

**The Change of Boundary between Public and Private Sector in Health
Care: Comparing Asian and Western Countries**

Panel session: *Comparing East Asian Welfare Regimes to Western Counterparts*

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Abstract

This paper is to examine the change of boundary between public and private sector in health care system in Asian and Western countries in last decades. The relationship between public and private sector regarding delivery and financing system has been controversial issue in welfare studies. Among health, pension, unemployment, and work injury programs, health program is most closely related to private sector – market, family, or company. With the enlargement of expenditure on health care, globalization, aging population, and reforms of health care system, the boundary between public and private sector in health care is encountered with the pressures to change. I examine the influence of institutional legacy (welfare regime and the role of state) on the change of the boundary between public and private sector in health care and whether the system of Korea and Japan has different effect on the boundary change.

Introduction

After “Golden Age” of welfare state in the 1950s and the 1960s, welfare state has encountered internal and external challenges since the late 1970s. The change of welfare state began from the United States and the United Kingdom with the conservative market reform in the 1980s. Retrenchment or restructuring of welfare state has become the main agenda regarding social policy. However, it is difficult to interpret this phenomenon as paradigm shift, transferring to new type, or race to the bottom because the variance of response of each country is big and the direction of change is not unique. In the United States and the United Kingdom, regulations were loosened and market-oriented policies were adopted. With the conservative reform in the United States and the United Kingdom, even social democratic countries adopted policies for slow down of the growth rate of social expenditure, increase in qualification requirements, budget retrenchment, overall or partial modification of welfare programs, and market-dependent policy introducing.

In the advanced industrial countries, the welfare state is faced with an important transition time: privatization of existing social and health services and transferring responsibilities of such services to lower units of government. These structural changes in welfare state have potential to change the political support for the welfare state, effectiveness, and efficiency of welfare state services. If public sector spending growth represented a more extensive welfare state, then the privatization represents a retreat. They have been considered as incompatible with each other. However, in the contemporary era, the opposite side of public is spotlighted and public/private mix systems are witnessed.

Due to financial strain or loss of political support, some welfare states were declared to be in a crisis and pressured to reform. Reformers in different countries are choosing reform options from quite different ‘menu’ (Myles and Pierson 2001). In Golden Age, the pattern of

welfare state changing was convergence, however, since the 1980s, it seems divergence. Governments have relied on an increasing diverse array of policy tools to address public problems in the last decades. Accompanying this diversification is a decided shift away from direct government to reliance on private organizations and mixed public/private delivery systems. The new policy tools include contracting for services, tax credits, government loans, the issuance of government bonds on behalf of private entities, and vouchers. Service delivery shift is demanded also by other factors. Changes in the labor market, including the rise of in workforce participation by women, have spurred wide spread demand for more childcare and support services.

Among health, pension, unemployment, and work injury programs, health program is most closely related to private sector – market, family, or company. With the enlargement of expenditure on health care, globalization, aging population, and reforms of health care system, the boundary between public and private sector in health care is encountered with the pressures to change. Health policy entails government's pursuit of three goals through both public and private means: the provision of citizens with access to health care; the assurance of the quality of health care; and the control of the costs of health care. National health policies are the result of centuries of political conflicts over the proper role of government in health (Immergut 2001). The relationship between public and private sector regarding financing system has been controversial issue in welfare studies, and also the relationship between state and market has been a central issue of health policy.

Then, since the 1980s, does globalization have effects on the welfare program? Does it make government shrink its role in welfare efforts? Do different welfare regimes respond to globalization differently? In this paper, I examine the effect of globalization on health care sector which is one of the targets to reform as well as pension since the 1980s in 19 Asian and Western countries. I also examine the influence of institutional legacy on the boundary

between public and private sector in health care system. Since the late 1990s, there have been debates about the possibility of new welfare regime in East Asia (Goodman, White and Kwon 1998; Holliday 2000; Jones 1993; Kwon 2005). Considering these debates, I examine whether Korea and Japan have different way from Western countries.

Globalization and Welfare

Scholars have investigated the growth of welfare state after the World War II and the retrenchment in the globalization era. Their interests are the growth of state responsibility in welfare provision and the public spending on welfare as indicators of welfare efforts (Esping-Andersen 1990; Stephens 1979). Previous studies on the relationship between globalization and welfare state have concentrated on the general welfare efforts (Béland 2005; Brady, Beckfield and Seeleib-Kaiser 2005; Garrett and Mitchell 2001; Huber and Stephens 2001; Pierson 1994; Pierson 2001; Rodrik 1997; Swank 2002). After Pierson's (1994) publications, the debates about the politics of retrenchment intensified (Starke 2006).

The effects of globalization may be positive causing expansion, negative triggering crisis and reduction, curvilinear contributing to convergence, or insignificant. There have been a lot of debates on the relationship between globalization and the welfare state, in other words, the relationship between economic openness and welfare policies. Brady, Beckfield, and Seeleib-Kaiser (2005) suggest several conclusions – Most indicators of economic globalization do not have significant effects, but a few affect the welfare state and improve models of welfare state variation. The few significant globalization effects are in differing directions and often inconsistent with extant theories. The globalization effects are far smaller than the effects of domestic political and economic factors. The effects of globalization are not systematically

different between European and non-European countries, or liberal and non-liberal welfare regimes. Increased globalization and a modest convergence of the welfare state have occurred, but globalization does not clearly cause welfare state expansion, crisis, and reduction or convergence. Ultimately, they suggest skepticism toward claims about globalization's effect on the welfare state.

Welfare Regime and Institutional Legacy

Recent works in both comparative political economy and social policy has focused on how configurations of policies, formal institutions, and organizational structures generate distinctive welfare state regimes or varieties of capitalism that operate in fundamentally different manners. Outcomes are generated not by some universal operating principles characteristic of a given type of actor or realm of activity but by intersections of organized practices (Esping-Andersen 1990; Hall and Soskice 2001; Huber and Stephens 2001; Pierson and Skocpol 2002). Welfare regime type does reflect not only characteristics but also the relationship among state, market, and civil society (Esping-Andersen 1990). The logic of path dependency is that once a program or policy is formed, it will persist, so that the formative moments of that program will determine its path for its continued existence (Thelen 1999). The concept of path dependency captures the common observation of the persistence of patterns of behavior and patterns of policy, even in the face of continuing challenges. Thus, even there is external threat, the distinction among

Social health care system is the outcome of politics, history, and cultural contexts. Health insurance programs of Korea and Japan have relatively long history comparing with other welfare programs. Health insurance was introduced relatively earlier other welfare programs

even both of Korea and Japan had delay to enforce the law. Health insurance in Korea and Japan began with similar type run by the multiple carriers based on occupation 1963 and 1922 respectively. Japan referred to the German health insurance system and Korea adopted the same type of health insurance system based on Japanese experience. They also show many aspects in common: private sector is dominant in the supply of medical services and private health insurance plays a minor role (Kwon and Suzuki 2000). Later, the health insurance system transfer from fragmented system to unified system, while Japan keeps fragmented system. However, they share two main schemes: employment based and region based system.

The type of welfare programs of Korea and Japan is social insurance which is compulsory and closely related employment status. When health insurance programs were introduced, both Korea and Japan need healthy and strong workforce for economic development and participation in war respectively. The beginning of welfare policies in Korea and Japan went hand in hand with strong state. As other East Asian countries adopted social welfare programs as policy instruments for economic development (Kwon 2005), the initial social policy programs covered mainly industrial workers in Korea. In the case of Japan, the participation in the World War II needed to strength labor force, thus the government introduced and expanded welfare programs. The social security programs took root as a part of the country's military and industrial strategy to ensure healthy and productive workers (Peng 2005). However, the key principles of welfare development in Korea and Japan have been shifting from selective social investment and authoritarianism to universal investment and democratic governance (Kwon 2005). However, their initial arrangements might constrain the current and future of each country's social policy as path dependence process operates.

Health Care Financing

Public control of funding can be measured in terms of the extent of public funding, the relative importance of taxes power and social security as different types of public funding as well as the power of government to control funding. Public control of provision can be measured in term of the share of public provision of health care (Blank and Burau 2004). Usually health care system is classified into National Health Service (NHS), Social Health Insurance (SHI), Consumer Sovereignty Model (CSM) systems considering delivery and financing (National Health Insurance Corporation 2007). However, in this paper, I classified health care system according to the relationship among public resources to distinguish pure state's effort in health care. Public health expenditure is composed of general government expenditure and social security schemes (OECD 2009). If the portion of general government expenditure or social security schemes is large, then it means that the state has strong control on the health funding.

Public health expenditure is composed of general government expenditure, which comes from tax revenues, and social security schemes, which comes from the contribution of employers and employees. The component ratio of public health expenditure may reveal whether the state is provider or regulator of welfare. If the level of government expenditure is high, state acts as provider, and if it is low, state does as regulator. Figure 1 shows the comparing the relationship between the funding sources from general government expenditure and social security scheme in 2005. The location on the quadrant may show the role of each county: on the second quadrant as regulator, and on the fourth as provider. The first quadrant is empty and the second one is filled with Austria, Belgium, France, Germany, Japan, Korea, Netherlands, and Switzerland whose fund from general government expenditure is low and fund from social security schemes is high. On the fourth quadrant,

Austria, Canada, Denmark, Finland, Ireland, Italy, New Zealand, Norway, Sweden, and the United Kingdom are located with high level of general government expenditure and low social security schemes. The only country located on the third quadrant is the United States with low general government expenditure and low social security schemes. In the case of the United State, the role of state is very weak both as provider and regulator.

<Figure 1 about here>

Each country's location on the quadrant is time-variant. The change of location may come from the reform of health care system. Thus, I trace the change of the location. Calculating with Table 1, from 1995 to 2005, generally locations moved left side and upward: decrease of the portion of general government expenditure and increase of the portion of social security schemes. On the contrary, the location of Korea moved right side and upward: both increase of the portion of general government expenditure and social security schemes. Even though they moved, their clustering did not change.

<Table 1 about here>

Comparing the out-of-pocket payment ratio, which is one of main components of private expenditure, and social security scheme ratio, the countries of high level of social security schemes scattered on the range of the ratio of out-of-pocket, while high level of general

government expenditure countries gathered between around 10% and around 20% (See Figure 2). Thus, the countries with high level of general government expenditure are expected to be more related with private sectors and also more vulnerable to the pressure of globalization.

<Figure 2 about here>

While total health expenditure has increased during the last decades, the public health expenditure has been decreased during the period even some countries show leaps and bounds except Korea and Japan. Generally during the last decades, the portion of public expenditure in total health expenditure has decreased little bit except the cases of Japan, Korea, and Switzerland (See Figure 3). For Japan, the increasing stopped around from the late 1990s. On the contrary, public expenditure of Korea and Switzerland has kept increasing. How can we explain the change of public health expenditure?

<Figure 3 about here>

Drawing on the arguments mentioned above, some hypotheses can be proposed as following:

H1: The more market is open, the less public health expenditure.

H2: Each welfare regime has different effect on the level of public health expenditure.

H2-1: The governments of East Asian countries pay less health cost than Western countries

H3: Social insurance system based countries have less public health expenditure.

H1 and H2 reflect globalization theory and welfare regime theory respectively. East Asian countries are late developing countries in terms of welfare and they subordinate social policies to economic policies. Thus, Korea and Japan are expected to regulator rather than provider (H2-1) (Holliday 2000). Social insurance system based countries are closely related labor market and the contribution from employers and employees are vulnerable to economic conditions. Thus social insurance based countries are expected to have less stable public funding for health than the countries based on the tax revenues.

Data and Method

Generally in welfare studies about the retrenchment, scholars suggested the ratio of public expenditure as the index for the change of welfare states (Esping-Andersen 1990; Huber and Stephens 2001; Swank 2002). The change of public expenditure ratio reflects the change of welfare system. Thus, in this analysis, the percentage of public health expenditure in total health expenditure is employed as dependent variable.

OECD Health Data (OECD 2009a) provides not only information related with health care but also social, economical, and demographical information. It covers 30 OECD countries, however, I selected 19 countries: 18 countries (Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherland, New Zealand, Norway,

Switzerland, Sweden, the United Kingdom, and the United States) generally studied in welfare studies and Korea. Data about the financial deficit and so on are also got from OECD database (OECD 2009b). Most of the data cover from 1980 to 2006. Except categorical independent variables, I use one-year-lagged variables for the analysis. So 356 cases are used in the analysis.

The categories of welfare regime are classified following Esping-Andersen (1999), and Korea and Japan are classified into East Asian regime which is different from Esping-Andersen's classification to test whether they show differences from conservative or liberal regime countries.

Health care financing system is classified into three categories as shown in Figure 1. Austria, Belgium, France, Germany, Japan, Korea, Netherlands, and Switzerland are low general government expenditure and high social security schemes group. Austria, Canada, Denmark, Finland, Ireland, Italy, New Zealand, Norway, Sweden, and the United Kingdom are high general government expenditure and low social security schemes group. The United States is low general government expenditure and low social security schemes group.

<Table 2 about here>

For the analysis of the effects on the public health expenditure, panel analysis was used. The structure of equation is

$$y_{ij} = x_{it}\beta + z_i\delta + (u_i + \epsilon_{it})$$

where x_{it} is $1 \times k$ vector of variables that vary over individual and time, β is the $k \times 1$ vector of coefficients on x , z_i is a $1 \times p$ vector of time-invariant variables that vary only over individuals, δ is the $p \times 1$ vector of coefficients on z , u_i is the individual-level effect, and ε_{it} is the disturbance term (Baum 2006).

Findings and Limits

The analysis was conducted with four models: Model 1 with basic independent variables, Model 2 adding welfare regime types, Model 3 adding financing type, and Model 4 with welfare regime types and financing types. The first hypothesis that the more market is open, the weaker public health, is not rejected in the all four models. Thus, the argument that globalization has negative effect on the public health expenditure is supported in this analysis. Even though other variables do not have statistically meaningful influence, considering that the data is not sample but population, the direction of each variable is same with common arguments: (1) the bigger size of economy, the more public expenditure, (2) the higher financial deficit, the less public expenditure, (3) the higher unemployment rate, the less public expenditure, and (4) the more old aged people, the higher public expenditure.

Generally public health expenditure of Korea and Japan is less than that of other welfare regime countries. It may be owing to that even public health expenditure of Korea has increase rapidly during the last decades, still the level of public expenditure is much lower than other countries. Thus the mean of public expenditure of East Asian regime is very low and the standard deviation is high. However, there exist the differences of public health expenditure among four welfare regimes. The portion of public expenditure of social democratic regime countries is higher than any other regime countries. The next is

conservative regime countries.

<Table 3 about here>

As we predicted with Figure 2, the public health expenditure of social insurance based countries is lower than that of tax revenue based countries. The public expenditure of the United States is much lower than social insurance or tax revenue based countries. Considering welfare regime and financing structure simultaneously, the effect of welfare regime and financing structure remain.

In the context of globalization, even though the public health expenditure of Korea and Japan has increased, they look still remain at the position of regulator rather than that of provider. As in Table 1, in 2005, the portion of general government expenditure in total health expenditure is 11.8% and 16.1% in Korean and Japan respectively. The average of percentage of general government expenditure in total health expenditure is 48.8% and 47.3% in 1995 and 2005 respectively. Comparing to other countries, their public expenditure have increased. However, it is due to the increase of social security schemes, not due to the government expenditure. Even though both countries have universal coverage, the insured are vulnerable to economic crisis.

Even I deal only funding dimension of health care in this paper, health care system can be classified based on the association of funding and provision system. Public control of provision can be measured in terms of the share of public provision in health care. The institutional context of health systems and the capacity of governments to address the pressures from ageing population and globalization continue to vary considerably between

countries (Blank and Burau 2004). In this analysis, the dimensions of provision and the authority of government are omitted. Regarding funding, Korea and Japan show relatively strong government control, however, concerning provision, they have weak government control different from other social insurance based countries. However, some other countries have high public control of funding and provision: the United Kingdom and Sweden. Other modes of governance and the extent of government authority in different countries can make diversity of health policy.

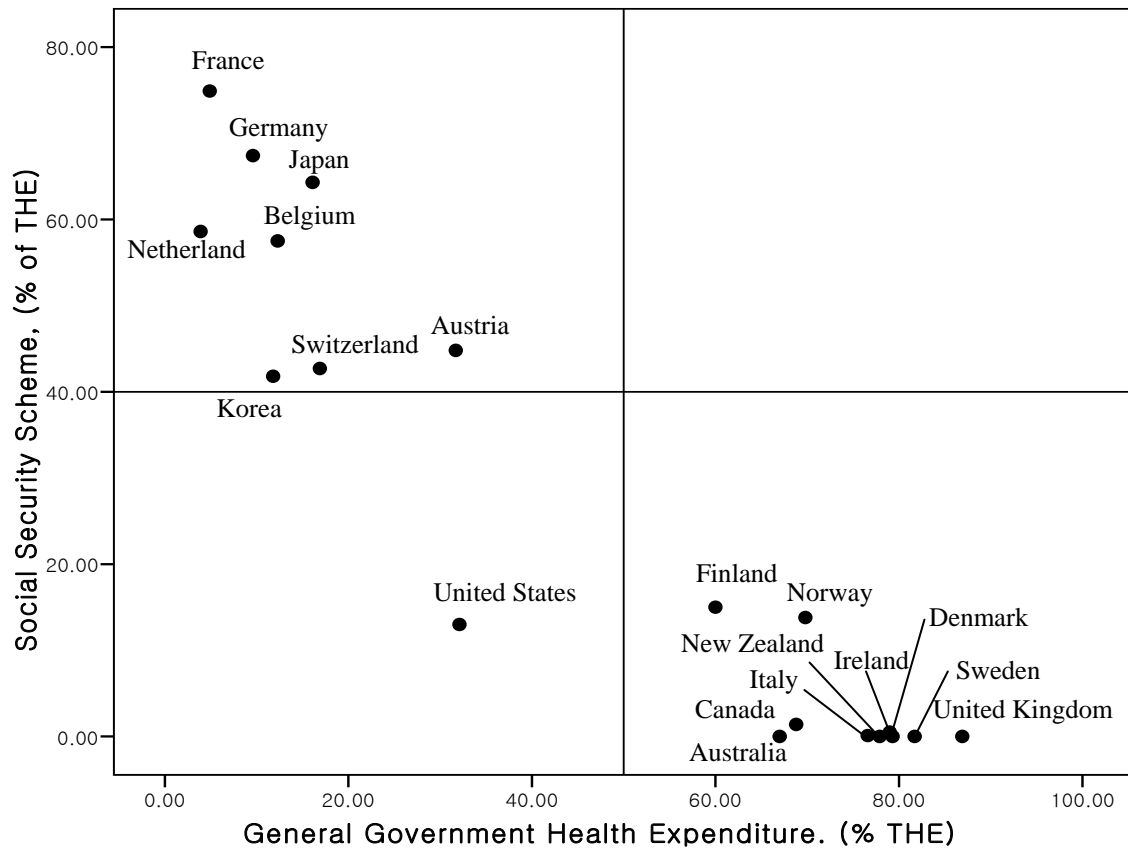
Like health care system has various types, the health expenditure structure has also complex components. As public health expenditure is composed of general government expenditure and social security schemes, private expenditure is composed of out-of-pocket payment and private insurance mainly. Not only public health expenditure had various changes in each country during the last decades, but also private expenditure might. Thus in future study, the analysis considering health care system in terms of government authority and the public/private expenditure structure simultaneously is needed.

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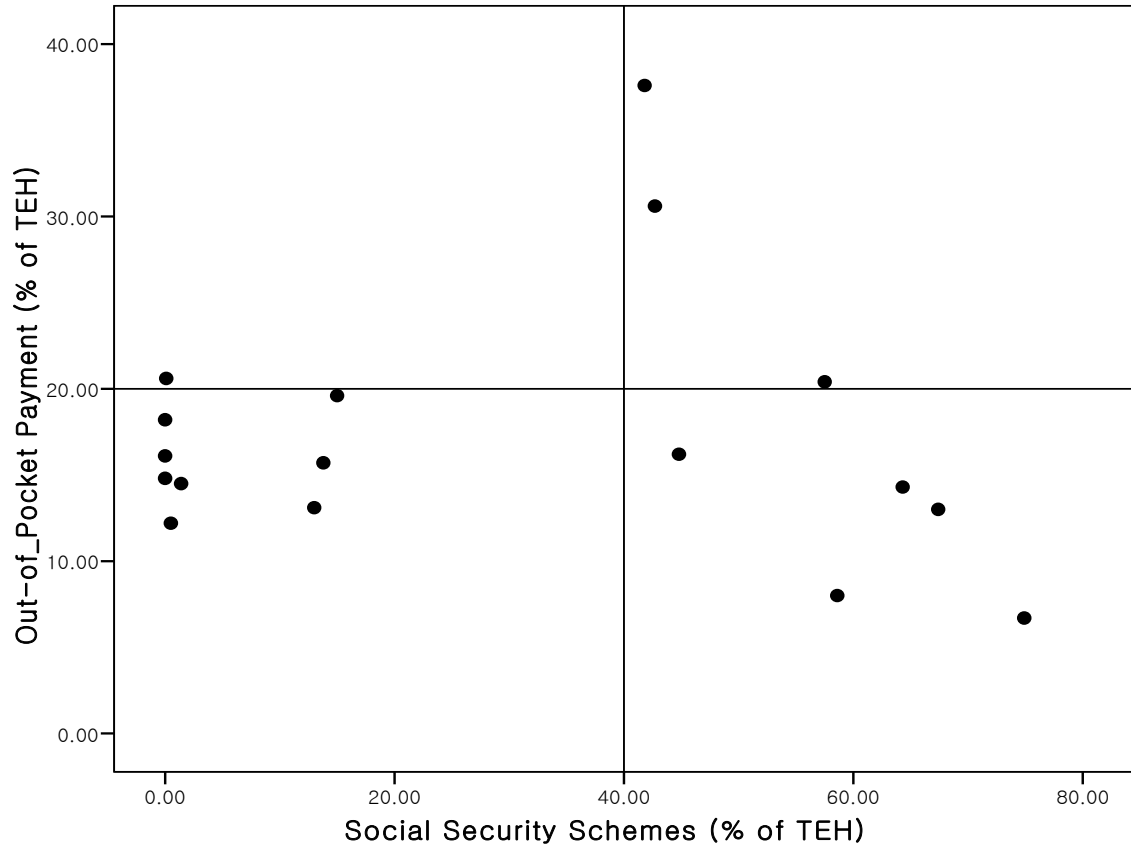
Figure 1. General Government Expenditure and Social Security Schemes in 2005



Source: OECD (2009)

Note: For Netherlands and New Zealand in 2002

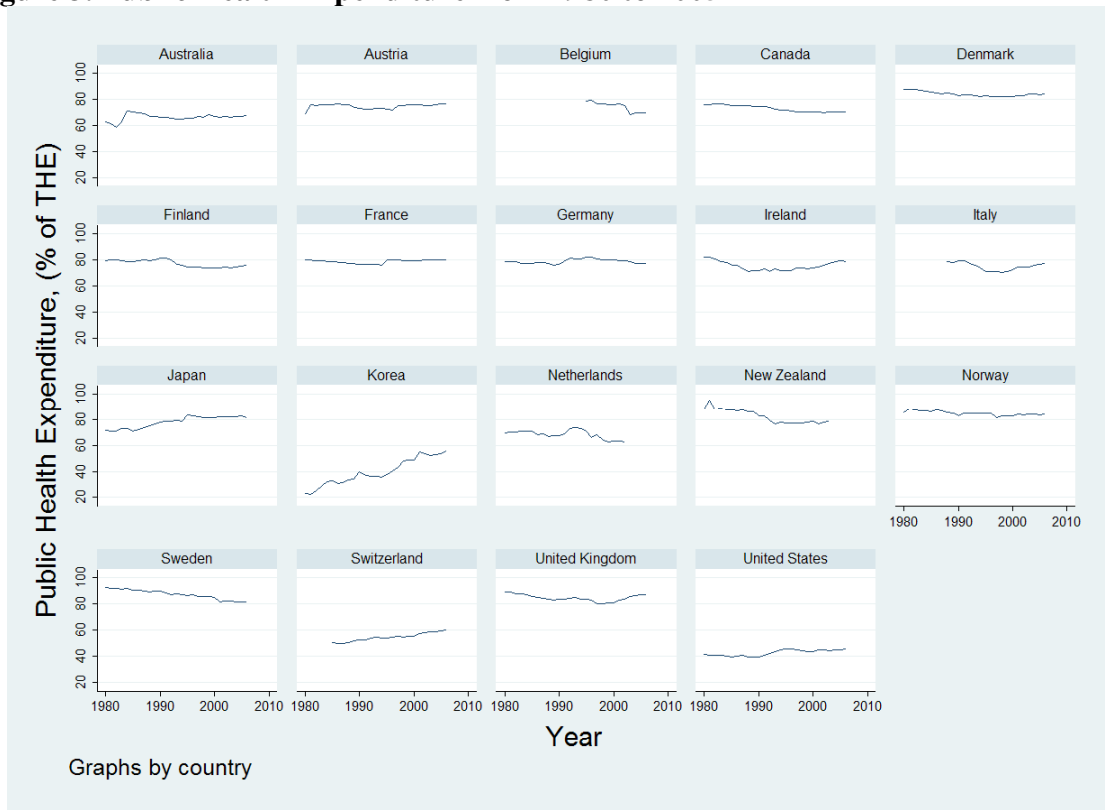
Figure 2. Social Security Schemes and Out-of-Pocket Payment in 2005



Source: OECD (2009)

Note: For Netherlands and New Zealand in 2002

Figure 3. Public Health Expenditure from 1980 to 2005



Source: OECD (2009)

Table 1. General Government Expenditure and Social Security Schemes in 1995 and 2005 (% of Total Health Expenditure)

Year	General Government		Social Security Scheme	
	1995	2005	1995	2005
Australia	65.8	67.0	0.0	0.0
Austria	32.2	31.7	40.4	44.8
Belgium*	10.9	12.3	57.1	57.5
Canada	70.3	68.8	1.1	1.4
Denmark	82.5	79.3	0.0	0.0
Finland	61.3	60.0	12.8	15.0
France	4.6	4.9	75.1	74.9
Germany	14.3	9.6	67.3	67.4
Ireland	71.0	79.0	0.9	0.5
Italy	70.5	76.6	0.3	0.1
Japan	15.2	16.1	67.9	64.3
Korea	8.0	11.8	30.0	41.8
Netherlands**	4.5	3.9	66.5	58.6
New Zealand**	77.2	77.9	0.0	0.0
Norway	84.2	69.8	0.0	13.8
Sweden	86.6	81.7	0.0	0.0
Switzerland	16.1	16.9	37.6	42.7
United Kingdom	83.9	86.9	0.0	0.0
United States	30.8	32.1	14.5	13.0

* : 2003-2005

** : 1995-2002

Table 2. Descriptive Statistics of Independent Variables

	Obs	Mean	Std. Dev.	Min	Max
In GDP per capita (US\$ PPP)	494	9.829	0.429	7.880	10.771
Deficit Rate	398	-3.742	9.525	-26.283	36.344
Unemployment Rate	484	6.844	3.425	0.200	17.000
Population over 65	494	13.657	2.896	3.819	20.162
Openness ((Import+Export)/GDP)	494	67.530	32.758	16.108	184.318

Table 3. Result of Regression Analysis with Panel Data

	Model 1		Model 2		Model 3		Model 4	
	Coef.	Std. Err.	Coef.	Std. Err.	Coef.	Std. Err.	Coef.	Std. Err.
GDP per capita	4.414 ^{***}	0.931	4.595 ^{***}	0.935	4.508 ^{***}	0.920	4.462 ^{***}	0.930
Financial Deficit	-0.072	0.040	-0.070	0.039	-0.075	0.039	-0.074	0.039
Unemployment	-0.135	0.109	-0.135	0.109	-0.147	0.108	-0.156	0.108
Over age 65	0.116	0.293	0.059	0.295	0.156	0.285	0.246	0.284
Openness	-0.080 ^{**}	0.023	-0.088 ^{**}	0.023	-0.089 ^{***}	0.023	-0.101 ^{***}	0.023
Liberalism			10.053	7.680			16.018 ^{**}	6.245
Conservatism			12.018	7.899			11.181	5.744
Social Democratic			20.397 ^{**}	7.756			19.694 ^{***}	6.023
High Gov/Low SSC					6.494	3.953	1.181	3.618
Low Gov/Low SSC					-33.396 ^{***}	8.867	-38.666 ^{***}	7.827
Cons.	33.246 ^{***}	7.297	19.987 [*]	9.599	30.762 ^{***}	7.427	19.690 [*]	8.347
R-sq	0.016		0.205		0.494		0.653	
sigma_u	9.591		9.142		8.134		6.345	
sigma_e	3.305		3.305		3.305		3.305	
rho	0.894		0.884		0.858		0.787	

Note 1. “^{*}”: p<.05”, “^{**}”: p<.01”, “^{***}”: p<.001”

2. Reference group for Model 2 is East Asian regime

3. Reference groups for Model 3 is Low Gov/High SSC