Reform in Korea*. Paris: OECD.
- Jones, R. S. (2009) *Health-Care Reform in Japan: Controlling Costs, Improving Quality and Ensuring Equity*. Paris: OECD.
- Jordan, J. (2010) Institutional Feedback and Support for the Welfare State: The Case of National Health Care. *Comparative Political Studies*, 43(7) 862–885.
- Kautto, M. (2002) Investing in Services in West European Welfare States. *Journal of European Social Policy*, 12(1) 53–65.
- Keidanren (2001) *Kōreishairyōseido Kaikaku Ni Kansuru Kihon-Teki Kangaekata [An Approach on the Elderly Health Care Reform]*. Tokyo: Keidanren
- Kelly, J. (1996) Union Militancy and Social Partnership. In: Peter Ackers Chris Smith and Paul Smith (eds.) *The New Workplace and Trade Unionism*. New York: Routledge, 77-109,
- Kelly, J. (1998) *Rethinking Industrial Relations: Mobilization, Collectivism and Long Waves*. London: Taylor & Francis.

- Kenporen (1999) Iryō hōkenseido kōzō kaikaku e no teigen [Recommendations to the medical insurance system structural reform], *Kenkōhoken [Health Insurance]* 53(4) 32-40.
- Kenporen (2002) *Iryō Seido Kaikaku No Arikata Ni Tsuite [On the Way of Health Care Reform]*. Tokyo: Kenporen.
- Kenporen (2005) *Aratana Kōreishairyōseido No Sōsetsu O Fukumu Iryō Seido Kaikaku Ni Mukete No Teigen [Recommendations towards Health Care Reform including New Medical System for the Elderly]*. Tokyo: Kenporen.
- Kenporen (2008) *Zaisei Chōsei Ichigenka Soshi Tokubetsu Inikai Saishū Hōkoku [Final Report of the Special Committee on Blocking Fiscal Adjustment and Insurance Integration]*. Tokyo: Kenporen.
- Kenporen (2014) *Health Insurance, Long Term Care Insurance and Health Insurance Societies in Japan*. Tokyo: Kenporen.
- Kikuchi, M (2010) Public Policy Processes and Citizen Participation in Japan. In Evan M. Berman, M. Jae Moon, and Heungsuk Choi *Public Administration in East Asia: Japan, South Korea, Chinese Mainland and Taiwan*. Boca Raton, FL: Taylor & Francis. 213-232.
- Kim, B. (2000) Hankuk Ūilyopohōmūi T'Onghapilwōnhwa : Sōngp'aeūi Kallimkil [Korean Experiment for the Unification of Multiple Health Insurers : A Road to Success or Failure]. *Pogōnhaengjōnghak'oeji [Korean Health Economic Review]*, 10(3) 108–128.
- Kim, E. (1997) *Big Business, Strong State: Collusion and Conflict in South Korean Development, 1960-1990*. Albany, NY: State University of New York Press.
- Kim, H. (1992) Chinpochōk Nochakwankyewa Chinpochōk Notongchohapchuūilūl Wihayō-Hankuk Nochakwanyeūi Kaehyōkkwa Saeloun Notonguntongūi Mosaek [For Progressive Business-Labour Relation and Labourism]. *Kyōngjewa Sahoe [Economics and Society]*, 15(9) 14–32.
- Kim, J. (2012) *The Operation of Nationwide Health Insurance and its Implications*. Seoul: Korea Institute for Health and Social Affairs.
- Kim, S. (2002) 1987nyōn Ihuūi Hankuknotonguntong [The Labor Movement in Korea since 1987]. *Han'gukchōngch'iyōn'gu [Journal of Korean Politics]*, 11(1) 197–244.
- Kim, S. (2011) The Political Dynamics of Policy Networks and Advocacy Coalitions in South Korea's Healthcare Policymaking: The 20 Years of Debates to Inaugurate a Single-Payer System. *Korean Journal of Social Welfare Studies*, 42(4) 61–102.

- Kim, Y. (1996) Ŭilyopohŏm kwanliunyŏngch'ekyewa kwanlyŏnchiptanŭi ihaekwankye: ŭilyopohŏm t'onghape taehan ch'anpanchiptanŭi ihaekwankye punsŏk [Responses of Interest Group to the Argument about Medical Insurance Scheme in Korea]. *Sahoebokchijŏngch'aek [Social Welfare Policy]*, 3(1) 195–207.
- Kim, Y. (1998) Minchunochountongŭi hyŏksinŭl wihan cheŏn [Suggestions for innovation in the democratic trade union movement]. *Nodongsahoe [Labour and Society]*, 25(1) 16-31.
- Kingdon, J.W. (1995) *Agendas, Alternatives, and Public Policies*. 2nd edition. New York, NY: Harper Collins.
- KLI. (2002) *Labor in Korea 1987~2002*. Seoul: Korea Labor Institute.
- Kokuho Shimbun (1997) Koizumi Kōshō, Yotō No “Kōrei-Sha-Betsu-Date Hoken” Ni Gimon [Minister Koizumi Call on the Question of Stability of the Elderly Health Insurance], 29 September, 5.
- Kokuho Shimbun (2001a) Kōhi Futan-Zō Muzukashī, `Gōri-Tekina Futan Suijun' To Wa [It Is Difficult To Put More Public Expense In Health Insurance System]. Kokuho Shinbun, 20 July 2.
- Kokuho Shimbun (2001b) Iryō Hoken, Shōrai Wa Ippon-Ka E, Jimukyoku-An To Wa Rinen De Tairitsu Ni [Medical Insurance Schemes Will Be Unified]. Kokuho Shimbun, 20 September 1.
- Kokumin Kenkōhoken Chūōkai (2004) Kokumin Kenkōhoken No Antei O Motomete: Iryō Hōkenseido No Kaikaku [Seeking of the Stability of the National Health Insurance: Reform of the Health Insurance System]. Tokyo: Kokumin Kenkōhoken Chūōkai.
- Kokumin Kenkōhoken Chūōkai (2012) Kokumin Kenkōhoken No Antei O Motomete: Iryō Hōkenseido No Kaikaku [Seeking of the Stability of the National Health Insurance: Reform of the Health Insurance System]. Tokyo: Kokumin Kenkōhoken Chūōkai.
- Konuma, S. (2003) *Shiryō Iryō Seido Kaikaku O Meguru Ronten [Issues Over the Health Care Reform]*. Tokyo: National Diet Library
- Koo, H. (2001) *Korean Workers: The Culture and Politics of Class Formation*. 1st edition. Ithaca, NY: Cornell University Press.
- Korpi, W. (1983) *The Democratic Class Struggle*. 1st edition. London: Routledge & Kegan Paul.
- Krasner, S. D. (1984) Approaches to the State: Alternative Conceptions and Historical Dynamics. *Comparative Politics*, 16(2) 223–246.

- Krauss, E. S. and Pekkanen, R. J. (2010) *The Rise and Fall of Japan's LDP: Political Party Organizations as Historical Institutions*. Ithaca, NY: Cornell University Press.
- Kübler, D. (2001) Understanding Policy Change with the Advocacy Coalition Framework: An Application to Swiss Drug Policy, *Journal of European Public Policy*, 8(4) 623–641.
- Kume, I. (1998) *Disparaged Success: Labor Politics in Postwar Japan*. Ithaca, NY: Cornell University Press.
- Kurata, S. (2009) *Shakai Hoken No Kōzō Bunseki: Shakai Hoshō Ni Okeru 'Rentai' No Katachi*. Sapporo-Shi: Hokkaidō Daigaku Shuppankai.
- Kwon, H. (1998) Democracy and the Politics of Social Welfare: A Comparative Analysis of Welfare Systems in East Asia. In: Roger Goodman Huck-ju Kwon and Gordon White (eds.) *The East Asian Welfare Model: Welfare Orientalism and the State*. 1st edition. London: Routledge, 27-74.
- Kwon, H. (2003) Divergent Constitution of Liberal Regimes: Comparison of the U.S. and German Automotive Supplier Markets. *Politics & Society*, 31(1) 93–130.
- Kwon, H. (2007) Advocacy Coalitions and Health Politics in Korea. *Social Policy & Administration*, 41(2) 148–161.
- Kwon, H. (2012) Politics of institutional change: Evolution of the Irish social concertation model. *Comparative European Politics*, 11(4) 481–510.
- Kwon, O. (2011) The logic of social policy expansion in a neoliberal context: health insurance reform in Korea after the 1997 economic crisis. *Theoretical Sociology*, 40(1) 645–667.
- Kwon, S. (2007) The Fiscal Crisis of National Health Insurance in the Republic of Korea: In Search of a New Paradigm. *Social Policy & Administration*, 41(2) 162–178.
- Kwon, S. and Reich, M. (2005) The Changing Process and Politics of Health Policy in Korea. *Journal of Health Politics, Policy and Law*, 30(6) 1003-1025.
- Kyōnghyang Shinmun (1987) Ŭipopōppulhapli Manhta Ŭihyōp Kaechōngkōnūi [Medical Associations Call for Health Insurance Reforms]. *Kyōnghyangshinmun*, 12 October 10.
- Kyōnghyang Shinmun (1988) Nongōch'on Ŭipolyo Koskossō Malssōng [Farmers Were Struggling Health Insurance Fee Issue]. *Kyōnghyangshinmun*, 25 January, 10.
- Kübler, D. (2001) Understanding Policy Change with the Advocacy Coalition Framework: An Application to Swiss Drug Policy. *Journal of European Public Policy*, 8(4) 623–641.

- Langwell, K. M. and Nelson, L. M. (1986) Physician Payment Systems: A Review of History, Alternatives and Evidence. *Medical Care Research and Review*, 43(1) 5–58.
- Leach, S. and Lowndes, V. (2007) Of Roles and Rules: Analysing the Changing Relationship between Political Leaders and Chief Executives in Local Government. *Public Policy and Administration*, 22(2) 183–200.
- Leduc, B. R. (2002) *Why Reforms Succeeded or Failed: Policy Competition and Regulatory Adaptation in Japan's Postwar Health Policy*. PhD. University of British Columbia.
- Leduc, B. and Leduc, B. R. (2003) The Anatomy of the Welfare-Zoku: The Institutional Complementarity of the Party Commissions and the National Reform Councils in LDP Decision Making. *Pacific Affairs*, 76(4) 569–592.
- Lee, J. (2012) *DPJ's Broken Promise and the End of the Anti-Koizumi*. Seoul: The East Asia Institute.
- Lee, K. (2002) *Ŭilyopochangkwa Ŭilyoch'Ekye [Financing And Delivering In Health Care]*. 1st Edition. Seoul: Kyeche'ungmunhwasa.
- Lee, K. (2010) *A Comparative Study On Health Policy Making Process Between South Korea And The United States: Focusing On Legislative Branches*. Seoul: The Korean Institute of Legislative Studies.
- Lee, Y. (2006) Varieties of Labor Politics in Northeast Asian Democracies: Political Institutions and Union Activism in Korea and Taiwan. *Asian Survey*, 46(5) 721–740.
- Lee, Y. (2011) *Militants or Partisans: Labor Unions and Democratic Politics in Korea and Taiwan*. Stanford, CA: Stanford University Press.
- Levi, M. (2009) Reconsiderations of rational choice in comparative and historical analysis. In: Mark Irving Lichbach and Alan S. Zuckerman (eds.) *Rationality, Culture, and Structure*. Cambridge, NY: Cambridge University Press, 117–133.
- Lieberman, R. C. (2002) Ideas, Institutions, and Political Order: Explaining Political Change. *American Political Science Review*, 96(4) 697–712.
- Light, D. And Levine, S. (1988) The Changing Character Of The Medical Profession: A Theoretical Overview. *Milbank Q*, 66(2) 10–32.
- Lim, S. (2010) Hankuk Ŭilyopohömcheto Ilwönhwa Kaehyöke Taehan Kyeküptongmaenglonchök Sölmyöng [Class Alliance Approach to the Unification Reform of National Health Insurance System in Korea]. *Sahoebogangyön 'gu*, 26(4) 121–158.

- Lin, C. (2002) *Shakai Hoshō Seido Kaikaku O Meguru Seiji Katei: Taiwan to Kankoku No Hikaku Bunseki [Political Process on the Social Security System Reform: Comparative Analysis of Taiwan and South Korea]*. PhD Dissertation. University of Tokyo.
- Lindert, P. H. (2004) *Growing Public: Volume 2, Further Evidence: Social Spending and Economic Growth Since The Eighteenth Century*. 1st Edition. Cambridge, NY: Cambridge University Press.
- Lowndes, V. And Robert, M. (2013) *Why Institutions Matter: The New Institutionalism in Political Science*. Basingstoke: Palgrave MacMillan
- Lynch, J. (2006) *Age in the Welfare State: The Origins of Social Spending on Pensioners, Workers, and Children*. 1st edition. Cambridge, NY: Cambridge University Press.
- Maarse, H. (2003) Has Solidarity Survived? A Comparative Analysis of the Effect of Social Health Insurance Reform in Four European Countries. *Journal of Health Politics, Policy and Law*, 28(4) 585–614.
- Maeilgyōngje (1977) Ūilyopohōmcheto Silsi [Health Insurance Is Coming Into Effect]. Maeilgyōngje, 1 July, 1.
- Maeilgyōngje (1980) Ūilyopohōm Ilwōnhwatwaeya [The Health Insurance System Need to Be Unified]. Maeilgyōngje, 1 March 7.
- Maeilgyōngje (1986) Ūipoilwōnhwa Nonūi Chint'ong [Fierce Debates on the Integration of All Health Schemes]. Maeilgyōngje, 13September, 11.
- Maeilgyōngje (1988) Nongōch'on Ūipo Kukkochiwōn Hyōn 35% Sō 50% Lo Nop'yō [Municipal Health Plans Will Be Increased]. Maeilgyōngje, 1 April, 1.
- Mahoney, J. (2000a) Path Dependence in Historical Sociology. *Theory and Society*, 29(4) 507–548.
- Mahoney, J. (2000b) Strategies of Causal Inference in Small-N Analysis. *Sociological Methods & Research*, 28(4) 387–424.
- Mahoney, J. And Thelen, K. (2009) A Theory of Gradual Institutional Change. In: James Mahoney and Kathleen Thelen (eds.) *Explaining Institutional Change: Ambiguity, Agency, and Power in Historical Institutionalism*. 1st edition. Cambridge: Cambridge University Press, 1-37.
- Mano, T. (2012) *Nyūmon Iryō Seisaku: Dare Ga Kimeruka Nani O Mezasu Noka [Introduction of Health Policy: Who Decides, What to Aim]*. Tōkyō: Chūōkōronshinsha.
- Martin, C. H., and Stronach, B. (1992) *Politics East and West: a Comparison of Japanese and British Political Culture*. Armonk, N.Y.: M.E. Sharpe.

- McGuire, J. W. (2010) *Wealth, health, and democracy in East Asia and Latin America*. New York, NY: Cambridge University Press.
- Meltzer, A. H. and Richard, S. F. (1981) A Rational Theory of the Size of Government. *Journal of Political Economy*, 89(5) 914–927.
- MHLW (2001) *Iryō Seido Kaikaku No Kadai To Shiten [Challenges and Perspectives of the Health Care System Reform]*. Tokyo: Ministry of Health, Labour and Welfare
- MHLW (2003) *Heisei 15-Kōsei Rōdō Hakusho [A White Paper on Welfare and Labour in 2003]*. Tokyo: Ministry of Health, Labour and Welfare
- MHLW (2005a) *Heisei 17-Nendo Kokumin Kenkōhoken Jittai Chōsa [National Health Insurance Survey in 2005]*. Tokyo: Ministry of Health, Labour and Welfare
- MHLW (2005b) *Iryō Seido Kōzō Kaikaku Shian [A Draft on the Health Care Reform]*. Tokyo: Ministry of Health, Labour and Welfare.
- MHLW (2006) *Heisei 18-Nendo Kokumin Iryō-Hi No Gaikyō [Report on National Health Expenditure in 2004]*. Tokyo: Ministry of Health, Labour and Welfare
- MHLW (2008) *Heisei 20-Nenban Kōsei Rōdō Hakusho [A White Paper on Welfare and Labour in 2008]*. Tokyo: Ministry of Health, Labour and Welfare
- MHW (1997) *21 Seiki No Iryō Hōkenseido — Iryō Hoken Oyobi Iryō Teikyō Taisei No Bappon-Teki Kaikaku No Hōkō [21 Century Medical Insurance System - Direction of Drastic Reform of the Medical Insurance and Healthcare Delivery System]*. Tokyo: Ministry of Health and Welfare.
- Miura, M. (2007) Koizumi Seikento Rōdō Seiji No Hen'Yō: `Tasū-Ha Shihai-Gata' No Seisaku Katei No Shutsugen [Politics of Labour Reform Under Koizumi Government: The Emergence of Majoritarian Decision-Making]. *Gyosei Kenkyu Sosyo [Annual Review of Public Administration]*, 42(1) 100–122.
- Mo, J. (1996) Political Learning and Democratic Consolidation: Korean Industrial Relations, 1987-1992. *Comparative Political Studies*, 29(3) 290–311.
- Moene, K. O. and Wallerstein, M. (2003) Earnings Inequality and Welfare Spending: A Disaggregated Analysis. *World Politics*, 55(4) 485–516.
- Mouer, R. (1989) Japanese Model of Industrial Relations: Warnings or Opportunities. *Hitotsubashi Journal of Social Studies*, 21(1) 105-124.
- Murillo, M. V. (2001) *Labour Unions, Partisan Coalitions, and Market Reforms in Latin America*. 1st edition. United Kingdom: Cambridge University Press.
- Musgrave, R. A. (1957) A Multiple Theory of Budget Determination. *FinanzArchiv*, 25(1) 33–43.

- Nakagawa, H. (2009) Kokumin Kenkōhoken No Genjō To Kadai [The Condition and Problem Of National Health Insurance]. *Refarensu [Reference]*, 703(1) 77–95.
- Nakakita, K. (2009) Nihon No Rōdō Seiji [Labor Politics in Japan]. In: Toshimatsu Shinkawa and Toru Shinoda (eds.) *Rōdō To Fukushi Kokka No Kanōsei: Rōdō Undō Saisei No Kokusai Hikaku [Labor and Possibility of Welfare State: International Comparison of Labor Movement Revitalisation]*. Kyōto: Mineruva Shobō,
- Nijhuis, D. O. (2009) Revisiting The Role of Labor: Worker Solidarity, Employer Opposition, and the Development of Old- Age Pensions in the Netherlands and the United Kingdom, *World Politics*, 61(02) 296–329.
- Nishimura, M. (1999) Iryō Hoshō Seido Kaikaku No Kentō Katei Rontento Hōkō-Sei [The Process of Health Reform and Its Direction in Japan]. *Keizai-gaku zasshi [Economic Research]*, 5(6) 5–15.
- Nordhaus, W. D. (1975) The Political Business Cycle. *The Review of Economic Studies*, 42(2) 169–190.
- North, D. C. (1990) *Institutions, Institutional Change and Economic Performance*. Cambridge: Cambridge University Press.
- OECD (2001) *OECD Health Data 2001 A Comparative Analysis of 30 Countries*. Paris: OECD.
- OECD (2003) *Health at a Glance: OECD Indicators 2003*. Paris: OECD.
- OECD (2008) *OECD Employment Outlook 2008*. Paris: OECD.
- OECD (2010) *OECD Health Data 2010*. Paris: OECD.
- OECD (2011) *Society at a Glance 2011*. Paris: OECD.
- Ogata, H. (2005) Hoken-Sha Kinō Kyōka-Ron No Keizai Seisaku-Gaku [Economic and Policy Studies of the Insurer Enforcement Theory]. In: Hisao Endo and Naomi Ikegami (eds.) *Iryō Hoken Shinryō Hōshū Seido [Medical Insurance and Medical Fee System]*. Tōkyō: Keisōshobō,
- Oliver, A. (2009) The Single-Payer Option: A Reconsideration. *Journal of Health Politics, Policy and Law*, 34(4) 509–530.
- Olson, M. (1965) *The Logic of Collective Action: Public Goods and the Theory of Groups*. Cambridge, MA: Harvard University Press.
- Osawa, M. (2007) *Gendai Nihon No Seikatsu Hoshō Shisutemu: Zahyōto Yukue [Social Security in Contemporary Japan: A Comparative Analysis]*. Tōkyō: Iwanami Shoten.

- Pae, K. (2008) *87nyŏn Ihu Notong Chohap Kwa Notong Untong: Hankuk Nosa Kwankye Sisūt 'Em Ŭi Pyŏnhwa Wa Milae Chŏnmang [Trade Unions and Labour Movements in Korea Since 1987]*. Seoul: Hankuknotongyŏnkuwŏn [Korea Labour Institute].
- Park, J. and Heo, Y. (2001) Sahoegaehyŏgundongŭn Chashinŭi Ihaegwan'gyerŭl Ttwiŏnŏmŏsŏ Haengdonghanŭn Kŏshida [Social Movement beyond Self-interest]. *Wŏlgan Pokchidonghyang [Monthly Welfare Trends]*, 32(1) 68-75.
- Park, S. (1992) Hankuknotonguntong, Kwayŏnwikiinka? [Is Korean Labour Movement In Crisis?]. *Ch'angjakkwa Pip'yŏng*, 76(1) 214–246.
- Parsons, C. (2016) Ideas and Power: Four Intersections and How to Show Them. *Journal of European Public Policy*, 23(3) 446-463.
- Pascall, G. (2010) Male-Breadwinner Model. In: Tony Fitzpatrick Huck-Ju Kwon and Nick Manning (eds.) *International Encyclopedia of Social Policy*. London: Routledge, 813–815.
- Pierson, P. (1994) *Dismantling the Welfare State?: Reagan, Thatcher and the Politics of Retrenchment*. Cambridge: Cambridge University Press.
- Pierson, P. (2000) Increasing Returns, Path Dependence, and the Study of Politics. *The American Political Science Review*, 94(2) 251–267.
- Pierson, P. (2004) *Politics in Time: History, Institutions, and Social Analysis*. United States: Princeton University Press.
- Porter, D. (1999) *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times*. New York, NY: Taylor & Francis.
- Ross, S. (2007) Varieties of Social Unionism: Towards A Framework for Comparison. *A Canadian Journal of Work and Society*, 11(2) 16–34.
- Powell, W. W. and DiMaggio, P. J. (eds.) (1991) *The New Institutionalism in Organizational Analysis*. Chicago, IL: University of Chicago Press.
- Powelson, J. P. and Stock, R. (1987) *The Peasant Betrayed: Agriculture and Land Reform in the Third World*. Boston, MA: Oelgeschlager, Gunn & Hain.
- Przeworski, A. and Teune, H. J. (1970) *The Logic of Comparative Social Inquiry*. New York: Wiley-Interscience.
- Quadagno, J. S. (2005) *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*. New York: Oxford University Press.
- Rehm, P., Hacker, J. S., and Schlesinger, M. (2012) Insecure Alliances: Risk, Inequality, and Support for the Welfare State. *American Political Science Review*, 106(2) 386–406.

- Reich, M. R., Ikegami, N., Shibuya, K., and Takemi, K. (2011) 50 Years of Pursuing a Healthy Society in Japan. *The Lancet*, 378(9796) 1051–1053.
- Rengō (1997) *21 Seiki Shakai Hoshō Bijon [Welfare Vision of 21st Century]*. Tokuo: Rengō
- Rengō (2002) *21 Seiki Shakai Hoshō Bijon [Welfare Vision of 21st Century]*. Tokuo: Rengō
- Rengō (2005) *21 Seiki Shakai Hoshō Bijon [Welfare Vision of 21st Century]*. Tokuo: Rengō
- Rengō (2010) *Kōreishairyōseido O Kangaeru: Rengō No `Taishoku-Sha Kenkōhoken Seido'(Kashō) No Kangaekata [Elderly Health Care System: The Concept of Retiree Health Insurance System]*. Tokyo: Rengō
- Rengō (2011) *Shin 21 Seiki Shakai Hoshō Bijon [New 21st Century Social Security Vision]*. Tokyo: Rengō
- Rice, T. H. and Labelle, R. J. (1989) Do Physicians Induce Demand for Medical Services? *Journal of Health Politics, Policy and Law*, 14(3) 587–600.
- Rose, R. (1991) What Is Lesson Drawing? *Journal of Public Policy*, 11 (1) 3- 30.
- Rosenbluth, F. M. and Thies, M. F. (2010) *Japan Transformed: Political Change and Economic Restructuring*. Princeton, NJ: Princeton University Press.
- Rothstein, B. (1992) Labor-Market Institutions and Working-Class Strength. In: Sven Steinmo Kathleen Thelen and Frank Longstreth (eds.) *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press, 33–56.
- Rothstein, B. (1998) The Political and Moral Logic of the Universal Welfare State. In: Carole Pateman Brian Barry and Robert E. Goodin (eds.) *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge, UK: Cambridge University Press, 144–170.
- Rothstein, B. (2005) *Social Traps and the Problem of Trust*. Cambridge, Cambridge University Press.
- Rowley, C and Yoo, K-S (2008) Trade Unions in South Korea: Transition Towards Neocorporatism?. In: John Benson and Ying Zhu (eds.) *Trade Unions in Asia an economic and sociological analysis*, Oxon: Routledge, 43-62
- Rueda, D. (2007) *Social Democracy Inside Out: Partisanship and Labour Market Policy in Advanced Industrialized Democracies*. Oxford: Oxford University Press.
- Sabatier, P. A. (1988) The Advocacy Coalition Framework: Revisions and Relevance for Europe. *Journal of European Public Policy*, 5(1) 98–130.

- Sabatier, P. A. (1998) An Advocacy Coalition Model of Policy Change and The Role of Policy-Oriented Learning Therein. *Policy Sciences*, 21(1) 29–68.
- Sabatier, P. A., and C. Weible. (2007) The Advocacy Coalition Framework: Innovations and Clarifications. In: Paul A. Sabatier (ed.) *Theories of the Policy Process*. Boulder, CO: Westview Press, 189–222.
- Saguchi, T. (1995) *Kokumin Kenkō Hoken: Keiseito Tenkai [National Health Insurance: Formation and Development]*. Tōkyō: Kōseikan.
- Saltman, R. B. And Figueras, J. (1997) *European Health Care Reform: Analysis of Current Strategies, WHO Regional Publications, European Series No. 72*. Copenhagen: WHO.
- Schmidt, V. A. (2002) *The Futures of European Capitalism*. New York: Oxford University
- Schmidt, V. A. (2010) Taking Ideas and Discourse Seriously: Explaining Change through Discursive Institutionalism as the Fourth ‘New Institutionalism’. *European Political Science Review*, 2(1) 1–25.
- Schmitter, P. C. (1974) Still the Century of Corporatism? *The Review of Politics*, 36(1) 85-131.
- Schmitter, P. C. And Streeck, W. (1999) *The Organization of Business Interests: Studying the Associative Action of Business in Advanced Industrial Societies*. Köln: Max Planck Institut Für Gesellschaftsforschung.
- Schut, F. T. And Van De Ven, W. P. M. M. (2005) Rationing and Competition In The Dutch Health-Care System. *Health Economics*, 14(1) 59–74.
- Schut, F. T. And Van Doorslaer, E. K. A. (1999) Towards A Reinforced Agency Role of Health Insurers In Belgium And The Netherlands. *Health Policy*, 48(1) 47–67.
- Shimazaki, K. (2005) Wagakuni No Iryō Hōkenseido No Rekishito Tenkai [History and Deployment of Japan’s Medical Insurance System]. In: Hisao Endō and Naomi Ikegami (eds.) *Iryō Hoken Shinryō Hōshū Seido [Medical Insurance and Medical Fee System]*. Tōkyō: Keisōshobō,
- Shimazaki, K. (2009) *The Development of a Health Insurance System for The Elderly and Associated Problem Areas*. Tokyo: Council of Local Authorities for International Relations
- Shimazaki, K. (2011) *Nihon No Iryō: Seidoto Seisaku [Japan’s Medical Care: System and Policy]*. Tokyo: Tokyo Daigaku Shuppankai.
- Shimizu, M. (2005) *Kantei Shudō: Koizumi Jun’Ichirō No Kakumei [Cabinet-Lead Politics: Koizumi’s Revolution]*. Tōkyō: Nihon Keizai Shinbunsha.

- Shin, D. (2003) *Social and Economic Policies in Korea: Ideas, Networks, and Linkages*. New York, NY: Routledge.
- Shinoda, T. (2007) *Koizumi Diplomacy: Japan's Kantei Approach to Foreign and Defense Affairs*. Seattle: University of Washington Press.
- Sin, Y. (2004) *Han'guk Ūryo Pokchi Chōngch'aengnon: 1989-YōN Kwa 1997-YōN ŪI Ūryo PohōM T'onghap IrwōNhwa Chōngch'aek KyōLchōNg Sarye Pigyo YōN'gu [Health Policy in Korea: The Case Study on Health Insurance Consolidation]*. PhD Thesis: Hankuk University of Foreign Studies.
- Sin, Y. (2010) Debates over the Integration of Medical Insurance System: Impact on the Democratization of Policy-Making Process. *Comparative Democratic Studies*, 6(2) 159-183.
- Skocpol, T. (1992) *Protecting Soldiers and Mothers: Political Origins of Social Policy in the United States*. 4th edition. Cambridge, MA: Belknap Press of Harvard University Press.
- Smith, K. and Larimer, C. (2009) *The Public Policy Theory Primer*, Philadelphia, PA: Westview Press.
- Smith, P. and Witter, S. (2004) *Risk Pooling in Health Care Finance and its implication*. Washington DC: World Bank.
- Social Security Advisory Council's Subcommittee on Medical Insurance (2004) *Dai 8-kai shakai hoshō shingikai iryō hoken buhai gijiroku [The Minutes of 8th Meeting]*. Tokyo: Ministry of Health, Labour, Welfare. Available from <http://www.mhlw.go.jp/shingi/2004/06/txt/s0623-4.txt> [Accessed 2 July 2014]
- Social Security Advisory Council's Subcommittee on Medical Insurance (2004) *Dai 7-kai shakai hoshō shingikai iryō hoken buhai gijiroku [The Minutes of 7th Meeting]*. Tokyo: Ministry of Health, Labour and Welfare. Available from <http://www.mhlw.go.jp/shingi/2004/05/txt/s0513-1.txt> [Accessed 3 February 2015]
- Somae, K. (2012) Jimintō Seiken-Ka Ni Okeru Iryō Seisaku [Health Care Policy under the LDP]. *Nenpō seiji-gaku*, 2012(1) 114–137.
- Song, J. (2012) Economic Distress, Labor Market Reforms, and Dualism in Japan and Korea. *Governance*, 25(3) 415–438.
- Starr, P. (1982) *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York, NY: Basic Books.
- Steinmo, S., Thelen, K., and Longstreth, F. (1992) *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge: Cambridge University Press.

- Stephens, J. D. and Huber, E. (2001) *Development and Crisis of the Welfare State: Parties and Policies in Global Markets*. 1st edition. Chicago, IL: University of Chicago Press.
- Suzuki, A. (2007) Sengonihon Rōdō Undō No Seisaku Shikō No Bunseki [An Analysis on the Policy-Oriented Labor Movement in Japan after World War II]. *Seikatsu Keizai Seisaku*, 127(1) 28–39.
- Swenson, P. A. (2002) *Capitalists against Markets: The Making of Labor Markets and Welfare States in the United States and Sweden*. New York: Oxford University Press.
- Tajika, E. and Kikuchi, J. (2003) Nihon No Iryō Hoken Kaikakuto `Kanri Sa Reta Kyōsō' [Medical Insurance Reform in Japan and 'Managed Competition']. *Kikan Shakai Hoshō Kenkyū [Social Security Quarterly]*, 39(3) 306–321.
- Takaoka, H. (2011) *Sōryokusen Taiseito 'Fukushi Kokka': Senjiki Nihon No 'Shakai Kaikaku' Kōsō [Welfare State under Total War]*. Tokyo: Iwanami Shoten.
- Talcott, P. D. (1999) Japan's Next Big Bang: Healthcare Reform Implications for U.S. Policy, Washington, D.C.: Japan Information Access Project,
- Talcott, P. D. (2001) Atsuryoku Gurūputo Nihon No Iryō Seisaku [Pressure Groups and Japanese Health Policy]. *The Quarterly of social security research*, 37(1) 29–43.
- Tang, S. (2010) *A General Theory of Institutional Change*. New York, NY: Routledge
- Tatara, K. and Okamoto, E. (2009) Japan: Health System Review. *Health systems in transition*, 11(5) 1–164.
- The Daily Yomiuri (1996) Tackle Snowballing Medical Costs. The Daily Yomiuri, 13 May, 2.
- The Daily Yomiuri (1997) LDP, Allies Seek New Health Insurance Plan for the Elderly. The Daily Yomiuri, 8 April, 2.
- The Daily Yomiuri (1999) Prop Up Health Insurance System. The Daily Yomiuri, 4 April, 6.
- The Daily Yomiuri (2009) DPJ at the Helm: Overhauling Health Insurance; DPJ's Determination to Abolish Current System for Aged Poses Problems. The Daily Yomiuri, 24 September, 2.
- The Daily Yomiuri (2012a) Don't Abolish Health Insurance System for Later-Stage Elderly. The Daily Yomiuri, 10 April, 2.
- The Daily Yomiuri (2012b) Noda Should Get DPJ Members On Board to Support Tax Bills. The Daily Yomiuri, 17 June, 2.

- The Japan Times (1997) Ruling Allies Agree to Make Insurance System for Elderly. The Japan Times, 22 August.
<http://www.japantimes.co.jp/news/1997/08/22/national/ruling-allies-agree-to-make-insurance-system-for-elderly/#.VfLpxk3lt9B> [Accessed by July 10 2015].
- The Japan times (2003) ‘Kenpo’ Deficit Widens. The Japan times, 19 July Available from <http://www.japantimes.co.jp/opinion/2003/07/19/editorials/kenpo-deficit-widens> [Accessed 20 November 2014].
- The Japan Times (2005) *Rengō* to Stress Part-, Full-Time Gap. The Japan Times, 6 October <http://www.japantimes.co.jp/news/2005/10/06/business/rengo-to-stress-part-full-time-gap> [Accessed 25 October 10 2014].
- The Japan Times (2009) Health Care for Older Seniors. The Japan Times, 1 October, 2.
- The Japan Times (2011) Welfare Reform and Cost Issue. The Japan Times, 14 June, 2.
- The Korea Herald (2001) Opposition Replaces Defiant Member to Force Parliamentary Vote on Medical Insurance Integration. The Korea Herald, 25 December <http://www.nexis.com/search/homesubmitForm.do> [Accessed 6 July 2015]
- The Korea Times (1999) 5 Mil. Join Campaign Against Health Insurance Integration. *Korea Times*, 27 September, <http://www.nexis.com/search/homesubmitForm.do> [accessed 6 July 2015].
- The Korea Times (2000) Medical Insurance Workers Resume General Strike. *Korea Times*, 17 April, 2000, <http://www.nexis.com/search/homesubmitForm.do> [accessed 6 July 2015].
- The Ruling parties’ medical insurance reform council (1998) *Ni ichi seiki no kokumin iryō: ryōshitsuna iryō to kai hōkenseido kakuho e no shishin [21st Century of National Health system: A Guide to good quality medical care and health insurance system]*, <http://www5.sdp.or.jp/central/timebeing/timebeing97/iryō-4-0829.html> [accessed 25 October 2014].
- Thelen, K. (1999) Historical Institutionalism in Comparative Politics. *Annual Review of Political Science*, 2(1) 369–404.
- Tongailbo (1990) Kökkulokanūn Chiyōkūipo [Municipal Health Insurance Schemes Is Going Backward]. Tongailbo, 21 November, 15.
- Tongailbo (1994) Chiyōkūipo Kwangyōkhwa Ch’Uchin [Municipal Health Insurance Schemes Will Make Integration. Tongailbo, 26 October, 2.

- Tsuchida, T. (2011) Kokuminkaihoken 50-Nen No Kiseki [The Trajectory of Universal Health Insurance for 50 Years]. *Kikan-Sha Hoshō Kenkyū*, 47(3) 244–256.
- Tsushima, T. (2003) Kenkōhoken Kumiaito Hoken-Sha Kinō No Kyōka [Health Insurance Unions and Strengthening the Insurer Function]. In: Yasuhiko Yamasaki and Hiroya Ogata (eds.) *Iryō Seido Kaikaku To Hokensha Kinō [Health Care Reform and The Insurer Function]*. Tōkyō: Tōyō Keizai Shinpōsha, 197–216.
- Tsutsumi, S. (2008) Kōreishairyōseidoto Kenpō [Elderly Health Care System and the Constitutional Law]. *Shūkan Shakai Hoshō [Social Security Weekly]*, 2477(1) 42–49.
- Tuohy, C. H. (2009) Single Payers, Multiple Systems: The Scope and Limits of Subnational Variation under a Federal Health Policy Framework. *Journal of Health Politics, Policy and Law*, 34(4) 453–496.
- Uchiyama, Y. (2010) *Koizumi and Japanese Politics: Reform Strategies and Leadership Style*. New York: Taylor & Francis.
- Ullrich, C.G. (2002) Reciprocity, Justice and Statutory Health Insurance in Germany. *Journal of European Social Policy*, 12(2) 123–136.
- Van Kleef, R. C. (2012) Managed Competition in the Dutch Health Care System: Preconditions and Experiences So Far. *Public Policy Review*, 8(2) 171–190.
- Van De Ven, W. P. M. M., Beck, K., Van De Voorde, C., Wasem, J., and Zmora, I. (2007) Risk Adjustment and Risk Selection in Europe: 6 Years Later. *Health Policy*, 83(2-3) 162–179.
- Van Der Veen, R. (2012) Risk and the Welfare State, In: Romke Van Der Veen, Mara Yerkes and Peter Achtenberg (eds.) *The Transformation of Solidarity: Changing Risks and the Future of the Welfare State*, Amsterdam: Amsterdam University Press, 13-30
- Vennesson, P. (2008) Case Studies and Process Tracing: Theories and Practices, In: Della Porta, D. and Keating, M. (eds.) *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective*. Cambridge, NY: Cambridge University Press, 223–39.
- Watanabe, H. R. (2012) Why and How Did Japan Finally Change Its Ways? The Politics of Japanese Labour-Market Deregulation since the 1990s. *Japan Forum*, 24(1) 23–50.
- Watanabe, H. R. (2015a) Institutional Change under Neoliberal Pressure: Japanese Regulatory Reforms in Labor and Financial Markets. *Asian Politics & Policy*, 7(3) 413-432.

- Watanabe, H. R. (2015b) The Struggle for Revitalisation by Japanese Labour Unions: Worker Organising After Labour-Market Deregulation. *Journal of Contemporary Asia*, 45(3) 510–530.
- Weingast, B. (2002) Rational-Choice Institutionalism. In: Ira Katznelson and Helen V. Milner (eds.) *Political Science: The State of the Discipline*. 1st Edition. New York: W.W. Norton, 660–692.
- Weir, M. M. (2006) When Does Politics Create Policy? The Organizational Politics of Change. In: Ian Shapiro Stephen Skowronek and Daniel Galvin (eds.) *Rethinking Political Institutions: The Art of the State*. New York: New York University Press, 171-186.
- Weir, M. And Skocpol, T. (1985) Keynesian" Responses to the Great Depression in Sweden, Britain, and the United States. In: Peter B. Evans Dietrich Rueschemeyer and Theda Skocpol (eds.) *Bringing the State Back In*. Cambridge: Cambridge University Press, 169–191.
- Welfare and Society Committee (1989) *Minute of the Hearing on Health Insurance Reform*. Seoul: National Assembly.
- Wilensky, H. L. (2002) *Rich Democracies: Political Economy, Public Policy, and Performance*. Berkeley, CA: University of California Press.
- Wlezien, C. (1995) The Public as Thermostat: Dynamics of Preferences for Spending. *American Journal of Political Science*, 39(4) 981–1000.
- Won, S. (2006) Lönkangpohömt'onghapnonchaengüi Chönkaekwachöngge Kwanhan Yönku [A Study on the Process of the Debate on the National Health Insurance System Integration in Korea]. *Sahoebokchijöngchi [Social Welfare Policy]*, 25(1) 159–180.
- Wong, J. (2001) *Democracy and Welfare: Health Policy in Taiwan and South Korea*. PhD Thesis. University of Wisconsin-Madison.
- Wong, J. (2004) *Healthy Democracies: Welfare Politics in Taiwan and South Korea*. Ithaca, NY: Cornell University Press.
- Wong, J. (2005) Adapting to Democracy: Societal Mobilization and Social Policy in Taiwan and South Korea. *Studies in Comparative International Development*, 40(3) 88–111.
- Yamasaki, Y. And Ogata, H. (2003) *Iryō Seido Kaikakuto Hokensha Kinō [Health Care Reform and the Insurer Function]*. Tōkyō: Tōyō Keizai Shinpōsha.
- Yomiuri Shimbun (2002) Kōrei Iryō Kaikaku Heiki 2 An Ni Uzumaku 'Sanpi', Futan Sontoku Kukkiru Ippon-Ka, Nankō Hisshi [The Health Reform Committee Proposed Two Ideas] Yomiuri Shimbun, 18 December, 5

- Yomiuri Shimbun (2003) Iryō Kaikaku Kihon Hōshin, 'Kōritsu-Ka' Nado Honshitsu Ni Wa Furezu [Healthcare Reform Basic Policy Does Not Deal with Its Efficiency]. Yomiuri Shimbun, 1 April 2.
- Yomiuri Shimbun (2009) Haishi No Hazu No 'Kōki Kōrei-Sha' Tōmen Iji... Nagatsuma Korōshō [Minister Akira Nagatsuma Decided to Postpone Abolishment of the Current Health Insurance Programme for Late Elderly]. Yomiuri Shimbun, 5 October 2.
- Yoshihara, K. and Wada, M. (2008) *Nihon Iryō Hōkenseido-Shi [The History of Health Insurance in Japan]*. Tokyo: Tōyōkeizaishinpōsha.
- Yoshioka, S (2009) Kōkikōreishairyōseido O Meguru Ikisatsuto Minaoshi No Dōkō [Background and Review of the Late Elderly Health Care System], *Rippōto Chōsa [Legislative Survey]*, 288(1) 76-91.
- Yu, S. and Anderson, G.F. (1992) Achieving Universal Health Insurance in Korea: A Model for Other Developing Countries? *Health Policy* 20(1), 289-299.
- Yuki, Y. (2004) *Fukushi Shakai Ni Okeru Iryōto Seiji: Shinryō Hōshū O Meguru Kankei Dantai No Ugoki [The Health Care and Politics in the Welfare Society]*. Tōkyō: Honnoizumisha.
- Yun, J. (2008) *Reforming the Dualities: The Politics of Labor Market Reform in Contemporary East Asia*. PhD Thesis. University of California, Berkeley.
- Zohlnhöfer, R., Herweg, N., and Huß. C. (2016) Bringing Formal Political Institutions into the Multiple Streams Framework: An Analytical Proposal for Comparative Policy Analysis, *Journal of Comparative Policy Analysis: Research and Practice*, 18(3) 243-256.

<Appendix1> List of interviewees

Japanese case

Affiliation	Place	Date of Interview
Assistant Director in Welfare Policy Division of Rengō	Tokyo	9 December 2014
Economic Policy Bureau in Keidanren	Tokyo	10 December 2014
Researcher in the “Welfare and Future Centre”	Tokyo	12 December 2014
Executive of a Health Insurance Society in “A” Company	Tokyo	15 December 2014
Head of Planning Department in Kenporen	Tokyo	17 December 2014
Head of Health Centre in Machida City (Tokyo)	Tokyo	19 January 2015
Physician	Tokyo	20 January 2015
Public Officer of Health Centre in Machida City, Nurse	Tokyo	22 January 2015
Public Officer, Municipal Health Insurance Division in Kunitachi City (Tokyo)	Tokyo	29 January 2015

South Korean case

Affiliation	Place	Date of Interview
Senior Director of Policy Division in the KCTU	Seoul	23 April 2015
Senior Director of Strategy and Planning in Korea Health and Medical Workers’ Union	Seoul	14 May 2015
Deputy Director of Human Resources Department in National Health Insurance Corporation	Seoul	27 May 2015

(Former a civil activist in “Solidarity for the Integration of the National Health Insurance”)		
Former Vice Chairperson of the KCTU	Seoul	29 May 2015