Divergence in the development of public health insurance in Japan and the Republic of Korea: A multiple-payer versus a single-payer system

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Abstract Japan and the Republic of Korea achieved universal health insurance coverage for their populations in 1961 and 1989, respectively. At present, Japan continues to operate a multiple-payer social health insurance system, while the Republic of Korea has moved to an integrated single-payer national health insurance structure. This article analyzes the influence of political economy in shaping the policy divergence found between these two Bismarckian health insurance systems. Issues addressed include differences in political power, the policy influence of business, the extent to which regional autonomy has developed and regional traits have been preserved, the level of political democratization, the form of political leadership, and the scale of development of the health insurance system. The article offers policy lessons derived from the two countries' experiences.

Keywords health insurance, political aspect, method of financing, scope of coverage, Japan, Republic of Korea

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Published by Blackwell Publishing Ltd, 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA

Introduction

Japan and the Republic of Korea (hereafter, South Korea) have more in common with one another than they do with Western countries. These two geographically contiguous nations operate legal systems rooted in civil law and Confucian cultural traditions are deeply ingrained. Considerable similarities stem from these common structural and cultural characteristics, but similarities also derive from direct influences, such as the diffusion of policy from one country to the other. Just as Japan, for instance, has assimilated Western approaches to medical care and the design of health insurance programmes, South Korea has, in turn, taken policy lessons from Japan. It would appear that Japanese experience is the source of inspiration for many South Korean policy developments. Nevertheless, despite many commonalities, the two countries also differ widely in many ways. In the field of health insurance, the Japanese health insurance system is composed of thousands of insurers. This is not the case for its South Korean counterpart. As will be discussed in this article, between 1998 and 2003 South Korea shifted from a social health insurance (SHI) system with multiple payers to a national health insurance (NHI) system with a single payer.[1]

As the example of health insurance underlines, these two countries, in spite of having similar backgrounds, have diverged as a consequence of having followed different reform processes. This article explores the influence of political economy and how this may have influenced the observed variance in national reforms. The article is structured as follows: the next section looks to the historical development of nationwide health insurance coverage in Japan and South Korea. This is followed by an examination of how the two systems came to diverge and the impact this has had on health system design. The political economy dimension of health insurance reform in the two countries is then discussed and a concluding section offers final observations.

The development of health insurance in Japan and the Republic of Korea

Japan

The first mandatory health insurance scheme[2] providing general health care to Japan's population came into effect in 1927 with the implementation of the Health

1. Lee et al. (2008) categorize National Health Insurance (NHI) as different from Social Health Insurance (SHI), thereby offering a category by means of which to classify the idiosyncratic development of the health systems of South Korea and Taiwan (China) witnessed since the 1990s.
2. Prior to the introduction of the mandatory health insurance scheme, there had been a form of health insurance for the military, public servants and some business employees since the second half of the

Table 1. *The development of public health insurance in Japan and South Korea*

	Japan	South Korea
Prior to the introduction of public health insurance scheme	1911: Workmen's Compensation scheme implemented 1922: Health Insurance Act written into law	1963: Health Insurance Act written into law 1964: Workmen's Compensation scheme implemented
Introduction and development of worksite health insurance	1927: Employment Health Insurance (EHI) implemented for blue-collar employees 1934: EHI expanded to businesses with five or more employees 1937: EHI expanded to white- collar employees 1939: EHI for white-collar employees established independently 1941: Insurance for government employees implemented 1941: EHI applied to employees' dependants 1942 EHI incorporated both blue- and white collar employees	1977: Compulsory health insurance implemented for businesses with 500 or more employees 1979: Insurance for government employees (KMIC) organized, and compulsory health insurance expanded to businesses with 300 or more employees 1981: Compulsory health insurance expanded to businesses with 100 or more employees 1983: Compulsory health insurance expanded to businesses with 16 or more employees 1988: Compulsory health insurance expanded to businesses with five or more employees
Introduction and development of municipal (locality) health insurance	1938: National Health Insurance (NHI) Act passed (NHI programmes by municipalities) 1958: New NHI Act passed 1961: NHI programmes applied to all municipalities, thereby realizing "health insurance for all"	1988: Compulsory health insurance expanded to cover farming and fishing communities 1989: Compulsory health insurance expanded to cover urban areas, thereby realizing "health insurance for all"
Unification or integration of health insurers	1968, 1973, 1984 and 2003: Co-payment rates adjusted and finally pegged uniformly at 30% in 2003 1983: Health Service System for the Elderly implemented 2008: Medical Care Scheme for the Senior Elderly implemented	1997: National Health Insurance Act for integration of health insurers passed 2000: National Health Insurance Corporation (NHIC) established as a single insurer 2003: Demarcation between worksite and locality insurance accounts under the NHIC removed

Insurance Act (Table 1).[3] The Employment Health Insurance (EHI), or *Kenko Hoken*, was composed of two schemes: the Government-managed Health Insurance (GMHI), which was predominantly targeted at workers of small- and medium-sized

nineteenth century. And a compulsory workmen's compensation scheme, intended to cover injuries at work, was introduced in 1911 in the form of a Factory Law.

3. This had been written into law in 1922, but implementation was withheld owing to earthquakes in the Kanto area.

enterprises and their families, and Society-managed Health Insurance (SMHI), largely embracing employees of large corporations and their families.[4] The EHI initially applied to blue-collar workers, serving businesses with ten or more employees on the payroll, which covered 3 per cent of the Japanese population. Thereafter, in 1934, coverage under the EHI expanded to businesses with five or more employees, then white-collar employees in 1937, and finally employees' dependants in 1941.

While employees and their families benefited from the coverage provided by the EHI, those deemed to be self-employed or non-employed, including farmers and fishermen, were left disadvantaged, having no employers to pay contributions on their behalf and no salaries from which to deduct their own contributions. The 1920s and 1930s saw the emergence of farmers' cooperatives, but their number and influence soon declined.

In response to this, the National Health Insurance Act, the legal framework for health insurance operated at the municipal level, was enacted in 1938. The municipal-level (locality) National Health Insurance (*Kokumin Kenko Hoken*) was not a compulsory scheme, but the national government did provide subsidies to the health insurers created by the municipalities. *Kokumin Kenko Hoken* continued to expand, with the number of insured persons increasing sharply after the outbreak of the Second World War — coverage was encouraged by means of government support that, among other goals, sought a healthy population fit for military service. By 1943, 70 per cent of the Japanese population came under the umbrella of health insurance coverage in one form or another (Campbell and Ikegami, 1998). However, with the government's financial situation worsening during the later stages of the Second World War, many municipal-level (locality) health insurance schemes were discontinued, resulting in the insurance coverage rate falling below 60 per cent of the population. The financing problem confronting national government and the municipalities reached its nadir immediately following 1945.[5]

In 1950, the year the Korean War broke out, the Japanese economy grew rapidly, resulting in an operating surplus for the EHI. This paved the way for many municipalities to resume the *Kokumin Kenko Hoken* and, by 1956, 68 per cent of the total population was covered by health insurance. The percentage of workers without health insurance coverage was estimated at 27 per cent. In the mid 1950s, Japan's two main political parties both competed for votes under the banner of

4. Shimazaki (2005) argues that the use of two schemes was well suited to the prevailing circumstances at that time, taking into consideration the fact that small companies were not able to manage their own health insurance society.

5. In 1947, General Headquarters went so far as to propose to expand significantly National Treasury subsidies with the aim of rebuilding the national health insurance programme (Yoshihara and Wada, 2008).

"health insurance for all", and by 1958 the National Insurance Act was passed, with universal health insurance achieved in 1961.

Republic of Korea

Health insurance, in the form of a social insurance programme, was introduced in South Korea in 1977 when it became legally mandatory for all large employers with 500 or more employees on the payroll to provide a health insurance programme (Table 1). Underlying and conducive to the introduction of the programme were a number of factors: sound economic fundamentals, which had been put into place through the successful implementation of the third Five-Year Economic Development Plan (1972-1976); a growing demand for social security provisions, owing in part to the absence of a national contributory pension programme at that time; the then incumbent President Park Jung-Hee's competitive mentality, not least with regard to the Democratic People's Republic of Korea; and the influence of Japan, first, in shaping the design of South Korea's pilot programmes for health insurance and, second, in that its institutions and experiences provided South Korea with unsurpassed information essential to minimizing trials and errors in the early development phases.

In 1979, a separate health insurance (administered by the Korea Medical Insurance Cooperation — KMIC) was organized for government employees and private school teachers. In July of the same year, compulsory health insurance was expanded to cover businesses with 300 or more employees, thereby enrolling 21 per cent of the entire population. Beginning in January 1981, businesses with 100 or more employees on the payroll were subject to health insurance. Coverage was then expanded further to include businesses with 16 or more employees in 1983 and expanded once more in 1988 to include those with five or more employees.

From January 1988, health insurance was expanded to cover farming and fishing communities. Membership for health insurance was based on the family unit, where the family head paid the contributions. A total of 134 health insurers were instituted; one in each county. Subsequently, in July 1989, 110 urban area health insurers were instituted, one in each city or metropolitan district. This development marked the achievement of universal health insurance, only 12 years after health insurance had been introduced to the country.

Two national systems for universal health insurance

As regards the structure of health insurance used to achieve "health insurance for all", a close similarity is found between Japan in 1961 and South Korea in 1989. Japan's insurers, which numbered almost 5,000, and those of South Korea, which numbered over 400, had a basic structure in common, as shown in Table 2. First,

Table 2. *Changes in the number of insurers and their share of total population in Japan and South Korea*

Japan				South Korea			
1961		2009		1989		2009	
Insurer	Number of insurers (% of population covered)	Insurer	Number of insurers (% of population covered)	Insurer	Number of insurers (% of population covered)	Insurer	Number of insurers (% of population covered)
GMHI	1 (21%)	NAHI	1 (28%)	Worksite insurance	154 (39%)	NHIC	1 (96%)
SMHI	1,091 (14%)	SMHI	1,497 (24%)				
MAA etc.[1]	79 (13%)	MAA etc.[1]	78 (7%)	KMIC	1 (11%)		
Municipal (locality) insurance	3,659 (49%)	Municipal (locality) insurance	1,953 (40%)	Municipal (locality) insurance	254 (45%)		
		Medical Care Scheme for the Senior Elderly	47 (40%) (implemented in 2008)				
Total	4,830 (98%)	Total	3,576 (99%)	Total	409 (94%)	Total	1 (96%)

Note: [1] This includes seamen's insurance and daily workers' insurance.
GMHI: Government-managed health insurance (since 2000, NAHI: National Association of Health Insurance); SMHI: Society-managed health insurance; MAA: Mutual aid association; KMIC: Korea Medical Insurance Corporation (for public servants and private teachers); NHIC: National Health Insurance Corporation.
Sources: Japan: Ministry of Health and Welfare (1961), National Federation of Health Insurance Societies (1962), and Health and Welfare Statistical Association (2011). South Korea: National Health Insurance Corporation (2010).

insurer organizations for specific professions, such as public servants and teachers, were formed independently: 13 per cent of the population belonged to such insurers in Japan, while 11 per cent of the population did so in South Korea. Second, in Japan, the GMHI, with the Social Insurance Agency as the single insurer, covered 21 per cent of the population, and the SMHI, comprising 1,091 insurers, covered a further 14 per cent. In South Korea, there was no government-managed provision as in Japan, but 154 worksite insurers covered 39 per cent of the population. Third, in Japan, 3,659 municipal-level (locality) health insurers, whose services were aimed largely at the self-employed and the elderly, covered 49 per cent of the population, as compared to South Korea where 254 municipal-level (locality) health insurers covered 45 per cent of the population.

Divergence between the two health insurance systems

Discussions on integrating health insurers in Japan

In Japan, questions have been raised periodically over problems about the health insurance system, which remains fragmented into thousands of insurers (3,576 as of 2009). Endeavours to address this fragmentation have been made largely in two directions (Table 3). First, a move toward *ichigenka*, or "harmonization in contributions and benefits", is under way. This seeks to remove differences in the value of the insurance contributions levied and the benefits offered by different insurers, but without altering the manner in which health insurers are organized.[6] This has been a consistent position taken by the Ministry of Health and Welfare and the Liberal Democratic Party. Second, an attempt is being made to reduce the number of health insurers ("organizational integration"). This entails two possible lines of action: a move whereby the market size of individual insurers is enlarged and the number of insurers is curtailed, while keeping worksite insurers and municipal (locality) insurers separate (*kouikika* or "enlargement"),[7] or a move whereby the two types of insurer — worksite and municipal (locality) — are integrated (*ipponka* or "streamlined integration").[8]

Harmonization of insurance contributions and benefits. Proposals for improving the equity of the health insurance system usually centre on equalizing co-payments. When "health insurance for all" was achieved in 1961, the co-payment rate was set

6. This differs from the discussions over the integration of health insurers addressed in this article in that the organizational structure remains separate.
7. Niki (2001) had proposed this programme as the most reasonable and practicable one, but this was before the Koizumi government decided on the *ipponka* programme as the policy direction to take.
8. This follows with the nature of integration outlined in this article, in that it seeks the merger of organizations.

Table 3. *Types of integration of health insurers in Japan*

Types	Japanese terminology	Contents	Examples
Harmonization in contributions and benefits	*Ichigenka* (Harmonization)	• To remove differences in contributions and benefits without changing organizational structure	• Measures to rectify the imbalances of contributions and gaps of benefits since the 1960s • Co-payment rates uniformly pegged at 30% in 2003
Organizational integration	*Kouikika* (Enlargement)	• To expand the size of individual insurers and curtail the number of insurers • To keep worksite insurers and municipal (locality) insurers separate	• "Health insurance for white-collar employees" incorporated into the Employee Health Insurance (EHI) in 1942 • General Headquarters' idea in 1947 • Ikeda administration's idea in 1961 • "Memorandum of understanding" in late 1980s • Democratic Party of Japan (DPJ) public pledge in 2009
Organizational integration	*Ipponka* (Streamlined integration)	• To integrate worksite insurers and municipal (locality) insurers under the same insurer	• Koizumi government's "Basic guideline" in 2003 to expand insurers, prefecture by prefecture

at 50 per cent in the municipal (locality) health insurance and for family members of insured workers under the EHI (no co-payment was borne by the insured workers in the EHI).[9] In a move to cope with financial deficits in the 1960s, the Ministry of Health and Welfare came up with a measure to rectify imbalances among contribution rates and gaps between benefits, thus initiating discussions over *ichigenka* (harmonization) (Yoshihara and Wada, 2008). The co-payment rate in the municipal (locality) insurance was lowered to 30 per cent in 1968, and the rate borne by family members in the EHI programmes decreased from 50 per cent to 30 per cent in 1973. *Ichigenka* (harmonization) emerged as a central reform theme when the Health Insurance Act was amended in 1984. As a result, co-payment rates were pegged at 20 per cent, and financial adjustments for risk equalization were implemented.

In 2003, co-payment rates increased and were pegged uniformly at 30 per cent, with the exception of 10 per cent for the elderly and 20 per cent for infants and children aged three or younger. Nonetheless, SMHI may offer additional benefits under the collective contracts covering employees. For instance, employees of large

9. In his memorial statement for "health insurance for all" in 1961, Yoshimi Furui, the then Minister of Health and Welfare, made it clear that the greatest task henceforth would be to adjust the imbalance between insurances (Mizumaki, 1993).

firms may have entitlement to longer periods of leave on health grounds. The operating profits of some insurers are such that they are able to reimburse part of the co-payment and to provide free or subsidized health examinations. The contribution rate charged by the EHI ranges from 3 per cent to 10 per cent of wages. Large firms often pay up to 80 per cent of the total contribution — well over the 50 per cent mark that is set as the lower limit by law. There is also wide variation in the contribution amounts charged by the municipal (locality) health insurance, with the highest contribution, in the town of Rausu in Hokkaido, being 4.7 greater than the lowest (Jones, 2009).

Organizational integration of health insurers. The debate about "organizational integration" goes back as far as 1942, the year in which "health insurance for white-collar employees" was incorporated into the EHI.[10] In 1947, the General Headquarters' "measure for the reconstruction of the locality health insurance" embraced the idea of incorporating various health insurance programmes into the municipal (locality) health insurance. However, this idea was not implemented and remained nothing more than an "idea" (Sugiyama, 1995; Sugita, 2008). A move toward "*ipponka*" (integration) emerged later as part of the process of discussing universal health insurance. The idea presented was that all insurance programmes operating in any given geographic area should be integrated into one that was centred on the municipal (locality) health insurance. This idea, however, was not acceptable under the terms of the new Act for municipal (locality) health insurance.

Immediately after achieving universal health insurance in 1961, the Ikeda administration discussed whether to merge both the employment-based and the municipal (locality) programmes into one (*ipponka*) — at a time when the GMHI had an operational deficit. After heated discussion on *ipponka* under Tsuneo Uchida, the then Minister of Health and Welfare, it was concluded that health insurance should "stay on a dual basis".[11] Discussions over *ichigenka* (harmonization) in 1984, as mentioned before, were later followed by those over *ipponka* (integration) upon requests from the Japanese Medical Association (Yoshihara and Wada, 2008). Discussions kicked off with the Ministry of Health and Welfare taking the lead.[12] However, neither the Liberal Democratic Party nor the Ministry of Health and Welfare were positive about *ipponka*. This led to the conclusion in 1989 that "while it was ideal to integrate health insurance systems into

10. "Health insurance for white-collar employees" was mapped out independently in 1939, and thus lasted for three years only.

11. The main reason suggested was that integration would result in a lower level of contributions and benefits without support from the National Treasury.

12. Memorandum of understanding exchanged among the Liberal Democratic Party and the Japanese Medical Association etc., contained the phrase: "*ipponka* (integration) in the health insurance system to be implemented within five years while seeking equality in contributions and benefits" (Yoshihara and Wada, 2008).

one, such a goal is to be pursued through the Health Service System for the Elderly for the time being".

When a measure of *ichigenka* was reached by means of the harmonization of the reimbursement level in the second half of the 1990s and early 2000s, the Japanese government established a new political objective: to enlarge the market size of insurers (*kouikika*), which is sometimes referred also to as *ichigenka* (Murakami, 2009). The "basic guideline for the health insurance system and the insurance payment system", prepared by the Koizumi government in 2003, decided to examine the restructuring and integration of insurers, prefecture by prefecture, in order to tackle the problem of fragmentation in the health insurance system. However, such reform sought gradual changes in line with a programme to equalize risk across the country's many health insurers, while maintaining the health insurance system's existing dichotomized structure (Health and Welfare Statistical Association, 2007).

The Medical Care Scheme for the Senior Elderly, which was established on a separate basis in 2008, seeks a degree of *ipponka* (integration). To mitigate the monetary burden added by the new scheme, the Liberal Democratic Party (LDP) administration made an attempt to re-adjust financing between employment-based insurers, dubbing it "*ichigenka* (harmonization) in the health insurance system". In 2009, the newly-elected Democratic Party of Japan (DPJ) administration made a commitment in its public policy pledge that it would abolish the Medical Care Scheme for the Senior Elderly and integrate all health insurers into the municipal (locality) insurers (Democratic Party of Japan, 2009). This move was dubbed *ichigenka* (harmonization) but, in fact, falls into *ipponka* (integration) in its nature. Contrary to that which was pledged, there were very few who thought such commitments would be realized in the near future, even among those who argued for *ipponka* (Sakurai, 2010), and even in the DPJ.[13]

The achievement of integration in the Republic of Korea

Disputes over integration during the expansion period of public health insurance. Disputes, often with a political dimension, over the integration of independent health insurers were ongoing in South Korea over the 20-year period from the early 1980s to the early 2000s. The expanded application of health insurance in 1979 led to a dispute over setting an optimum size for insurers. When Chun Myung-Kee, Minister of Health and Social Affairs, sought to launch a plan for integrating the existing "network of health insurers" and the insurer for government employees and teachers (KMIC) into one, the network branded it as "integrationism". This marked

13. Umemura and Nagao (2009), a DPJ Senator, also insisted on the integration of insurance contributions, namely, *ichigenka.*

the initiation of long-lasting controversies.[14] The majority of bureaucrats within the Ministry were against the plan proposed and spearheaded by the Minister and supported by a minority of bureaucrats. The proposed plan collapsed when the President instructed the Minister to conduct a full-scale review.[15] Turbulence erupted later in 1983 when some of the pro-integration bureaucrats were ousted from the Ministry. This served as an opportunity for the ongoing integration reform to be perceived as congruous with the "democratization" movement that, at that time, was campaigning against the authoritative style of South Korea's government. This turned out to be "the first round of the integration controversy" (Kim, 2000).

With the announcement of the planned extension of health insurance coverage to those working in the farming and fishing industries in January 1988, anger towards health insurance broke out across the country. Farmers, in particular, spontaneously opposed the proposed plan that mandated high levels of contributions. With farmers continuing to oppose health insurance, progressive social organizations such as the Citizen's Coalition for Economic Justice and the People's Solidarity for Participatory Democracy, which had emerged during the democratization campaign in 1987, added their voice to the debate. A National Medical Insurance Bill, which was in favour of the integration of insurers, passed the National Assembly in March 1989. However, with a critical national press continuing to publish reports that health insurance increased the financial burden faced by employees, the then President Roh Tae-Woo exercised his right of veto over the Bill, leading toward universal health insurance under multiple insurers. The ensuing campaigns that were led against this decision failed to revive the proposed National Medical Insurance Bill. This was the "second round of the integration controversy" (Kim, 2000) under the government of President Roh Tae-Woo.

Pursuing integration and universal health insurance. When the civilian government led by President Kim Young-Sam came to power in 1993, disputes over

14. The integration opponents claimed that it would be consistent for the state to provide medical care using taxes as the main source of financing, as does the National Health Service (NHS) system of the United Kingdom, and not to integrate all the countrywide insurers into a single insurer. It was unclear what the outcome of this would be (Lee, 1989). Among the integration proponents, there were many who wanted to see the system converted into an NHS, although thinking it better to implement the integration of organizations while maintaining the social insurance system of financing, since a radical shift in institution might have ended up being impracticable (Cho, 1988). But a majority of integration proponents insisted that since the NHS system would most likely lead to a problem of the under-supply of medical care, it would be better to take advantage of the strengths of the two systems by integrating the funds only, while relying upon social contributions for financing, and leaving the supply of medical care to the private sector.

15. In this process, the Federation of Medical Insurers, newly established as the successor to the "network of insurers", was put in charge of reviewing all the health insurance claims and an integrated computer processing system was also put into operation.

the integration of insurers resumed. Opposition was led by a "nationwide federation for health insurance integration and the expanded application of insurance", created in April 1994. A total of 22 workers', farmers', and progressive social organizations joined the federation. In the tumultuous political atmosphere of 1997, in which President Kim Young-Sam withdrew from the then ruling party in October, the party proposed and passed a partial integration bill, the Medical Insurance Act, at the National Assembly in December.

The election of Kim Dae-Jung as President in December 1997 was instrumental to the implementation of the integration reform. His administration included the reform among its top 100 policy objectives and introduced the "health insurance integration spearheading planning unit", thereby mapping out specific plans. The new integration bill, the National Health Insurance Act, was written into law in January 1999. The integration reform was designed in three phases. In the first phase, starting in October 1998, 227 municipal (locality) insurers and the health insurance for government employees and teachers were integrated into the National Medical Insurance Corporation (NMIC). In the second phase, in July 2000, the NMIC and 140 employment-based insurers were integrated into the National Health Insurance Corporation (NHIC), while the Health Insurance Review and Assessment Service (HIRA) was established on an independent basis. Although this completed the integration reform, worksite and municipal (locality) insurances were still held in separate accounts. The third phase included a process whereby this demarcation between the two was removed in January 2003. This was "the third round of integration controversies" (Kim, 2000) under President Kim Young-Sam and President Kim Dae-Jung.

The outcome of organizational change in the Republic of Korea

Japan and South Korea had much in common in terms of the health insurance structure in 1961 and 1989, when universal health insurance was achieved in both countries, respectively. There were thousands of insurers in operation throughout Japan and hundreds of insurers in South Korea. Following reform, South Korea now operates an integrated single-payer system, completely different from that of Japan as shown in Table 2. The integration reform brought about much change.

First, professional expertise among the staff of insurance organizations has been enhanced, helping to secure the basis for the strategic purchase of health care (WHO, 2000). The potential benefits of information and communication technologies (ICT) are being better realized, since the standardization of operational processes has been made more readily possible under the new single insurer scheme. The HIRA embarked upon an assessment of the appropriateness of

antibiotics and injection medications and launched Pay-for-Performance (P4P) for procedures for acute myocardial infarction (AMI) and Caesarean section for all tertiary hospitals (Jeong, 2010a). The HIRA receives all medical claims from medical providers for reimbursement following treatment by means of electronic data interchange (EDI), accumulating information on a real-time basis. The NHIC is building an important database that incorporates information on the insured. This data is analyzed and put to extensive use as a basis for drafting insurance policies.

Second, managerial costs have been reduced. The weight of managerial costs as a measure of total health insurance expenditure fell from 8.5 per cent in 1997 to 2.4 per cent in 2008 (Jeong, 2010b). The number of branch offices of the NHIC dwindled from 397 with 15,036 staff personnel to 250 with 10,716 staff personnel after the merger. The larger risk pool also permitted a reduction in the size of the financial reserves required to meet possible insolvencies. The cross-subsidization between insurers (inter-pool financial transfers) became unnecessary.

Third, it remains to be seen how far horizontal equity will be augmented. As the fund pool grew bigger in size, the spread of risks increased, thereby ameliorating the conditions on which to lift horizontal equity (Martin, Rice and Smith, 1998). However, these expected results are still to be observed fully in South Korea's health insurance scheme. Inke and Xu (2009) show that lower-income quintiles allocated a higher share of their total household consumption expenditure to health insurance contributions than did higher-income quintiles during 1995-2007 in every insured group in South Korea. In contrast, the redistributive impacts of health insurance are emerging as a result both of the expanded list of available medical care services and the lowering of co-payments implemented since the mid 2000s.

Discussion: The comparative political economy of reform

In this section, the interests and power of various stakeholders will be reviewed using power resources theory as the theoretical framework, and then evaluated against other explanations. The theory of power resources underlines that an unaffiliated individual with no organization (channel) representing his or her interest is not empowered to be fully rewarded (Korpi, 1983; Kellermann, 2005). For instance, variations observed in the capacity of the working class for collective action explain cross-national differences in the distributive outcomes of government social policies. Other explanations stem from the nature of industrial capitalism, which requires a certain degree of redistribution to maintain economic efficiency and state-built institutional structures that mediate preferences over distributional policies.

The role of stakeholders

Health insurance workers' trade unions. In South Korea, vested interests were centred previously on the right of each insurer to control their respective reserve fund. The integration of insurers meant the transfer of these independently-controlled funds into the newfound nationwide insurance organization and the abandonment by each insurer of their vested interests. This was something not done lightly, as evidenced by the worksite insurers having remained consistently opposed to integration. Generally, health insurers, including worksite and municipal (locality) insurers, expressed their political views directly or through the trade unions of their employees. The trade unions, naturally, took a particular interest in the possible implications of integration for the levels of health insurance contributions to be levied and for the scale of insurance benefits to be provided. In the process of discussing the issue of integration in the 1990s, the two nationwide trade union federations exhibited differing stances. Representing the interests of municipal (locality) health insurers, the Korean Confederation of Trade Unions (KCTU) supported integration, while the Federation of Korean Trade Unions (FKTU), representing the interests of worksite health insurers, did not. The KCTU was deemed to hold greater power resources — including union density, union centralization and bargaining coordination — and, ultimately, it was the stance backed by this federation that was successful.

In the case of Japan, municipal (locality) health insurers insisted on *ipponka* (integration). While it might be argued that integration was sought to promote a greater degree of equity in access to health insurance, actually, their insistence upon *ipponka* seems to have been intended to ease their debts. However, this insistence gradually faded and had little impact on the integration discussion. In Japan, there was no trade union that constituted a power resource among the municipal (locality) insurers run by local governments. Moreover, the EHI societies that provide health insurance coverage to employees did not want the status quo altered, especially as regards the possible integration of the municipal (locality) health insurers who offered coverage to the non-employed. Their concern was that when two or more social insurance pools are unified, typically, the less-profitable and higher-risk pool will see its financial position strengthened and the more-profitable and lower-risk pool will see its position weakened. On this basis, employment-based insurers with their wealthier and younger (healthier) members (and powerful companies) resisted integration. This has been one of the main barriers to change in Japan.

Business managers. In spite of a perception among employers that integration may heighten health insurance costs, health insurance has won overall acceptance in

both countries, not least since this has contributed to the stability of employment. As stated, there is a belief that business managers will be opposed to integration as it implies the abandonment of the vested rights achieved through the control of funds. In reality, it would appear that business managers in South Korea took relatively little note of the integration reform, being more preoccupied with the economic problems created by the 1998 Asian financial crisis.

Medical providers. The Korean Medical Association was in favour of integration, the primary reason being the need to reduce the incidence of overdue hospital bills. The expectation was that the payment problems encountered by many small insurers would be removed by instituting an integrated large-scaled organization — while small individual insurers may at times run operational deficits, a national health insurance system should be capable of balancing its finances. Nevertheless, medical provider groups were generally less interested in the integration reform than they had been for the pharmaceutical reform in 2000, since they apparently had no direct interest at stake.

Conversely, the Japanese Medical Association (JMA), under the leadership of its President Takemi, insisted that the EHI programmes be integrated with the municipal (locality) insurance, with the justification that this could realize consistent, life-long medical care and remove observed differences in the ability to pay (Arioka, 1997). The JMA sought also to dismantle the SMHI in the belief that it, being operated separately, caused financial losses to the GMHI. However, the JMA did not clearly indicate whether insurers should be integrated at prefecture or municipality level. The JMA has been in support of the separate establishment of the "Medical Care Scheme for the Senior Elderly" since 2000, when Tsuboi took office as President of the Association (Yoshihara and Wada, 2008).

Civil organizations. Civil organizations, such as the Citizen's Coalition for Economic Justice and the People's Solidarity for Participatory Democracy, represented mainly by progressive scholars as well as middle-class activists, played a pivotal role in South Korea's integration reform. Civil organizations engaged positively with the issue because they saw the reform as a relatively clear social issue. The engagement by civil organizations conveys a strong message about the importance of this issue for citizens — on this occasion, rather than being passive beneficiaries of policies, they sought active political involvement. In the main, the civil organizations were comparatively free from economic interests.

In the case of Japan, few civil organizations entered discussions about the potential organizational changes to the health insurance system. And relatively little attempt has been made to create a social movement to push forward the reform agenda. As such, the civil organizations of the two countries manifested themselves in quite different ways as regards the question of health insurance integration.

Bureaucratic groups and political parties. The responsibility for implementing reforms lies with bureaucrats. The bureaucratic group in South Korea's Ministry of Health was, more often than not, sceptical and passive about the integration reform.[16] The logic of "consistency in administration" would also have affected bureaucrats' behaviour, in that it entails their adherence to "corporatism" (a multiple-insurer system). This engendered a form of "path-dependency" (Wilsford, 1994). Meanwhile, the right to appoint the chief executive of the insurers — particularly, municipal (locality) insurers — , now numbering into the hundreds, was too attractive to lose on the part of the bureaucrats or political parties. Although their role was primarily one of policy implementation, the bureaucrats in South Korea gradually turned toward a reform-oriented position as the policy environment changed.

The bureaucratic group in Japan's Ministry of Health and Welfare were also inclined toward dual-based operations between worksite and municipal (locality) insurers. Like their South Korean counterparts, they did not want to face the confusion and friction that was expected to arise from an abrupt shift within the current system. They noticed with concern differences in income between employees and self-employed workers. Conversely, the bureaucrats in municipalities and local government preferred the integration (*ipponka*) of insurers into municipal (locality) health insurers. However, the Ministry was not willing to transfer the authority for the EHI over to the municipal (locality) health insurance. Though the Democratic Party of Japan had come to power and had made a public pledge to integrate insurers, realizing this political commitment has shown to be very difficult.

Policy environment

Factors for policy diffusion and policy divergence. Diffusion of policy occurs when one government's decision about whether to adopt a policy innovation is influenced by previous choices by other governments (Walker, 1969; Collier and Messick, 1975; Simmons, Dobbin and Garrett, 2006; Graham, Shipan and Volden, 2008). During the period spanning South Korea's introduction of health insurance and the realization of universal health insurance (1977-1989), the role of administrative bureaucrats in the shaping of policies was much more influential than that of scholars or civic groups. The majority of bureaucrats that joined government service prior to the 1980s, when the health policies were being mapped out, had majored in law or public administration and they had not had the experience of

16. There was a move among some minority groups of bureaucrats to take the initiative in supporting and implementing the integration reform, but later they found themselves pushed out of power for some time.

studying overseas. As a consequence of time and information constraints, policy-makers relied on cognitive shortcuts, a process that favoured policy diffusion (Weyland, 2005). Bureaucrats could travel to neighbouring Japan to undertake field trips or to seek advice when required. South Korea was in a favourable position to apply Japanese laws and institutions, since Japan's influence had led it to introduce a legal system similar to that of Japan. This made the policy diffusion from Japan to South Korea much stronger than that which occurred from European countries, such as the Netherlands and Germany, to Japan.

The elite bureaucrats who joined government service later in the 1980s benefited from overseas studies sponsored by the government. They found themselves with ready access to overseas institutions other than those in Japan. At the same time, scholars — who now wielded influence as a result of the movement toward greater democratization — played a substantial role in studying foreign medical institutions and introducing these ideas into South Korea. As a result, there was a heightened demand for reform.

While Japan and South Korea certainly share more with each other than they do with Western countries, closer examination reveals their differences also. First, in Japan, regional traits stand out distinctly. The tradition of local autonomy remains intact, in spite of its close dealings with Western countries. In contrast, in South Korea, and under the long-standing influence of a centralized political system, national uniformity was preferred over regional autonomy.

Second, it is evident that the President represents the core of political power in South Korea, whereas it is less evident with whom political power rests in Japan. In Japan, there is a limit to how much political lead can be taken in coordinating various interest groups. This applies even to the Prime Minister, for this appointment is the product of compromise between political parties. According to the theory of industrial structures, the redistributive impact of state action is thought to be lower in countries where political power is diffused and many actors have the ability to block changes to the status quo (Kellermann, 2005). Japan's experience would appear to be a good example of this. In South Korea, in contrast, the election of Kim Dae-Jung as President opened a window of opportunity for the integration reform. Representing the core of political power, he managed to achieve reform by pronouncing his commitment to the reform. The role played by President Kim, based on his personal leadership, lent itself to a style of policy-making that could be characterized as "forcing consensus" (Wong, 2004).

Third, the health insurance systems differed in the length of time (Wilensky, 1975) they took to become established and the extent to which they developed in the two countries. Japan's health insurance system can be traced back for almost a century and is characterized by the influence of entrenched stakeholders. Over the years, the Japanese system has evolved slowly to the country's changing needs. This makes institutional shifts even more difficult. By contrast, with its comparatively

short history of health insurance, and with vested rights not so deeply rooted, South Korea was able to set goals for measures that, elsewhere, might have been thought as too ideal to achieve. South Korea pursued such ideal reforms by first learning intensively from the lessons of Japan's health insurance system.

Economic crisis. The financial crisis that hit South Korea at the end of 1997 affected the nation's health insurance system. First, the crisis facilitated a shift of political power, which paved the way to reforms. Second, the Asian financial crisis made the strengthening of social solidarity a top political priority, which provided an incentive to promote the integration of health insurers. The economic depression which has endured in Japan since the 1990s has provided the impetus to map out the Medical Care Scheme for the Senior Elderly in 2008, but has not yet led to integration.

Democratization and social security. According to Wong (2004), South Korea found it possible to rapidly expand social security as part of the "democratization" process of the 1980s and 1990s. And South Korean proponents of the integration of health insurers, including most civil organizations, considered integration as part of the process to expand social security. Shifts in the political environment, including democratization and the rise of major grass-roots civil organizations, opened a window of opportunity in favour of reform. The democratization drive helped alter the incentives and ultimately the decisions of policy-makers. Vote-seeking politicians needed to promote popular policies and those who were advocating health care reforms — from bureaucrats to grass-roots activists — adapted to this new political context (Wong, 2004). Reforms that lead to changes in vested rights rarely occur overnight. However, the rapid democratic drive that gained ground in South Korea provided the impetus that made such a difficult task possible in a relatively short period.

Why did things change in South Korea, but not in Japan? Though parliamentary democracy was firmly established in Japan, the perception that social security was granted preferentially by bureaucratic elites was deeply entrenched, not least because of the long-held political monopoly of the LDP. Affecting change to the fundamental features of such a deep-rooted health insurance system, especially one that had been shaped by elite bureaucrats, was deemed impossible perhaps. There was no shift in political power during the period when the health insurance system was designed and implemented — if change did occur, this was more likely to stem from changes in the policy alignment of the incumbent political party rather than as a result of a shift in power per se. In such a context, politicians were able to operate in a climate of political certainty, with little need to be receptive to public opinion. Health policy experts and major ideologues, as well as civil organizations, found difficulty in formulating ideas about the need for fundamental reform. Thus,

reform proposals seeking fundamental change to the health insurance system seldom found their way on to political agendas.

Concluding observations

This article has investigated the process whereby Japan and South Korea, which previously both operated multiple-payer SHI systems, now find themselves with distinct models of health care. The causes for this divergence have been analyzed through the lens of comparative political economy: differences in political power, the policy influence of business, the extent to which regional autonomy has developed and regional traits have been preserved, the level of political democratization, the form of political leadership, and the scale of development of the health insurance system. From this comparative perspective, a number of observations can be presented.

First, it is not possible to conclude that either the corporative approach (multiple-insurer system) or the integrative approach (single-payer system) is superior. Nonetheless, a large risk pool can offer advantages, not least in a context of rising health care costs and population ageing. In the initial phases of introducing health insurance in Japan and South Korea it was not administratively feasible to combine coverage extension on a major scale with programme integration. Over time, with the development of an institutional framework for health insurance and the creation of infrastructure for data processing, the administrative environment has changed. Large insurers now have the capacities to manage effectively large population groups.

Second, to integrate coverage under one insurer, it is now possible to challenge the argument that employees and self-employed workers should first pay the same uniform level of health contributions. Opponents of integration insisted that reform of the income-reporting systems and contribution-levying formula should precede organizational integration. However, the imposition of uniform contributions on two population groups whose situations are different would be inequitable: the method of imposing health insurance contributions on self-employed workers has been mapped out, tailored appropriately to their situations, and solidly established in both countries. The integration reform in South Korea demonstrates that it is not differences in the contribution formula that prevent the integration of funds which cater to different population groups. To realize successful integration, it is sufficient to merge the financial and administrative controls, without unifying the contribution methods. In South Korea, professional expertise for the strategic purchase of health care has developed rapidly under the single-payer system now covering the entire population.

In sum, this article may have important policy implications as regards to whether Japan should move to a single-payer system and whether developing

countries should likewise develop such a system from the outset. First, with regard to Japan, while it may seem that the country would best benefit from a single-payer system, its health system has been tailored to its politico-economic circumstances. Japan is a populous country with a long tradition of local autonomy compared to South Korea. Despite conspicuous differences between the country's regions, each region is relatively well equipped with a good medical care system capable of providing quality care ranging from primary to tertiary health care. Accordingly, this would suggest that there are good arguments for operating health insurance organizations on a regional basis. However, the argument in favour of a decentralized regional structure does not extend to smaller areas, such as municipalities. It can be argued that the fragmented structure of Japan's insurers, numbering almost 3,600, should be reorganized into fewer but larger organizations.[17]

In the case of developing countries, a number of comments can be offered. Those countries seeking to develop universal coverage would be served best by a single-payer system. However, the implementation and extension of coverage under such a system would present important challenges. Based on experience, universal coverage is often achieved through a variety of schemes. Japan's experience suggests that an institutional shift toward a single-payer system will be too difficult to achieve. In contrast, South Korea's experience shows that it is possible to achieve universal coverage with a large number of insurers and then to switch over to a single-payer system. From a strategic perspective, a possible alternative would be to define from the outset an official policy goal to extend coverage to population groups gradually using appropriate insurance mechanisms and then, ultimately, to switch to a single-payer system. By means of trial and error, this is the policy lesson offered by the experience of South Korea over a 20-year period.

17. Small insurers limit the risk-pooling and redistributive effects of social insurance, exacerbating financial disparities between funds. Under a mandatory insurance scheme, it is difficult to see the advantages of competition between insurers surfacing (van de Ven and Ellis, 2000). There is little or no competition among health insurers even though they remain numerous in Japan, as they were also in South Korea before the integration reform in 2000 (Kwon, 2008). These small insurers, as quasi-autonomous and non-profit bodies, form the essence of the compulsory national health insurance scheme. All insurers offer the same benefit package, with very few exceptions. They are not permitted to cherry-pick healthy and wealthy individual members or to discourage older or poorer individual from enrolling; nor are individuals permitted to shop around for the most attractive plan. "Autonomy and competition", as the rationale of the multiple-payer system, is hard to find among mandatory insurers.

Bibliography

Arioka, J. 1997. *Sengoiryouno 50 nen — iryouhokenseidono butaiura* [50 years of post-war medical care — Behind the scenes of the medical insurance system]. Tokyo, Japan Medical Journal Company. In Japanese.

Campbell, J.; Ikegami, N. 1998. *The art of balance in health policy: Maintaining Japan's low-cost, egalitarian system*. Cambridge, Cambridge University Press.

Cho, H. J. 1988. *Hanguk euiryobojangi naagal guil* [The way forward for Korea's medical security system] (Symposium for medical system for healthy life, Seoul, 3 September). Seoul, Doctor's Network for Realizing Humanism. In Korean.

Collier, D.; Messick, R. E. 1975. "Prerequisites versus diffusion: Testing alternative explanations of social security adoption", in *American Political Science Review*, Vol. 69, No. 4.

Democratic Party of Japan. 2009. *Minshutou seisakusyu INDEX 2009 iryouseisaku* [Index 2009 (Collection of Democratic Party Policies) and Manifesto 2009]. Tokyo. In Japanese.

Graham, E.; Shipan, C.; Volden, C. 2008. *The diffusion of policy diffusion research* (Conference paper, preliminary draft, 104th Annual Meeting of the American Political Science Association, Boston, 28-31 August). <http://polisci.osu.edu/faculty/cvolden/GSVDiffusionResearch.pdf> (accessed on 03.10.2011).

Health and Welfare Statistical Association. 2007 and 2011. *Annual statistical report of trends in insurance and pensions*. Tokyo. In Japanese.

Inke, M.; Xu, K. 2009. *An analysis of the health financing system of the Republic of Korea and options to strengthen health financing performance*. Geneva, World Health Organization.

Jeong, H.-S. 2010a. "Kankokuno keonkouhokenni okeru P4P no tounyu" [Introduction of Pay-for-Performance (P4P) in Korea's National Health Insurance], in *Gekkankikin* [Monthly Fund], Vol. 51, No. 1. In Japanese.

Jeong, H.-S. 2010b. *Expanding insurance coverage to informal sector populations: Experience from Republic of Korea* (World Health Report 2010 Background Paper, No. 38). Geneva, World Health Organization.

Jones, R. 2009. *Health-care reform in Japan: Controlling costs, improving quality and ensuring equity*. Paris, Organisation for Economic Co-operation and Development.

Kellermann, M. 2005. *Power resources theory and inequality in the Canadian provinces* (Conference paper, Harvard Comparative Political Economy Workshop, Cambridge, 7-8 October). <http://www.ces.fas.harvard.edu/conferences/cpeworkshop/can_inequality.pdf> (accessed on 03.10.2011).

Kim, Y. M. 2000. "Euiryoboheom tonghabeui ihaegwanguye" [Interests in the integration of health insurers], in J. C. Lee (ed.), *Hanguk euiryo daenonjaing* [Big debates centered upon Korea's medical care]. Seoul, Sonamu. In Korean.

Korpi, W. 1983. *The democratic class struggle*. London, Routledge & Kegan Paul.

Kwon, S. 2008. "Thirty years of national health insurance in South Korea: Lessons for achieving universal health care coverage", in *Health Policy and Planning*, Vol. 24, No. 1.

Lee, K. S. 1989. "Euiryoboheom tonghab nonrieui byeonhwawa munjejeom" [Changes in and problems of the logic of proponents for the integration of medical insurers], in J. C. Lee (ed.), *Hanguk euiryo daenonjaing* [Big debates centered upon Korea's medical care]. Seoul, Sonamu. In Korean.

Lee, S. Y. et al. 2008. "The national health insurance system as one type of new typology: The case of South Korea and Taiwan", in *Health Policy*, Vol. 85, No. 1.

Martin, S.; Rice, N.; Smith, P. 1998. "Risk and the general practitioner budget holder", in *Social Science and Medicine*, Vol. 47, No. 10.

Ministry of Health and Welfare. 1961. *Kousei hakusyo 1961* [White paper for health and welfare]. Tokyo. In Japanese.

Mizumaki, T. 1993. *Kouseishou kenkyu* [Study on the Ministry of Health and Welfare]. Tokyo, Koubunsha. In Japanese.

Murakami, M. 2009. *Iryouhoukaino shinhannin* [The real culprit of the medical system's collapse]. Tokyo, PHP Shinsho. In Japanese.

National Federation of Health Insurance Societies. 1962. *Shakaihosyou nenkan* [Social security yearbook]. Tokyo. In Japanese.

National Health Insurance Corporation. 2010. *Gukmingeongangboheom samshipnyeonsa* [Thirty-year history of Korean National Health Insurance]. Seoul. In Korean.

Niki, R. 2001. *21 seikisyotouno iryouto kaigo* [Medical care and long-term care in the early 21st century]. Tokyo, Keisoshobo. In Japanese.

Sakurai, M. 2010. "Interview", in *Gekkan hokenshinryou* [Monthly Insurance Care], Vol. 65, No. 1. In Japanese.

Shimazaki, K. 2005. "Wagakunino iryouhokenseidono rekishito tenkai" [The history and development of the Japanese medical insurance system], in H. Endo and N. Ikegami (eds.), *Iryouhoken shinryouhoushu seido* [Health insurance system and fee reimbursement system]. Tokyo, Keisoshobo. In Japanese.

Simmons, B. A.; Dobbin, F.; Garrett, G. 2006. "Introduction: The international diffusion of liberalism", in *International Organization*, Vol. 60, No. 4.

Sugita, Y. 2008. *Senryousyokini okeru minsyukano soukoku — iryouhokenkousouwo megutte* [Competing ideas for health insurance plans in the early stages of the U.S. occupation of Japan]. Osaka, Ex Oriente – Osaka University of Foreign Studies. In Japanese.

Sugiyama, A. 1995. *Senryoukino iryoukaikaku* [Medical reform under the GHQ occupation]. Tokyo, Keisoshobo. In Japanese.

Umemura, S.; Nagao, K. 2009. *Pandorano hakowo akeyou* [Let's open the Pandora's Box]. Tokyo, Epic. In Japanese.

Ven, W.P.M.M. van de; Ellis, R. P. 2000. "Risk adjustment in competitive health plan markets", in J. P. Newhouse and A. J. Culyer (eds.), *Handbook of health economics*. Amsterdam, Elsevier.

Walker, J. L. 1969. "The diffusion of innovations among the American states", in *American Political Science Review*, Vol. 63, No. 3.

Weyland, K. G. 2005. "Theories of policy diffusion: Lessons from Latin American pension reform", in *World Politics*, Vol. 57, No. 2.

WHO. 2000. *Health systems: Improving performance* (World Health Report, 2000). Geneva, World Health Organization.

Wilensky, H. L. 1975. *The welfare state and equality: Structural and ideological roots of public expenditure*. Berkeley, University of California Press.

Wilsford, D. 1994. "Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way", in *Journal of Public Policy*, Vol. 14, No. 3.

Wong, J. 2004. *Healthy democracies: Welfare politics in Taiwan and South Korea*. New York, NY, Cornell University.

Yoshihara, K.; Wada, M. 2008. *Nihon iryouhoken seidoshi* [The history of the Japanese medical insurance system]. Tokyo, Toyokeizai Shinbunsha. In Japanese.