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Diversity in Moving Towards Integrated, Coordinated and Equitable Social Protection Systems

Experiences of Japan, the Republic of Korea, and Taiwan, Province of China

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Acronyms

Japan Case Study

CEFS	Council for the Estimation of the Fee-for-Medical Service in Social Insurance
CSIMCC	Central Social Insurance Medical Care Council
CSIMCC	Central Social Insurance Medical Care Council
EHI	Employees' Health Insurance
EPI	Employees' Pension Insurance
ESO	The Education System Order
GMHI	Government-managed Health Insurance
MoE	Ministry of Education
MoHLW	Ministry of Health, Labour and Welfare
MoHW	Ministry of Health and Welfare
NHI	National Health Insurance
NP	National Pension
SMHI	Society-managed Health Insurance
SSC	Social Security Council

Republic of Korea Case Study

BOAPA	Basic Old-Aged Pension Allowance
CSM	Contribution to School Management
ELCI	Elderly Long-term Care Insurance
MoHW	Ministry of Health and Welfare
NBLSS	National Basic Livelihood Security System
NHI	National Health Insurance
NHIC	National Health Insurance Corporation
NPI	National Pension Insurance
NPP	National Pension Plan
USAMGIK	United States Army Military Government in Korea

Taiwan, Province of China Case Study

CEPD	Council for Economic Planning and Development
CLA	Council of Labour Affairs
DPP	Democratic Progressive Party
GEI	Government Employees' Insurance
LI	Labour Insurance
NCHE	Negotiation Commission on Health Expenditure
NHI	National Health Insurance
NPI	National Pension Insurance
OAA	Old Age Allowance
WAAF	Welfare Allowance for Aged Farmers

Abstract

This paper aims to draw lessons that may help address issues of fragmentation in welfare systems in China and other countries. To do so it reviews how Japan, the Republic of Korea (ROK), and Taiwan, Province of China, established their welfare systems. In particular, it examines how they dealt with fragmentation in government provision of welfare benefits and social services in the areas of primary health care and medical insurance, compulsory education, social assistance and basic pension programmes.

Research on these three East Asian cases shows that there are many similarities in their social policies in terms of the influence of the Second World War's historical legacy on their welfare institutions, and how rapid industrialisation also affected the shape of these institutions. All three considered poverty an "economic structural problem" to be solved through private employment rather than public assistance, and social policy was understood as both a short-term strategy to legitimise political power and as a pre-emptive measure to contain the problems of industrialisation. Also, while all three cases have been struggling with increasing inequality over the past two decades, they performed well in terms of poverty and inequality reduction up to the 1990s.

Based on the analysis of these experiences, this paper challenges the assumption that a welfare state is a luxury that can only be built after reaching a certain level of economic development. It also notes that the content, nature and timing of public sector provision of different welfare services and transfer schemes are affected by the historical institutional infrastructures specific to each of the welfare schemes. Seen in this light, each scheme is distinct in terms of the actors, processes and institutions involved. The paper therefore questions the ability of the welfare regime approach to explain the development of welfare states in different countries and regions, as such an all-encompassing approach may well mask variations across the different sectors within a welfare state.

The paper also points out that interactions among different welfare schemes may create structural isomorphism, in the sense that similar levels of integration/fragmentation can be observed across different welfare schemes in each country or region. While it is difficult to draw lessons on the sequencing of integration of fragmented welfare schemes, the experiences of ROK and Taiwan show that schemes which were financially unstable or internally unequal were the first to be integrated. However, fragmentation of welfare schemes does not necessarily preclude universal coverage. The two features can still be compatible when there is a set of institutions to create institutional complementarity and maximise synergies between fragmented welfare schemes.

Last but not least, the role of government as a mediator and coordinator among different interests is key to welfare reform. It is complemented by private sector and civil society organisations, which also play a crucial role in the process, through improving welfare accessibility and translating public demand into policies.

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Introduction

China's fragmented social protection system, with its significant coverage gaps and high administrative costs, is not unique, considering advanced welfare states' experiences in their early stages of welfare system development. For instance, many Scandinavian countries have had a number of insurance schemes for a vast range of occupationally differentiated social strata, which were diminished as welfare states expanded (Kangas and Palme 2005). However, a national unified system was not the automatic result of this expansion, but rather of consistent policy efforts to address the problems of fragmentation. These include conflicts and tension over who should get what, which tier of government should regulate and administer the system and who should bear the costs. These countries' distinctive political, economic and social institutions identified and generated solutions to social problems, and shaped the diverse ways they phased out fragmented schemes and established a nationwide system. However, they are diverse in terms of their impact on poverty and inequality. Some are highly universal and egalitarian, while others are universal but stratified, as Esping-Andersen (1990) describes with social democratic and conservative models. This observation immediately raises important questions for policymakers struggling with the problems of welfare provision's fragmented systems, for example: what were the institutional features of these systems that overcame fragmentation in welfare provision? What were the key institutions facilitating the fragmented system's transition into an integrated and coordinated system? How can a system be unified without sacrificing equality?

To answer these questions, this chapter reviews and extracts lessons from the experiences of Japan, the Republic of Korea (ROK) and Taiwan, province of China in building up their welfare systems. In particular, it addresses how they dealt with fragmentation in state provision of welfare benefits and social services in the areas of primary health and medical insurance, compulsory education, and social assistance and basic pension programmes. Research on state provision of social benefits and services in these three East Asian countries or regions have found many similarities among their social policies. First, the historical legacies of the welfare provision systems, in particular in the areas of health and education established under Japanese imperialism, have had a significant influence on post-war welfare institutions. Second, the institutions, actors and processes of rapid industrialisation have affected the shape of welfare institutions. Third, poverty was considered an "economic structural problem" to be solved through private employment rather than public assistance, and social policy was understood as both a short-term strategy to legitimise political power and as a pre-emptive measure to contain the problems of industrialisation (Ku 1995; Kwon 1999; Manow 2001; Peng 2005; Yi 2007). Fourth, although all three cases have been struggling with increasing inequality over the last two decades (Chung 2014; Jones 2007; Vere 2005), until the 1990s they had performed well in terms of poverty and inequality reduction in various social and economic spheres, such as wage and income, education and health (Jacobs 2000; Kwon 2005). These three similar experiences provide good examples for those countries with rapid industrialisation facing the task of developing welfare systems to overcome fragmentation, and unifying their system of welfare provision in an equitable and sustainable way.

The paper is structured as follows: it will explain the diverse types of fragmentation, and suggest an institutional complementarity approach as an analytical framework of those policies to unify systems. Then we move on to explain the experiences of three cases in the fields of primary health and medical insurance, compulsory education, social assistance and basic pension schemes. Based on the findings, we will suggest policy guidelines, particularly how to configure institutions for moving towards integrated, coordinated and equitable systems of welfare provision.

Fragmentation and Institutional Complementarity

1. Fragmentation of System of Welfare Provision

In social policy studies, fragmentation is interpreted in three ways. Research focusing on multilevel governance and welfare state variation highlights the fragmentation of authority between the central, regional (provincial), and local government levels, i.e. vertical fragmentation. Another variant deals with the degree of coordination between plural actors on the same government level, particularly in delivering specific benefits or services, i.e. horizontal fragmentation (Rauch and Vabo 2008). A typical example of horizontal fragmentation is internal divisions within a specific scheme to address a specific risk. This could be intra-sectoral fragmentation, which is more often found in developing than developed countries. When ad hoc "short-termism" dominates the design and implementation of social protection schemes to address a specific risk, specific welfare provision systems are more likely to be fragmented. Intra-sectoral fragmentation is accompanied by duplication, inefficiency and ineffectiveness in meeting needs. Many loopholes and gaps are created in the welfare provision system, which in turn becomes a source of corruption. It is argued that fragmentation in either form is negatively related to welfare state universalism, and a concentrated government system rather than a dispersed governance system is more likely to coexist with universal welfare solutions (Rauch 2005).

The other strand of research focuses on functional fragmentation such as inter-sectoral division. In the 1990s, inter-sectoral fragmentation of social security systems became perceived as problematic in European welfare states when governments shifted objectives from income protection to labour market integration, which closely links income maintenance and employment (van Berkel and Borghi 2008; Champion and Bonoli 2011). The lack of coordination between labour and social policies became a bottleneck, preventing governments from addressing social risks such as unemployment, invalidity or sickness.

2. Understanding Context and Institutional Complementarity for Drawing Lessons

Two major problems of lesson-taking or policy transfer are decontextualisation and monopolisation of good institutions. First, many policies and institutions transferred from one country to another have been installed without taking historical and institutional contexts into account, and consequently could not produce a comparable result to that original context. The case in point would be the examples of failed cash transfer programmes modelled after Brazilian and Mexican cases transferred to other developing countries (World Bank 1993; Soares 2012). Second, there might be not one but several different institutional forms associated with "good" performance. Discussions on a variety of capitalisms found various institutional forms to have good performance in such dimensions as productivity enhancement, wage moderation and capital control (Amable 2003). Both cases strongly indicate a necessity to probe into institutional context, in particular institutional relationships, i.e. how institutions in different domains interact and affect performance in other, as well as in their own, domains. Theories of institutional complementarity provide us with a useful analytical tool to explain these issues. In these theories, institutional complementarity is broadly understood as the following: two institutions are complementary when the presence of one increases the efficiency of the other (Aoki 1994). Therefore, institutional benchmarking becomes more complex since the efficiency of one institution for institutional benchmarking may be the result of presence of the other institution. The specifics of how to make institutions complementary are likely to differ from country to country, depending on the power of the state vis-a-vis the private sector, as well as in terms of administrative capability, the degree of flexibility and sophistication of the existing system, and the underlying

political economy. Therefore, taking lessons or policy transfer should involve the efforts to identify the institutional configuration rather than a single institution to produce a certain outcome in a specific context, and come up with its own configuration reflecting historical and institutional contexts. It is equally true in analysing and understanding various ways of integrating the fragmented welfare provision schemes or systems such as centralization, unification and coordination of disparate schemes.

3. Basic Services and Transfers: Health, Education, Income Transfer for the Aged and Social Assistance

The concept of "basic" is political and highly contentious. Basic services and transfers vary depending on the way a country defines and realises social security. However, without variation, the fundamental elements of these basic services and transfers are often defined as "primary" services and transfers in national legislation or decrees. We are going to focus on these primary services and transfers which are assumed to constitute basic elements in the areas of health, education, income transfer for the aged, and social assistance, such as primary health care, compulsory education, and social assistance for the poor and basic pension for the elderly.

Primary Health Care and Health Insurance

Primary health care is a multidimensional concept composed of both public and personal health services. It can be defined as a certain set of medical specialties (i.e. family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology), a certain set of activities (i.e. curing or alleviating common illness and disabilities), a level of care of setting (i.e. an entry point to a system that includes secondary care by community hospitals and tertiary care by medical centres and teaching hospitals, or a set of attributes such as accessible, comprehensive, coordinated, continuous and accountable care), and care characterised by first contact, accessibility, longitudinality and comprehensiveness. Within a context of health care systems as a whole, primary care is understood in both senses of "first in time or order" or "first contact", i.e. the entry point or ground floor of health care delivery and of "chief, principal or main" care that is central and fundamental to health care (Donaldson, Yordy et al. 1996). The WHO definition expands the parameters of primary health care, emphasising the importance of socio-economic, environmental and behavioural factors affecting health and populations by including public health measures such as sanitation and availability of clean water (WHO 1978). Although there is a lack of clarity and consensus about the concept's meaning, primary health care defined and used by any country shares many of these definitions. In analysing primary health care defined in broad sense as above, we will pay attention to all the actors, institutions and processes involved in delivering care "first in time or order". Our focus will be the relationship between primary health care and health insurance in the process of integrating each country's health systems. We will explain the process of integrating fragmented systems while focusing on the nature of national insurance systems, financing (premiums, government spending, cost containment measures, etc.), benefits packages, reimbursement of health care costs and supervisory systems.

Compulsory Schooling

The difference in basic schooling across countries has long been recognised as one of the keys to global income inequalities (Easterlin 1981; Gregorio and Lee 2002). Expenditure on public schooling is one of the most positively productive social services in terms of raising national product per capita. Yet this truth was not always translated into policies for universal compulsory schooling when countries started industrialisation, and various institutional obstacles to expanding mass schooling

emerged. Landed classes such as the Junker aristocracy in Prussia blocked the provision of education by the central government and left it to local forces. Britain's education reform was delayed by suffrage restrictions and government centralisation (Lindert 2004). Factors such as capitalist social control, the dominance of religion, vested interests within the education sector, and decentralisation of finance and curriculum, are often obstacles to a centralised and universally mandatory school system. Different political, economic, social, and cultural contexts have shaped education. One major consensus on development of centralised and mandatory school systems for all is that the state-building process is associated with education (Melton 1988; Green 1990). This finding is also prominent in Japan, the ROK and Taiwan. All three cases established universal compulsory primary schooling in their early developmental phases and expanded compulsory schooling to higher levels.

Social Assistance and Basic Pension

Social assistance includes all means-tested benefits in cash and kind, including those that provide benefits to higher income groups (Gough et al. 1997). It aims at addressing the problems of material deprivation, which links with basic pension for the elderly to provide their basic security as a first tier of the pension system. We will explain social assistance schemes and basic pensions for the elderly in the three cases, all of which share commonalties in social assistance policies and pension schemes. Social assistance schemes clearly favoured labour market solutions rather than state provisions; the pension systems were established and developed along lines of occupational status.

Case Studies: Japan, the Republic of Korea, and Taiwan, Province of China

All three cases have significantly different characteristics from those of advanced countries, reflecting late industrialisation with a strong developmental state. All are considered champions of developmental states, at least during the rapid industrialisation period, which was characterised by strong leadership of bureaucrats, the state's financial control, a state and capital alliance to promote strategic export industries, and exclusion, albeit with varying degrees across countries and time, of labour from politics. All three achieved rapid economic growth with low inequality and low levels of social expenditure. Research on the welfare provision system—particularly on the totality of welfare output composed of government, market, and household, i.e. the regime characteristics—also considers the key characteristics of these countries' welfare states more or less similar. Japan until the 1990s was often described as a hybrid of conservative and liberal welfare regimes, but having more similarities to the conservative welfare regime, owing to the stratified nature of its state welfare provision (Esping-Andersen 1992; Esping-Andersen 1999). Ku (1997) also suggested that the Taiwanese welfare state can classify as a conservative welfare regime for similar reasons. The three cases fall under the same regime category, highlighting the specific nature of developmentalist political economy, meaning social policy's subordination to, or instrumentalisation for, economic or industrial priorities such as productivist and/or developmental welfare regime (Holliday 2000; Gough 2001; Kwon 2005).

Regime-centred characteristics, however, may mask the cross-sectoral differences between countries belonging to the same regime, particularly in social service areas such as health care and education (Kasza 2002; Kautto 2002; Bambra 2005). The more variables with which we examine regime characteristics, the more variation we can find between countries sharing the same regime category. For instance, an empirical study with a large set of indicators by Lee and Ku (2007) found that from the 1980s to 1990s, the ROK and Taiwan, unlike Japan, shared peculiar welfare regime characteristics such as low/medium social security expenditure, high social investment, more extensive gender

discrimination in salary, medium/high welfare stratification, a high non-coverage rate for pensions, high individual welfare loading, and high family welfare responsibility. The Taiwanese tax cut responding to the 2008 global economic crisis effectively reduced the ratio of tax revenues to GDP. The national tax burden ratio fell from 20 per cent in 1990 to 11.9 per cent in 2010, the world's sixth lowest, even below that of Singapore at 13.5 per cent, and Hong Kong at 13.9 per cent (Chang 2012). This is in stark contrast to Japan and the ROK, whose national tax burden ratios are 27.6 per cent and 25.1 per cent, respectively. This suggests a different institutional environment for welfare reform in these countries (OECD iLibrary 2013). To explain how these three cases overcame fragmented systems of welfare provision, rather than regime characteristics, we must pay attention to key institutions and their specific relationships in areas of health, education and pension, as well as the historical and institutional context in which they were formed.

Case I: Japan

Primary Health Care and Health Insurance

Japan's health system is characterised by the separation of curative medicine and preventive services differentiated by funding and delivery mechanisms. The country has achieved its universal coverage of health curative care through various public and private insurance schemes with about 3,400 insurers as of 2012, and is marked by the predominance of private health care providers. They are largely classified into two categories: employer-based and residence-based insurance schemes. One major employer-based health insurance scheme constituting this multi-payer system is the government-managed fund (from October 2008, a quasi-governmental body and public corporation called the Japan Health Insurance Association) for small to medium-sized companies' employees and their dependents, which is often called "Public-corporation-run Health (Kyoukai Kenpo)". For employees (and their dependents) of large companies, meaning 700 workers as of April 2013, is "Health Insurance Society (Kenpo Kumiai) which is managed by more than 1000 independent insurance societies. Another scheme is mutual aid society-managed funds for government employees and dependents, often called "Mutual-Aid Associations' Health Insurance (Kyousai Kumiai Kenpo)". Residence-based insurance schemes include municipal funds for the self-employed, retired and unemployed known as National Health Insurance (NHI) (Kokumin Kenkou Hoken). Another scheme is comprised of prefecture funds for those aged 75 and above, known as Medical System for the Latter Stage Elderly (75 years and over) (Kouki Koureisya Iryou Hoken). Each scheme has different premium rates (Tatara and Okamoto 2009; Matsuda 2012; Japan Medical Association 2013)[1] (for a comparison of each insurer, see Appendix 13).

In this system, curative medicine and preventive services are separated, while primary and specialist care are not explicitly divided. Funded by general tax, preventative services are delivered mainly by local public health authorities, while curative medicine is funded through contribution-based insurance and delivered by private and public practitioners (Tatara and Okamoto 2009). More than 90 per cent of clinics are privately owned by either individuals or medical corporations, but they all provide primary as well as specialist care, which most physicians are trained to deliver. Specialist care requires hospitalisation, and hospital outpatient departments usually provide expensive medical services (Matsuda 2012; WHO and Ministry of Health 2012).

[1] There are also about 165 health insurance societies that managed funds for some occupational groups, such as medical doctors, dentists, pharmacists and lawyers. Most of these funds belong to the Japan National Health Insurance Association, which coordinates funds of National Health Insurance (Kokumin Kenkou Hoken).

Although individuals cannot freely choose their plans, they can freely choose health care providers regardless of their different insurance schemes since there is no system to designate health care providers for primary health care. The unified scales of fee-for-service and the same benefit package are applied to all the insured. Since 2000, long-term care for the elderly has been covered under the municipality-administered health insurance system, which set various scales of premiums based on income and ability to pay. The government plays a regulatory role by setting the fee schedule and giving subsidies to various insurance scheme stakeholders such as local governments, insurers and service providers to implement its policies. It also establishes and enforces detailed regulations for insurance funds and providers. Although the government has strong regulatory power over health care financing and insurance operation, the control of health care service delivery is left largely to medical professionals.

Although the system is fragmented, it has been lauded for its equitable universal coverage at low cost. Compared to other OECD countries, Japan has demonstrated the greatest longevity and the lowest infant mortality rates. The country's health system serves as a typical example of intra-sectoral integration to generate synergies between different insurance schemes. Since many insurance societies also provide different kinds of welfare benefits and services, the Japanese case is also an example of integration between different welfare service provision programmes in both private and public sectors.

The system of fragmented insurance schemes under a unified regulatory framework has been shaped by the interactions between both central and local governments of a strong state, and community-based public health movements. The system's institutional origins can be traced back to the pre-war period with evidence first found in the Factory Act of 1911. This made it obligatory for employers to help their workers if they became ill or were injured, provided that the injury occurred on the job. Modelled after Bismarckian system, the health insurance system based on the Health Insurance Act of 1922 was implemented in 1927, which initially covered only blue-collar workers. Small companies without the management capacity or sufficiently large risk pools had government serve as insurer, which we call the Government-managed Health Insurance (GMHI). Companies with more than 300 workers used self-managed health insurance societies, which we call Society-managed Health Insurance (SMHI). The government's strong intervention in business, in particular during the 1930s wartime planned economy, was seen as analogous to the Soviet economy's structure. This made possible the widespread company-based health and welfare schemes, together with the guarantee of lifetime employment, a seniority-based wage system, and company unions (Okazaki 1994). Sangyo Hokoku Kai, a form of company union, dealt with a broad range of company-level issues that included welfare as well as allocation of resources and production; this provided a strong organisational basis for the development of company-based welfare programmes including health insurance. The union was at the centre of industrial relations, a pillar of the wartime planned economy; but this also shaped the fragmented system of health insurances.

Both GMHI and SMHI expanded their coverage rapidly, from 1.9 million in 1927 to 5.63 million in 1941. The Public Health Centre Act of 1937 was established to prepare for the war that had just started in China, as well as to tackle TB, which had caused a number of deaths. The following year, the National Health Insurance Act (NHI Act) was created to protect health and welfare, mainly of farmers (Tatara and Okamoto 2009). Also in 1938, the newly established Ministry of Health and Welfare (MoHW) took over the various responsibilities of the Home Office, the Ministry of Education (MoE), and the Ministry of Trade and Industry such as physical activity, hygiene, prevention of diseases, and labour. The number of public health centres staffed with two doctors, one pharmacist, one clerk, three hygienic instructors and three public health nurses increased from 49 in

1937 to 770 in 1944. Under the NHI Act, the municipal authorities could organise their own health insurance system for their residents, called Municipal NHI or translated as Citizens' Health Insurance. Establishing health insurance funds and scheme membership was not compulsory, but both increased over time. The number of (municipal) insurers rose from 168 in 1868 to 10,158 in 1943, while the number of insured rose from 578,759 to 37.3 million people over the same period. Thanks to these insurance plans, in 1944, about 68.5 per cent of Japan's total population of 73.06 million had some kind of health insurance coverage (Tatara and Okamoto 2009).

Self-employed people such as farmers and fishermen, as well as most small-company employees were not included in the GMHI, however. The coverage rate of these two statutory insurance systems was less than eight per cent of the total population in 1941. The reimbursement system depended on the contract between individual insurers and providers until 1942. The following year, the Council for the Estimation of the Fee-for-Medical Service in Social Insurance (CEFS) was established, composed of the Japanese Medical Association, SMHI Association and the GMHI Association. The council's purpose was to set the fees for services reimbursed by insurance, and to set standards for various systems of reimbursement such as capitation systems for GMHI; others for SMHI were standardised with a fee-for-service system in 1944.

The overall structure of the health system continued after the war. In 1964, the bureaus of Public Health, Medical Affairs, and Prevention were established within the MoHW. The bureaus of Hygiene and Welfare were set up in prefectures to deal with public health under the Local Government Act of 1947. The system of central decision over the fee-for-service schedule based on the stakeholder consultation continued, and was strengthened after the war. The CEFS merged with the Council for Social Insurance for Medical Care, which had been monitoring and supervising medical practices and became the Central Social Insurance Medical Care Council (CSIMCC). It was the council's role to decide insurance coverage of medical services, devices and medicines, and to set the 1950s level of fees for services. After a series of consultations between the General Headquarter of Supreme Commander for the Allied Powers (1945-1952) and the Japanese government, a new NHI Act was passed in 1958. This made it compulsory for all municipal governments to establish their own insurance system in fiscal year 1960, with a reimbursement rate of 50 per cent. As a result, all persons in Japan were covered by some kind of insurance by 1961(Tatara and Okamoto 2009). Due to the growing importance of rural constituents since 1945 to the National Diet's politicians, the increasing budget transfers from central to municipal governments strengthened the financial stability of the local government-run insurance society. The local governments with financial difficulty received the larger transfer in various forms through public schemes, public works and agricultural subsidies. Other sources include the establishment of incentive mechanisms to attract the business investment epitomised by Tanaka Kakuei's Plan for the Remodelling of the Japanese Archipelago in the early 1970s; the Regional Promotion Facilities Corporation from the mid-1970s; and three 1980s policies to establish technology-based business in the "periphery" (Caldor 1988). In particular, the health insurance subsidy to the local government was crucial, since despite its fluctuation, the share of the national government expenditure has been always larger than that of the local governments.

Table 1. The Share of Central and Local Government in Support of Medical Costs (per cent)

	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005	2010
National government	15.7	22.1	24.2	28.9	30.4	24.8	24.6	24.2	24.7	25.1	25.9
Local government	4	3.9	3.5	4.6	5.1	4.5	6.8	7.5	8.5	11.4	12.2
Premiums to health insurance schemes	50.4	53.5	53	53.5	53.2	58.2	56.3	56.4	53.4	49.2	48.5
Co-payment by patient	30.8	20.6	19.3	13	11.3	12.5	12.3	11.9	13.5	14.4	12.7

Source: Calder, 1988; White Paper on Health, Welfare and Labour, 1995, 2000, 2005, 2010. Ministry of Health, Labour and Welfare. Electronic data from http://homepage2.nifty.com/tanimurasakaei/zaigen.html for the year of 1990.

The role of company-based health insurance plans is quite significant in understanding the financial integration of health insurance, since they have assumed part of the medical benefit costs for the elderly since 1982. The government established a financial pooling system for the elderly in which the National Foundation of Health Insurance Societies, an organisation consisting of big industries, donates part of its fund to the pool. In 1982, medical benefits for the elderly were financed through national government contributions (20 per cent), local government contributions (10 per cent, divided between prefectural and city, town, or village governments), contributions from the employer-based health insurance schemes, and the residence-based health insurance schemes (Ohi, Akabayashi et al. 1998).

In addition to this financial integration mechanism, there are institutional devices that tie them into a unified system to avoid inefficiency and redundancies. First, the Medical Sub-Council and the Health Insurance Sub-Council of the Social Security Council (SSC), a statutory body within the Ministry of Health, Labour and Welfare (MoHLW), have established national strategies and guidelines on quality and safety, cost control, and fee schedule (Matsuda 2012). The CSIMCC, an advisory committee to the MoHLW, is composed of seven providers (five physicians, two dentists, and one pharmacist), seven payers (four insurers, including government representatives, two employers and two labour representatives) and six public interest representatives (including three economists and one lawyer). Every other year, they join medical professionals, represented by medical doctors, to negotiate the fee schedule according to SSC guidelines to limit the overall increase in costs. Based on the stakeholders' consultations with the SSC and the CSIMCC, this centralised system has contained and standardised medical costs.

Second, the quality of medical care and hospitals' safety-related capacities are assessed and certified by both civil society and the government. The non-profit Japan Council for Quality Health Care was founded in 1995 to implement third party hospital accreditation; as of 2011, the organisation has assessed about, 30 per cent of all hospitals. The Medical Care Act Amendment of 2006 established patient safety centres in each prefecture to handle complaints and consultations concerning medical treatment, while the Act on the Protection of Personal Information of 2005 legally obliges patients to be informed, and medical records to be disclosed to medical professionals, to enhance the quality of medical care and safety (WHO and Ministry of Health 2012).

Third, health professionals' societies also contribute to integrating fragmented insurance funds. Specialist medical doctors' societies produce clinical guidelines, and the Pharmaceutical and Medical Devices Agency, a government regulatory agency, assesses the medical, social and ethical

implications of technology and medical devices. These institutions that assure the unified system of fragmented insurance plans are only possible with a very developed system of horizontal and vertical consultations, which is a major feature shaping the Japanese political economy, in particular the production system.

However, the Japanese health care system is not without weak points. Owing to underinvestment, hospital quality is deteriorating; many are understaffed with run-down facilities. In addition, the prescription drug consumption rate is disproportionately high. Some feel Japan's universal coverage has sacrificed quality (Marmor 1992). Quality of care has improved in urban areas since the war, but it varies geographically. The fragmented nature of Japan's hospital network and the lack of government control over physicians and facilities are often blamed for this regional disparity (Henke, Kadonaga et al. 2009). Even with the fragmented system of multiple health insurances, people can get good basic care and are less likely to be bankrupted by medical bills thanks to strong public-private partnership mechanism to regulate price, and redistributive mechanisms between insurance plans. However, the poor quality control regarding care and hospital infrastructure that fuels regional disparity, and the system's increasing financial burden as a result of an ageing population and other structural changes threatens its sustainability. These threats to long-term viability demand major reforms such as redefining central and local government roles in health care provision and insurance schemes, as well as improving quality of health care (Shibuya, Hashimoto et al. 2011).

Compulsory Education

Despite various problems such as fierce competition, (often dubbed "examination hell,") school violence and bullying,[2] Japan has one of the world's best records of school enrolment and literacy, with 100 per cent enrolment in compulsory elementary schools (six years) and lower middle schools (three years) and no illiteracy. Although high school is not compulsory, enrolment is over 96 per cent nationwide and nearly 100 per cent in cities, while the drop-out rate is only two per cent (Sinkovec 2012).

Although the current education system has been shaped by reforms that started at the end of the Second World War, there is still controversy about to what extent this system parts from pre-war institutions. In particular, institutional legacies of the organisational structure regarding schools and school governance are especially prominent in elementary and lower middle schools. The compulsory education system's origin can be traced back to the first educational reform of the 1870s.

As the fief system was abolished and prefectures were established throughout the country in 1871, the central government for the first time could introduce a unified educational structure for the entire nation. All prefecture schools were under direct control of the Department of Education, established that same year. However, despite the abolition of the fiefs, former fief lords could retain their power as prefectural governors and could limit the central government's influence in local affairs. The power balance was significantly skewed to the central government after the 2 January 1872 dissolution and reapportionment of the prefecture, in which 305 prefectures were consolidated into 75, and the central government appointed those with closer ties to the Meiji government as governors (MEXT 2013b).

The Education System Order (ESO) of 1872 marked the beginning of the Japan's first reform process, which transformed feudalistic "dual" education systems into the modern "unified" education system

[2] The assessment of an education system, in particular a schooling system, through only enrolment ratios and literacy is grossly incomplete. As for the critical review of research on the Japanese education system in both English and Japanese until 1999, see Okano, K. and M. Tsuchiya. 1999. *Education in Contemporary Japan*. Cambridge, UK: Cambridge University Press.

modelled after the Western models. These Western-style systems incorporated "a highly centralised administrative structure with an emphasis on state-run normal schools" from France, a "system of higher education rooted in a handful of elite public universities" from Germany, and the "English model of Spartan-like, character-building preparatory schools stressing moral discipline" (Passin 1965; Beauchamp 1987 p.300). Although most school systems were completely new, the decentralised territory-based governance system, one of the main features of the Japanese fief structure, still provided a basis for education governance under the newly established school district system. Widespread traditional elementary schools for the general public called Terrakoya helped open modern elementary schools throughout the country, while the fief schools for the samurai class' higher education constituted the base from which middle- and higher-level schools developed following the ESO (Passin 1965; MEXT 2013b).

One of the major elements of the modern school system was students learning abroad; upon their return, they disseminated knowledge through various private and public schools. Since the Meiji Restoration, the concepts of Civilization and Enlightenment had been the order of the day, and various schools had incorporated courses in Western learning into the existing Chinese curriculum of traditional subjects. Sending promising young students to study abroad and hiring foreign experts at home were both tools for intensive learning (Beauchamp 1987). Although they were small in number, schools for girls were also established in this context (MEXT 2013b).

One of the ESO's three major guidelines was to establish a school district system in which university, middle schools, and elementary schools were the basic institution in each of the eight university districts. This meant setting up 32 middle school districts in each university district and 210 elementary school districts in each middle school district, whose respective names were the university district, the middle school district, and the elementary school district. This system was intended to provide at least one elementary school for approximately 600 persons and one middle school for 130,000 persons (MEXT 2013a). This ambitious plan fell short owing to financial difficulty,[3] and the school district system was replaced with the prefecture government-centred system in 1879; however, the system design that emphasised regional parity in terms of access to schools, remained a target for future central and local governments.

Following the 1881 establishment of the Meiji Constitution and National Diet, as well as the 1885 introduction of the cabinet system, the following year, the newly founded MoE created four- and three-year elementary schools. The latter was for those of lower income groups and had a very basic curriculum. The MoE also promulgated compulsory four-year elementary education. Although the three-year institution was tuition-free, parents were obligated to pay school fees for the four-year school. The overall enrolment rate even decreased from 53 per cent in 1883 to 45 per cent in 1887, reflecting the economic difficulty in rural areas, where more than 83 per cent of the working population resided (Nihon Kindai Kyouiku Jiten Hensyuu Iinkai 1971; Macpherson 1987). Although students enrolled in three-year elementary schools increased from 182,295 in 1886 to 785,829 in 1889, its share against the total number of elementary school students was less than 28 per cent throughout the period (Tanaka 1984). The concept of education also changed from being a source for personal success, to serving as an instrument for national development and prosperity. The 1890 Imperial Rescript on Education gave both legal form and moral force to a system that supported the rise of militarism and ultra-nationalism during the 1920s and 1930s, and was an extension of the 1880s

[3] The enrolment rates in the 1870s were as low as 28 per cent in 1873 and 40 per cent in 1877. In particular, the girls' enrolment rate was only about 30 per cent. Nihon Kindai Kyouiku Jiten Hensyuu Iinkai (1971). Gimukyouiku Syuugakuritsu. *Dictionary of Modern Japanese Education* (in Japanese). Editorial Committee for History of Modern Japanese Education, Heibonshya.

nationalistic understanding of education (Beauchamp 1987). However, most four-year elementary education was still fee-paid, and the enrolment rate was still low. In 1900, the government established a principle of "no-tuition for elementary schools" but gave autonomy to individual schools to determine tuition fees. The central government also provided subsidies to cover elementary school teachers' salaries. This reduced the number of elementary schools collecting tuition fees from 17,000 in 1900 to 1,968 the following year; in 1901, only nine per cent of schools and 15 per cent of students were fee-paying (Ito 1968). The enrolment rate increased from almost 73 per cent in 1899 to 81 per cent in 1900, 90 per cent in 1902, 95 per cent in 1905, and reached 97.38 per cent in 1907 (Nihon Kindai Kyouiku Jiten Hensyuu Iinkai 1971). Compulsory elementary school education was extended to six years in 1908. The no-tuition principle was widely implemented, and in 1917, less than one per cent of students were enrolled in the fee-paying elementary schools, which constituted only three per cent of all elementary schools (Ito 1968).

After the Second World War, a series of reform bills, including the Basic Act on Education of 1947, the Special Act on Educational Civil Servants of 1954, the Provisional Act on Political Neutrality of Teachers for Compulsory Education of 1954, and the Act on Organization and Management of Local Education Administration of 1956 shaped the new structure of the Japanese school system. Overall, those acts served to strengthen the central government's power. Although education committees were established at the local level, the MoE appointed all the committee members, who lacked the power to decide the budget or curricula for local education (Kanai 2011).

Within this strong centralisation process, the Basic Act on Education of 1947 promulgated nine years of fee-free compulsory education for those between six and 15 years old by central or local government-run schools.[4] Apart from the length, one major difference between compulsory schooling of the pre- and post-war periods is the interpretation of "compulsory education".[5] Pre-war official documents discuss "forced" or "compelled" education, and the government intervened to ensure children received the state-mandated level of education. After the war, this understanding changed dramatically. Citizens now realised their obligation to have their children receive compulsory education, and believed that the state had a legal and ethical responsibility to provide support (Ito 1968). The framework of compulsory education was strongly influenced by two factors: first, the state's responsibility to provide support for compulsory education as a part of post-war reform for a new democratic Japan, and second, financial difficulty. Although there were heated governmental and parliamentary debates over how much the government should finance compulsory education, the final decision was that the tuition fees for compulsory education would be free only at government-run schools. Private schools could collect tuition fees (MEXT 2013a) since the government thought only a small number of parents could afford private school tuition (Nihon Kindai Kyouikusiryou Kenkyuukai 1995).[6]

This system contributed to universal compulsory education coverage since the majority of elementary and middle schools were already run by either national or local governments. In 1948, the share of private elementary schools and enrolled students were 0.4 per cent and 0.2 per cent, respectively, while the share of private middle schools and enrolled students were 5.3 per cent and 7.1 per cent (see

[4] In the case of special school for disabled children between the ages of six to 14, compulsory education was limited to a certain age groups in the early phase, and complete compulsory education for all ages between six and 14 being was achieved in 1956.

[5] Compulsory education is a context-bound and historical concept. One of the widely accepted definitions is associated with the concepts related to the right to education recognised in the International Covenant on Economic, Social and Cultural Rights. This is a universal entitlement, which includes the right to free, compulsory primary education for all, as well as a responsibility to provide basic education for individuals who have not completed primary education.

[6] Another big departure from the pre-war education system was to interpret compulsory education in age terms rather than school terms, meaning that children between six and 14 should receive elementary-level education rather than to attend a specific type of school.

Appendix 3). The government had strong regulatory mechanisms on these private schools. Dominance of compulsory education's public sector has continued until present day, with only a slight change in the share of private elementary schools. This is mainly owing to the consistent allocation of government budget to elementary and middle schools, about 70 per cent of the education budget on average (see Appendix 4).

Since the 1950s, school facilities and learning environments, particularly those in inaccessible areas, have seen dramatic improvement. Under the 1954 Law for the Promotion of Education in Remote and Isolated Areas, the government can give financial incentives to teachers working in mountainous and remote regions. The School Lunch Law of 1954 and the Law of the Free Distribution of Textbooks in Compulsory Education Level of 1963 have also contributed to reducing educational costs. Civil society organisations played a notable role in reducing compulsory education costs, especially concerning the free textbook distribution. This was organised as a part of the democratisation movement to resist political forces reverting to pre-war nationalist ideology (Yi 2009; Aoki 1984).

The Japanese education system often surprises outsiders with its institutional continuity, the dark side of which is an inability or incapacity to change the system itself. However, there have been several attempts. The Central Council for Education's Report called for comprehensive expansion of the education system in the early 1970s; other initiatives included the National Council on Education Reform initiative in the early 1980s and 1990s, and the recent revision of the Basic Act of Education in 2006. Most debates have been over concepts of quality rather than quantity, such as internationalisation, government control, and liberalisation of education, as well as issues regarding information technology, and lifelong learning (Hood 2001). The reform also focused on enhancing the overall system quality as we can see in the Special Act for Securing Capable Educational Personnel in Compulsory Education Schools for the Maintenance and Enhancement of School Education Standards of 1974. According to this, during the period from 1974 to 1978, salaries of elementary and middle school teachers improved drastically, exceeding the levels earned by general civil servants. Since the 1990s, reforms on financing compulsory education made significant progress when new reforms called for the central government to intervene less in local affairs. As local governments assume more responsibility for taxing and spending, the central government's share of compulsory education expenditure dropped from 50 per cent to 33 per cent in 2008 (Saito 2011). Although this negatively impacted some local governments' finances, the burden seemed centred on upper level higher education rather than compulsory education, which did not change much in terms of organisational structure.

Social Assistance and Pension for the Elderly

The issues of poverty and inequality have only recently attracted attention in Japan's policy debates. In fact, in terms of poverty and inequality reduction, cross-nationally Japan fared well over the three post-war decades. However, economic growth has been inconsistent, and disadvantaged groups suffer owing to inequalities and poverty (Milly 1999). The rapid economic growth and visibly enhanced living standards conjures up the image of an egalitarian middle-class society, concealing various poverty and inequality issues that have been increasing since the 1980s (OECD 2006). One major cause was unequal income distribution among the working-age population as a result of increased unemployment, non-regular forms of employment and an ageing workforce (Inaba 2011). Although social spending as a share of GDP has been expanding regarding population ageing, the number is still below the OECD average, and the proportion that low-income households receive is small. One main problem is that the poor not only receive little government assistance, but also bear a heavier tax

burden than those in many other OECD countries (Inaba 2011) (as for the safety net programmes in both cash and benefit, see Appendix 8). Low benefits and heavy tax burdens on the poor carry the formative traces of public assistance schemes established after the Second World War.

Between the end of the war and the early 1960s, the government established both public assistance and social insurance schemes.

Table 2. Public Assistance and Social Insurance Schemes Established by the Early 1960s

Year	Public Assistance	Contribution-based Insurance
1946	The Livelihood Protection Act (the former social assistance act or means-tested social assistance)	
1947	The Child Welfare Act	The Unemployment Insurance Act
		The Industrial Accident Compensation Insurance Act
1949	The Act for the Welfare of Persons with Physical Disabilities	
1950	The Livelihood Protection Act (the present social assistant act – widening its scope and creating right of appeal)	
1954		Reform of the Employees' Pension Insurance
1958		National Health Insurance Act (Amendment of 1938 act)
1959		National Pension Act (Implemented in 1961)
1960	The Act for the Welfare of Persons with Intellectual Disabilities	
1961		Reform of the National Health Insurance (managed by local authorities),
		The National Pension Insurance (a flat-rate scheme managed by local authorities)

Source: Uzuhashi 2009; National Institute of Population and Social Security Research, 2014

The first government-provided public assistance programme for the poor was the Livelihood Protection (Seikatsu Hogo) Act of 1946. This guaranteed a minimum standard of living for all citizens by providing the necessary benefits according to the level of poverty. However, the government's main principle in addressing poverty was to encourage overall income equality through work (Milly 1999), which meant that the able-bodied poor were not entitled to public assistance benefits. The law was not changed despite Article 25 of the Constitution, which stipulates the poor's entitlement to livelihood protection. Things shifted in 1950, when it became the state's responsibility to maintain the minimum standard of living for all, on condition of a means test (Inoue 1994; Uzuhashi 2009). The Minseiin system, inherited from pre-war system, had government-commissioned voluntary local agents – called Minseiin – evaluating the elderly, the poor, the disabled, children and single-parent families in villages of around 100 to 200 households; this played a crucial gatekeeper role to the poor's eligibility for public assistance benefits (Goodman 1998).[7]

Current Japanese pension system is multi-tiered, consisting of public and private pension schemes. The first tier, the Basic Pension which provides flat rate basic pension of a universal coverage was established in 1961 when the National Pension (NP) was introduced for the self-employed,

[7] Goodman also relates the Minseiin system with the amount of staff of the Japanese welfare ministry, which is far smaller than other countries. For instance, in 1976, the Japanese Ministry of Health and Welfare had 11,200 staff while the US Department of Health, Education, and Welfare, with only double the Japanese population, had 155,100. In the late 1990s, the number of voluntary workers under the Minseiin system was 190,000, while the number of paid local government welfare officers for the whole of Japan was only 15,000 (Vogel 1980; Goodman 1998).

fishermen/farmers, unemployed, housewives and those who were not covered by the Civil Servants' Insurance and Employees' Pension Insurance (EPI). Since provincial governments would administrate both NHI and NP, costs and fragmentation problems could be minimised.

With an aim of reducing direct transfers to the poor, the government implemented policies to address poverty through generating jobs, granting agricultural subsidies and subsidies to small-sized companies, establishing a minimum wage and assigning public works projects, which strengthened various contribution-based insurance policies (Milly 1999). These policies could redistribute resources from industrial centres to rural areas owing to the rapid economic growth (Estevez-Abe 2009).

Emphasising income growth supplemented by selective social policies meeting specific needs was effective in terms of reducing inequality and poverty up until the 1970s at least, and placed 1960s Japan on egalitarian par with Australia and Sweden (Sawyer 1976). The political democracy created an environment where both progressive and conservative politicians could negotiate with social forces, in particular trade unions, to establish a social contract for growth and equality (Milly 1999).

Despite these egalitarian growth policies, there were several disadvantaged groups. During the 1960s to 1970s when the Japanese economy recorded rapid growth, the elderly suffered. Although labour force participation rates for ageing workers continued to be higher in Japan than in other industrialised countries, these workers could not get decent jobs because they had lower education levels compared to their younger colleagues. In addition, early mandatory retirement ages failed to take into account longer life expectancies, and the gap between retirement and the minimum pension age as significant. This placed many elderly people in financially vulnerable positions (Milly 1999). Livelihoods of those outside of labour market were also damaged as the youth went to urban areas, leaving their parents behind. In response, the government established the Elderly Welfare Act of 1963, which aimed at responding to various needs including income maintenance for the poor and care service for single-elderly households. This partly reflects the increasing social concern about the welfare of the elderly, as we can see when in 1966 the Day to Respect the Elderly was established as a national holiday.

Another disadvantaged group was women, particularly those of working age. Their labour market participation rate has been on par with other industrialised countries such as Australia, France and Germany, i.e. about 50 to 60 per cent, or at almost 80 per cent when including the self-employed. However, Japanese women have continuously suffered from gendered wage differentials, benefits and job security, which were far lower than those countries with similar participation rates (Milly 1999; Uzuhashi 2009). This has continued despite the Equal Employment Opportunity Act of 1986 and its 1997 revisions, which aimed at eliminating discrimination in the hiring and promotion processes.

The size of benefit packages and scope of government provision started expanding in the late 1960s. In 1968, fees for NHI service borne by the insured persons dropped from 50 to 30 per cent of the whole medical bill, and in 1972, the Children's Allowance was introduced. The government further reduced co-payment of health care, also from 50 to 30 per cent, for the insured employees' dependent families. Also increased were benefits of EPI and NP as well as the non-contributory welfare benefits through various measures, which included the introduction of sliding scale indexing system. The government also made medical service for the elderly aged 70 and above free in 1973, now labelled "the first year of welfare in Japan" (Uzuhashi 2009). Despite the increase of social spending, the amount in terms of GDP share was still far below than other European welfare states, and

concentrated on medical care and pensions for the elderly, leading to an obviously biased welfare system. However, this did not cause any financial problem as long as the economy kept growing and could absorb the youth in the labour market (Estevez-Abe 2009).

Since the early 1980s, Japan faced multiple challenges that led to a series of social protection system reforms. Limited investment opportunities in domestic industry coupled with loose monetary policy in the face of the yen's rapid appreciation resulted in a credit bubble. This accelerated speculative investments in securities and property markets. Related social problems such as unemployment, environmental issues and declining quality of life became more visible. As the primary workforce for post-war economic growth reached retirement age and the birth rate started to drop, Japanese population began ageing. Public pressure, in particular from trade unions, civil society and the media, to ensure adequate income security and social services forced the government to launch a series of welfare reforms. However, the approach, continued the underinvestment in social protection and concentration of available resources in the pension funds, which led to the abolishment of free medical service for the elderly aged 70 and over in 1982. In addition, in 1984 the employer-based health insurance schemes reintroduced service fees to be borne by the insured and it amounted to 10 per cent of the entire medical bill. The government reduced benefits in NP and EPI in 1986 and changed the EPI's entitlement age from 60 to 65 in 1994 (Uzuhashi 2009).

One reason for the failed fundamental welfare system reform lies with the political institutions. Japan's election system was comprised of multi-member electoral districts without proportional representation. In this system, multiple candidates from the same party competed against each other over voters, and the optimal vote allocation among same-party candidates within the same district became more important than the increase of overall votes for party. This system hindered fundamental reform and facilitated piecemeal and patchwork changes to appease organized voters, for example the elderly (Estevez-Abe 2009). This continued until 1994 when the proportional representation system was introduced.

The industrial policy to generate jobs and reduce income inequality with low-cost welfare schemes was heavily dependent upon contribution-based insurance schemes and targeted public assistance to the poor. However, this continued with the rapid economic growth up until the early 1970s, and then into the bubble economy in the late 1980s. Then in the early 1990s the bubble burst, and the Japanese economy plunged into stagnation.

In response, the government started tightening the budget further, and carried out more reform, facilitated by the 1994 electoral system reform. Since the major objectives were to address the financial problems and at the same time, problems of an ageing population, the nature of reform cannot be said to be monolithic "retrenchment". First, such changes in demography (ageing), family structure (the increase of one-person households and single elderly-person households), and labour market (the increase in female labour market participation) have forced the government to increase its role in providing long-term care, introducing in 2000 the Long-Term Care Insurance (LTCI) policy. Official documents revealed that reducing fiscal outlay was also a major LTCI objective. This perpetuated the systemic problem of gender inequality; female family members were providing home care, and the remaining professional care workers suffered from low wages and job insecurity (Abe 2010). Second, the central government reduced their financial expenses across social security schemes, in particular pensions and medical services. It also caused a financial burden for local governments in Livelihood Protection Benefits, Child Rearing Allowances and the running costs of welfare facilities such as nursing homes for the elderly and the infirm (Uzuhashi 2009). As of 2011, three-quarters of

the benefits exclusively financed from tax revenues come from the central government budget, and prefecture and municipal governments provide the rest. Shouldering 25 per cent of the burden disincentives local governments to certify eligible persons and provide benefits (Inaba 2011). Although the share of social security expenditure including pensions, medical services, welfare and others drastically increased from 9.5 per cent of GDP in 1975 to 23.1 per cent in 2010, the level is still not high compared to other countries (see Appendix 9). In particular, social expenditure on public assistance schemes, child allowance and personal social services excluding long-term care, medical care and pension is remarkably small, i.e. about 10 per cent. This shows the lack of improvement of Japanese public assistance programmes' benefit levels compared to those of other countries. For instance, international comparison of functional social expenditure shows that family and incapacity-related benefits, the major components of Japan's public assistance, are equivalent to only 2.11 per cent of GDP, compared to 6.86 per cent in the UK, 5.57 per cent in Germany, 5.32 per cent in France, and 9.16 per cent in Sweden (see Appendix 9).

Although the increased rate of public assistance was lower than pensions and medical care over the last three decades, marginalised groups could still seek protection from public assistance schemes thanks to the active civil society organisations and movements. For instance, the Organization of Homeless People forced the government to abolish the permanent residency requirement that enabled access to public assistance, and as of 2009, they started receiving benefits (Inaba 2011). In 2002, the "Law to Promote the Independence of Homeless People" was established to provide the homeless with support to find stable employment, counselling, job training, housing and medical care. As of 2007, the largest groups receiving public assistance are households headed by the elderly (45.1 per cent), families who have a member with disabilities (36.4 per cent), and single-mother households (8.4 per cent) (Inaba 2011).

Case II: The Republic of Korea

Primary Health Care and Health Insurance

The Republic of Korea's (ROK) health care system can be characterised as universal health coverage by National Health Insurance (NHI) as a single payer, the predominance of private hospitals and clinics in medical service delivery, the concentration of health care personnel and facilities in urban areas, disparity in health care quality between urban and rural areas and relatively high out-of-pocket payment for health care services. These closely related characteristics are both causes and consequences of the health insurance system's previously fragmented structure, along with political, economic and social factors. This section will explain the development process of the health care system, focusing on the development of NHI and its relationship with primary health care. Additionally, it will pay particular attention to private providers' role in different stages of the health insurance system development.

After the independence of South Korea in 1945, the government's health policy priority was to prevent communicable diseases and promote public health, such as providing sanitation rather than the provision of curative care. Curative care was considered to be taken care of by private hospitals and clinics, which were under-staffed and lacked resources. Meanwhile the medical education system was reorganised based on the US-style medical specialist system, and under the heavy influence of the US Army Military Government in Korea (USAMGIK), which led the country between 1945 and 1948. Despite the WHO recommendation to establish a health system based on general practitioners with medical doctors licensed after a four-year medical school education, the newly established Korean

government instituted a medical education system that required six years of medical school followed by five years of training as intern and resident in a teaching hospital to qualify as a "proper" medical doctor (Lee 1969; Cho 1990). These stringent and long-term requirements established the Korean health system as specialist-centred and ideal for secondary or tertiary rather than primary care.

Primarily funded by foreign aid resources, in 1945, small numbers of public health centres began appearing in rural areas to meet the health care needs of the local residents. Numbers did not change significantly until the 1970s, when the government started intensive investment for rural development (Shin and See 2002). In addition, the public sector was hollowed out partly because medical doctors, already few, preferred to work for the private rather than public sector owing to the poor working conditions and low pay of public health sector work.

The growing number of private pharmacies provided a first point of consultation, prescription and medicine dispensing to those who could not access hospital care for geographic or financial reasons. Established primarily by pharmacists after four years of university pharmacy education, these rapidly expanded after the Korean War. Although the law to separate prescribing and dispensing of medicines was legislated in the early 1950s, the government's weak enforcement capacity resulted in rather a long list of over-the-counter medicines. A few could pay high fees sought services from hospitals and clinics, while the poor—the majority of the population—went to pharmacies for medicines dispensed without prescription (Cho 1990).

The government has strengthened the public health sector through investment in rural public health centres, in particular since the early 1970s when the Saemaul Movement (New Village Movement) established a wide range of intensive rural development projects. Additionally, the scheme mobilised licensed medical doctors, then exempted from military service, for public health centres; however, the preponderance of private hospitals continued (Douglass 2014; Yi 2014).

The NHI development can be divided into three distinctive stages: a pilot stage with very little coverage in a few companies (1965 to June, 1977), a compulsory health insurance stage during which the coverage gradually increased from 10.49 per cent to 51.3 per cent of the population (July 1977 to 1987), and a universal national health insurance stage (since 1988) (Kwon 1999). In this gradual expansion process, health insurance financing has been heavily dependent upon the contributions from employers and the employees. The government's role, in particular in the first and second stages, was mainly regulating health insurance system, such as reviewing claims and payment to health care providers, and standardizing benefit package across various insurance schemes.

In the first (pilot) stage, health insurance was not compulsory and only several voluntary health insurance funds (insurance societies) were formed around companies or resident areas. The government did not fund these insurance societies, and participation rate was low. In total, 11 company- and/or residence-based insurance societies covering only 0.2 per cent of the population existed as of June 1977 (Kim 2002). Each insurance society had an individual contract with its own service provider, and entitlement to health care service was often confined to a specific area. The contribution rate was set low but the demand was high. As a consequence, these cooperatives' financial situations worsened. Recognising the problems of voluntary schemes such as financial difficulty and low participation rate, in 1970, the government decided to change health insurance from voluntary to compulsory. However, this scheme was not implemented until 1977 because of the economic difficulties caused by international oil shock.

Second-stage health insurance coverage gradually expanded through legislation making health insurance mandatory for companies of a certain size. The system for claim review and payment to providers was established based on consultation with the then-already powerful interest group of medical doctors, the Korean Medical Association. The scheme adopted the fee-for-service system with a limited set of services, and the level of fees was set lower than the market price. However, the NHI payment system, in particular the fee-for-service system, had built-in difficulties in containing costs compared to the prospective system such as "global budget" or "Diagnosis-related group". Limited as it was, the fee-for-service system encouraged overuse of medical technology as well as the use of uninsured expensive medicines, and consequently resulted in a high volume and intensity of service (Kwon 2009; Yi 2014). Regarding financing, the contributions from both employers and employees combined with patient co-payments accounted for almost all of the scheme's financial resources. Meanwhile the government provided only meagre administration costs for the health insurance cooperatives, but continued its role as regulator. The financial reliance on the employees and employers was one reason the government targeted salaried employees through designating companies of a certain size, for instance, those exceeding 500 employees in 1977; 300 employees in 1979; 100 employees in 1981 and 16 in 1983, making it much more feasible to collect contributions in a stable and sustainable way (Kwon 1999). Government employees and teachers joined the NHI in 1979. These companies have their own avenues, which include single company-based health insurance societies or multiple companies-based health insurance. However, according to the law, the government fixed contribution rate and quasi-government organisations centrally reviewed health providers' claims. Payment to providers was also handled centrally. For industrial workers as well as government and school employees, contribution was proportional to wage income and shared equally between employees and employers. Until the merger of the insurance funds, the average contribution rate was 5.6 per cent (of wage income) for government and school employees, and 3.75 per cent for industrial workers, which is a range of 3.0 to 4.2 per cent depending on the insurance society, whose own contribution rate was subject to approval by the Ministry of Health and Welfare (MoHW) (Kwon 2009).

Development of a tax system also provided a favourable environment for collecting contributions (Lee 2014). A variety of tax incentives were often used by the government to induce private companies to engage in economic and social activities that seem desirable for economic and social development, which facilitated the tax system. Under a rapidly growing industrial sector with increasing revenues, the system in the compulsory health insurance stage allowed companies or occupational groups to establish individual health insurance societies based on their own independent insurance funds. This expanded coverage gradually reached most employees and their dependents in the industrial sector, i.e. 51.1 per cent of the total population, by 1978.

As the mandatory clause applied to small and medium-sized companies, the number of insurance societies gradually increased. Some cooperatives with small memberships started to suffer from financial difficulties and managerial inefficiency (Kim 2002). In response, the government established a rule in 1980 that companies with fewer than 3,000 employees should merge to establish a single cooperative. The overwhelming power of the developmental state regarding business reduced the potential veto power from the business sector (Yi 2007; Ringen, Kwon et al. 2011). Employer organisations both for big chaebols (family-controlled conglomerates) and small and medium-sized companies saw the state reaching down to the shop floor in the absence of strong trade unions, which

[8] This process of expanding health insurance coverage was also accompanied by the Medical Aid Programme, established in 1977, in which the public health sector provided health services to those receiving benefits under the Public Assistance Programme (Kwon 1999).

facilitated this merger (Hart-Landsberg 1993). This partial merger initiative resulted in the decrease of single company-based insurance societies from 494 in 1977 to 70 in 1985 by forcing small and medium-sized companies to form a single insurance society that then expanded to include new members (see Appendix 1).

The third stage began in 1987 with the politics of democratisation. Suddenly, there was intense political competition for votes, and civil society groups, in particular those of farmers who had been outside of health insurance coverage, emerged as powerful political force. Concern about the health inequity between the insured and uninsured was growing as health care providers charged higher fees to those outside the insurance schemes. Political parties facing the democratic presidential election championed a universal health insurance system covering all the uninsured as a solution to health inequity. This third stage resulted in establishing universal health insurance through expanding the existing system. This meant that those covered now included those without salaried jobs such as farmers, the self-employed, informal sector employees as well as the unemployed who remained outside the health insurance system in the form of residence-based health insurance societies. While income was the only basis for employee contributions, the residence-based insurance societies set their contributions by assessing income, property, and household size. The benefit package was identical across all schemes regardless of the contribution size. However, members of residence-based health insurance societies in poor areas found their burden of contributions as a proportion of income greater than for those in rich regions. Furthermore, structural problems such as decreasing population, high prevalence of poor health, and an increased number of elderly drove up health expenditure and reduced revenues. Under civil society pressure, particularly farmers' organisations, the government provided 50 per cent of the expenditure of these residence-based insurance societies, which signified the state's changing role in the provision of health services, from regulator to provider.[9] The government helped to establish residence-based cooperatives, and the number of health insurance societies drastically increased. Well-established administrative organisations across the country, in particular in rural areas through the intensive rural development programme, facilitated the establishment of residence-based health insurance societies. Although they were organisationally independent, the Association of Medical Insurance, composed of health insurance societies, helped coordinate financial and administrative functions of member societies. While strongly regulating the association, the government granted it power over member societies and authority over service providers (Kim 2002). The association could review and audit the reimbursement of health service fees, and redistribute financial risks among member societies. These included the Stabilization Fund for Insurance Finance for the financially vulnerable health insurance societies to which wealthier company-based cooperatives and state-owned corporations contributed more than did the residence-based cooperatives. The association was a quasi-governmental organisation to regulate, coordinate and administer fragmented cooperatives and private health care service providers. It provided a strong organisational basis for the government, which as of 1998 began trying to fix fragmented health insurance.

However, this coverage expansion based on "additive reform" could not sort out the NHI's inherent problems. High levels of out-of-pocket payments constituted 59.7 per cent of all health care financing in 1990, owing to the small benefit packages and the lack of cross-subsidization among societies. This threatened the financial stability of insurance societies with low contribution levels but high reimbursements for services (Kwon, 1999; Wong 2004). However, the government introduced a regional health care system in 1989 that divided the country into 140 medium-sized health care

[9] The provision of the government to residence-based cooperatives gradually decreased to 26.3 percent in 1999, which became one of the major reasons for residence-based cooperatives' financial difficulties (Lee 2006).

regions and eight large health care regions. The arrangement made a compulsory referral system in which all patients should visit a clinic or health centre in their region before they could go to a general hospital. The idea was to cut costs by reducing unnecessary visits to expensive hospitals, but it failed to impact the reduction of costs as we can see in the increase of deficit since 1997 (Kwon 1999). Another initiative to sort out the financial instability was a new bill to establish the National Health Insurance Fund. Proposed by the opposition parties and passed at the National Assembly, the idea was to transfer money from a stable fund—such as for employees of government and big companies—to a weak fund—such as regional funds with self-employed, farmers, or those employed in the informal sector. However, the president feared losing support from the upper and middle classes and vetoed the bill (Kwon 1999).

As the use of the health services increased, however, the number of societies with a deficit in the balance of payment increased from one in 1991 to 15 in 1993, then to 183 in 1997. Government funding to residence-based health insurance societies was 50 per cent of the revenue in 1988, but fell to 25.6 per cent in 1999, which accelerated their financial difficulties (Kwon 2003); Lee 2006). As a response, some residence-based insurance societies had to increase contributions from the insured persons, but their ability to pay was limited. Residence-based insurance societies were too small to pool their members' financial risks, and they were vulnerable to financial shocks owing to members' illness. Their administrative costs were also the highest (9.5 per cent) while the insurance society for government employees and teachers' costs ran 4.8 per cent. Furthermore, the residence-based insurance societies' top-down appointment of CEOs lowered the chances for better management of autonomous funds, evident in the German system of autonomous sickness funds (Seitz, Koenig et al. 1998; Kwon 2003). Health insurance societies with financial difficulties demanded integration with other financially stronger insurance societies, mainly company-based health insurance societies. The Asian Financial Crisis and the newly elected President Kim Dae-jung opened a window of opportunity for reform. Concerns about health care financing inequality and differences in financial capacity among insurance societies grew during the crisis. Progressive civil society groups, academics, trade unions of residence-based insurance societies, farmers' organisations and small and medium-sized firms with financial difficulties supported the president's initiative to merge the insurance societies and improve their horizontal equity. Opponents such as employers, big company-based insurance societies, and health providers were distracted by economic woes and were concentrating on corporate reform and employment adjustment. For their part, health providers focused on issues concerning prospective payment systems, as well as separating drug prescribing from dispensing, another issue the new government tried to introduce (Kwon 2003).

Health insurance societies' financial instability became a major issue for the 1997 presidential election. Having made health insurance cooperative integration an election promise, the Kim Dae-Jung government merged health insurance societies into a single insurance fund despite protests from the opposition parties and company-based cooperatives just after they came into power (Wong 2004). It reduced resistance from service providers who feared the single insurer's increasing power by establishing an independent tripartite institution composed of government representatives, insurers, service providers and consumers to review and audit the fee reimbursement for the service system.

Before the merger, there were three different types of health insurance programmes:

- Health insurance for industrial workers and their dependents (36.0 percent of the population)
- Health insurance for teachers and government employees and their dependents (10.4 percent of the population

- Health insurance for self-employed workers, known as residence-based insurance society members (50.1 percent of the population) (Kwon 2003).

President Kim's government initially merged the residence-based health insurance societies with the insurance society for government employees and teachers to create the National Health Insurance Corporation (NHIC) in 1998. The societies for industrial workers were incorporated into the NHIC in 2000, which meant that the NHI now had one single unified insurer. The rationale behind the merger was to make a positive impact on horizontal equity among different types of insurance societies, in particular between those of residence-based insurance societies and others, rather than across the entire population.

The NHIC set a uniform contribution schedule for all members who had belonged to residence-based insurance societies, and provided a discount on monthly contributions for people considered disadvantaged in terms of income and geographical region. After the merger, 62.2 per cent of households paid less ($3.80 on average) than the pre-merger level, and 37.8 per cent paid more ($5.60 on average). For example, the average rate of contribution increase was 36.3 per cent for the residents of one of Seoul's wealthiest counties. This improved equity among the residence-based insurance society members (Kwon 2003), as well as industrial workers, since about 56.6 per cent of those insured paid a lower contribution. In other words, the greater the earnings, the greater the contribution increase (Kwon 2003) (see Appendix 14).

This unified system of national health insurance is not without financial problems, owing to the rapidly ageing population, small benefit packages, overtreatment by private health providers for profit and a large share of out-of-pocket payment, namely 47 per cent of national health expenditure in 2004 (Kwon 2009). However, it has successfully reduced inefficiencies and fragmentation of the previous national health insurance system.

Compulsory Education[10]

The Japanese colonial authority that ruled Korea as a protectorate from 1905 and 1910 and then as a colony until 1945, established the foundation of modern education, albeit with distinctive features that strengthened their regime. The colonial government introduced Western school systems and curriculum, but with a strong "Japanisation" element, emphasising Japanese language learning and cultural values. Officials stressed primary education but promoted vocational school for secondary education; this way they could train workers for colonial policy implementation, such as land surveying (Kang 1997).

However, during the 1930s, the colonial regime emphasised both primary and secondary education, in particular Japanese language instruction, to prepare for wars in Asia and beyond, to strengthen the Japanese identity among Koreans and to increase human capital (for an overview of this trend, see Appendix 6). To that end, there was also a strong demand from the media and academia to legislate universal primary education. The Japanese colonial government implemented policies to expand primary education, such as the "one village, one school policy", which ran from 1929 to 1937. Because of a lack of educational resources, the colonial government relied on school fees, and instead of increasing six-year primary schools established a four-year system, which accounted for 46.8 per cent of all primary schools in 1936 (Kim 2005). Although primary education continued expanding, severe financial constraints resulted in students' underachievement in literacy and numeracy.

[10] This part has borrowed substantially from Yi (2014).

Universal compulsory primary education was not legislated until the end of colonial rule (Sano 2006). Nor did the Japanese colonial government pay attention to educational gender disparity. Female enrolment for primary school was consistently lower than their male counterparts, stagnating at less than half of male enrolment rates, and fell even lower at the secondary education level. According to several estimates of 1940s primary schools, the female enrolment rate was either 24.2 or 33.1 per cent in 1942, while male enrolment reached 56.3 or 75.5 per cent (Kim 2005).

The Japanese colonial government's recruitment system also impacted Korean attitudes toward education and education systems. After taking a competitive, merit-based examination, Koreans could qualify as intermediate-level managers. As the number of schools increased, from 1921, the Japanese colonial government established public teachers' colleges and recruited Korean teachers. Entrance was highly competitive; those who passed the exams had to demonstrate both a strong loyalty to Imperial Japan and a high level of academic competence. For Koreans, passing the exams and working for the Japanese colonial government meant upgrading their political, economic and social status, which is partly why society began focusing on children's higher education.

The enrolment ratio gradually increased during the Japanese colonial period to around 33 per cent in 1939, already higher than in other South and Southeast Asian countries such as Burma, India, Indonesia, and Pakistan in the 1950s (UNESCO 1954; Myrdal 1968). These estimates indicate that colonial Korea witnessed an improvement in education even during severe economic exploitation.

Features of Japanese-introduced education systems, such as Japanisation, militaristic discipline, use of education as a colonial policy tool, the dual structure of education for Japanese and Koreans, and the deficit of attention to female education consolidated and continued for almost 40 years, strongly influencing Korea's post-independence education development. Some characteristics have been retained, or even revived, while others have been modified or disappeared completely.

After liberation, a crucial educational policy task of the USAMGIK from 1945 to 1948 was to de-Japanese existing Korean institutions, transforming them into an American-style system (Meade 1951). De-Japanisation continued under President Rhee Syngman's First Republic. An anti-Japanese sentiment was embedded in the period's education policies.

A key challenge in establishing a new education system was the high rate of illiteracy in the Korean language. This was owing to the colonial policy that standardised the Japanese language and banned Korean on school campuses. In 1945, estimates concluded that 78 per cent of the population was illiterate in Korean. An additional challenge was the shortage of Korean educators who could properly teach school subjects in their native language. According to 1939 statistics, most teachers under the colonial regime were Japanese, accounting for 40, 80 and 76 per cent of the teachers in primary, secondary and higher education, respectively. The number of Korean graduates of secondary and higher education was insufficient to fill the primary school vacancies left by the Japanese (Sorensen 1994). Teaching materials, including Korean textbooks, were also not readily available.

In order to sort out the education problems, policies were implemented and institutions were built. In 1945, the USAMGIK established the Education Policy Council, where about 100 Korean intellectuals discussed the policies to establish education foundation. One example was the expansion of secondary education to include one senior high school per sub-province (approximately 130 sub-provinces existed in the country in 1945). Another hotly debated issue was the year structure in school systems: 6-3-3-4 vs. 6-6-4. A system initially compromised of 6-4-2-4 years at each education level was adopted in 1949, but changed to a 6-3-3-4 system in 1951, acknowledging the financial difficulties

required to finish a four-year junior high school (Lee, Choi et al. 1998). One important recommendation was making six-year education compulsory between 1946 and 1951. The government was obligated to provide financial resources, establish institutions to produce teachers and set up local-level supervisory committees. There had been a series of initiatives for compulsory education such as the increase in the education budget and the establishment of the clause of six-year compulsory and free education in the new Constitution of 1948, the Education Act of 1949 and the Plan for Six-Year Compulsory Education of 1953. In 1959, the ROK achieved a 95 per cent enrolment rate for those children aged between six and 12 years (Lee, Choi et al. 1998). It is notable that from 1953 to 1959, about 80 per cent of the education budget was spent on compulsory education.

Several policies and institutions cultivated an enabling environment for the compulsory primary education. First, the government established a series of budget-related laws to secure financing, such as the Education Tax of 1951, the Fiscal Grant for Compulsory Education of 1958 and the Act of Fiscal Grant for Local Education of 1958. These laws were repeatedly revised to further secure the budget, in particular against financial ministries' tendency to allocate the minimum available resources for compulsory education (The National Assembly of the Republic of Korea 1968). The Act of Fiscal Grant for Local Education of 1958 also strengthened the central government's power, granting full authority to decide the budget allocated to local educational facilities.

Second, both USAMGIK and the Rhee government increased the number of qualified teachers by issuing licenses to those with secondary education. They actively supported in-service training and established teachers' colleges. The government's emphasis on secondary and higher education was instrumental in increasing teaching staff. From 1945 to 1948, the number of elementary school students rose by 82 per cent, while secondary school students increased by 183 per cent. During the same period, the number of available teachers increased by 55, 569 and 268 per cent at the elementary, middle and secondary levels, respectively (Krueger 1982). Most notably, to respond to the exploding demand for education, in particular higher education, which Koreans previously had difficulty obtaining under Japanese colonialism, USAMGIK facilitated the free establishment of universities. As a result, the number of universities increased from 19 in 1945 to 42 in 1948, of which more than half were private universities (Kim 1979). Teaching quality also improved as higher education expanded. Until the 1970s, governments established and managed a flexible system in which different types of institutions produced teachers for various school levels (Lee, Choi et al. 1998).

Third, central government's resources and power to establish or close institutions helped regulate schools. This included controlling wage policy and responding to teachers' changing demands by unilaterally adjusting salaries (Yoon, Park et al. 2012).

The expansion of secondary education private sector development is also noticeable. In 1945, the proportion of private schools at all levels was only 19 per cent. By 1952, the share had reached around 40 per cent with a rapid increase at the secondary and higher education levels, accounting for 44.4 per cent of total middle school, and 50.7 per cent of total high school students in 1965 (UNESCO 1955; Korea Institute of Curriculum and Evaluation 2009). Although the private sector share is substantial in higher education and senior high schools, the share of private junior high schools is also significant; about 17 per cent of junior high school students were in private schools in 2013 (See Appendix 7).

The private sector expansion was a consequence of consistent government policies encouraging private investment in education generally, and in secondary and higher education specifically. Although the government spent most of the education budget (more than 75 per cent) on primary

education, it incentivised private investment in secondary and higher education through various policies such as the land reform. In the late 1940s, both USAMGIK and the Rhee government regarded land reform as imperative for political reasons (Cummings 1981), and landowners were desperate to regain their properties' value. The Rhee government established the Law on Special Compensation for the Land Owned by the Education Foundation to encourage landowners to invest their land for public good such as religious activities and education. Knowing that compensation would be small and the process delayed, landowners donated their properties to established private schools, in particular secondary schools and universities. In this way, they could retain their lands' value in different forms, such as private school assets (Editorial Committee for Korean Education 10 Year History 1960). Land reform and related policies created a momentum that made new resources available for investment in education. During this transition from colonialism to liberation, the Korean system of universal primary education was based in the public sector, while the private sector provided the bulk of secondary and higher education.

One problem these policies could not solve was the lack of primary school facilities, particularly the number of classrooms. Financial difficulties prevented the government from building enough educational infrastructures to accommodate increasing numbers of students. They had to start coming in two, three, or even four shifts ranging from early morning to late evening, and sat in overcrowded classes with 65 and 70 students (Lee, Choi et al. 1998). Another problem was the increased competition. With more primary school graduates now taking entrance exams for junior high school, parents had to pay for private cram schools, leading to financial burdens. In order to address this problem, the government abolished the junior high school entrance exam from 1969.[11]

Various control measures were established, regarding oversized classes, increased junior high enrolment, and students' transition between primary and secondary schools. Primary school guidance counsellors encouraged graduates to choose other options than junior high schools, and the government only allowed those who deposited money for entrance fees to enrol (Lee, Choi et al. 1998). These measures clearly show that abolishing the entrance test did not aim at expanding educational opportunities, but at reducing the fierce competition. However, this only transferred problems from primary to junior high school education, where students were preparing for competitive senior high school entrance tests. Similarly, in 1974 that exam was also abolished; instead, students entered a lottery system that assigned them to any school in the same district. This system guaranteed facilities and teaching staff of a similar quality, guaranteed by strong government regulation. The government also recruited both public and private school teachers, administered financial subsidies and closed down poorly performing schools throughout the 1970s (Lee, Choi et al. 1998). However, the gap between schools' educational environments, in particular those between urban and rural areas, remained unaffected and remains a serious problem in the Korean education system.

Abolishing the entrance test meant providing more opportunities for students to earn junior and senior high school educations. Junior high enrolment rates increased from 41.4 per cent in 1965 to 95.1 per cent in 1980, and reached almost 100 per cent in the early 1980s. The senior high school rate increased from 26.4 per cent in 1965 to 63.5 per cent in 1980, and reached 94.6 per cent in 1997 (Lee, Choi et al. 1998).

[11] The abolition of entrance tests for junior high school was called the "715 Revolution" named after the date it was announced. Preparing the policies was done secretly, even the open consultation (Kim 1968).

The enrolment rate of three-year junior high schools reached 82 per cent when the extension of compulsory education from six to nine years was implemented in 1985, initially in remote areas. Since all the students of both public and private junior high schools were required to pay school fees, the compulsory education policy for remote-area students meant fee-free junior high schools. However, even though the coverage was extended to sub-provincial areas during the 1990s, by 2001, only 19 per cent of junior high school students could benefit from fee-free compulsory education. As the enrolment rate reached more than 95 per cent, civil society organisations demanded fee-free compulsory education for all junior high schools. After the ROK joined the OECD, comparisons to other member countries with nine to 12 years of free compulsory education also influenced the government's new policies (National Archives of Korea 2006). The government completed extension of tuition-free compulsory education of junior high school in 2004. However, most middle schools collected donations from students called Contribution to School Management (CSM), established by the School Management Committee, which was made up of parents, teachers and regional stakeholders. Since compulsory education accounted for up to about 26 per cent of certain school budgets in 2004, the government increased junior high school budgets to reduce the share of CSM in response to growing civil demand for free compulsory education. In 2012, the Constitutional Court abolished collecting CSM in public schools (Voice of People 2012). As for private schools, CSM's collection rate has been decreasing, and is currently less than $15 to $25 per student per month on average. This is far lower than the private cram school costs for junior high school students, which can run an average of $270 per student per month (Munhwa.com 2013).

Social Assistance and Basic Pensions

The ROK's first public assistance programme was the Livelihood Protection Programme of 1961, which encouraged strong workfare principles, family-help principles, and residualism to relieve poverty of the extreme poor who could not work and had no relatives or families to help. The programme targeted those aged 18 or below or 65 and above as well as pregnant women and disabled men without relatives to rely on. The programme granted four kinds of benefits and services: livelihood protection, free medical services, maternity protection and funeral ceremony costs. However, this excluded the unemployed and low-wage workers in urban areas as well as seasonal workers in rural areas, who also suffered from a lack of basic food and clothing. Although the revised programme hired these people to do public works projects, the scale and salaries were not enough to cover those working poor (Yi 2007).

The 1970s was the ROK's pension decade. In addition to the 1960 government-run pension schemes for civil servants, additional plans emerged for public school teachers and military personnel. The first national pension scheme, the National Welfare Pension Plan of 1973 was established to first, secure funds available for government's heavy and chemical industrialisation plan, and second, to enhance national legitimacy (Kwon 1999; Yi 2007). However, the plan wasn't implemented until 1988 owing to economic difficulties caused by the oil crisis. Instead, the government used direct and indirect regulations to force companies to provide their workers with occupational welfare (Yi 2007). However, in 1975 the government established the Private School Teachers Pension scheme, despite the aforementioned economic difficulties. The Public School Teachers' Pension Scheme and the increasing importance of private schools in secondary education made the private school teachers' demands more pressing. The government initially did not consider playing the role of financier in insurance scheme for teachers, but strong pressure from school owners and teachers led to the government paying a third of contributions to teachers' pensions, in addition to contributions from school owners and teachers. Consequently, private school teachers were to contribute 5.5 per cent of

their salary, the government two per cent, and employers 3.5 per cent. In return, the government established various fund management regulatory schemes as well as a single unified organisation called the Private School Pension Foundation that incorporated all private schools. This fund could only be invested in the National Investment Fund, which was established specifically for investment in heavy and chemical industries, despite the fact that investment profits were far less than those of others funds (the Korea Teachers Pension, 1994, p. 84).

Although the field absorbed highly educated workers, the 1970s concentrated investment in heavy and chemical industrialisation caused inflation and inequality; in particular there was a growing wage gap between large heavy industry and chemical companies, and small, labour-intensive companies. Having staged a coup d'état in 1980, the government of President Chun Doo-hwan (1980-87) froze civil servants' and public enterprise workers' wages in 1984, and forced private enterprises to follow the example of state-owned companies (Whang, 1992, p. 318). It held these wage increases below five per cent until 1987. In addition, the government used state-owned banks as agents to control private company wage increases. The banks pressed their borrowers, mostly large firms, to reduce their debt-equity ratio to specific targets before granting raises (Haggard and Collins, 1994, p. 89-90). Heavy-handed repression of workers and strong promotion of company-based occupational welfare schemes were central tenets of this wage control regime (Yi 2007).

During the Chun government, the major principle of welfare policy was to mobilise private resources for public welfare programmes. Although the 1980 Plan for the Extension of Medical Treatment for People of Low Income aimed to increase those covered by the Medical Protection Scheme from 2,140,000 to 3,720,000—which was almost 10 per cent of the total population in 1981—the government did not pay all costs. About 75 per cent of beneficiaries had to pay some of their medical treatment fees. This meant that despite coverage expansion, there was no drastic change in the government's spending on welfare and social security (Yi 2007).

The government mobilising private resources, as well as acting as regulator but non-financier, also held true in the public assistance programmes for the elderly and the disabled. In addition, the government campaigned to promote civil society's voluntary participation in providing social service to the poor.

In 1980, the government established the Courteous Treatment Scheme for the Elderly. This moralistic programme encouraged the maintenance and development of a sound family system based on the idea of "respecting the elderly and honouring one's parents". Under this scheme, citizens aged 70 and over received free public transportation and free access to public utilities. The following year, the government extended, and increased the range of welfare benefits to those aged 65 or over. In 1982, it established the Constitution for the Welfare of the Aged and carried out various campaigns to promote virtues within the family and community, which they called, "fundamental solutions" to solve the elderly's problems (The Government of the Republic of Korea, 1982, p. 306). Although distributing cash benefits for those elderly without family or careers was debated, the law's final version excluded these benefits (The National Assembly Secretariat, 1981, p. 27).

In 1980, the government surveyed disabled citizens' living conditions, influenced in part by the upcoming UN Year of the Disabled in 1981. In addition, the government promoted various dedicated events and programmes to enhance its international image. The 1981 decision to hold the 1988 Olympic Games in Seoul further inspired the government. In June 1981, it passed an Act of Welfare

for the Mentally and Physically Disabled; however, most funds were raised by charity organisations and private institutions (The Government of the Republic of Korea, 1981, p. 265).

Although the ROK previously had institutions such as elections, a parliament and political parties, most agree that 1987 began the transition to democracy, with the first direct presidential election in 26 years—which was carried out with reasonable transparency (Linz and Stepan, 1996, pp. 3, 4). However, democratisation, also saw drastic changes in various economic and social dimensions. The state's power in disciplining private company employers, including *chaebols*, began to weaken. In particular, the emergence of trade unions as a powerful social force helped shape the future welfare system.

The competitive presidential election held in December 1987 provided an arena for active debate over social welfare. Candidates made election pledges to establish and expand programmes including ones providing national pensions, building public housing, and stipulating minimum incomes. In order to mobilise electoral support, the government also legislated regulations related to livelihood such as the Enforcement Regulations of a Minimum Wage (November, 1987), the Enforcement Regulations of the National Pension Plan (October, 1987), and the Amendment of the National Health Insurance (December, 1987). The latter two announced that the government would implement a national pension scheme for private sector workers and would expand National Health Insurance coverage. In terms of funding, both pension and health insurance schemes had mixed elements. While the National Pension Plan (NPP) reserved the right to mobilise private resources for workers' welfare, the NHI's amendment stipulated that the government should pay half of the premium for newly included resident members. Although this was matched by contributions from the residence-based health insurance societies, the injection of government funding represented a significant shift from regulator to financier in the social insurance system (see the previous section on primary health care and national health insurance).

The early period of Roh Tae-woo's democratic government (1987–1992) was unstable, as he had not won majority support but instead split his opposition. He needed to broaden his constituent base, particularly as the 1988 National Assembly election approached. A rapid economic expansion in the late 1980s was due in part to lower oil prices, lower world-interest rates and a stronger Japanese yen which helped Korea compete with Japan in export markets; this provided an environment for the government to carry out welfare schemes serving both as financier and regulator.

The NPP for workers was one example of this new approach. In 1988, all employees between the ages of 18 and 60 were covered, excluding beneficiaries of other public pension programmes such as civil servants, private-school teachers, and military personnel. Initially, any workplaces with 10 or more employees were compulsorily covered; from 1992, coverage expanded to include workplaces with five to nine workers. There are four kinds of benefits under the scheme: old-age pension, invalidity pension, survivors' pension and a lump-sum redundancy payment. The basic old-age pension was to be paid out to 60-year olds insured for 20 years or longer, at an average level of 40 per cent of the last monthly wage. For those who could not afford full-pension contributions, the special pension or lump sum payment would be distributed according to a sliding scale.

The plan is defined as a "benefit-funded scheme with a redistributive element among workers" (Kwon 1999). However, although the government subsidised a small portion for administration costs, overall funding was dependent upon employee and employer contributions. The combined contribution rate had been fixed at three per cent of the average wage for five years beginning in 1988, but would be

increased to six per cent for the five years beginning in 1993, and raised again to nine per cent after 1998.

As shown in the table below, the NPP gave employers a new financial burden worth one and a half per cent of their employees' average monthly income. Caught between the need for workers' welfare measures and strong employer resistance, the government devised a funding method in which, from 1993, 33 per cent of contributions would be transferred from reserved funds for retirement pay that employers had to set aside according to the Labour Standard Law. This reduced the employers' financial burden, but employees had no way of assessing how this would affect their final pension and retirement pay.

Table 3. Schedule of Contribution Rates

Year	1988-1992	1993-1997	1998-
Employee (% of average wage)	1.5	2.0	3.0
Employer (% of average wage)	1.5	2.0	3.0
From retirement pay reserve (% of average wage)	–	2.0	3.0
Total (% of average wage)	3.0	6.0	9.0

Source: the Ministry of Health and Social Affairs 1992. *White Paper of Public Health and Social Affairs*. Kwach'ŏn, the Ministry of Health and Social Affairs, 268.

This policy solution to link retirement pay and the pension plan shows that the government considered the relationship between social insurance and occupational welfare programmes to be substitutional rather than complementary (Yi 2007). Along with the NPP — which partly replaced retirement pay — came various occupational welfare schemes, which directly imposed welfare provision obligations on workers. In a similar vein, the government also strengthened rules and regulations, forcing employers to improve the programmes, for example, the Company Welfare Fund. Introduced by the previous government, this scheme had been a recommendation rather than a legal obligation, so less than 25 per cent of companies had been running the programme. In 1988, it became mandatory, with the Ministry of Labour proposing a bill stating that companies should contribute five per cent of their net profit before tax. Employers strongly objected, stating that legally enforcing the establishment of welfare funds was a direct government intervention into company fund management, as well as the imposition of another tax. Despite a strong lobby of employers' organisations, in 1991, the government legislated the Act of the Company Welfare Fund, by which the establishment of funds was subject to agreement between employers and workers. Relying on this law, trade unions were able to make company welfare funds a legitimate bargaining issue (Yi 2007).

The year 1990 introduced the Child Care Act, which made it compulsory for companies with more than 1000 employees to establish nurseries; the following year, the number was reduced to 500 employees. This was another aspect of policy measures that encouraged married women to work in response to the labour shortage. The law provided a platform for many women's organisations to campaign for female workers' welfare (Korea Women's Association United 1998).

The 1990s witnessed drastic changes in both economic and social spheres. Since the late 1980s, the GDP growth rate gradually decreased and was recorded at under five per cent in 1992, far lower than in the 1970s and early 1980s. Based on lifetime employment and increasing labour costs, the government cited the rigid labour market as the primary cause of the economic slowdown. It tried to introduce a more flexible system that made lay-offs easy, and reduced the indirect labour costs that had been rising as the now-powerful trade unions focused on increasing occupational welfare benefits

and wages. In addition, the government abandoned wage-control policy by leaving it to industrial bargaining between employers and trade unions. As space for industrial bargaining emerged, a new federation of national-level trade unions called the Korean Confederation of Trade Unions emerged with radical agendas on labour laws, working conditions and wages. Together with existing organisation, the Federation of Korean Trade Unions, the new confederation contributed to expanding the scope of industrial bargaining to welfare issues (Yi 2007). To address the resultant social problems of labour reforms, the government implemented unemployment insurance and expanded the coverage of the national pension from private sector workers to rural residents in 1995 (Yi and Lee 2005).

Starting in 1993, the government implemented financial liberalisation through a set of hybrid policies including deregulating interest rates, re-regulating foreign exchange and opening capital markets to foreign investors, as well as abolishing policy loans, and loosening capital controls. At the same time, the private sector's short-term debt rose until it reached three times higher than the average level of non-OECD developing countries. This caused a financial crisis in Korea, intensified by the 1997 Asian Financial Crisis, where many Korean companies, including big conglomerates, went bankrupt. Both the crisis and the government response of devaluating Korean currency caused the national economy to contract to almost negative six per cent, and the unemployment rate to rise from less than three per cent on average over the previous two decades, to eight per cent in 1998. Social consequences were even more serious. Inequality grew; the Gini index increased from 0.291 in 1996 to 0.316 in 1998, and the poverty rate rose from just over nine and a half in 1996 to 19.2 in 1998 (Yang 2014).

The 1997 presidential election was the forum to present policies that could solve economic and social problems. The new government of President Kim Dae-jung implemented a series of economic reform measures that followed mainly neo-liberal prescriptions (Mo and Moon 1998; Yang 2014). However, it also minimised social problems by expanding the coverage and benefits of the four major state-administered social insurance schemes for industrial accidents, health, pensions and unemployment, as well as reforming public assistance programmes.

In particular, the measures responding to rising unemployment were notable. In 1998 and 1999, the government spent about just over eight and a half per cent of the budget on unemployment-related emergency measures, including benefits, public works, training, employment subsidies, loans and tuition support, and food assistance for the children of the unemployed. Insurance coverage extended from full-time workers of firms with more than 30 employees in 1995, to all employees including part-time and temporary workers in 1998. The duration of benefits extended from two months to one year, and the eligibility period was shortened from one year to three months of work history (Yang 2000). Also, pension coverage extended from rural residents to urban residents in 1999, and the NPP became a unified scheme for the entire population.

The government also established a new public assistance system, the National Basic Livelihood Security System (NBLSS) to provide the poor with a minimum level of income as a right, regardless of their ability to work. This indicates a radical break from the old scheme in which benefits were not available to households that included at least one person aged between 18 and 64 deemed capable of working, even if their income was less than the minimum cost of living. This marked a significant change in the ROK's history of social welfare in that the notorious "Elizabethan poor law" type of public assistance was finally replaced with modern, rights-based poverty relief (Chung 2014; Yang 2014). In 2008, the elderly accounted for about 26.5 per cent of NBLSS recipients, since 45.1 per cent

had incomes below half the population median in 2005, the highest old-age poverty rate among the 30 OECD countries (Chung 2010).

In 2008, the government implemented two important policies to address the elderly's problems, in particular the elderly poor. First, the additional Basic Old-Aged Pension Allowance (BOAPA), improved on the 2007 Law on the Basic Old-Aged Pension Allowance. This was a policy response to NPP's low membership and embryonic state, which saw only 25 per cent of the total elderly in 2008 actually receiving benefits. Under the new law, and depending on the local government's financial condition, the national government would provide budget support ranging from 40 to 90 per cent. Now, five per cent of three-year average earnings of national pension members went to the relatively poor – 60 per cent of the elderly aged 65 and over in 2008. That number increased to 70 per cent in 2009. The number of recipients grew from 61 per cent in 2008 to 68.6 per cent in 2009 (Chung 2010). As of 2010, the size of benefits was about $83 per month for those living alone and $133 per month for those with spouses. However, this is too small to address poverty, given that the 2010 average minimum wage was $874, already one of the lowest in terms of ratio of minimum wage to median wage among OECD countries. Announcing its plan for long-term care insurance in 2001 after a series of consultations and pilot projects, in 2008 the government finally implemented the Elderly Long-term Care Insurance (ELCI) to meet the long-term care needs of people over the age of 65, and all age-related, long-term care services to people under the age of 65 in both domiciliary and institutional settings. The insurance contribution of 4.7 per cent of wages is added onto the existing health insurance contribution, and the estimated government spending on long-term care insurance is 25.4 per cent of total spending. Although the share of the people over age 65 needing long-term care stood at 12.5 per cent, the government set the threshold of ELCI coverage at just over three per cent, indicating its financial limitations. The NHI staff played gatekeeper; as of 2009, over four per cent of elderly benefits now come from ELCI. Since users are obligated to pay for user fees, such as 15 per cent of home care costs and 20 per cent of institutional care services, low-income elderly living alone tend to prefer institutional care, but cannot afford the fees. Conversely, the rich who mostly live with their dependents prefer care from family members rather than ELCI social workers, since they do not trust the quality of service (Yoon, Park et al. 2010).

Despite development of public assistance and of insurance schemes, in particular those for the elderly, there are problems to address. The ROK has rapidly expanded coverage for insurance schemes since the late 1980s, but has imposed strict rules on contributory obligation for insurance benefits, and has been reluctant to implement policies subsidising low-income groups. Consequently, a large segment of low-income people in the informal and marginal sectors are still excluded from benefit entitlement (Chung 2014). This is particularly serious for rural residents. According to survey research conducted by Choi and Hwang in 2007, only 53.2 per cent of rural residents joined the NPP compared to the national average of 75.6 per cent (Choi and Hwang 2007; Chun and Lee 2010). Therefore, real effective coverage is very low, and, excepting health insurance, most programmes actually protect about only half of the legally entitled population (see the Appendix 10) (Chung 2014). The NBLSS tripled the number of beneficiaries and the amount of the budget, which is a remarkable achievement. However, the remaining "family responsibility rule" by which the applicant's children or parents should fall below a certain income threshold is thought to be responsible for excluding about 0.6 million households or one million (mostly elderly) poor people from receiving social assistance benefits in 2008. Furthermore, the NBLSS means test is estimated to have excluded 70.1 per cent of those below the government-set official poverty line (People's Solidarity for Participatory Democracy 2009).

President Park Geun-hye's election pledge of expanding benefits and coverage of the BOAPA (Gicho Noryeong Yeongeum), regardless of the income, has been scaled back recently owing to budget pressure. Today, only 70 per cent of the elderly would receive the benefits of the Basic Pension Allowance (Gicho Yeongeum, BPA) which replaced BOAPA in 2014. One of the major policy intensions associated with the BPA is to expand the coverage of basic level of pension. Since the benefits from the BPA would be reduced depending on the amount beneficiaries could receive from the NPP, the BPA benefits substitutes a part of NPP benefits rather than augment them (Cho 2013; Choi and Hunny 2013).

Case III: Taiwan, Province of China

Primary Health Care and Health Insurance

Established in 1995, the National Health Insurance (NHI) of Taiwan covers about 99 per cent of the population (23,074,487 people) as of 2010. With various contribution schedules dependent upon occupational and income status, the government pays 100 per cent of the contributions for the low-income unemployed, while the high-income, self-employed insured pay 100 per cent of the premium themselves (Lee, Huang et al. 2010). The NHI replaced 13 occupation-based insurance funds covering about 60 per cent of the population: 14 per cent, 77 per cent and 57 per cent of those under 20, 20-64 and over 65 years of age, respectively. Among these were 10 different public insurance schemes covering various groups, including Labor Insurance (1950), Government Employees Insurance (1958), Farmers' Insurance (1985) and Low-Income Household Insurance (1990). Together, they covered 59 per cent of Taiwan's population of 21.4 million (Cheng 2003).

Crucial to understanding the development of the health insurance system is the history of many public insurance schemes for government employees—including civil servants, military personnel and the employees of state-owned companies who were the first groups to be covered by various types of social insurance, including health insurance in the 1950s. These government employees constitute the majority of the nearly one and a half million immigrants from Mainland China (Cheng 2001; Wong 2005). In response to a legitimacy crisis borne of its retreat to Taiwan, the Kuomintang (KMT) carried out large-scale political purges and set up mechanisms to strengthen its power. One avenue in the 1950s was establishing health insurance schemes as a part of a social insurance system based on government-controlled occupational unions and farmers associations.

In 1950 when the central government implemented military service-men's insurance (MSI), the Taiwan Provincial Government implemented the Labour Insurance (LI) for the workers of state-owned companies. Since then, the LI expanded its coverage of industrial labour on many occasions. Those in private firms with 10 employees and over were covered starting from 1951. Fishery labours were included in 1953, and sugarcane plantation workers were included in 1956.

In 1958, the central government formally legislated the Labour Insurance Act along with the Government Employees' Insurance (GEI) Act. The LI act gave the central government direct involvement in the administration of the LI (Lee 1992; Gong 1998; Lin 1998; Lin 2002). Like MSI and GEI, the LI covered a variety of risks including that of maternity, injury and sickness, medical care, disability, old age, death, and a funeral allowances in which only medical care was benefit in kind (Ku, 1997).

Since then, the government extended health care coverage to both public and private sectors by extending LI and establishing insurance for fishermen, sugarcane growers and government employees,

both current and retired. The coverage of the LI was extended in 1965 to those who were employed in the government sector but were unqualified for the GEI, such as technicians and school-bus drivers.

These social insurance schemes provided "bundled benefits" packages, of which health care accounted for the majority of insurance expenditure (Wong 2005). Consequently, most workers in large companies, and a segment of self-employed and agricultural workers, were covered by health insurance. However, despite increased coverage, benefit size was small and health service quality was poor. Most insurance did not cover members' dependents or outpatient care. Moreover, only a few public hospitals were designated to deliver health care to insured members. Although the contribution rate of workers was low, and those of both the government and employers was as high as 20 to 40 per cent, and 80 per cent, respectively, the benefit package was designed to cover only catastrophic health expenditure by providing expensive inpatient care (Wong 2004). Medical agencies had to make separate contracts for each scheme, meaning LI members could only receive insured medical service from contracted agencies. The cost was paid directly by the LI and GEI, and insured patients had no co-payment; health care providers worked on a fee-for-service system, with a limited list of insured services. The hospitals and clinics usually charged unregulated market prices for services rendered to those without health insurance, and these elevated prices caused approximately 80 per cent of the 1980s population to suffer adverse effects.

Social insurance contribution rates differed between the LI and GEI programmes. For LI, employers paid 80 per cent of the contribution while members provided the remaining 20 per cent, which worked out to be seven per cent of their monthly income. Self-employed workers enrolled in the voluntary LI programme paid 70 per cent of the contribution, while the government paid the remaining 30 per cent. As for government employees, the government paid 65 per cent and the employees paid the rest, which also added up to seven per cent contribution of their monthly wages. In 1977, their monthly contribution rate increased to nine per cent (Wong 2005).

Until the late 1960s, only five per cent of the population had insurance. Even if dependents and spouses had been included, this would not have risen to more than 20 per cent. As a result, health insurance—considered a tool for social and labour control—did not cost the government and employers much.

As the economy and living standards grew, the demand for medical service and health care increased dramatically. Furthermore, to respond to the 1970s diplomatic setbacks and legitimacy crisis, the government expanded health insurance coverage to white-collar workers, their spouses and their dependents. The benefit package also included outpatient care (Wong 2004). Those employed in firms with five or fewer employees were enrolled in LI on a non-voluntary basis. The contribution rate of self-employed workers who enrolled on a voluntary basis was reduced from 70 to 60 per cent, with the government paying the remaining 40 per cent (Wong 2005). The payments for outpatient care exceeded those of inpatient care in the 1970s and the coverage rate was increased from 19.8 per cent of the total population in 1970, to 38.7 per cent in 1980, to more than 40 per cent in 1985 (Chow 2001, 32; Lin 1997, 115). However the continued exclusion of dependents and self-employed workers was a barrier to further expansion. Although the health insurance had limited coverage, Taiwan's social insurance structural organisation was more or less an integrated system with few insurance carriers, compared to the ROK system prior to its merger. Although decentralised insurance units such as trade unions collected contributions to social insurance programmes, the funds were consolidated. Financial pooling across wage groups and occupational risk-pooling was thus greatly enhanced. However, inequality between schemes such as LI and GEI was significant. First, the LI did not provide coverage

for members' dependents, which means children and the aged were excluded, despite the fact that most frequent users of health care services tended to be these specific age groups. Conversely, beginning in 1982, GEI started to provide social insurance benefits to dependents. Second, members claiming the LI's lump sum old-age benefits would forfeit their medical care coverage, which meant that they had to choose either lump sum old-age benefits or health care. However, the 1965 revised GEI programme meant retired members could enjoy both health care coverage and old-age benefits, which were twice what the LI provided (Wong 2005).

Another 1980s policy emphasis dealt with increasing health care resources, such as expanding medical education, with an objective of one physician and four hospital beds per 1000 people. In 1983, the newly launched Group Practice Centers Programme addressed the urban-rural physician imbalance, and the government began assigning doctors who had received medical scholarships to positions in rural areas (Chiang 1997). However, public hospitals also charged as if they were private hospitals, keeping the financial barriers high (Chiang 1997).

Health insurance now handled the growth in outpatient care; this meant greater coverage as well as increased administrative burdens. In order to reduce costs, the government established a rule known as "payment without review", which enabled the insurance body to pay a fee for service up to a set price. This measure to reduce administrative costs produced an unintended consequence, that is, an overinvestment in expensive private sector medical facilities that were seeking more profits. Accelerating the process was a good investment environment, in the form of public subsidies and administrative guidance for investment in medical facilities that had begun in the 1960s (Rodrik, Grossman et al. 1995). The increased competition among hospitals owing to urban areas' accumulated human resources and physical infrastructure was also a cause for overinvestment, particularly from the private sector. This resulted in two health care delivery system consequences: the private sector now dominated the public sector, and the hospitals kept expanding (See Appendix 2). In the 1980s, the share of private hospital beds had exceeded that of the public sector. Many small clinics offering primary health care in both urban and rural areas closed down because of fierce competition with large private hospitals. The share of clinics decreased substantially from 83 per cent in 1963 to 54.6 per cent in 1982 (Chow 2001; Lee 2007, p. 63). In 1987, the government's quality-control policy measures, which included setting minimum staffing levels, also contributed to this trend of concentrating medical capital in large hospitals, since the cost was too high for small clinics (Cheng 2003).

With this expansion of health infrastructure, the political liberalisation that broadened Non-KMT forces' participation from local to national levels in the 1980s helped expand health insurance coverage. Responding to the opposition political party's strong demand for better social policy programmes, in 1988 the government implemented Farmers' Insurance covering all farmers. This social insurance expansion can be described as "crisis and compensation" (Calder 1988) which means, in authoritarian Taiwan, policy innovation was always initiated in response to a ruling party's political crisis. This could mean immediate and visible threats during the election, or the uncertainty in maintaining power in upcoming elections (Wong 2005). The standard response was to implement redistributive policies such as land reform, agricultural policies and social welfare provisions. The KMT leadership understood that the extreme socioeconomic inequality, in particular between Mainlanders and ethnic Taiwanese, was a potential source of political conflict and crisis. Even so, the social welfare response, in particular health insurance, strategically selected its targets, and remained piecemeal up to the early 1980s before the democratisation began in 1987 (Wong 2005).

The democratisation process that began with lifting martial law in 1987 provided both the KMT and opposition parties with strong political reasons for radical reform of redistributive policy. The health insurance was one of the major policy areas for reform since the LI and GEI were imbalanced in terms of the size and generosity of health benefit package. Such imbalance had been causing increasing public discontent. Chiang Ching-kuo's KMT government announced its plan for single-payer universal health insurance system, the National Health Insurance (NHI), in the late 1980s, which was implemented in 1995.

Apart from politics, the increasing demand for better health care, the elevated health care costs owing to the massive investment, and the expanded health insurance coverage which resulted in the financial crisis of both the LI and GEI shaped the NHI's three objectives. These included ensuring equal access to adequate health care for all citizens (i.e. redistributive equity), keeping health care costs at a reasonable (or socially affordable) level (i.e. cost containment), and promoting efficient uses of health care resources (i.e. systemic efficiency) (ROC Council for Economic Planning and Development 1990). To achieve these objectives, a four-point framework for health care reform was prepared:

- integration of the then 12 different health insurance schemes into a single, publicly managed health insurance fund;
- replacement of the pre-existing provider payment system based on a fee-for-service scheme with a global budget system whereby the insurance carrier or third-party, along with provider representatives, would set and adhere to an annual budget;
- maintaining the pre-existing payroll contribution, as opposed to general tax, but adjusting the proportion of contributions by employers; and
- introducing co-payment or user fee system which would discourage patients from making unnecessary visits to the doctors (Wong, 2005).

A broad consensus among providers, employers, and consumers was imperative to implement this single-payer health insurance with a global budget system. The government set up the Negotiation Commission on Health Expenditure (NCHE), a committee that which, besides itself, consists of representatives of providers, employers, consumers, scholars and experts (Chiang 1997). The newly established Bureau of National Health Insurance (NHI) consolidated all existing social health insurance schemes under the NHI and set up six regional offices to process enrolment and review claims, which increased administrative efficiency. As the only payer in NHI financing, the government had an interest in containing overall health spending, which demanded more coordination between itself, health providers and consumers. Although the NCHE helped make a consensus on the co-payment scales to reduce abusive or wasteful medical services, capped out-of-pocket payments to protect low-income families, and created a prospective payment system to reduce overtreatment, the NHI has continuously suffered financial deficits from 1998 (Lu and Hsiao 2003; Hung and Chang 2008). This condition is likely to worsen owing to the ageing population, the influx of expensive new drugs and technologies and the increasing demand for better health care quality. Another contributing factor is the profit-seeking private health providers' inappropriate management. For instance, adopting new technology often causes increased hospital costs and results in excessive capacity of hospitals. (Hung and Chang 2008).

Largely excluding civil society organisations, social movements and opposition parties, the state apparatus dominated NHI's design and implementation. This was owing to the KMT's strategy and capacity to control NHI-related legislation, as well as the other groups such as opposition political

parties and forces being too fragmented to voice any coherent challenges to the government's plan (Wong 2005).

Implemented in March 1995, Taiwan's administratively and financially centralised universal health insurance known as the NHI covers a wide range of health and medical care provided by clinics and public and private hospitals, all under contract. All members enjoy equal and comprehensive benefits excluding cosmetic surgery, long-term care, dentures, hearing aid and prosthetics. In 2010, the NHI covered about 99 per cent of the total population. Co-payment is not required for patients with major illnesses requiring long-term, expensive treatment, those residing in mountainous areas or on offshore islands, those from low-income households, and for those veterans and their dependents. Other exemptions include childbirth and preventive health services. Although patients' out-of-pocket payments fell from 48 per cent of the total amount spent on health care in 1993 to 30 per cent in 2000, and although the co-payment rate is modest compared to that of other countries, it is still considered regressive because rates are fixed and unvaried by a patient's income (Lu and Hsiao 2003). As for the legally established contribution rate, numbers increased from 4.25 per cent of the employee's monthly income in 1995, to 4.55 per cent in 2007 and 5.17 per cent in 2010. Contribution share varies across the different insured categories, as indicated by the table below.

Table 4. Contribution Ratio of Different Insurance Categories

Classification of the Insured			Contribution Ratio (%)		
			Insured	Group Insurance Applicants (i.e. employers and associations)	Government
Category 1	Civil servants, volunteer servicemen, public office holders	Insured and dependents	30	70	0
	Private school teachers	Insured and dependents	30	35	35
	Employees of publicly or privately owned enterprises or institutions	Insured and dependents	30	60	10
	Employers Self-employed Independent professionals and technical specialists	Insured and dependents	100	0	0
Category 2	Occupation union members Foreign crew members	Insured and dependents	60	0	40
Category 3	Members of farmers', fishermen's and irrigation associations	Insured and dependents	30	0	70
Category 4	Military conscripts, alternative servicemen, military school students on scholarships, widows of deceased military personnel on pensions, prisoners	Insured	0	0	100
Category 5	Low-income households	Household members	0	0	100
Category 6	Veterans and their dependents	Insured	0	0	100
		Dependents	30	0	70
	Other individuals	Insured and dependents	60	0	40

Source: National Health Insurance Administration, Ministry of Health and Welfare, http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=591&WD_ID=591&webdata_id=3153 accessed 2 January 2014.

Although it is difficult to definitively judge the NHI's impact in terms of health financing equity, owing to the lack of available data and the absence of solid method, Lu and Hsiao's (2003) analysis using WHO's Fairness in Financial Contribution (FFC) index shows that Taiwan's equity in financing health care has improved since the implementation of the NHI (0.992 in 1998 versus 0.8981 in 1994), and is more equitable than others such as Canada (0.974), Germany (0.978), and Japan (0.977) in 1998.

In addition, the NHI has introduced various cost containment measures. These include a diagnosis-related group payment system for common diseases, a sliding fee schedule for outpatient visits above a reasonable volume standard, and separate global budgets for hospital outpatient and inpatient services. Overall, NHI's establishment has contributed to providing more equal access to health care and financial risk protection, and managing health spending increase.

Compulsory Education

In 2014, Taiwan will implement 12 years of compulsory education, but even in 2012, it had almost 100 per cent enrolment for both six-year elementary and three-year lower level secondary (middle) school. To achieve these remarkable rates, government-run elementary and middle schools are crucial for providing education. In 2013, about 97.5 per cent and 88.8 per cent of elementary and middle school students attended government-run elementary and middle schools, which accounted for 98.6 per cent and 97.7 per cent of all elementary and middle schools, respectively (see Appendix 5). The government budget for education, however, was just 3.6 per cent of GDP in 2010, lower than that of Hong Kong (4.4 per cent), South Korea (4.6 per cent) and Japan (5.2 per cent).

Taiwan's remarkable economic development comes from many factors, such as land reform, Japanese colonial infrastructure, American economic aid, a decline in fertility rates, a stable Confucian family structure, a free labour market, a strong and relatively autonomous state, small and medium-sized enterprises, and education (Kuznets 1979; Amsden 1986; Liu and Armer 1993). In particular, empirical analysis of education's effect on economic growth between 1953 and 1985 shows that nine years of primary and junior high school education—rather than those of senior high and college—contributed much to economic growth based on textiles, basic metal products, chemicals, plastics and food-processing industries (Liu and Armer 1993). The nine-year primary and junior high school education met industry needs for workers with basic education and skills rather than higher levels of training.

Taiwan's education system, in particular compulsory education, absorbed a lot of Japanese influence.[12] In 1898, the Japanese colonial government established, the first modern six-year public and private elementary schools, all of which, were heavily Japanised in terms of language teaching and methods, curricula and organisational structure. In Korea, private schools fostered the anti-Japanese movement, but Taiwan's schools had more Japanese teachers than Taiwanese ones, and could not play a role in nurturing nationalistic sentiment (Hirotani and Hirokawa 1973).

Various types of schools such as public eight-year elementary and middle schools in urban areas, and four- and two-year elementary schools in rural areas were established starting from the early 1900s, but most costs were covered by parental contributions. In 1915, secondary schools for Taiwanese

[12] The Japanese influence was far more significant in Taiwan than in Korea. Unlike Korea, Taiwan had never been an independent state with its own indigenous bureaucratic and landed elite. In the absence of preexisting cohesive and legitimate organs of state power in Taiwan, the Japanese had an open opportunity for establishing their own structure of control and guidance (Wade 1990). The education system was not an exception to this.

were established, but focused on practical skills; the level of education was far lower in quality than in the same level schools for Japanese. One of noticeable exception is medical schools. Suffering from a bad sanitary environment and tropical diseases, the Japanese colonial government established medical schools to produce Taiwanese doctors in 1900, which was the first public higher education available to the local population (Hirotani and Hirokawa 1973). Graduates became not just medical doctors but formed an influential and powerful group in Taiwanese society. Pro-Japanese groups formed by Taiwanese increased in number, particularly after 1919 when higher education institutions for Taiwanese rapidly increased.

After Japan started invading mainland China in the early 1930s, anti-Japanese sentiment increased, along with demand for skilled and educated workers for the war. The colonial government implemented policies to "Japanise" the Taiwanese by increasing the enrolment rate of elementary and secondary school in which the use of Chinese language was banned. In public elementary schools, numbers grew from 32.6 per cent in 1930 to 57.6 per cent in 1940, while the quantity of Taiwanese students in secondary engineering schools increased from 197 in 1931 to 998 in 1941 (Hirotani and Hirokawa 1973).

After the war, the KMT government's takeover of Taiwan did not just mean their liberation from Japan, but the imposition of a different "foreign" regime; after all, the Taiwanese had been heavily assimilated into Japanese culture and language for 50 years. Mainlanders implemented policies that discriminated against the local Taiwanese; they monopolised higher political positions, designated Mandarin Chinese rather than the local Hakka as the official language, and paid the Taiwanese even lower salaries than they had gotten during the Japanese colonial regime. This soon invoked Taiwanese resistance, culminating in a violent clash between the KMT government and local people in February 1947 (Shackleton 1998). Establishing a highly centralised education policy to indoctrinate "Chineseness" into the Taiwanese became a government imperative, and was aided by two factors. First, Taiwan's elementary school enrolment rate was almost twice of that of Korea, estimated at more than 70 per cent. This provided a good basis for six years of free compulsory education for children aged between six and 12 years as stipulated in the constitution (article 160). Second, many intellectuals who could readily assume posts of Japanese teachers arrived after the KMT's defeat in China.

After the KMT's 1949 retreat to Taiwan, a major government concern was preventing communist insurgencies in rural areas. Establishing schools and having children receive primary education were pre-emptive policies, together with land reform, the organisation of pro-government famers' associations and nominal local elections (Wade 1990). Between 1950 and 1965, when the enrolment rate of elementary school reached almost 97 per cent, the number of primary students more than doubled, from a little over 900,000 to almost 2.3 million. Even with the rapid increase, the government kept quality high, spending additional resources per each primary school student.

Under the martial law of 1949, the KMT established an authoritarian and centralist education system based on the inculcation of the government's version of Chinese nationalism. This centralisation of power in the educational administration also shaped educational content through standardising textbooks, intervening in university management, establishing new schools and regimenting all school levels. To respond to the increasing demand for higher education, the government expanded the number of schools. This made attending higher education increasingly competitive; to ensure fair and transparent competition in entrance exams for higher education institutions, authorities established strict rules and regulations as well as a national examination system (Yamanokuchi 2008).

The 1968 educational reform was an extension of the "Chinisation" of the KMT government. It was also a response to the increasing demand for skilled workers from labour-intensive industries. The reform made drastic changes that shaped the education system up until the 1990s. While resisting public pressure for expansion of higher education to elevate status and reproduce elite groups, the government expanded vocational schools at the senior high school and junior college levels, separating them from the highly selective academic high schools and colleges (Liu and Armer 1993).[13] The government also extended the period of schooling without entrance exams and school fees from six to nine years, meaning elementary school graduates could enroll in assigned, same-district middle schools with no tuition fees.[14]

After 1987, when martial law was lifted, the democratisation process and industrial shift to more technology-intensive production brought drastic changes to the education sector. First, many civil society organisations formed a pressure group for education reform. After the first "Non-Governmental Conference on Education", organised by 32 non-governmental organisations in 1988, the year 1994 saw the formation of the "410 Education Reform League" composed of 410 civil society organisations (Wang 2012). It heralded a new beginning of education policy reform, since for the first time a grassroots movement had formed a substantial pressure group. Particularly notable is its role in enhancing school quality by decreasing class size and reducing the entrance examination burdens for those entering senior high schools and colleges. Second, responding to this pressure, in November 1994 the government established a Council on Education Reform as a part of a broad reformist framework that also included the areas of politics and the judiciary. Composed of mainly independent experts including the director, Nobel Prize Winner Dr. Y.Z. Lee, the council proposed to reduce central government regulation over education administration, curricular and teaching methods of primary, secondary and higher education. Third, educators saw a systemic change with the advent of the Teacher Education Act of 1994. The system in which only the national normal universities and teacher colleges could produce teachers for primary and secondary schools was changed; now every university and college could set up a teacher education programme if it met Ministry of Education (MoE) requirements. Fourth, the Joint Entrance Examination System underwent serious alterations. Originally this was a national-level single unified examination system for senior high school entrance, and the source of not only fierce competition but also of students being concentrated in specific schools. Beginning in 1996, the new system now combined both recommendation and examination for senior high and vocational schools to allow students to enter community high schools without testing. Fifth, that same year all primary education textbooks were open to the market; any book publisher could now issue books for designated school use after receiving MoE approval. Sixth, the Basic Act of Education (Article 9) of 1999 restricted the central government's role to planning and implementing national education policy, as well as supervising, monitoring and evaluating local education. And finally, the Local Institution Act of 1999 (Articles 18 and 19) clearly stipulates that municipalities or provinces have the authority to establish and manage education at all levels of school (including pre-school), as well as social education. Depending upon their finances, local governments can find this either a challenge or an opportunity. Notably, during the Asian Financial

[13] Both strong demand for skilled workers and the government's emphasis on vocational education resulted in the bigger number of vocational high school students than those of normal high schools since 1971. It reached its peak in 1994 when the number of vocational high school students was double that of normal high school. However, the dominance of the vocational high school has decreased since then, and reversed in 2002.

[14] The major change in this presidential decree was the abolishment of entrance examination and school fees for junior high school, which had prevented a considerable number of motivated primary graduates from continuing their education. Although universal education up to junior high school began in 1968, the formal extension of compulsory education up to junior high happened in 1982, when the "forced enrolment decree", based on the National Education Act of 1979, making enrolment to middle school compulsory was established (Liu and Armer 1993).

Crisis in 1997, the National Parliament abolished the clause that guaranteed at least 15 per cent of the total budget for expenses on education, science and technology (Pan and Yu 1999).

Discussions on extending compulsory education have continued. In 2003, the National Educational Development Conference came to a consensus on promoting the progressive realisation of 12 years of national basic education. When carrying out the national census, the National Education Research Centre Preparation Group found that 78.4 per cent of those surveyed also supported 12 years of national basic education.

In response, in 2007, the government announced the Twelve-Year Basic Education Plan, which aimed to extend the compulsory education from nine to 12 years by reducing the gaps between urban and rural education, as well as the cost gap between vocational and normal high schools in both public and private sectors. In June 2013, the National Parliament passed the Law of Senior High School Education that has acted as the basis of a 12-year compulsory education system from 2014 (Lee 2013). According to the law, non-citizens, repeaters and private school students will not benefit from free tuition programmes. However, there has not been a plan for a revision of the existing subsidy scheme for senior high school students, such as the Project for Promoting Measures to Help General and Vocational High School Students Pay Tuition Fees.[15] Given the high percentage of students transitioning from junior to senior high schools, which was 97.7 per cent in 2011, the act also aims to change the entrance examination system from the single nation-wide entrance examination to the new multiple-channel entrance system, and consequently boost poorly performing rural schools in preparing their students for the higher education entrance examination (Gao 2012).

Social Assistance and Basic Pensions

Taiwan's post-war social policy has been dominated by state-initiated social insurance schemes. Beginning with LI, the authoritarian KMT government launched 16 different social insurance schemes by 1995. During this period, family allowances did not exist, and income security for low-income households was a small amount of poor-relief style benefits. Unemployment insurance was not introduced until 1999.

The income security schemes before 1987 were limited, and heavily based on social insurance programmes tied to occupations such as civil servants, teachers, military personnel and private sector workers. One underlying idea of this occupation-based system was to reduce workers' mobility, providing an element of social control (Chen 2005).[16]

The income security system for the elderly was mainly based on both old-age benefits from insurance and old-age payments from employers. The system was based on three major insurance schemes established along occupational lines: LI (employees of public and private companies, and self-employed), MSI (social insurance for military personnel) and GEI (social insurance for civil servants and teachers) (see Appendix 11). Starting with workers employed in companies with at least 20 employees, LI was extended to companies with 10 or more workers, as well as to the self-employed and fishermen, and on a voluntary basis, to those working in companies with fewer than ten employees by 1953. As the government legislated both LI and GEI as national-level insurance in 1958, the overarching administrative and financial responsibilities for social insurance were transferred from

[15] Some categories of students such as disabled students, students from low income families, students from single-parent families, and indigenous students have been exempted from fees in private normal and vocational high schools, and various categories of students have received different amounts of government subsidies (The Ministry of Education, Taiwan, 2013).

[16] For instance, civil servants transferred to private firms found that their work experiences in public departments were not automatically incorporated into the calculation of work years in the insurance system for the private sector workers.

provincial jurisdiction to the central government. Two principal cabinet ministries carried out the collection of insurance funds and the administration of the separate schemes. The Ministry of Examination (Examination Yuan) managed the GEI, while the LI was under the administrative aegis of the Ministry of the Interior (the Bureau of Labor Insurance) until 1988 when the newly established Council of Labor Affairs started to be in charge of the LI (Wong 2004).

Although these schemes were important tools for promoting old-age security, their ability to protect the aged from poverty have been questioned in many respects. First, the coverage is limited. For instance, although the LI is the largest in terms of its membership, it only covered a workforce of 8.8 million, equivalent to only 38.2 per cent of the total population in 2007. Second, the main form of benefits is a lump-sum benefit rather than an annuity. Those insured by the LI scheme received old-age lump-sum benefits. The can receive occupational pensions only if they satisfied the qualifying criteria regulated by either the Labor Standard Law or New Pension Act of 2008. Third, the burden of contribution is substantial for those with high risk of income loss. In the case of self-employed workers enrolled in the voluntary LI scheme, enrolees paid 70 per cent of the monthly contribution, while government subsidised the remaining 30 per cent (Wong 2004).

Another source of income security for the elderly were old-age benefits from employers legislated by the Labour Law and the Government Employees Retirement Law. Contributors could usually collect their benefits from insurance schemes when they reached retirement age, but they could not claim old-age benefits from their employers if they had lost their job before retirement, which played a huge role in limiting worker mobility. For their part, employers tried to avoid paying workers old-age benefits by closing down and opening a new company, or dismissing employees before they reached their retirement age (Chen 2005). The lack of regulation concerning portable entitlement to occupational pensions further disadvantaged employees, in particular, low-income workers in jobs with a high turnover rate (Shih and Mok 2012). The short time span of Taiwan's small and medium-sized companies was both cause and result of this employers' old-age payment system development (Wu 1997). The Labour Standard Law of 1984 significantly strengthened labour protection and increased the costs of firing workers; this helped ensure employees received old-age payments from their employers. However, this was mostly true for those in large and medium-sized companies; labourers in small companies felt a limited impact (Kan and Lin 2011; Shih and Mok 2012).

However, even workers that received old-age benefits from both the LI and the employers' lump-sum payment, the earnings replacement rate would be at best 33 per cent. By contrast, government employees and military personnel could gather up to 90 per cent, or even exceed 100 per cent of pre-retirement income (Fu 1994; Guo 1998; Lin 2005).

Third source of income security is social assistance. Taiwan's first social assistance law was the Social Relief Law of 1943, which aimed to help those living in poverty owing to age, youth, pregnancy, disability or disaster. The system was residual and targeted at very low-income families. Replaced later by the Social Assistance Law of 1980, the new policy provided benefits to those with low income rather those affected by causes of poverty. However, it lacked specific selection criteria, and gave discretionary power to government officials, who set up very low poverty lines. The population covered by social assistance schemes gradually fell (Ku 1995).

But as social assistance scheme coverage declined, the government was instituting additional policies, and social insurance schemes began to grow.[17] Social insurance coverage increased from 12.0 per cent of the population in 1965 to 45.8 per cent in 1997, as social assistance coverage declined from 8.9 per cent of the population in 1965 to only 0.5 per cent in 1997 (Huang and Ku 2011).

Political democratization affected this shift of policy from social assistance to social insurance type income security. Martial law was lifted in 1987; in 1992, the opposition Democratic Progressive Party (DPP) successfully mobilised electoral support by promising universal, non-contributory old-age pension (or allowance, OAA) Since then, politics—in particular, the DPP's universalist welfare policy and the KMT's economy-first policy—have dominated the discourse on social security system in Taiwan. This was particularly true of the income security system. Poverty among the retired population, especially farmers who were not mandatorily covered by insurance schemes, was a hot political issue in the 1990s (Chen 2005; Lin 2005). In the 1990 election, the DPP proposed a universal non-contributory OAA (*lao-ren nianjin*, translated as old-age pension), which gained ample support. The KMT responded by launching its allowance programme for the poor elderly population in 1993, and extending the eligibility by up to 250 per cent of the poverty line in 1994 (Huang and Ku 2011). As a result of these political debates, the non-contributory Welfare Allowance for Aged Farmers (WAAF) providing a flat rate benefit to targeted beneficiaries was established in 1995. However, the benefits were modest.[18]

Although the KMT government established various social assistance schemes such as the Living Allowance for Middle- to Low-Income Elderly People (1994), the WAAF (1995), and the Living Allowance for Elderly People (2002), it did not reform the old-age income security system that heavily favoured government employees and military personnel with modest social assistance programmes. Still, owing to a generous replacement rate of pension schemes, the financial burden on the government grew. In 1995, when the "health" part of the insurance schemes merged into NHI, the government-financed public service pension system changed into a "Contributory Pension Fund" supported by joint-funding from government and participants. Public and private school personnel in 1996, and then military personnel in 1997, also took part in this fund.

In 1997, the KMT government made a significant move in welfare reform. First, in 2000, it launched a new two-tier pension system composed of a first-tier of flat-rate pension for all and a second-tier, contribution-based occupational pension related to earnings (Shi 2010). However, the 1999 earthquake put these policies on hold. Second, it revised the Social Assistance Law and specified the poverty line at 60 per cent of per capita consumption expenditure of the previous year. Although the estimate by scholars and government about the potential beneficiaries was about five to eight per cent of the total population, the 1999 actual take-up rate was only 0.85 per cent, since the government put strict conditions on the benefits. In particular, the broad definition of "family members" whom the government considered the applicants could potentially rely on reduced the number of eligible applicants and consequently resulted in exclusion errors. Another problem was the benefits' small size. Although the government increased the level, the cash payout only covered around 50 per cent of minimum expenditure (Huang and Ku 2011).

In 2000, the first non-KMT government in the history of post-war Taiwan took power; under the DPP, the old-age income security debate continued. The DPP proposed two pension reform plans for

[17] For instance, the government relaxed the enrolment standards of the LI, the urban middle class wage-earners were allowed to join the scheme in the 1980s. It resulted in a 130 percent increase of enrolees in the 1980s (Lin 2005).
[18] The allowance for farmers, for instance, was no more than one-eighth of the average monthly income (Lin 2005).

discussion. The first plan presented a defined-contribution, first-tier pension for those not insured by any current pension systems, and an existing occupation-based pension related to earnings. The second plan consisted of a universal, non-contributory basic pension (first tier) to be financed by the sales of public enterprises as financial resources, and the existing occupation-based pension insurance funded by reduced premiums and government contributions. Brought before the Legislative Yuan—where the DPP was still a minority party—both plans, in particular the non-contributory basic pension, faced criticism for financial unsustainability. This legislative bottleneck continued in the midst of economic recession in the early 2000s. The public wanted the government to focus on reinvigorating the economy rather than undergoing welfare reform, and the DPP postponed introducing the new pension system by announcing they would "give priority to economic development and delay social welfare reforms" (Ku 2003; Lin 2005).

Although the government had prioritised economic development, the pension reform debate continued. However, the issue was often engulfed in the partisan politics and competition over policy solutions among different administrations, such as the Council for Economic Planning and Development (CEPD) and the Council of Labour Affairs (CLA), and the process stalled. In order to avoid being blamed for the pension-reform stalemate, in particular from those excluded, politicians across the parties went for an easy option, increasing old-age allowances for farmers when they faced the 2004 elections (Shi 2010).

After a series of public hearings and planning meetings between 2002 and 2006, the CLA drafted a bill that was passed in the Legislative Yuan in July 2008, and was set to launch in January 2009. Introducing the National Pension Insurance (NPI) meant covering those without other coverage, such as the unemployed or housewives, and annuitising the LI pension (Shi 2010).

The 2008 introduction of the NPI and the LI pension annuitisation led to attaining comprehensive coverage. The new system integrates existing military personnel, public school teacher and labour pension schemes, as well as individual accounts and farmers' non-contributory welfare subsidies; however, it is still highly fragmented. A number of occupationally segregated pension insurance or allowance schemes operate concurrently with various degrees of old-age protection. Different from the previous two-track system, with social insurance as the main, and social relief as the subsidiary form of retirement security, the new system amalgamated individual savings accounts and new elements of social subsidy. However, it remains fragmented along lines of occupation, inequality and regressive redistribution between insurance schemes (see Appendix 11).

The global economic crisis in the late 2000s significantly affected the Taiwanese economy and society (Chow 2009). In addition to deteriorated economic performance, the financial crisis caused increased unemployment, income inequality and poverty. In particular, the increase of youth and lower middle-aged (20-29) unemployment rate was notable. While the middle and old-aged (45 years and over) group was heavily affected during the two previous economic crises of 1982-1986 and 1998-2000, in the late 2000s, youth and middle-aged (i.e. 25-44) group was the one that suffered, accounting for about 60 per cent of the all unemployed (Chen and Lui 2011).[19] According to data of Directorate-General of Budget, Accounting and Statistics, Executive Yuan, while the average unemployment rate was 5.85 per cent in 2009, the average unemployment rate of the 20-24 year-old age group was 14.67 per cent, and that of the 25-29 year-old age group was 8.77 per cent (see Appendix 12). The weak social security system that has seen decreased spending in terms of GDP

[19] Youth and middle-aged (25-44) unemployed people accounted for 55.78 percent and 57.44 percent of the unemployed in 2008 and in January 2009 respectively.

share since early 2000 served to magnify the social impact of the global economic crisis (Chen and Lui 2011).

In addition, in 2008 the government created a shopping voucher programme, a kind of universal cash benefit paid to all, to respond to the global financial crisis. However, it was only provided once and offered a relatively low single payment of NT 3,600, which was about eight per cent of the annual poverty line. Although the take-up rate was close to 100 per cent, research shows that the shopping voucher's small benefit amount had little effect on income equality (Huang and Ku 2011).

The pension system's financial sustainability became a major policy concern of the Ma Ying-jeou government, and President Ma announced the overhaul of the Taiwanese pension system in early 2013. The recent government's pension reform bills, currently awaiting legislative approval, aim to restructure retirement plans for private sector workers, military personnel and public school teachers. The bills proposing changes to benefits, replacement rates, and retirement age would increase contributions, push for later retirement, and reduce benefits. The reform bills have sparked protests and dented popularity ratings for Ma and the ruling KMT party (Bowie 2013).

Conclusion

Developmental trajectories of these health and pension schemes show diverse contexts and pathways to expand the coverage involving diverse actors, institutional arrangements and processes to reduce fragmentation. Japan's system, which includes intra- and inter-sectoral insurance societies, coordinates the management of both health and pension schemes and transfer of members' health and old-aged health care resources between these schemes, but the overall structure remains fragmented. In contrast, the ROK and the Taiwan province of China, both began with fragmented health schemes, but achieved single-payer system through the strong state's role in coordinating different health insurance schemes. In both cases, the government played a significant role in redistributing resources from financially sound insurance schemes to those less secure. The question is how did the ROK and Taiwan eventually unify their fragmented insurance schemes, while Japan's combination of health finance, efficient governments and swift economic growth still produces a fragmented health system, in the sense that there is no one single payer? Even more interesting, Japan, the ROK and Taiwan are all archetypal models of the developmental state's rapid economic growth. They all started with fragmented systems and expanded in a similar trajectory, up to the point where the ROK and Taiwan started transforming fragmentation into single unified-payer systems.

We may be able to highlight the politics of democratization as a key factor explaining this divergence. Introduction of elections has created a space where political parties compete over solving the system's problems. Compared to piecemeal and gradual expansion of the existing system under authoritarian regimes in the ROK and Taiwan, the changes initiated by ruling parties facing democratisation in both countries were much more transformative, since those in power realized that they could no longer rely on selective political coalitions and had to target broad popular support to win the election. In the context of political democratization, structural and institutional factors such as Taiwan's division within opposition political parties and forces, and the participatory mechanisms and dialogue including key interest groups such as providers and consumers which can be found in both ROK and Taiwan played a significant role in weakening resistance and reduce the costs of reforming the insurance system.

By contrast, Japan has lacked these factors. First, the transition from authoritarianism to democracy during the 1940s and 1950s was mainly controlled and guided by foreign forces, and never created the

political space for policy change. What politicians needed to garner votes was the capacity to maintain status quo rather than change. Second, the prime minister's weak executive power, partly owing to intra-party factional politics, and the strongly entrenched bureaucracy in national and local governments have made radical policy changes difficult. Frequent ministerial reshuffles, particularly in social and labour affairs, and the resulting weak leadership may have reinforced this bureaucrat-dominant decision-making system. This was a major factor for economic success, but was not the driving force for social policy reform (Oyama and Takeda 2010). The system in which "the politicians reign and the bureaucrats rule" was effectively working at least until the mid-1970s (Johnson 1978). Although neither politicians nor bureaucrats tried to integrate fragmented insurance societies, bureaucratic resistance to any radical reform would have been significant, as demonstrated by the privatisation process of a post office case under Junichiro Koizumi's leadership. Third, Japan's bureaucracy incapacity also contributed to the continuity of this fragmented insurance society. Since the mid-1970s when the politicians gained strength, the bureaucrats could not take full control in shaping public policy and had to consult frequently changing, politically appointed ministers. The "dual government" in which politicians and bureaucrats compete and compromise did not create a favourable environment for radical policy changes. Since the early 1990s, after 10 years of stagnation, increasing demand for strong political leadership resulted in several radical reforms, such as changing the electoral system to abolish intra-party factional competition and corruption, streamlining the administration by reducing the number of ministries, and enhancing the capacity of prime ministers and their cabinets to exercise leadership. These reforms led to a limited success of several economic and public policy reforms such as the aforementioned privatisation of the post office, but not to social policy reform.

Integrated or not, the welfare provision development in terms of coverage expansion in Japan, the ROK and Taiwan offers several important policy messages for universalization and integration of social welfare system. First, it challenges the assumption that a welfare state is a luxury that can only be built after reaching a certain level of economic development. All three cases planned, or started to build, social benefits and services targeting a substantial number of people either before or during industrialisation. Reasons included nation building, legitimacy enhancement, social integration and resource mobilisation for industrialisation. Second, institutional infrastructure's uneven development trajectory of different services and transfers (i.e. health, education and pension) has affected the contents, nature and timing of public sector provisions for different services and transfer schemes. In all three cases, infrastructure of compulsory education developed well before the start of massive post-Second World War industrialisation, and achieved universal coverage well before other systems of welfare provision did the same. Third, related to the second lesson, each system of benefits and service provision has its own distinctiveness in terms of the actors, processes and institutions involved, and creates distinctive institutional complementarity. It questions the explanatory capacity of the welfare regime approach of a specific country's welfare state development, which can mask the variations across the different sectors of welfare state. Fourth, as each system of welfare benefits and service provision expands coverage, their interaction creates structural isomorphism, in which a particular principle dominates to facilitate government coordination. In Japan, both health and pensions have equally fragmented systems. The same insurance societies dealing with these schemes are the key institutions in creating this structural isomorphism. The ROK went for a single-payer system for health schemes. Except for pension funds for government employees and private school teachers, the National Pension Service covers the whole population, and all schemes are defined-benefit, funded schemes. Addressing inequality between different schemes for similar services, as well as ensuring unified systems for all beneficiaries became a key political strategy to mobilise support. For its part, Taiwan is exceptional in this convergence trend, as pension schemes are still

fragmented in terms of rules and regulations concerning beneficiaries and benefits. However, as health insurance became unified, the Taiwanese government did plan for a more unified pension system for greater coordination efficiency, as recent reform attempts have shown. Fifth, a fragmented welfare provision system does not necessarily prevent coverage for a whole population. With significant government funding, and a well-organised system of coordination in covering and allocating adequate budgets for the target groups, nations can achieve universal coverage. Fragmentation and universalization can be compatible when there is a set of institutions to create institutional complementarity to maximize the synergies between fragmented insurance schemes. Redistributive policy transferring resources from rich administrative units to the poor ones, and substantial civil society participation, as seen in the case of Japan, can be central to making this institutional complementarity. Sixth, universal entitlement to join the contribution-based insurance scheme in which the insured have to pay substantial premiums is less likely to guarantee actual universal coverage of benefits and services. This is owing to the reluctance of low-income residents to pay premiums, as in the case of the ROK. Seventh, both Korean and Japanese health systems (and to lesser extent, the Taiwanese) show that the private sector can play a role in enhancing accessibility to health care systems. However, it should be noted that in both countries the state, rather than market, has played a leading role in making public-private partnership and shouldered the burdens of certification, controlling reimbursement of insured services, and monitoring quality of service, and consequently managing these insurance systems. Eighth, it is difficult to draw a lesson on the sequence of universalisation, or integration of fragmented schemes from the three cases we have observed; however, what we find in the ROK and Taiwan's experiences is that systems of welfare service or transfer with financially unstable, or internally unequal schemes, were the first to be integrated. Political pressure from the users of services played a key role in determining which welfare provision system should be prioritised. Ninth, as previously mentioned, in all three cases civil society organisations have helped shape the reform of welfare systems provision. Various spaces provided by the democratic system, such as a publicly accessible judiciary, public hearings and consultations, and open and transparent electoral systems provide ample opportunities for people to translate their demands into policies. Finally, again, the role of government as a mediator and coordinator among different interests is a key to reform. Governments without adequate capacity to exercise leadership over multiple players are more likely to complicate systems or cause harm than they are to make a synergistic integrated system. The systems of benefits and service provisions we review in this paper are diverse, and not without their unique problems and challenges, but all take as their foundation the strong role of the state in coordinating different interests.

Appendices

Appendix 1. Number of Health Insurance Cooperatives in ROK by Year

		1977	1981	1985	1989	1993	1996	1997	1998	1999
Company-based cooperatives	Single-company cooperative	494	114	70	71	70	63	63	63	60
	Cooperative for multiple companies	19	71	74	83	83	82	82	82	82
	Subtotal	*513*	*185*	*144*	*154*	*153*	*145*	*145*	*145*	*142*
Residence-based cooperatives	Rural area	n.a.	n.a.	n.a.	137	136	94	92	92	0
	Urban area	n.a.	n.a.	n.a.	117	130	133	135	135	0
	Subtotal	*8*	*10*	*13*	*254*	*266*	*227*	*227*	*227*	*0*
Trade-based cooperatives		n.a.	1	12	0	0	0	0	0	0
Total		**521**	**196**	**169**	**408**	**419**	**372**	**372**	**372**	**142**
State-owned corporation to administer medical insurance for government employees and teachers		0	1	1	1	1	1	1	1	1

Source: Author's modification based on (Kim 2002). Note: n.a. = Not available.

Appendix 2. Health Care Indicators: Taiwan, Province of China, 1960-1994

		1960	1970	1980	1990	1994
Health Care Resources	Number of physicians (per 1000 persons)	0.5	0.4	0.7	1.0	1.1
	Number of hospital beds (per 1000 persons)	0.7[a]	2.4[b]	3.2[c]	4.1	4.5
	Percentage of public hospital beds	71.3[a]	60.8[b]	53.3[c]	42.7	39.9
Health Care Financing	Per capita health spending (USD)	n.a.	n.a.	78	330	599
	Health spending as share of GDP	n.a.	n.a.	3.3	4.2	5.1
	Share of population insured (%)	6.3	7.9	16.0	47.3	57.0

Source: Author's modification based on (Chiang, 1997) Notes: [a] 1961; [b] 1971; [c] 1982.

Appendix 3. Japanese schools and students by year and sector

	Elementary Schools									
	total	National government run	Local government run	Private	share of private schools	Total	National government run	Local government run	Private	share of students in private schools
1948	25,237	91	25,050	96	0.4	10,774,652	44,469	10,706,599	23,584	0.2
1949	25,638	86	25,329	223	0.9	10,991,927	42,232	10,905,837	43,858	0.4
1950	25,878	81	25,702	95	0.4	11,191,401	42,887	11,123,449	25,065	0.2
1951	26,056	77	25,874	105	0.4	11,422,992	43,847	11,351,453	27,692	0.2
1952	26,377	78	26,184	115	0.4	11,148,325	44,358	11,073,690	30,277	0.3
1953	26,555	76	26,352	127	0.5	11,225,469	44,939	11,148,176	32,354	0.3
1954	26,804	76	26,590	138	0.5	11,750,925	44,864	11,669,345	36,716	0.3
1955	26,880	76	26,659	145	0.5	12,266,952	45,691	12,181,255	40,006	0.3
1956	26,957	76	26,730	151	0.6	12,616,311	46,050	12,529,459	40,802	0.3
1957	26,988	76	26,755	157	0.6	12,956,285	46,239	12,866,071	43,975	0.3
1958	26,964	75	26,731	158	0.6	13,492,087	46,618	13,398,465	47,004	0.3
1959	26,916	76	26,681	159	0.6	13,374,700	46,490	13,279,428	48,782	0.4
1960	26,858	76	26,620	162	0.6	12,590,680	45,968	12,495,514	49,198	0.4
1961	26,741	75	26,505	161	0.6	11,810,874	45,911	11,716,706	48,257	0.4
1962	26,615	75	26,379	161	0.6	11,056,915	45,674	10,962,450	48,791	0.4
1963	26,423	74	26,189	160	0.6	10,471,383	45,644	10,376,601	49,138	0.5
1964	26,210	73	25,976	161	0.6	10,030,990	45,460	9,935,044	50,486	0.5
1965	25,977	72	25,745	160	0.6	9,775,532	45,389	9,678,329	51,814	0.5
1966	25,687	70	25,457	160	0.6	9,584,061	45,467	9,486,011	52,583	0.5
1967	25,487	70	25,257	160	0.6	9,452,071	45,983	9,353,035	53,053	0.6
1968	25,262	71	25,029	162	0.6	9,383,182	46,409	9,283,028	53,745	0.6
1969	25,013	71	24,781	161	0.6	9,403,193	46,778	9,301,825	54,590	0.6
1970	24,790	71	24,558	161	0.6	9,493,485	47,215	9,391,425	54,845	0.6
1971	24,540	71	24,308	161	0.7	9,595,021	47,468	9,491,804	55,749	0.6
1972	24,325	71	24,092	162	0.7	9,696,233	47,480	9,592,677	56,076	0.6
1973	24,592	71	24,358	163	0.7	9,816,536	47,354	9,712,707	56,475	0.6
1974	24,606	71	24,373	162	0.7	10,088,776	47,036	9,984,363	57,377	0.6
1975	24,650	71	24,419	160	0.6	10,364,846	46,868	10,259,848	58,130	0.6
1976	24,717	71	24,486	160	0.6	10,609,985	46,762	10,504,577	58,646	0.6
1977	24,777	71	24,544	162	0.7	10,819,651	46,596	10,714,312	58,743	0.5
1978	24,828	71	24,591	166	0.7	11,146,874	46,301	11,041,244	59,329	0.5
1979	24,899	71	24,662	166	0.7	11,629,110	46,204	11,522,896	60,010	0.5
1980	24,945	72	24,707	166	0.7	11,826,573	46,144	11,720,694	59,735	0.5
1981	25,005	73	24,766	166	0.7	11,924,653	46,355	11,819,002	59,296	0.5
1982	25,043	73	24,802	168	0.7	11,901,520	46,689	11,795,275	59,556	0.5
1983	25,045	73	24,804	168	0.7	11,739,452	47,149	11,632,497	59,806	0.5
1984	25,064	73	24,822	169	0.7	11,464,221	47,300	11,357,064	59,857	0.5
1985	25,040	73	24,799	168	0.7	11,095,372	47,400	10,988,104	59,868	0.5
1986	24,982	73	24,739	170	0.7	10,665,404	47,513	10,557,749	60,142	0.6
1987	24,933	73	24,692	168	0.7	10,226,323	47,541	10,118,229	60,553	0.6
1988	24,901	73	24,658	170	0.7	9,872,520	47,527	9,763,547	61,446	0.6
1989	24,851	73	24,608	170	0.7	9,606,627	47,400	9,496,553	62,674	0.7
1990	24,827	73	24,586	168	0.7	9,373,295	47,304	9,262,201	63,790	0.7

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1991	24,798	73	24,557	168	0.7	9,157,429	47,234	9,045,154	65,041	0.7
1992	24,730	73	24,487	170	0.7	8,947,226	47,231	8,834,049	65,946	0.7
1993	24,676	73	24,432	171	0.7	8,768,881	47,226	8,654,680	66,975	0.8
1994	24,635	73	24,390	172	0.7	8,582,871	47,248	8,468,014	67,609	0.8
1995	24,548	73	24,302	173	0.7	8,370,246	47,318	8,254,741	68,187	0.8
1996	24,482	73	24,235	174	0.7	8,105,629	47,248	7,990,020	68,361	0.8
1997	24,376	73	24,132	171	0.7	7,855,387	47,294	7,739,957	68,136	0.9
1998	24,295	73	24,051	171	0.7	7,663,533	47,334	7,548,163	68,036	0.9
1999	24,188	73	23,944	171	0.7	7,500,317	47,351	7,385,068	67,898	0.9
2000	24,106	73	23,861	172	0.7	7,366,079	47,288	7,251,265	67,526	0.9
2001	23,964	73	23,719	172	0.7	7,296,920	47,260	7,182,433	67,227	0.9
2002	23,808	73	23,560	175	0.7	7,239,327	47,238	7,124,712	67,377	0.9
2003	23,633	73	23,381	179	0.8	7,226,910	47,152	7,111,695	68,063	0.9
2004	23,420	73	23,160	187	0.8	7,200,933	46,958	7,084,675	69,300	1.0
2005	23,123	73	22,856	194	0.8	7,197,458	46,720	7,079,788	70,950	1.0
2006	22,878	73	22,607	198	0.9	7,187,417	46,484	7,067,863	73,070	1.0
2007	22,693	73	22,420	200	0.9	7,132,874	46,202	7,011,876	74,796	1.0
2008	22,476	73	22,197	206	0.9	7,121,781	45,871	6,999,006	76,904	1.1
2009	22,258	74	21,974	210	0.9	7,063,606	45,507	6,939,922	78,177	1.1
2010	22,000	74	21,713	213	1.0	6,993,376	45,016	6,869,318	79,042	1.1
2011	21,721	74	21,431	216	1.0	6,887,292	44,580	6,763,713	78,999	1.1
2012	21,460	74	21,166	220	1.0	6,764,619	43,257	6,642,721	78,641	1.2
2013	21,132	74	20,837	221	1.0	6,676,948	42,111	6,556,537	78,300	1.2

Source: e-Stat Japanese government statistics portal
http://www.e-stat.go.jp/SG1/estat/GL02020101.do?method=extendTclass&refTarget=toukeihyo&listFormat=hierarchy&statCode=00400001&tstatCode=000001011528&tclass1=000001021812&tclass2=&tclass3=&tclass4=&tclass5=

Middle Schools										
Number of Schools						Number of Students				
	Total	National government run	Local government run	Private	share of private schools(%)	Total	National government run	Local government run	Private	share of students in private schools(%)
1948	16,285	98	15,326	861	5.3	4,792,504	24,568	4,429,423	338,513	7.1
1949	14,200	95	13,317	788	5.5	5,186,188	30,371	4,864,066	291,751	5.6
1950	14,165	92	13,302	771	5.4	5,332,515	31,435	5,031,862	269,218	5.0
1951	13,836	86	13,004	746	5.4	5,129,482	31,933	4,870,055	227,494	4.4
1952	13,748	84	12,952	712	5.2	5,076,495	31,948	4,853,144	191,403	3.8
1953	13,685	82	12,920	683	5.0	5,187,378	32,813	4,978,878	175,687	3.4
1954	13,773	81	13,008	684	5.0	5,664,066	33,475	5,449,008	181,583	3.2
1955	13,767	81	13,022	664	4.8	5,883,692	34,062	5,667,651	181,979	3.1
1956	13,724	81	13,001	642	4.7	5,962,449	34,400	5,745,727	182,322	3.1
1957	13,622	81	12,913	628	4.6	5,718,182	34,510	5,504,428	179,244	3.1
1958	13,392	80	12,694	618	4.6	5,209,951	34,573	5,004,476	170,902	3.3
1959	13,135	80	12,460	595	4.5	5,180,319	34,598	4,969,327	176,394	3.4
1960	12,986	79	12,304	603	4.6	5,899,973	34,819	5,657,251	207,903	3.5
1961	12,849	79	12,159	611	4.8	6,924,693	35,674	6,642,691	246,328	3.6
1962	12,647	79	11,951	617	4.9	7,328,344	36,032	7,031,096	261,216	3.6
1963	12,502	78	11,804	620	5.0	6,963,975	36,075	6,690,651	237,249	3.4
1964	12,310	78	11,611	621	5.0	6,475,693	35,914	6,232,155	207,624	3.2
1965	12,079	76	11,384	619	5.1	5,956,630	36,018	5,739,621	180,991	3.0
1966	11,851	75	11,159	617	5.2	5,555,762	36,595	5,356,434	162,733	2.9
1967	11,684	75	11,004	605	5.2	5,270,854	37,392	5,082,108	151,354	2.9
1968	11,463	75	10,787	601	5.2	5,043,069	37,981	4,860,214	144,874	2.9
1969	11,278	76	10,610	592	5.2	4,865,196	38,253	4,685,073	141,870	2.9
1970	11,040	76	10,380	584	5.3	4,716,833	38,097	4,536,538	142,198	3.0
1971	10,839	76	10,195	568	5.2	4,694,250	37,900	4,511,771	144,579	3.1
1972	10,686	76	10,042	568	5.3	4,688,444	37,517	4,503,756	147,171	3.1
1973	10,836	76	10,195	565	5.2	4,779,593	37,253	4,592,736	149,604	3.1
1974	10,802	76	10,165	561	5.2	4,735,705	36,909	4,548,102	150,694	3.2
1975	10,751	76	10,120	555	5.2	4,762,442	36,685	4,573,225	152,532	3.2
1976	10,719	76	10,092	551	5.1	4,833,902	36,501	4,643,594	153,807	3.2
1977	10,723	76	10,100	547	5.1	4,977,119	36,445	4,785,410	155,264	3.1
1978	10,778	76	10,151	551	5.1	5,048,296	36,328	4,857,562	154,406	3.1
1979	10,746	76	10,118	552	5.1	4,966,972	36,159	4,779,920	150,893	3.0
1980	10,780	76	10,156	548	5.1	5,094,402	35,997	4,908,665	149,740	2.9
1981	10,810	77	10,183	550	5.1	5,299,282	35,975	5,111,854	151,453	2.9
1982	10,879	77	10,252	550	5.1	5,623,975	36,137	5,429,701	158,137	2.8
1983	10,950	77	10,314	559	5.1	5,706,810	36,261	5,506,783	163,766	2.9
1984	11,047	78	10,402	567	5.1	5,828,867	36,408	5,622,895	169,564	2.9
1985	11,131	78	10,472	581	5.2	5,990,183	36,674	5,777,753	175,756	2.9
1986	11,190	78	10,517	595	5.3	6,105,749	36,917	5,885,843	182,989	3.0
1987	11,230	78	10,555	597	5.3	6,081,330	37,067	5,855,407	188,856	3.1
1988	11,266	78	10,585	603	5.4	5,896,080	37,008	5,665,968	193,104	3.3
1989	11,264	78	10,578	608	5.4	5,619,297	36,502	5,386,134	196,661	3.5
1990	11,275	78	10,588	609	5.4	5,369,162	35,851	5,130,708	202,603	3.8

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1991	11,290	78	10,595	617	5.5	5,188,314	35,170	4,942,223	210,921	4.1
1992	11,300	78	10,596	626	5.5	5,036,840	34,811	4,782,499	219,530	4.4
1993	11,292	78	10,578	636	5.6	4,850,137	34,678	4,588,523	226,936	4.7
1994	11,289	78	10,568	643	5.7	4,681,166	34,575	4,415,185	231,406	4.9
1995	11,274	78	10,551	645	5.7	4,570,390	34,500	4,300,507	235,383	5.2
1996	11,269	78	10,537	654	5.8	4,527,400	34,423	4,255,168	237,809	5.3
1997	11,257	78	10,518	661	5.9	4,481,480	34,382	4,207,655	239,443	5.3
1998	11,236	78	10,497	661	5.9	4,380,604	34,415	4,107,590	238,599	5.4
1999	11,220	78	10,473	669	6.0	4,243,762	34,479	3,972,115	237,168	5.6
2000	11,209	76	10,453	680	6.1	4,103,717	33,732	3,835,338	234,647	5.7
2001	11,191	76	10,429	686	6.1	3,991,911	33,647	3,724,711	233,553	5.9
2002	11,159	76	10,392	691	6.2	3,862,849	33,544	3,597,997	231,308	6.0
2003	11,134	76	10,358	700	6.3	3,748,319	33,504	3,482,087	232,728	6.2
2004	11,102	76	10,317	709	6.4	3,663,513	33,453	3,394,055	236,005	6.4
2005	11,035	76	10,238	721	6.5	3,626,415	33,402	3,350,507	242,506	6.7
2006	10,992	76	10,190	726	6.6	3,601,527	33,407	3,320,772	247,348	6.9
2007	10,955	76	10,150	729	6.7	3,614,552	33,228	3,327,531	253,793	7.0
2008	10,915	76	10,104	735	6.7	3,592,378	33,069	3,302,207	257,102	7.2
2009	10,864	75	10,044	745	6.9	3,600,323	32,460	3,308,105	259,758	7.2
2010	10,815	75	9,982	758	7.0	3,558,166	32,077	3,270,582	255,507	7.2
2011	10,751	73	9,915	763	7.1	3,573,821	31,681	3,287,437	254,703	7.1
2012	10,699	73	9,860	766	7.2	3,552,663	31,580	3,269,759	251,324	7.1
2013	10,628	73	9,784	771	7.3	3,536,201	31,456	3,255,326	249,419	7.1

Source: e-Stat Japanese government statistics portal
http://www.e-stat.go.jp/SG1/estat/GL02020101.do?method=extendTclass&refTarget=toukeihyo&listFormat=hierarchy&statCode=00400001&tstatCode=000001011528&tclass1=000001021812&tclass2=&tclass3=&tclass4=&tclass5=

Appendix 4. Share of Japanese government spending on elementary and middle schools in the education budget by year

1960	1965	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
79.6	74.8	75	75.2	74.8	72.5	71.6	71.6	71.5	70.7	70.4	70.3	69.9	69.7
1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	
69.7	69.8	69.6	69.8	69.8	70	70.1	70.3	70.3	70.3	70.7	71.2	71.3	

Source: e-Stat Japanese government statistics portal
http://www.e-stat.go.jp/SG1/estat/GL08020101.do?_toGL08020101_&tstatCode=000001011528&requestSender=dsearch

Appendix 5. Elementary and Middle Schools in Taiwan, Province of China (2013) by Sector

		Elementary Schools	Middle Schools
Number of Schools	Government-run	2,613	721
	Private	37	17
Number of Classes	Government-run	53,634	25,421
	Private	1,007	2,224
Number of Students	Government-run	1,264,084	738,351
	Private	33,036	93,579

Source: Ministry of Education https://stats.moe.gov.tw/files/main_statistics/b.xls.

Appendix 6. Schools and students during Korea's colonial period*

Type of education	School type	Schools/ Students	Year 1915	1920	1930	1940
Primary education	Traditional form of private village school for elementary education	Schools	23,441	25,482	15,036	4,105
		Students	229,556	292,625	150,892	158,320
	Modern primary school[a]	Schools	1,519 (429)	1,342 (681)	2,240 (1,727)	4,700 (4,483)
		Students	112,384 (60,660)	158,293 (107,285)	514,110 (459,457)	1,543,507 (1,385,187)
Vocational education[b]	Vocational middle school	Schools	70	46	83	139
		Students	1,540	788	3,520	8,261
	Vocational high school	Schools	20	31	52	90
		Students	1,422	1,951	8,757	22,855
Secondary education	Public secondary school Type I[c]	Schools	2	5	15	121[d]
		Students	882	1,346	6,198	32,753[d]
	Private secondary school Type I[c]	Schools	2	9	9	–
		Students	278	1,672	4,776	–
	Public secondary school Type II[c]	Schools	–	5	11	–
		Students	–	2,045	5,792	–
	Private secondary school Type II[c]	Schools	–	0	0	–
		Students	–	0	0	–
	Public female secondary school Type I[c]	Schools	2	2	6	–
		Students	250	268	1,556	–
	Private female secondary school Type I[c]	Schools	2	5	10	–
		Students	128	441	2,866	–
	Public female secondary school Type II[c]	Schools	–	12	24	51
		Students	–	2,276	7,546	12,443
	Private female secondary school Type II[c]	Schools	–	–	1	13
		Students	–	–	162	5,035
Higher education	Public professional college	Schools	0	4	5	–
		Students	0	613 (265)[f]	1,192 (835)[f]	5,225[e] (–)[f]
	Private professional college	Schools	1	3	8	–
		Students	14 (14)[f]	201 (137)[f]	1,410 (332)[f]	–
	Public teachers college	Schools	–	1	3	10
		Graduates	–	29 (29)[f]	437 (181)[f]	2,643 (–)[f]
	Public Kyungseong Imperial University	Japanese students	–	124 (in 1924)	599	720
		Korean students	–	44 (in 1924)	276	455

Notes:
* In 1910, the total population of Korea was estimated at 13,128,780 and the number of school-aged children was about 2.6 million.
[a] Figures include those of various forms of private and public schools for primary education excluding traditional village schools. Figures in ( ) are the numbers of public schools. [b] Figures of vocational schools include those of both public and private schools in agriculture, fishery, commerce and engineering. In 1943, the numbers of students in these schools were: 14,150 (agriculture); 968 (fishery); 10,545 (commerce); and 2,802 (engineering). [c] "Type I" is for Korean students and "Type II" is for Japanese students.
[d] Both public and private female and male secondary Type I schools. [e] Statistics for public and private schools. [f] Figures in ( ) are the number of Japanese students. – Indicates data non-existent.
Sources: Japanese Colonial Governor-General Office (various dates) based on Hirotani and Hirokawa (1973) and Lee et al. (1997).

Appendix 7. Number of Schools, Classes and Students in ROK by Sector (2013)

		Number of Schools	Share (%)	Number of Classes	Share (%)	Number of Students	Share (%)
Primarty Schools	Central government run	17	0.3	387	0.3	9,798	0.4
	Local government run	5,820	98.4	118,082	98.5	2,733,287	98.2
	Private	76	1.3	1,427	1.2	40,915	1.5
	Total	5,913	100.0	119,896	100.0	2,784,000	100.0
Junior High Schools	Central government run	9	0.3	186	0.3	5,764	0.3
	Local government run	2,520	79.4	46,688	82.1	1,479,595	82.0
	Private	644	20.3	9,969	17.5	318,830	17.7
	total	3,173	100.0	56,843	100.0	1,804,189	100.0
Senior High School	Central government run	19	0.8	515	0.9	14,737	0.8
	Local government run	1,355	58.4	33,622	56.6	1,053,424	55.6
	Private	948	40.8	25,268	42.5	825,542	43.6
	Total	2,322	100.0	59,405	100.0	1,893,703	100.0

Source: Korean Educational Development Institute 2013.

Appendix 8. Major government safety net programmes (cash and in kind) in Japan

Eligible persons	Cash benefits	In-kind benefits
Sick Elderly	Assistance for households who take care of their own elderly (limited), called Long-term Care Insurance System	Health care services, Home-based services, Institutional services
People with disability	Disability pensions	Institutional services
Children	Child-rearing allowance for single-parent households, Child Allowance	Institutions for special children
Poor	Public assistance (livelihood, education, housing, long-term care, etc.)	Health care services
Unemployed	Unemployment benefits	Personal Support Model Project (pilot project)

Source: Inaba 2011.

Appendix 9. International Comparison of Social Expenditure (as a percentage of GDP) in Fiscal Year 2009

	Elderly	Survivors	Incapacity related benefits	Health	Family	Active labour market programme	Unemployment	Housing	Other Policy Areas	Total
Japan	10.99	1.45	1.15	7.19	0.96	0.43	0.39	0.16	0.25	22.97
USA	6.08	0.77	1.7	8.47	0.7	0.15	0.88		0.74	19.49
UK	7.34	0.1	3.03	8.08	3.83	0.33	0.65	1.45	0.22	25.03
Germany	9.12	2.16	3.46	8.65	2.11	1.01	1.68	0.65	0.18	29.02
France	12.33	1.94	2.12	8.97	3.2	0.99	1.53	0.85	0.44	32.37
Sweden	10.24	0.55	5.42	7.33	3.76	1.13	0.73	0.48	0.71	30.35

Source: National Institute of Population and Social Security Research of Japan 2013, p.10

Appendix 10. Actual coverage of major social insurances in ROK, 1985–2010

Year	Total Employees (thousands)	Non-agriculture Employees		Actual coverage			
		Total numbers (thousands)	Share in total employees (%)	Public Pensions[a]	Health Insurance Programme[b]	Worker Injury Insurance[c]	Employment Insurance Programme[d]
1985	14,970	11,165	74.6	5.5	44.1 (51.1)	40.3	–
1990	18,085	14,629	80.9	31.2	–	51.6	–
1995	20,414	17,729	86.8	41.1	–	44.5	23.7
1996	20,853	18,237	87.5	42.2	–	44.7	23.7
1997	21,214	18,644	87.9	40.3	–	44.2	23.0
1998	19,938	17,330	88.9	38.8	–	42.8	29.7
1999	20,291	17,765	87.6	58.5 (85.7)	–	41.9	34.1
2000	21,156	18,650	88.2	60.8 (81.9)	–	50.9	35.2
2001	21,572	19,125	88.7	59.9 (80.70	–	55.3	36.1
2002	22,169	19,771	89.2	60.4 (79.6)	–	52.9	36.2
2003	22,139	20,189	91.2	62.2 (82.9)	–	51.8	35.6
2004	22,557	20,732	91.9	60.0 (80.8)	–	50.0	36.4
2005	22,856	21,041	92.1	60.0 (80.3)	–	56.8	38.2
2006	23,151	21,366	92.3	60.7 (82.0)	–	54.2	39.8
2007	23,433	21,707	92.6	61.6 (83.4)	–	58.4	42.2
2008	23,577	21,629	91.7	61.9 (83.2)	–	62.3	43.6
2009	23,506	21,541	91.6	63.3 (84.8)	–	64.4	45.3
2010	23,829	21,904	91.9	64.8 (86.2)	–	64.8	46.2

Notes:

[a] The figures include those contributing premiums to national pensions, civil servant pensions and school teachers' pensions. The figures in the brackets include the people who should pay contributions based on the legal criteria, but are offically exempt by the government due to their low income, in addition to the actual receipients of the pension (the number in the left column).

[b] Health insurance began to cover the entire population from 1989, but it is difficult to estimate the number of non-recipients due to non-payment of contributions. It is roughly estimated that the actual receiving rate of health insurance is more than 90 percent. In 1985, the 51.1 percent included those protected by the medical assistance programme.

[c] The actual coverage of all employees in the non-agricultural sector is calculated from (the number of employees covered by the Worker Injury Insurance Programme / all the employees in the non-agricultural sector) x 100.

[d] The actual coverage of all employees in the non-agricultural sector is calculated from (the number of workers covered by the Employment Insurance Programme / all the employees in the non-agricultural sector) x 100.

[c, d] The actual coverage rate of the Worker Injury Insurance Programme and the Employment Insurance Programme includes the special category of workers who should be covered, but are legally excluded due to their particular job characteristics (e.g. heavy truck drivers, golf club caddies and teachers for homework studies).

- Indicates not applicable.

Sources: For 1985–2007: Wook 2010, p. 72; for 2008–10: Ministry of Health and Welfare 2012. From Chung 2014.

Appendix 11. The three pillar pension system in Taiwan, Province of China

Occupational groups		First pillar	Second pillar	Third pillar
Private sector	Farmers	Farmer allowance		
	Others (housewives, unemployed, etc.)	National pension insurance		
	Self-employed			
	Employed workers	Labour insurance	Labour Pension Act (individual accounts)	Private savings and commercial insurance
	State enterprise workers			
Public sector	Civil servants	Social insurance for civil servants, teachers		
	Military personnel	Social insurance for military personnel		

Source: Author's modification based on Shi and Mok 2012.

Appendix 12. Time series of Unemployment Rate by Age Group in Taiwan, Province of China (Unit: Per cent, Annual Average)

Year & month	Total	15~19 years	20~24 years	25~29 years	30~34 years	35~39 years	40~44 years	45~49 years	50~54 years	55~59 years	60~64 years	65 years & over
1978 Ave.	1.67	3.95	3.77	1.54	0.64	0.38	0.43	0.43	0.82	0.76	0.43	0.17
1979 Ave.	1.27	3.12	3.36	1.02	0.42	0.23	0.24	0.32	0.48	0.47	0.41	0.00
1980 Ave.	1.23	3.21	3.13	1.09	0.44	0.31	0.19	0.29	0.43	0.44	0.29	0.00
1981 Ave.	1.36	3.75	3.50	1.12	0.50	0.40	0.35	0.34	0.44	0.38	0.17	0.04
1982 Ave.	2.14	5.18	5.45	2.02	0.98	0.88	0.64	0.56	0.88	0.71	0.59	0.00
1983 Ave.	2.71	6.60	6.49	2.65	1.44	1.18	0.90	0.99	1.26	1.22	0.57	0.00
1983 Jan.	2.73	5.80	6.98	2.25	1.25	1.26	1.09	1.35	1.12	1.76	0.93	0.00
1984 Ave.	2.45	5.85	6.24	2.65	1.30	1.00	0.71	0.72	0.98	1.02	0.69	0.12
1985 Ave.	2.91	7.53	7.12	3.05	1.76	1.21	1.13	0.91	1.25	1.20	0.79	0.20
1986 Ave.	2.66	6.76	6.79	2.95	1.50	1.22	1.05	1.01	0.95	0.82	0.89	0.24
1987 Ave.	1.97	5.57	5.39	2.13	1.04	0.84	0.62	0.65	0.66	0.62	0.44	0.12
1988 Ave.	1.69	5.02	4.78	1.95	0.94	0.70	0.56	0.57	0.43	0.40	0.55	0.12
1989 Ave.	1.57	5.03	4.39	1.88	0.89	0.68	0.50	0.55	0.47	0.42	0.25	0.22
1990 Ave.	1.67	5.68	4.79	1.92	0.99	0.84	0.64	0.64	0.52	0.36	0.22	0.03
1991 Ave.	1.51	4.93	4.41	1.91	0.91	0.76	0.62	0.49	0.55	0.41	0.23	0.11
1992 Ave.	1.51	4.98	4.70	2.00	1.00	0.64	0.53	0.52	0.48	0.35	0.31	0.08
1993 Ave.	1.45	4.78	4.60	1.94	0.96	0.68	0.53	0.48	0.45	0.40	0.25	0.10
1994 Ave.	1.56	4.96	4.67	2.19	1.19	0.74	0.65	0.60	0.45	0.43	0.29	0.13
1995 Ave.	1.79	5.59	5.16	2.55	1.36	1.00	0.82	0.78	0.70	0.42	0.31	0.12
1996 Ave.	2.60	7.47	6.72	3.65	2.08	1.65	1.49	1.37	1.20	1.05	0.65	0.15
1997 Ave.	2.72	7.35	6.76	3.68	2.15	1.84	1.63	1.61	1.76	1.31	0.80	0.28
1998 Ave.	2.69	8.26	7.01	3.61	2.06	1.76	1.60	1.64	1.60	1.20	0.68	0.19
1999 Ave.	2.92	9.03	6.83	3.82	2.42	2.08	1.87	1.89	1.79	1.35	0.87	0.29
2000 Ave.	2.99	9.04	6.89	3.77	2.59	2.24	1.98	1.93	1.85	1.61	0.92	0.24

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2001 Ave.	4.57	13.64	9.65	5.46	4.19	3.72	3.36	3.34	3.08	2.41	1.33	0.06
2002 Ave.	5.17	14.59	11.31	6.46	4.64	3.87	4.00	3.84	3.60	2.78	1.45	0.13
2003 Ave.	4.99	13.84	10.95	6.26	4.16	3.61	3.85	3.97	3.77	3.77	2.69	0.14
2004 Ave.	4.44	13.00	10.44	5.69	3.86	3.12	3.18	3.22	3.56	3.01	2.19	0.07
2005 Ave.	4.13	11.97	10.33	5.75	3.63	2.84	2.81	2.89	2.91	2.63	2.08	0.43
2006 Ave.	3.91	11.46	10.10	5.92	3.80	2.86	2.40	2.31	2.50	2.25	1.60	0.28
2007 Ave.	3.91	11.13	10.56	5.87	3.87	2.76	2.81	2.47	2.33	1.95	1.29	0.16
2008 Ave.	4.14	11.42	11.89	6.38	3.89	2.97	2.63	2.76	2.65	2.33	1.38	0.17
2009 Ave.	5.85	13.55	14.67	8.77	5.82	4.64	4.23	4.27	4.14	3.54	2.00	0.13
2010 Ave.	5.21	10.93	13.51	8.15	5.19	4.10	3.77	3.89	3.50	3.06	1.50	0.19
2011 Ave.	4.39	11.22	12.71	7.11	4.32	3.32	3.02	2.99	2.66	2.44	1.57	0.15
2012 Ave.	4.24	9.80	13.17	7.08	4.34	3.37	2.76	2.55	2.35	2.14	1.69	0.17
2013 Nov.	4.16	10.40	14.08	7.21	4.24	3.22	2.44	2.57	2.19	2.02	1.07	0.03

Source: "Time Series", National Statistics Republic of China (Taiwan). (Accessed December 30, 2013). http://eng.stat.gov.tw/ct.asp?xItem=15761&ctNode=1609&mp=5

Appendix 13. Comparison of Each Insurer in Japan

Comparison of Each Insurer

	Municipality controlled National Health Insurance	National Health Insurance society	Public-corporation-run health insurance	Society-managed, employment-based health insurance	Mutual Aid Association	Medical system for the elderly aged 75 and over
Number of insurers (End of March 2011)	1,723	165	1	1,458	85	47
Number of members (End of March 2011)	35.49 mil. (20.37 mil. Households)	3.27mil.	34.85 mil. (The insured 19.58 mil. Dependents 15.27 mil.)	29.61 mil. (The insured 15.57 mil. Dependents 14.03 mil.)	9.20 mil. (The insured 4.53 mil. Dependents 4.67 mil.)	14.34 mil.
Average age of members (FY2010)	49.7	39.0	36.3	34.0	33.4	81.9
Average income (total compensation) (FY2010) (* 1)	¥910,000 ¥1,580,000 per household (FY2009)	¥3,470,000 ¥7,430,000 per household (*2) (FY2008)	¥1,370,000 ¥2,420,000 per household (*3)	¥1,960,000 ¥3,720,000 per household (*3)	¥2,290,000 ¥4,670,000 per household (*3)	¥800,000 (FY2010)
Amount used to work out the premiums per member (FY2010)	¥740,000 (*4) ¥1,290,000 per household (FY2009)	- (*5)	¥2,090,000 (*6) ¥3,700,000 per household (*3)	¥2,810,000 (*6) ¥5,330,000 per household (*3)	¥3,190,000 (*6) ¥6,510,000 per household (*3)	¥670,000 (*4) (FY2010)
Healthcare expenses per member (FY2010) (*7)	¥299,000	¥176,000	¥156,000	¥138,000	¥140,000	¥905,000
Average premium per member (FY2010) (*8) <amount including employers' contribution>	¥81,000 ¥142,000 per household	¥126,000	97,000 yen <193,000 yen> 172,000 yen <344,000 yen> per insured person Health insurance premium rate: 10.0% (FY2012)	93,000 yen <207,000 yen> 177,000 yen <394,000 yen> per insured person Health insurance premium rate: 7.67% (FY2010 audit estimate)	112,000 yen <224,000 yen> 227,000 yen <455,000 yen> per insured person Health insurance premium rate: 8.03% (FY2010 audit estimate)	¥63,000
Government subsidies (Fixed rate portion only)	50% of benefits, etc.	42% of benefits, etc. (*9)	16.4% of benefits (*10)	Fixed amount contribution to those associations that are in financial hardship	Nil	Approx. 50% of benefits
Amount of government subsidies (*11) (Average based on FY2012 budget)	3,445.9 billion yen	284.2 billion yen	1,182.2 billion yen	1.6 billion yen		6,177.4 billion yen

(*1) Means "total income, etc." (an amount worked out by subtracting work-related expenses, salary earners deduction, and public pension deduction and so on from the total earning).
Under the municipality-managed national health insurance scheme and medical care system for the latter-stage elderly people, this is "total income and forestry income" plus "brought-forward deduction in relation to miscellaneous income" and "amount of separate transfer income". The figure is worked out based on, in case of municipality-managed national health insurance scheme, "National Health Insurance Survey" and "Survey of Insured Persons under the Medical Care System for the Latter-stage Elderly People" in case of medical care system for the latter-stage elderly people.
The figures for national health insurance association are the data for your reference worked out by adding up the standard taxable income for municipal locality tax (total income after such deductions as basic deduction and income deduction including dependent family deduction and spouse deduction etc), basic deduction, and "income deduction other than basic deduction (such as dependent family deduction, spouse deduction etc)" (an estimated amount calculated using the figure obtained by dividing the amount of income deduction for each bracket (excluding basic deduction) applicable to "standard taxable income for those who have salary income and businesses income etc" worked out from "FY2009 survey of the current taxation status etc with respect to municipal locality tax" conducted by Ministry of Internal Affairs and Communications by number of tax payers).
As for Kyokai Kenpo, association-managed health insurance, and mutual aid association, the figure is a reference value worked out by subtracting an amount equivalent to salary income deduction from "an amount to be used to work out the insurance premium per subscriber" (the amount obtained by dividing the total amount of standard remuneration with the number of subscribers).
(*2) The amount per household is worked out by multiplying the amount per subscriber with average number of person per household.
(*3) Means an amount per insured person.
(*4) This is the standard taxable amount (a base to calculate the insurance premiums) worked out by old provisory method. Being a method used to calculate the bases on which the insurance premiums of the medical care system for the latter-stage elderly people and most municipality-managed national health insurance schemes are worked out, the old provisory method calculates the amount by subtracting basic deduction etc from the amount of total income (the amount worked out by subtracting work-related expenses, salary earners deduction, and public pension deduction etc from the total amount of earning).
(*5) Not included because, with regard to national health insurance association scheme, the calculation method to work out the income and insurance premiums is widely different from one insurer to another. According to the data from 2009 income study, the standard trade-by-trade taxable incomes for municipal locality tax are 6.41 million yen for medical practitioners national health insurance association, 2.21 million yen for dentists national health insurance association, 2.18 million yen for pharmacists national health insurance association, 1.25 million yen for general trades national health insurance association, and 0.70 million yen for building industry related national health insurance association. The average amount of the whole sector, calculated based on the number of insured persons for each association, is worked out to be 2.15 million yen (no income study was conducted in 2010).
(*6) This is the amount obtained by dividing the whole amount of standard remuneration with the number of subscribers.
(*7) Figures for healthcare expenditure per subscriber for Kyokai Kenpo and association-managed health insurance scheme are preliminary ones. In addition, figures for mutual aid association are healthcare expenditure assessed by the assessment/payment agent.
(*8) The insurance premiums per subscriber for municipality-managed national health insurance scheme/the medical care system for the latter-stage elderly people were estimated based on the insurance premiums arranged/set out for the year; and, premiums of employee insurance were estimated based on the insurance premiums cited in the final accounts of expenditures and revenues. The amount of insurance premiums does not include the portion for aged care.
(*9) Average based on FY2012 budget
(*10) The rate of government subsidies for Kyokai Kenpo to June 2010 in the FY2010 budget was 13.0% excluding the contribution to the latter-stage elderly people medical care system.
(*11) State subsidies and grants for the long-term care insurance levy, specified health examination/specified healthcare guidance, etc., are not included

Source: "About Health System in Japan". Ministry of Health, Labour and Welfare. (Accessed December 30, 2013).
http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html

Appendix 14. Effect of the new (uniform) contribution schedule on contributions to industrial workers' health insurance in ROK (simulation results), 2000

Standardised monthly income: contribution base (10,000 won)	Rate of change in contributions (%)	Average change in monthly contributions (won)
0-52	–41.0	–7,934
52-75	–24.2	–5,588
75-100	–17.6	–5,082
100-126	–11.5	–3,999
126-154	–6.1	–2,492
154-199	3.0	1,371
199-249	9.6	5,311
249-303	15.9	10,232
303-	33.9	29,455

Source: (NHIC 2000) from (Kwon 2003)

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