SOCIAL INSURANCE PROGRAMS IN SOUTH KOREA AND TAIWAN
A HISTORICAL OVERVIEW

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Introduction

The aim of this research paper is to provide some background information on the Republic of Korea (ROK; South Korea, hereafter Korea) and the Republic of China on Taiwan (ROC on Taiwan, hereafter Taiwan) for a study of social policy in both countries. This presentation consists of four major sections. The first section presents some selected social-economic indicators as well as the political development in Korea and Taiwan. The figures on socio-economic indicators are based on the national statistical records that are broadly utilized by both academic researchers and policy makers. The description of the political development, on the other hand, is based on secondary sources. The second section briefly explores the historical development of social insurance programs in Korea and Taiwan. The main focus is on how the different social programs are formulated rather than on how they are implemented. The third section outlines some characteristics of the national medical insurance systems in Korea and Taiwan. Thereafter the paper clarifies some overlooked, but nonetheless critical issues for studying social policy in Korea and Taiwan. More specifically, it discusses the relationship between medical care and statutory medical insurance in an international context. This discussion is further developed into an analysis of the relationship between government social welfare effort and government social expenditure as well as into a discussion on the issues of the entitlement to statutory medical insurance and the concept of social citizenship in the context of Korea and Taiwan.
Country information

Korea - an overview

Economic growth, industrialization and social transformation

Korea’s modern economic development did not commence until the early 1960s. The main obstacles to development were the partitioning of the nation at the end of World War II, the sudden severing of the Korean economy from the Japanese economic bloc, and the destructive civil war between the South and the North (1950-1953). During the post-Korean War period (1954-1962), the rate of GNP (Gross National Product) growth was relatively low (3.8 percent per year) despite a massive inflow of foreign aid. During the years between 1963 and 1989, however, Korea experienced extraordinary economic growth in terms of GNP, except during the one year of 1980. The high growth rate of GNP has rapidly raised the income of the Korean population. Initially, in 1963, per capita GNP was only US$ 100. This ranked Korea as one of the poorest countries in the developing world. By 1989, the figure had risen to US$ 5,210. The rise of per capita GNP took place despite the great increase in the Korean population from 27.3 millions in 1963 to 44.2 millions in 1993.

Rapid industrialization implied a shift in employment out of agriculture and into the industrial sector. The share of the work force in agriculture decreased from 63.0 percent in 1963 to 14.7 percent in 1993. By contrast, the share in the industrial sector rose from 8.7 percent in 1963 to 24.4 percent in 1993. With rapid industrialization came unusually rapid urbanization. The share of the urban population was only 28.0 percent in the early 1960s. However, this share rose to 48.2 percent in 1975, and then increased further to 57.3 in 1980 and to 74.4 percent in the late 1980s. One of the characteristics of urbanization in Korea was the formation of metropolitan areas.

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1 Key statistical data on socio-economic development in Korea are found in appendix 1 at the end of this research paper.
4 Ibid., p. 315.
The five metropolitan cities, i.e. Seoul, Busan, Inchon, Daejeon, and Daegu, alone account for 44.9 percent of the total Korean population.\textsuperscript{7} As a result of urbanization, the average household size in Korea declined from 5.73 persons in 1960 to 3.82 in 1990.\textsuperscript{8}

A significant transformation in Korea’s demographic structure has also taken place during the period studied. The annual population growth rate started at 2.6 percent in 1966. The rate steadily decreased and was less than 1 percent in 1989.\textsuperscript{9} The low life expectancy of the population, coupled with a high birth rate, made for a youthful population until the 1960s. The birth rate, however, declined sharply during the 1960s and 1970s owing to the successful implementation of family planning programs. In 1960, the birth rate was 42.1 per thousand, but the figure had decreased to 23.4 by 1980. A further decline to 15.4 had occurred by 1989.\textsuperscript{10} At the same time, the average life expectancy increased from 52.4 years in 1960 to 70.7 years in 1989.\textsuperscript{11} As a result, the proportion of those over 65 years old increased from 3.0 percent in 1963 to 4.8 percent in 1989. In terms of numbers, the elderly increased from 0.86 million in 1963 to 2.05 millions in 1989.\textsuperscript{12}

Another important demographic trend was the formation of smaller family units. However, intergenerational family solidarity has remained strong, something which has been explained by the age-old Confucian family tradition. As Choi noted, urban children often give financial aid to their parents and/or grandparents in rural areas. This strong sense of family solidarity also exists among brothers and sisters, who are often ready to help each other in times of emergency or hardship.\textsuperscript{13}

Parallel with these social transformations, the growth of modern medical care resources is also apparent. In 1963, there were 3.3 physicians per ten thousand people. The figure for 1993 was 11.7 physicians. With regards to the hospital beds, there were 4.0 beds per ten thousand people in 1965. The figure for 1993 was 28.5 beds.\textsuperscript{14}

\begin{itemize}
\item \textsuperscript{7} Moon, S. (1996), p. 199.
\item \textsuperscript{8} Korea National Statistical Office (1995), p. 63.
\item \textsuperscript{9} Ibid., p. 71.
\item \textsuperscript{10} Ibid., p. 69.
\item \textsuperscript{11} Ibid., p. 69.
\item \textsuperscript{12} Ibid., p. 67.
\item \textsuperscript{13} Choi, H. K. (1998), pp. 718-719; See also Chang (1985) and Son (1996).
\end{itemize}
Political transformations

The political development in Korea since 1948 has been characterized by instability and fluctuations. This is well evidenced by the frequent revision of the national constitution, as well as the frequent shift in the political leadership since 1948, when the modern Korean government was born following 35 years of Japanese colonialism (1910-1945) and three years of the United States’ military administration (1945-1948).\(^\text{15}\) However, these political transformations were determined less by the will of the Korean people than by their political leaders’ desire to stay in power. Between 1948 and 1988, Korea had nine constitutional amendments, four national referenda, and nine different heads of state. During the same period, presidents were sworn into office nineteen times, not to mention the six acting presidents. Six regimes and six interim administrations have risen and fallen. During the critical period from 1962 to 1987, military coups d’etat and authoritarian governments dominated the political arena.\(^\text{16}\)

In Korea, the ruling parties have fared no better than the ruling regimes. More specifically, with the downfall of the Rhee regime, his ruling Liberal Party collapsed; the demise of the short-lived Chang Myon regime weakened the ruling Democratic Party (DP); the assassination of Park Chung Hee in 1979 ended both his eighteen-year presidency and the domination of the Democratic Republican Party (DRP). With the rise of the Chun Doo Hwan regime, the Democratic Justice Party (DJP) emerged as the ruling party. Conversely, Chun’s exit from power in 1988 resulted in the extinction of the DJP.\(^\text{17}\)

All these regimes were basically authoritarian, although the Roh regime is often considered relatively democratic. This is because the Roh regime gave high priority to eliminating past vestiges of authoritarian rule. Examples of the Roh regime’s democratic measures include the release of political prisoners, the abolition of press censorship, the introduction of campus autonomy and the removal of restriction on overseas travel.\(^\text{18}\)

Political power has to a great extent been concentrated in the hands of the president. One factor helping authoritarian presidents was that the bureaucrats, representing a social elite, were highly flexible and pragmatic in

\(^{15}\) Ek (1972), pp. 35-42 and pp. 66-70.
\(^{17}\) Ho (1996), pp. 5-6.
\(^{18}\) Bedeski (1994), p. 27.
policy-making.\textsuperscript{19} On the other hand, the legislature has often been loud, but ineffective. The ruling party predominates, while opposition parties are in constant disarray, playing largely subservient role in the process of public policy making.\textsuperscript{20}

In the specific domain of medical insurance policy, the Ministry of Health and Social Affairs is the highest authority. Besides the Ministry of Health and Social Affairs, there exists one additional ministry in the government that is involved with medical insurance policy. This is the Economic Planning Board. Headed by the Vice-Prime Minister, it has overall responsibility for macro-planning and for setting resource allocation priorities for medical insurance.\textsuperscript{21}

Taiwan – an overview

\textit{Economic growth, industrialization and social transformation}\textsuperscript{22} Unlike Korea where modern economic development commenced only in the early 1960s, Taiwan’s modern economic development began in the early 1950s, and the country experienced impressive economic growth during the years 1950-1995 as evidenced by the high growth of per capita GNP.\textsuperscript{23} In 1952, per capita GNP stood at US$186. By 1990, the figure had risen to US$ 7,413. Per capita GNP then increased further to US$12,396 in 1995.\textsuperscript{24} The rise of per capita GNP took place despite the great increase in the Taiwanese population from 8.1 millions in 1952 to 21.3 millions in 1995.\textsuperscript{25}

\textsuperscript{20} Ho (1996), pp. 432-434.
\textsuperscript{21} The Economic Planning Board in Korea has been the key guidance agency for economic development since 1962, when Korea seriously began experiencing national economic development (Wade, 1988, p. 137). It is responsible for such matters as the establishment of national economic plans, the formation and the execution of the government budget, the mobilization of resources, investment, technical development, and economic cooperation with foreign countries and international organizations. The significance of this Board is indicated by the fact that it is chaired by the Vice-Prime Minister (A Handbook of Korea, 1994, p. 278).
\textsuperscript{22} Key statistical data on socio-economic development in Taiwan are shown in appendix 2 at the end of this research paper.
\textsuperscript{23} CEPD (Council for Economic Planning and Development) (1998).
\textsuperscript{24} Ibid.
\textsuperscript{25} Ibid., p. 20.
Rapid economic growth implied a shift in employment from agriculture to industry. The share of the work force in agriculture decreased from 56.1 percent in 1952 to 10.6 percent in 1995. By contrast, the industrial sector, which accounted for only 16.9 percent of all employees in 1952, had increased its share to 34.9 percent by 1975. Industrial employment peaked at 42.8 percent in 1988. It gradually declined to 38.7 percent in 1995.26

Rapid urbanization paralleled industrialization in Taiwan. In 1950, only 24 towns and cities in Taiwan had populations over 5,000. By the early 1980s, such places numbered almost 70.27 Taiwan’s urbanization patterns, however, differ from those of most other industrializing countries in the sense that the country does not have a lopsided concentration of population in a few metropolitan centers. As an island, it is geographically compact, thus assuring even rural residents of relatively easy access to an urban center.28 Furthermore, many industries in Taiwan are located in small cities and towns. This is due to the government’s industrial policy of the 1960s, designed partly to absorb excess rural labor and partly to utilize an inexpensive rural labor force.29

A significant transformation in Taiwan’s demographic structure has taken place since 1950. Annual population growth was 3.3 percent in 1952. It increased to 5.0 percent in 1969, and then slowed to 1.0 percent by 1986. The low population growth in the 1970s and 1980s is due to the successful implementation of a family planning program. In 1995 the population growth rate amounted to less than 1 percent.30 Until the 1950s, the low life expectancy of the population, coupled with a high birth rate, resulted in a youthful population. This in turn led to employment pressure. In 1952, the crude birth rate was 43.3 per thousand. This figure had declined to 22.8 by 1978 and it then declined further to 15.54 by 1992.31 At the same time, the average life expectancy increased from 53.4 years in 1951 to 71.9 years in 1995.32 As a result, the percentage of those over 65 years of age increased from 2.5 in 1952 to 7.6 in 1995.33

26 Ibid., p. 32.
29 Bello and Rosenfeld (1992), p. 188 and p. 201.
Another important demographic trend was the formation of smaller family units. In step with rapid industrialization, Taiwan’s traditional lineage system has been breaking down. Thus fewer people today live together in extended family system. Nuclear family ties, however, have remained strong. Lee and her colleagues’ study on intergenerational support in Taiwan provides evidence of this. According to it, as recently as in 1994, the vast majority of married children, both sons and daughters, provided financial support for their parents, irrespective of co-residenceship. This was so in spite of the Western assumption that economic and social changes accompanying industrialization tend to reduce support from adult children to parents.  

Parallel with these social transformations, the growth of modern medical care resources is also apparent. In 1960 there were 4.5 physicians per thousand people. By 1965, this figure had decreased to 4.0 due to the rapid increase in population. The number of physicians per thousand then rose to 11.5 in 1995. With regards to the hospital beds, there were 18.9 beds per ten thousand people in 1975. The figure for 1995 was 49.0 beds.

Political transformations
As noted earlier, the modern Korean government has experienced frequent changes in its national constitution and political leadership since its birth in 1948. In contrast, the modern government in Taiwan exhibited no visible change in its national constitution or political leadership until the mid-1980s. The fact is that the modern government in Taiwan is a direct successor to the Nationalist government that was established in mainland China back in 1928, as evidenced by their official name, the Republic of China (ROC). In retreating to Taiwan in 1949 after their defeat by the Communists on Mainland China, the Nationalists brought along their formal constitution, national-level party and government structures. They superimposed these on the party and governmental structures of one province, the land mass of which was 0.37 and the population 1 percent of China’s total. The Nationalist government has never relinquished its claim to be representing the whole of China since its retreat to Taiwan. The Nationalist government’s claim to be the legal government of China in turn rests on, or rather, is justified by the constitution’s assertion of this claim; and the first

34 Lee, Parish and Willis (1994).
National Assembly is the incarnation, as it were, of the constitution. The first National Assembly, consisting of 2,691 delegates, was elected in 1947 before the Nationalists fled to Taiwan.\textsuperscript{37}

The first National Assembly exercised three important functions: to elect the president and vice-president, to recall them and to amend the constitution. This implies that it had very little to do on a day-to-day basis besides its function as the embodiment of constitutional continuity as pointed out earlier. This continuity, however, began to break down with the appearance of a political reform movement that aimed to correct the existing distortion of political representation in Taiwan, beginning in the mid-1980s. Some of the important political reform measures taken since then include the legislation on the voluntary retirement of senior parliamentarians in 1989 and the election of delegates to the second National Assembly in 1991.\textsuperscript{38} The second National Assembly assumed the task of revising the 1947 Constitution between March and May of 1992. The outcome of this constitutional revision included the direct election of the president by universal suffrage and the shortening of his term in office from 6 years to 4 years.\textsuperscript{39}

Until 1996 the presidency in Taiwan was not subjected to popular vote, but instead was routinely renewed by the National Assembly. Chiang Kai-shek, who was elected by the first National Assembly in 1948, stayed in office until his death, on April 5, 1975. Between March 21, 1978 and January 13, 1988, after a brief acting presidency, his son Chiang Ching-Kuo held the post. The presidency was turned over to the Taiwan-born Lee Teng-hui, an American-educated agronomist, on March 21, 1988.\textsuperscript{40} On March 20, 1996, Lee Teng-hui won Taiwan’s first direct presidential election with 54 percent of the vote.\textsuperscript{41}

Below the National Assembly and the president is a government structure that follows the ROC’s founding father Sun Yat-sen’s concept of a fivefold division of power, the so-called five councils (Yuan). In addition to Montesquieu’s three divisions of government, i.e executive, legislative, and judiciary, Taiwan also has branches for examination (in charge of the civil service tests) and control (in charge of investigating official malfeasi-

\textsuperscript{37} Ibid., p. 59.  
\textsuperscript{39} Ibid.  
\textsuperscript{40} The Republic of China Yearbook (1997), pp. 665-674.  
\textsuperscript{41} Starr (1997), p. 283.
sance, with the power to impeach). In the absence of a functioning democracy, the five-power division did not function as intended until 1987.

The legislative council had been largely inactive. The majority of its membership consisted of Nationalist politicians elected from the Mainland who held their seats through 1991. Until 1969, the only representatives at the national level from Taiwan Province were the few legislators elected from the province in 1947. In 1985 there remained 339 legislators (out of the maximum of 773 allowed in the 1947 electoral law), and of these only 98 had been elected on Taiwan. The Nationalist party revealed a sign of its waning power in the legislative council when it lost a number of seats to the opposition in the nation-wide legislative elections held in 1989, in 1992 and in 1995. However, it still holds its dominant position within the legislative council, while the opposition parties are split among themselves.

In the specific domain of medical insurance policy, the Department of Health within the Executive Yuan is the highest authority. It discusses and decides on statutory and budgetary bills concerning medical insurance. It is placed lower than ministries and councils within the governmental hierarchy. Beside the Department of Health, there exist three additional governmental organizations that are involved in medical insurance policy. They are the Council of Labor Affairs, the Ministry of Personnel and the Council for Economic Planning and Development. The Council of Labor Affairs is responsible for financing and operating labor insurance. The Ministry of Personnel is in charge of administrating the government employers’ insurance. The Council for Economic Planning and Development, which is headed by the Prime Minister, has overall responsibility for macro-planning and the setting of priorities for resource allocation for medical insurance.

Summary

So far, a brief description of the socio-economic and political transformations that Korea and Taiwan have undergone during the past four decades has been provided. What is worth emphasizing in the cases of the two

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43 Copper (1999), pp. 92-96.
48 Ibid., p. 100.
countries is not the socio-economic transformation in itself but the extremely short time-span of three to four decades under which the socio-economic transformation took place. It has also been noted that the employment structure in both Korea and Taiwan today shows more proximity to the Western industrialized societies than to those of other industrializing societies. The description, however, also suggests that despite a profound socio-economic transformation over the past four decades, strong family relationships still prevail in both countries.

Despite the common view that both countries have had authoritarian regimes, they differ considerably in their histories of political transformation. The political transformation of Korea has been more unstable than that of Taiwan. Between 1948 and 1988, Korea had nine constitutional amendments, frequent shifts in political leadership, as well as the rise and fall of different ruling political parties. On the other hand, Taiwan until the mid-1980s maintained the same national constitution, experienced no obvious change in political leadership, and the dominance of the ruling Nationalist party prevailed in political arena.

Historical development of social insurance programs in Korea and Taiwan

This section describes briefly the historical development of social insurance programs in Korea and Taiwan from 1950 onwards. To begin with, both Korea and Taiwan introduced social insurance programs for public sector employees earlier than those for the general population. For instance, in Korea special pension programs for government employees, military personnel and private school teachers have been operating since 1960, 1962 and 1973 respectively.\(^49\) In Taiwan, similar programs have also been operating since 1958, 1953 and 1980 respectively.\(^50\) In any case, the description in the following is limited to the social programs that are intended to promote welfare for the general population. Emphasis will be laid on the modern social insurance agencies, as well as the orientation of the social insurance programs. In this process, two institutional characteristics

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\(^49\) Kim and Oh (1992), p. 68.
of social policy in Korea and Taiwan will become clear. One is that the role of the state in operating social insurance programs is essentially limited to that of regulator, rather than to that of direct fiscal provider. In other words, the daily administration of the social insurance programs is often entrusted to semi-public organizations whose financial management is also separated from the management of general government revenues.\(^{51}\) The other is that in both Korea and Taiwan, the emphasis in social insurance is laid on short-term productivity maintenance programs rather than long-term income maintenance programs. Moreover, it will also become clear that the statutory medical insurance program is the most prominent social insurance program in Korea and Taiwan. This is because statutory medical insurance is targeted to both the wage-working and non-wage-working populations, while the other social insurance programs are primarily targeted to the wage-working population. Moreover, this is one of the statutory social insurance programs towards which the state has directed its regulatory role for the longest period. For this reason, the statutory medical insurance programs in Korea and Taiwan can be considered as the most significant welfare effort by the governments of two countries in the post World War II era.

The information in Table 1 indicates that Taiwan introduced occupational injury insurance and medical insurance much earlier than Korea, while Korea introduced old-age pension insurance and unemployment insurance earlier than Taiwan.

Table 1 *Legislation on Social Insurance Programs in Korea and Taiwan, 1950-2001*

<table>
<thead>
<tr>
<th></th>
<th>Korea</th>
<th>Taiwan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational injury</td>
<td>1963</td>
<td>1950</td>
</tr>
<tr>
<td>Health</td>
<td>1963</td>
<td>1950</td>
</tr>
<tr>
<td>Old-age pension</td>
<td>1988</td>
<td>In progress</td>
</tr>
<tr>
<td>Unemployment</td>
<td>1995</td>
<td>1998</td>
</tr>
</tbody>
</table>


Korea introduced occupational injury insurance in 1963. This insurance program was financed solely by contributions from employers. The employers’ contribution is calculated on the basis of the total amount of wages, as well as the risk contingency rate, at each workplace. The daily administration of the program is entrusted with the Labor Welfare Corporation, a semi-governmental body. Initially, it covered the industrial workers at firms with 500 employees or more. Its coverage was successively expanded for the past four decades to include the workers at firms with over 5 employees. As of 1996, 39.3 percent of the total working population was covered by this social insurance program.\(^5^2\)

The medical insurance program in Korea was introduced in 1963 at the same time as the occupational injury insurance. Its coverage was almost nil until 1975 due to the lack of a compulsory clause in the initial law. The medical insurance law with the inclusion of the compulsory clause was adopted in 1976. This insurance program is principally intended to remove financial barriers in accessing costly medical care. It is mainly financed by contributions from both employees and employers. Since 1977 the coverage of the medical insurance program was expanded successively and reached almost universal coverage by 1989.\(^5^3\) In addition, a separate medical assistance program was implemented in 1977 in order to provide medical care to those who are outside working force and therefore are incapable of paying the medical insurance premium.

The National Pension Program was introduced in 1988. As a financing principle, a funding system, a kind of compulsory saving, instead of a pay-as-you-go system, was adopted.\(^5^4\) The pension premium is shared equally by employees and employers with no state subsidy. The pension fund operates separately from the general government accounts. The National Pension Corporation, a semi-governmental body, is entrusted with the responsibility of fund management. Initially, the program covered the workers at businesses with ten employees or more. After more than ten years in operation, all categories of the wage-earning population were brought under the National Pension Program. The pension fund is still in its accumulation stage. This is because a partial early retirement pension is not to be paid to those who have made the 15-year contribution until the year 2002, while a

\(^{5^4}\) Rejda (1999), pp. 149-150.
full old-age pension is not to be paid to those who have made the 20-year required contribution only until the year 2008.\textsuperscript{55}

In July 1995, Korea introduced unemployment insurance, naming it symbolically the Employment Insurance Program, as the last social insurance program among the four major social insurance programs. The monthly contribution to the unemployment insurance fund was stipulated at 0.6 percent of the average wage, to be shared equally by employer and employee. As of June 30 1997, approximately 20.3 percent of the total working population were covered by the employment insurance.\textsuperscript{56}

In the case of Taiwan, the labor insurance program was launched in 1950, first under provincial regulations, but later becoming statutory in 1958. It was intended to provide insurance coverage mainly to private sector workers. Labor insurance coverage consists of two types: occupational injury insurance and ordinary medical care insurance. The responsibility of paying for the premium for medical care insurance is shared by employees, employers, and the government in the proportion 2:7:1, while the responsibility of paying for the premium for occupational injury insurance is entirely born by employers. The employers’ contribution varies depending on the total reported wages, as well as the risk contingency rate at each work place. The daily administration of the Labor Insurance was entrusted to the Bureau of Labor Insurance, a quasi-governmental body. By mid-1998, approximately 34.2 percent of the total population was covered by the occupational injury insurance program.\textsuperscript{57} A separate Farmers’ Health Insurance has been in operation under the Bureau of Labor Insurance since 1985. With the launching of the National Health Insurance in 1995, the administration of ordinary medical care insurance was transferred to the semi-governmental Central Bureau of National Health Insurance.

The medical insurance programs for civil servants were inaugurated in 1958 and for private school teachers, and administrative staff in 1970. The Central Trust of China, a government-owned financial enterprise, was in charge of the daily administration of the medical insurance programs for these two groups. In the two decades of the 1970s-1980s, several medical insurance programs, covering retired civil servants, private school teachers and administrative staff and their relatives, were introduced, and the ad-

\textsuperscript{56} Kim, J. and Yo (1998), pp. 221-226.
ministrative and financial management of those medical insurance programs was placed under the purview of the Central Trust of China. Similar to the case of the Labor Insurance, the administration of these state-sector medical care insurance programs was transferred to the Central Bureau of National Health Insurance in 1995.\(^{58}\)

As explained above, all three major medical insurance schemes were incorporated into the National Health Insurance in 1995. After only one year’s operation, the program coverage was legally extended to 93.3 percent of the total population. With this figure, National Medical Insurance became the most developed social insurance program in Taiwan.

At the end of 1998, Taiwan legislated the Unemployment Insurance Law. It has been revised twice since then and was finally put into force on December 31, 2000. The monthly contribution to the unemployment insurance fund was stipulated to be one percent of the average wage, which is shared equally by employer and employee.\(^{59}\) Taiwan has not yet seen the introduction of a national old age pension program for ordinary citizens, although the debates on its establishment have been going on for several years. Instead, it still maintains the old separate pension programs for private sector employees, government employees, and private school teachers and staff which together cover 54 percent of the population aged between 15 and 64.\(^{60}\)

For the interest of comparison it is useful to refer to the study by Peter Flora and Jens Alber, which focuses on the variations in the introduction of social insurance laws as well as the chronological development of four major social insurance programs in Western European countries.\(^{61}\) According to Flora and Alber’s periodization on the development of the welfare state, it can be said that in the cases of Korea and Taiwan, the occupational injury insurance and medical insurance programs had reached the completion phase by the mid-1990s, while the old-age pension insurance and un-

\(^{58}\) Ibid, pp. 255-256.


\(^{60}\) Kwon, H. (2001a), p. 85. At the final stage of writing this dissertation, the Taiwanese government released a new draft of a pension plan that will subsequently replace the earlier pension system. Basically, the new pension plan consists of three optional programs, individual retirement accounts and two types of annuity insurance. All these three programs are designed to not put any strain on the government budget and at the same time to ensure that all workers are covered ([Taipei Journal, 2002-01-04], p. 1 and p. 4).

employment insurance programs are still in the introductory phase or extension phase. What is important to point out is that both in Korea and Taiwan, the medical insurance program is the most developed among all four major social insurance programs in terms of coverage in proportion to the total population.

The significance of medical insurance among various social insurance programs in the context of Korea and Taiwan is also demonstrated in the purpose of the statutory medical insurance programs. In her study on the sequential development of social insurance programs in eighteen Western industrialized societies, Schneider divides different social insurance programs into two categories on the basis of their objectives. The first category includes the social insurance programs that are intended to provide economic and social security. Occupational injury insurance, sickness and maternity benefits belong to this first category. The second category includes the social insurance programs that are purported to promote social equality. Unemployment insurance and family allowances belong to this second category.62

If we take a closer look at the statutory medical insurance programs in Korea and Taiwan, they are primarily designed to provide equal access to medical care and are secondarily purported to shield individuals and families from financial risks caused by a long-term hospitalization or technically specialized medical treatment. There is no specific provision for sickness benefits. These facts suggest that the statutory medical insurance programs in Korea and Taiwan function more as a mechanism to promote social equality and less as a mechanism to provide social and economic security. The above description of other social insurance programs and the characteristics of the statutory medical insurance programs in Korea and Taiwan further indicate that, during the period under study. The welfare debate in these two countries has primarily concerned more the issue of social equality and has been less focused on the issue of social and economic security, with entitlement to the statutory medical insurance programs occupying the central area of political contention. In the next section attention is paid to some characteristics of the national medical insurance systems in Korea and Taiwan.

Characteristics of the National Medical Insurance Systems in Korea and Taiwan

Historical patterns of the extension of entitlement to statutory medical insurance

Korea and Taiwan diverge in their historical patterns in the extension of entitlement to statutory medical insurance as Figure 1 illustrates.

![Figure 1 Increase in Medical Insurance Coverage, 1950-1996](image)


In the case of Korea, the increase in the medical insurance coverage was concentrated to the period between 1976 and 1990, with the largest increase taking place in the latter part of the 1980s. In contrast to the case of Korea, Taiwan shows a gradual increase starting from the 1950s, with the most substantial increase taking place in the 1990s.

However, the statutory medical insurance systems in these two countries show a convergence by the mid-1990s in terms of their near universal coverage. By 1996, 93.3 percent of Taiwan’s population and 98.0 percent of...
Korea’s population were legally insured under their respective statutory medical insurance programs.\textsuperscript{63}

In the case of Taiwan, the 6.7 percent of the population who are outside the national insurance systems include aborigines in the remote areas, prison inmates and others.\textsuperscript{64} In the case of Korea, the medical care of the remaining population, such as the elderly without relatives and others who are not capable of working, is covered legally by the Medical Assistance System, which has been in operation since 1977.\textsuperscript{65}

As far as medical insurance coverage is concerned, the medical care systems in the two countries come close to those in advanced Western countries. In any case, the great variation in the extension of entitlement to statutory medical insurance in these two cases clearly indicates the discretionary nature of statutory medical insurance policies on the part of the governments of the respective countries.

Method of financing

Both systems are basically financed by the contributions shared by employees, employers and, only in some cases, government subsidies. It should be noted here that the figures for Korea in Table 2 are drawn from the year 1994, while the figures for Taiwan in Table 3 are drawn from the year 1997. The financing formula shown in the tables has remained unchanged since then. Table 2 illustrates how medical insurance premiums are shared by the various parties in Korea.

Table 2 \textit{Share of contribution of the various parties to the National Medical Insurance System in Korea, 1994 (percent)}

<table>
<thead>
<tr>
<th>Population categories</th>
<th>Insured (%)</th>
<th>Employers (%)</th>
<th>Government (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees in public sector</td>
<td>50</td>
<td>-</td>
<td>50</td>
</tr>
<tr>
<td>Private school employees</td>
<td>50</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>Employees in private business</td>
<td>50</td>
<td>50</td>
<td>-</td>
</tr>
<tr>
<td>Self-employed and others</td>
<td>50</td>
<td>-</td>
<td>50</td>
</tr>
</tbody>
</table>


\textsuperscript{64} Interview with Yen-Hsiu Liu (1998-08-17).
In the case of Korea, both the insured and the employers pay 1.5 to 4 percent of wages, according to wage levels, while the government assumes a partial cost for administration. The insured include not only the wage earners themselves but also their dependents. Dependents to the wage earners include their children, brothers and sisters under 20 years old and parents-in-laws, and they are insured by way of their family connection to the wage earners. Korea’s rather simple contribution formula is the legacy from decisions made in the earlier phase of medical insurance development.\footnote{Son (1998), p. 19.}

Table 3 illustrates how medical insurance premiums are shared by the various parties in Taiwan.

**Table 3** Share of contribution of the various parties to the National Medical Insurance System in Taiwan, 1997 (percent)

<table>
<thead>
<tr>
<th>Population categories</th>
<th>Insured (%)</th>
<th>Employers (%)</th>
<th>Government (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil servants</td>
<td>40</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td>Dependents of civil servants</td>
<td>40</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Teachers in private school</td>
<td>40</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Dependents of teachers in private school</td>
<td>40</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Employees in private business</td>
<td>30</td>
<td>60</td>
<td>10</td>
</tr>
<tr>
<td>Employers or self-employed, professionals and technicians</td>
<td>100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Workers without employers and seamen</td>
<td>60</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>Farmers and Fishermen</td>
<td>30</td>
<td>-</td>
<td>70</td>
</tr>
<tr>
<td>Dependents of military personnel</td>
<td>60</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td>Low-income households</td>
<td>0</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Veterans</td>
<td>0</td>
<td>-</td>
<td>100</td>
</tr>
<tr>
<td>Dependents of veterans</td>
<td>70</td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td>Others</td>
<td>60</td>
<td>-</td>
<td>40</td>
</tr>
</tbody>
</table>

*Source: Bureau of National Health Insurance [Taiwan] (1997), p. 42*

The Taiwanese system of financing medical care is more complicated than Korea’s. More specifically, the insured pay 1.275 percent of wages for themselves plus an additional 1.275 percent of wages for each dependent, up to 6.375 percent of wages for 5 or more dependents, while the employers pay 2.55 percent of wages for employees, plus an additional 3.468 percent of wages for dependents, regardless of the number of the insured dependents. In addition, the government pays 0.425 percent of wages for dependents.
employees and dependents, plus any deficit in program cost.\textsuperscript{67} The complicated Taiwanese contribution formula indicates that they were a combined product of earlier practices, as well as of considerable political compromise before the inauguration of the National Medical Insurance in 1995.\textsuperscript{68} Three things are clear from the above discussion. First, both the Korean and Taiwan governments are heavily involved in financing their respective national medical insurance systems, although the contribution by Taiwan’s government is a much higher percentage than that in Korea. Second, there is a close relationship between the insured and their positions in the labor market for receiving medical care within the national medical insurance systems in these two countries. Third and lastly, the dependents are insured by way of their family connection to the wage earners. This makes the systems vulnerable in times of labor market instability.

Benefits

As shown above, the contributions to statutory medical insurance vary depending on the insured’s occupation or income. However, all the insured are entitled to receive uniform medical insurance benefits. In the case of Korea, the insurance benefits encompass benefits in kind (medical care benefits and maternity benefits) and benefits in cash (medical grants, maternity grants, funeral grants, reimbursement of expenses paid by patients, maternity allowance) and physical examination expenses. Of these insurance benefits, medical benefits in kind take the lion’s share of all the benefits provided.\textsuperscript{69}

In the case of Taiwan, the insurance benefits encompass almost all kinds of treatment and care required by illness and injury, such as examinations, checkups, tests, consultations, surgery, medications, medical supplies, therapies, nursing and hospitalization.\textsuperscript{70} From this review, it is clear that statutory medical insurance in Korea and Taiwan can be characterized as “medical insurance” rather than both the “income maintenance insurance” and “medical insurance” which are found in the majority of the OECD countries.

\textsuperscript{68} Son (2001), p. 50.
The national medical insurance systems of the two countries that are legally instituted and in practical operation today show similarities in the institutional features of medical care financing and administrative modes and medical care delivery systems.

Administrative and financial management

Comparing Korea and Taiwan, we find that they have some similarities, not only in their financing mechanisms and medical insurance benefits, but also in their choice of organizational arrangements. The Korean national medical insurance system had long maintained multiple, decentralized administrative and financial jurisdictions. The end result was the accumulation of a financial surplus in the funds with healthier membership populations (mostly the funds with urban wage-earners) on the one hand, and the accumulation of a financial deficit in the funds with membership based on rural and urban self-employed and the general population on the other hand. These problems of financial imbalance, as well as of administrative inefficiency, have been the focus of social policy debates for the past decade or so in Korea after the attainment of universal statutory medical coverage in 1989. They were finally resolved by the July 2000 medical care reform by which a new semi-governmental agency, the National Health Insurance Corporation, took over the earlier separate financial and administrative jurisdictions. The effect of this reform of the administration and financial management of the Korean national medical insurance remains to be seen. Two things are certain: one is that this integrated structure will or should enhance the sentiment of equality among the general public; the other is that this unified administrative and financial structure will or should permit the government to exercise more effective control over the management of the national medical insurance system in general and medical care expenditure in particular.

In the case of Taiwan, the launching of the National Health Insurance Plan in 1995 brought the earlier separate administrative and financial jurisdictions of different medical insurance schemes under the Bureau of Na-

tional Health Insurance. The unified administrative and financial management of the Taiwanese health care system allows the Taiwanese government to exercise a more effective control of medical care cost by way of a global budgeting system. The global budgeting system means that an aggregate medical care cost for the whole population is calculated and fixed in advance for one year ahead.

Medical care resources

Table 4 below indicates that the medical care resources in both Korea and Taiwan are predominantly in the hands of private medical care providers, although Korea shows a higher proportion of private hospital beds than Taiwan does.

Table 4 Distribution of medical resources between public and private sectors, 1994

<table>
<thead>
<tr>
<th>Health resource</th>
<th>Korea</th>
<th>Taiwan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>11.5(^a)</td>
<td>n.a.(^c)</td>
</tr>
<tr>
<td>Private</td>
<td>88.5(^a)</td>
<td>n.a.</td>
</tr>
<tr>
<td>Hospital beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public(^b)</td>
<td>23.0</td>
<td>39.0</td>
</tr>
<tr>
<td>Private</td>
<td>77.0</td>
<td>61.0</td>
</tr>
</tbody>
</table>

*Note:* a. The figures are from 1997.  
b. Public hospital beds include hospital beds owned by national, city, and local governments as well as non-profit organizations.  
c. n.a. signifies data not available.  
*Sources:* Korean Hospital Association (1997); Director-General of Budget, Accounting and Statistics [Taiwan] (1997)

What is worth mentioning here is that the dominance of the private sector in providing medical care in Korea and Taiwan is not something unique, but is prevalent in many other countries in Asia, as Newbrander and Moser

\(^{73}\) Chiang (1997), p. 231. It is highly probable that the medical policy-makers and the technocrats in Taiwan were aware of the ineffectiveness of the administrative and financial decentralization of the Korean medical insurance system in controlling the medical cost as well as the inequality in medical care benefits.


\(^{75}\) Yang, B. (1997).
have pointed out.\textsuperscript{76} In any case, the dominance of the private sector in providing medical care in Korea and Taiwan is likely to cause increases in medical care cost in the future. It is also worth mentioning here that in the two remaining East Asian Tigers, Hong Kong and Singapore, the medical care resources are frequently owned by the public sector.\textsuperscript{77} By this standard, one can see that Korea and Taiwan exhibit a significant deviation from the general rule of the East Asian welfare system, in which the state often plays the role of regulator in the area of social policy.\textsuperscript{78} More specifically, as far as the ownership of the medical care resources are concerned, the governments of Korea and Taiwan clearly function as regulators while the governments of Hong Kong and Singapore function as direct providers.

Reimbursement, Flat-rate Out-patient User Charge, Co-payment and Referral System

In both Korea and Taiwan, the insured obtains medical services from various medical care providers (physicians, clinics, hospitals, pharmacists), who work on a contract basis with the National Health Insurance Corporation in the case of Korea and the Bureau of National Health Insurance in the case of Taiwan.\textsuperscript{79} Medical care providers are then reimbursed via a fee-for-service arrangement, with fees set by the government via those two official medical insurance agencies. The fee-for-service payment system operates so that the medical care provider is paid for every defined item of service.\textsuperscript{80} The fee-for-service system permits choice and flexibility while avoiding waiting-time problems. However, it tends to increase the volume of medical treatment and thus also incurs costs in the long run.\textsuperscript{81}

Both Korea and Taiwan maintain the fixed out-patient user charge system, the co-payment system as well as the patient referral system. The fixed out-patient user charge system means that the insured bears a fixed amount of the cost of each visit to doctor, while the co-payment system means payments of a fixed flat-rate fee for every kind of a defined list of services. On the other hand, the patient referral system implies that the in-

\textsuperscript{76} Newbrander and Moser (1997), p. 4.
\textsuperscript{78} Kwon, H. (1998).
sured is recommended to attend local clinics before he/she visits specialists in large hospitals. Each of these measures are consciously chosen with specific aims in mind. The flat-rate out-patient charge system is aimed at encouraging conscientious use of medical care resources by the public, while the co-payment system is designed to control the increase in medical care costs. The patient referral system is purported to increase the effectiveness of medical care resource utilization.\(^{82}\) Needless to say, all these measures are designed to have one and the same function, to control the growth in medical care spending in the future in the presence of the sub-optimal fee-for-service medical care payment system in both countries.

Some critical issues

Medical care and statutory medical insurance in an international context\(^ {83}\)

For a century or so, the gradual expansion of a state’s responsibility for taking care of its citizens’ well-being has even come to embrace the medical care needs of individual citizens.\(^ {84}\) In the case of almost all Western industrialized countries, medical care is provided either by a national health service or under a social insurance system. What makes the two systems different is the way they are financed. While national health service is financed out of the general revenue of government, a social insurance system is financed entirely or in large part by special contributions from employees, employers and in some cases even the state.\(^ {85}\) For this reason, the social insurance system requires special provisions to ensure that low-income individuals and families have medical insurance contributions paid on their behalf or that some alternative arrangements are made to guarantee access to medical care.

During the post World War II era, the governments of many industrializing countries in Asia, Africa and Latin America have attempted to provide medical care to the whole population through social insurance mecha-

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\(^{83}\) ‘Statutory’ as distinct from ‘private’.

\(^{84}\) de Swann (1988).

\(^{85}\) Freeman (1999), p. 82. The exception to these two general models for medical care financing is the private medical insurance model found in the United States and Switzerland. (OECD, 1987, p. 24).
nisms. However, as demonstrated in Table 5 below, the number of successful cases in terms of bringing the whole population under statutory medical insurance coverage are few and far between.

Table 5  *First year for statutory medical insurance legislation and legal coverage in some selected industrializing countries (Insured population as proportion to total population)*

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>1970</th>
<th>1996</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>1934</td>
<td>55.4</td>
<td>90.0</td>
<td>34.6</td>
</tr>
<tr>
<td>Brazil</td>
<td>1934</td>
<td>9.0</td>
<td>96.3</td>
<td>87.3</td>
</tr>
<tr>
<td>Chile</td>
<td>1915</td>
<td>69.6</td>
<td>91.0</td>
<td>21.4</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1968</td>
<td>0.0</td>
<td>25.5</td>
<td>25.5</td>
</tr>
<tr>
<td>Korea</td>
<td>1963</td>
<td>0.0</td>
<td>97.9</td>
<td>97.9</td>
</tr>
<tr>
<td>Mexico</td>
<td>1935</td>
<td>24.9</td>
<td>58.0</td>
<td>33.1</td>
</tr>
<tr>
<td>Peru</td>
<td>1936</td>
<td>12.3</td>
<td>72.4</td>
<td>60.1</td>
</tr>
<tr>
<td>Philippines</td>
<td>1969</td>
<td>0.0</td>
<td>38.0</td>
<td>38.0</td>
</tr>
<tr>
<td>Taiwan</td>
<td>1950</td>
<td>8.4</td>
<td>93.3</td>
<td>84.9</td>
</tr>
<tr>
<td>Thailand</td>
<td>1990</td>
<td>0.0</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Uruguay</td>
<td>1907</td>
<td>64.0</td>
<td>88.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

*Notes:* a. Proportion to all paid employees in the country.
   b. These figures are from 1998.
   c. This figure is approximate and not derived from primary sources.


Countries such as Argentina, Brazil, Chile, Mexico, Peru and Uruguay, which are often considered to be social security pioneers among Latin American countries, adopted their first statutory medical insurance laws already in the earlier part of the twentieth century. On the other hand, Asian

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86 Hong Kong, Singapore and Malaysia, former British colonies, are excluded in the table because the three countries adopted different strategies in financing medical care, namely the national medical service system (Ramesh and Asher, 2000, pp. 90-93 and pp. 95-101). The same holds true for Cuba, a state socialist country, which adopted a National Medical Service in 1970. African countries are also excluded due to the insignificant portion of their population employed in the urban formal sector and consequently very low social insurance coverage ranging from 1.11% of the total population in Chad to 24.07% of the total population in Tunisia as of 1989 (Gruat, 1990). Although the data are rather outdated, it is assumed that no substantial growth in statutory medical insurance coverage took place for the past decade, considering the political instability as well as the chronic economic crisis in this part of the world.

countries such as Indonesia, Korea, Philippines, Taiwan and Thailand adopted their first statutory medical insurance laws in the latter part of the twentieth century. What distinguishes Korea and Taiwan from other Asian and Latin American countries is that these two countries enacted laws on universal medical insurance coverage in such a short period of time. The distinctiveness of Korea and Taiwan is also demonstrated by a substantial improvement in their health indicator as Table 6 shows.

Table 6 *Infant mortality rate (per 1,000 live births)*

<table>
<thead>
<tr>
<th></th>
<th>1960</th>
<th>1996</th>
<th>% of Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>60</td>
<td>22</td>
<td>63.3</td>
</tr>
<tr>
<td>Brazil</td>
<td>116</td>
<td>36</td>
<td>69.0</td>
</tr>
<tr>
<td>Chile</td>
<td>114</td>
<td>12</td>
<td>89.5</td>
</tr>
<tr>
<td>Indonesia</td>
<td>139</td>
<td>49</td>
<td>64.7</td>
</tr>
<tr>
<td>Korea</td>
<td>85</td>
<td>9</td>
<td>89.4</td>
</tr>
<tr>
<td>Mexico</td>
<td>92</td>
<td>32</td>
<td>65.2</td>
</tr>
<tr>
<td>Peru</td>
<td>142</td>
<td>42</td>
<td>70.4</td>
</tr>
<tr>
<td>Philippines</td>
<td>80</td>
<td>37</td>
<td>53.8</td>
</tr>
<tr>
<td>Taiwan</td>
<td>23a</td>
<td>6b</td>
<td>73.9</td>
</tr>
<tr>
<td>Thailand</td>
<td>103</td>
<td>34</td>
<td>67.0</td>
</tr>
<tr>
<td>Uruguay</td>
<td>51</td>
<td>18</td>
<td>64.7</td>
</tr>
</tbody>
</table>

*Note:* a. The figure is from 1967.  
b. The figure is from 1995.  


The infant mortality rate is a particularly important health indicator. It is also employed as a welfare indicator. Moreover, the infant mortality rate is closely related to the quality and equity of a country’s medical care provision. Table 6 shows that to varying degrees every one of the countries here under review has experienced a decrease in infant mortality during the past 35 years. The table shows that Chile and Korea are the two countries that have made the most progress, recording 89.5 percent and 89.4 percent respectively. However, the infant mortality rate in Chile is higher than Ko-

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88 The definition of infant mortality rate is given as follows: “The annual number of deaths of infants under one year of age per 1,000 live births. More specifically, the probability of dying between birth and exactly one year of age time 1,000.” (UNDP, 1998, p. 218).  
rea’s. A case in point is Brazil. As Table 5 shows, Brazil appears to have reached universal medical insurance coverage. However, its infant mortality rate is six times higher than that of Taiwan. These statistical facts can serve as an important evidence for the overall efficiency and effectiveness of the medical care provisions in Korea and Taiwan.\(^90\)

Turning to the extension of statutory medical insurance coverage, there are several factors that impinge on the level of statutory medical insurance coverage in the context of developing countries. The most important factor is related to the occupational structure, i.e. the proportion of the active population employed in the formal or modern sector. For a government that plans to establish medical insurance on the basis of the social insurance principle, it is administratively more convenient and economically less burdensome to protect urban regular wage-earners than farmers and the urban and rural self-employed. Obviously, the reasons are that the former are concentrated, they are more easily identified, and they earn salaries which are taxable and have employers capable of paying the social insurance contribution, while the opposite is true of farmers and the self-employed.

A second major factor in influencing the level of medical insurance coverage has to do with the efficiency and effectiveness of the social insurance agencies charged with the task of registering and keeping records of employers and employees, collecting contributions, and paying benefits in a timely manner to those entitled to them.\(^91\)

The third major factor is social as well as political. Personal income in many non-Western industrializing countries tends to be more unevenly distributed than in the Western industrialized countries, and this is often reinforced by disproportionate access to political power and influence. In other words, those who are less privileged lack political power to influence political leaders to establish a medical insurance program for them. It can also be due to the resistance of those who already enjoy medical insurance benefits to further extensions of medical insurance coverage for the underprivileged, in fear of their rising tax burden and/or a possible dilution of their medical insurance benefits.\(^92\)

\(^{90}\) The discrepancy between the Brazil’s medical policy at a central governmental level and its actual application at a region level is well described in the study by Atkinson (2000).

\(^{91}\) Mesa-Lago (1994), pp. 180-185; Ron, Abel-Smith and Tamburi (1990), p. 34.

Judging from the variations in medical insurance coverage, as well as the various factors influencing the level of medical insurance coverage, it can be assumed that in the context of industrializing countries, the extension of entitlement to statutory medical insurance to the whole population not only indicates the level of performance of the statutory medical care provision, but also a general trend in the ‘government social welfare effort’ in these industrializing countries.\(^93\)

**Government social welfare effort and government social expenditure**

In the previous section, it was contended that the varying levels of statutory medical insurance coverage in some industrializing countries could be regarded as reflecting the varying levels of government social welfare efforts in those countries. However, this definition, which is also applicable in studying social policy in Korea and Taiwan, differs from the established definition of government social welfare effort. The reasoning behind applying a new operational definition of government social welfare effort in this study is provided in the followings.

The majority of social policy studies employed government social expenditure as a proxy in measuring the government social welfare effort when they analyzed social policy during the immediate post World War II period. It should be noted that this previous practice is a specific product of the circumstances that prevailed in the Western industrialized societies where the state often is presumed to assume the role of direct financial provider to different social provisions. Moreover, as Julia S. O’Connor and Robert J. Brym have succinctly pointed out, the use of government social expenditure as a proxy in measuring government social welfare effort reveals some discrepancies regarding what it actually includes, depending greatly on the origin of the statistical data. For instance, in the International Labour Organization’s (ILO) statistical data, government social expenditure includes the greater part of social transfer payments and to a lesser extent a small portion of government civil consumption expenditure. On the other hand, the statistical data originated from the OECD encompass all public expenditure exclusive of military spending. The end result of the varying conceptualisations of and measurements for government social ex-

\(^93\) A similar view is expressed by Christopher Abel and Peter Lloyd-Sherlock in their study on medical policy in Latin America (Abel and Lloyd-Sherlock, 2000).
penditure is the varying explanations regarding differences in social policy.  

When it comes to the cases of Korea and Taiwan, employing the level of social expenditure as a measurement for a country’s welfare efforts encounters a similar problem, as the following discussion of social expenditure in Korea and Taiwan demonstrates. This problem exists because the two countries under study have employed different social statistical definitions. More specifically, Korea’s social expenditure includes only conventional social expenditure such as medical care, social insurance and welfare service. On the other hand, Taiwan’s social expenditure is a composite of a wide variety of expenditure. It not only includes some conventional social expenditures such as social insurance, social assistance, public housing, social education, community development, welfare services, medical care and employment service and vocational training, it also includes some Taiwan-specific expenditures such as Chinese refugee assistance, public employees’ salary supplements, public relations with international social associations and normal grain price supplements. This statistical problem in conducting a comparative study has clearly been pointed out by Alain Desrosières. He contends that different countries tend to employ different criteria in their collection of national social statistics. This national specificity of social statistics stems from the way in which states have been constructed and have established their legitimacy. The national social statistics of Korea and Taiwan are good examples that provide support for his contention.

Table 7 shows the share of social expenditure in total government expenditure for the period of 1971-1996. It should also be noted here that neither expenditure on education nor unemployment insurance benefits, two of the conventional government social provisions which also certainly differ in character, are included in the figures in the following table.

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94 O’Connor and Brym (1988). See also the critic by Frances G. Castles (1994).
97 There is no doubt that the expenditure on education is a “true” welfare expenditure. However, unemployment insurance benefits could be a kind of dis-welfare expenditure which arises from the failure of labour market policy. This is one of the reasons why over the past ten years or so many social scientists have begun paying attention to the welfare outcome indicators in terms of life expectancy at birth, infant mortality, literacy, access to safe drinking water and others, instead of the conventional state welfare indi-
Table 7 Percentage of Social Expenditure in Total Government Expenditure, 1971-1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Korea</th>
<th>Taiwan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971-1980 average</td>
<td>5.7</td>
<td>11.0</td>
</tr>
<tr>
<td>1981-1990 average</td>
<td>8.0</td>
<td>15.1</td>
</tr>
<tr>
<td>1991-1996 average</td>
<td>10.3</td>
<td>18.9</td>
</tr>
</tbody>
</table>


Two facts are worth noting in Table 7. One is that in both Korea and Taiwan, the share of social spending in total government expenditure has steadily increased for the past four decades. Another important fact is that throughout the whole period, Taiwan’s social expenditure is considerably higher than that of Korea. The gap in government social expenditure between Korea and Taiwan was even greater in the 1990s than it was in the 1970s. One can therefore draw the conclusion that in terms of the governments’ social spending, Taiwan’s government welfare effort is greater than that of Korea’s. This is undoubtedly related to the fact that the Taiwanese definition of social expenditure is broader than that of Korea.

Apart from the fact that social expenditures in Korea and Taiwan are incomparable due to their different criteria for collecting social expenditure data, there is one other important reason for not employing the magnitude of government social expenditure as a proxy in measuring the government social welfare effort, but rather the actual coverage of the statutory medical insurance programs used in this study. This is the fact that in East Asian countries such as Korea and Taiwan, the state has not been playing the role of direct fiscal provider to different social welfare provisions, as Kwon has astutely pointed out in his comparative studies.98

With specific regard to the financing of medical care, both Korea and Taiwan adopted the social insurance principle. Medical insurance contributions made by individual citizens do not end up in the government purse, but go directly to semi-governmental agencies.99 Moreover, the financial management of the semi-governmental agencies are separated from the government’s overall budget plan. Therefore when a person receives medic-
The entitlement to statutory medical insurance and the concept of social citizenship

The fundamental importance of entitlement to statutory medical insurance on the part of Koreans and Taiwanese can be demonstrated by its frequent association with the normative concept of ‘citizenship’ or ‘equality’.

The notion of ‘citizenship’ was first suggested by the British theoretician Thomas H. Marshall over half a century ago when he discussed the definition of the rights and duties of modern citizens in capitalist society. According to him, ‘citizenship’ is a “status bestowed on those who are full members of a community.” All citizens are thus equal with respect to the rights and duties with which this status is bestowed. He further elaborated that citizenship consisted of three parts, or elements: civil, political and social. First, the civil element is comprised of the rights necessary for individual freedom, such as the right to own property and to enter valid contracts, and to practice a profession of one’s own choice. Second, political citizenship consists of the right to participate in the exercise of political power.

The third and the most important element of citizenship is social citizenship. Unlike the first two parts of citizenship, the definition of social citizenship is relatively vague and ambiguous, and constituted a wide range of rights, “from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society” [Emphasis added].

\footnote{Kwon, H. (1998), p. 32.}

\footnote{Marshall (1950). See further Paul Spicker’s statement. He contends: “…the terms which are used in normative criteria are often contested concepts. The effect of imposing meanings on specific principles can be arbitrary: people do not necessarily mean the same thing when they think of ‘citizenship’ or ‘equality’, ….” (Spicker, 1996, p. 74). See also Albert Weale’s general discussion on the concept of social rights as well as his}
What is relatively apparent in his discussion on social citizenship is that its meaning can differ from country to country and from one time period to another. It is therefore by no means apparent of what the rights based on social citizenship are comprised or how they would be applied to individual men, women and children in different societies and at different times.\textsuperscript{102}

As Gøsta Esping-Andersen admits in his discussion on the transition to welfare states, the Western public in general and Western social scientists in particular frequently tend to connect the concept of social citizenship with the social insurance programs aimed at income maintenance.\textsuperscript{103} For instance, Walter Korpi interprets the quality of sickness insurance, measured by the replacement level for a single worker, the replacement level for a couple with two minor children and the number of waiting days as important criteria for the development of social citizenship in his social policy analysis of the OECD countries.\textsuperscript{104} On the other hand, Joakim Palme identifies the quality of old-age pensions, measured by the qualifying conditions, the method of financing, the entitlement to a future pension, the number of recipients of old-age pensions, and the level of benefits, as a significant indicator for the development of social citizenship.\textsuperscript{105} Further, Gøsta Esping-Andersen defines social citizenship as the capacity of social programs for ‘de-commodification’, i.e. the degree to which social programs allow people to maintain a living standard independent of pure market forces.\textsuperscript{106}

In any case, the discussion above shows two things clear. One is that the concept of social citizenship has been subjected to shifting interpretation depending on the researchers. The other is that the earlier interpretation of the concept of social citizenship have exclusively been based on the experiences of the Western European societies

\textsuperscript{103} Esping-Andersen (1995), p. 260. I would rather say that it is the North European public in general and the North European social policy specialists in particular who frequently tend to connect the concept of social citizenship with the social insurance programs aimed at income maintenance. See also the study by Alexander Hicks (1999) \textit{A Century of income security politics}. As the title of his book indicates, he describes social policies in West European and North American countries as a century of income security politics.
\textsuperscript{104} Korpi (1989), p. 315.
\textsuperscript{105} Palme (1990), pp. 28-34.
\textsuperscript{106} Esping-Andersen (1990), p. 3.
I have pointed out earlier in the comparison of the historical development of social insurance in Korea and Taiwan that the welfare debate in these two countries has concerned more the issue of social equality and has been less focused on the issues of social and economic security, with entitlement to the statutory medical insurance programs occupying the central area of political contention. For this reason, it seems not unfair to argue that in the context of Korea and Taiwan, the entitlement to some forms of statutory medical insurance can be considered as an important indicator for the development of social citizenship in their respective societies. Or to put it modestly, it can be one of the essential elements of social citizenship. For this reason, this paper argues that the level of statutory medical insurance coverage could be employed as a crude indicator for government social welfare effort in the context of Korea and Taiwan. Furthermore, the extension of statutory medical insurance should be considered as the extension of social citizenship.

Some support for the above argument is found in studies on the modernization of medical care in both countries. In both Korea and Taiwan, the day-to-day medical care provided by modern Western-trained doctors has traditionally been a privilege for urban, middle and high income groups. By the same token, in the initial stage of statutory medical insurance development, entitlement to statutory medical insurance was frequently a privilege for the urban, regular wage-earners.  

Three other significant conditions support this interpretation. The first condition is that entitlement to statutory medical insurance is universal. The second condition is that the medical insurance contributions are based on the ability to pay, but benefits are based on the individual’s need, which tends to promote equality and social solidarity. The third condition is that all citizens are entitled to uniform medical care benefits irrespective of their occupation, sex, age, or residence, although there is a tendency to reinforce the preexisting family relationship for the non-wage-working population to get entitlement to statutory health insurance.

In sum, this paper argues that in order to understand the logic behind social policy in these countries, it is necessary to make a substantial modification of the prevailing definitions of the concepts ‘government social wel-

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fare effort’ and ‘social citizenship’, as well as to make some adjustment of those concepts to the circumstances which prevail in Korea and Taiwan.\footnote{A certain degree of support for this decision is found in the statement made by Adam Przeworski and Henry Teune. They write: “Phenomena became facts when they are expressed in some language. The problem is that the same language may not be applicable across all systems but may have to be adjusted to specific systems.” (Przeworski and Teune, 1970, p. 13).}

Conclusion

This paper has provided some background information on Korea and Taiwan for a study of social policy in both countries.

The country information shows that both countries have experienced a rapid economic growth and have undergone an equally profound socio-economic structural change during the post-World War II period. It also shows that despite a profound socio-economic transformation over the past four decades, strong family relationships still prevail in both countries.

On the other hand, the two countries differ considerably in their histories of political transformation. The political transformation of Korea has been more volatile than that of Taiwan, which is indicated by the frequent revisions of the national constitutions and the changes in the political leadership in Korea.

The section on the historical development of social insurance programs in Korea and Taiwan shows two institutional characteristics of social policy in both countries. One is that the role of state in operating social insurance programs is essentially limited to that of regulator rather than to that of direct fiscal provider. The other is that in both Korea and Taiwan, the emphasis on social insurance is laid on short-term productivity maintenance programs rather than long-term income maintenance programs. Moreover, it also shows that the statutory medical insurance program is the most prominent social insurance program enacted in Korea and Taiwan in terms of population coverage.

The section dealing with some characteristics of the national medical insurance systems in Korea and Taiwan shows that the two countries diverge in their historical pattern regarding the extension of entitlement to statutory
medical insurance, but show similarities in the institutional frameworks for medical care financing and administrative modes and medical care delivery systems.

The major argument of this paper is that the level of statutory medical insurance coverage could be employed as a crude indicator for government social welfare effort in the context of Korea and Taiwan. This contention is grounded on two facts. One is that government social expenditure in Korea and Taiwan neither captures the dynamics of the respective governments’ welfare effort, nor does it adequately reflect the government welfare effort. The other is that both Korea and Taiwan have succeeded in launching programs that give a near universal medical insurance coverage to the population. It is worth bearing in mind the information and the contention made in this paper in further studying the social policy in Korea and Taiwan.
References


Ek, Å. J. (1972) Koreanskt kalejdoskop, Verbum/stdiebokförlaget, Karlskrona [Swedish].


Appendix 1
Key statistical data on Korea, 1963-1993

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<tr>
<th>Year</th>
<th>GNP Growth (%)</th>
<th>Per Capita GNP (US$)</th>
<th>Total Population (in 1,000)</th>
<th>Agriculture (%)</th>
<th>Employment Structure Industry (%)</th>
<th>Service (%)</th>
<th>Life Expectancy (years)</th>
<th>65 + (years)</th>
<th>Physicians per 10,000 (persons)</th>
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Notes: a. n.a. signifies information not available.
   b. The figure is from 1991.


Appendix 2
Key statistical data on Taiwan, 1952-1995

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Sources: Council for Economic Planning and Development (1998); Department of Health (1994); Directorate-General of Budget, Accounting and Statistics (1997)
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