Comparing the Health Care Systems of High-Performing Asian Countries

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Abstract

The newly industrialised and high income economies of East Asia perform remarkably well on a range of health system indicators. We adopt an institutional lens to examine and compare the similarities and differences in health care financing and provision in the paired cases of Singapore, Malaysia, Taiwan and South Korea. This illuminates how, despite seemingly common global, regional and functional demands, reformers have responded through diverse means to different institutional constraints. Moreover, some of these cases illuminate the cognizance of reformers with respect to vulnerabilities in their own health care systems enabling effective, albeit ongoing, management.

Key words: institutions, health care, East Asia, policy reform, cognizance

1. Introduction

The newly industrialised and high income economies of East Asia perform remarkably well on a range of health system indicators (OECD 2012). This is despite extraordinary and shared pressures on the demands and costs of their health care systems, including population ageing, rapid economic growth and urbanisation, and relatedly epidemiological changes. While some of these pressures are familiar to the western world, there is little doubt that the challenges are amplified in Asia. From an institutional perspective, the diversity of Asian health care arrangements and their trajectories of reform are instructive. They illuminate that, despite seemingly common global, regional and functional demands, there are diverse means through which policymakers can respond.

This article examines and compares the similarities and differences in health care financing and provision in the paired cases of Singapore, Malaysia, Taiwan and South Korea. The financing and provision arrangements are conceived as articulations of the broader institutional context. The modest contribution is to document the diversity of the health care topography in these countries and consider the applicability of western concepts and propositions to the East Asian context. More specifically, the analysis departs from the European categories of Beveridgean and Bismarkian systems and theoretical propositions from institutional perspectives on health...
care. Comparative analysis of Asian health care institutions and experience is a relatively new academic endeavour in the English-speaking world. For policy-makers, the message is simply to recognise that hybrid solutions are possible and cognizance of context is crucial (Phua & Wong 2014).

2. How Do Institutions Matter to East Asian Health Care Reform?

A key tenet of institutional analysis is that the origins of institutions matter to policy-making and have consequences for trajectories of policy reform and their outcomes. This staple of western academic comparative studies has since become mantra, also in health care research. For policy reformers, this literature highlights how they are constrained in reform efforts since new initiatives emerge within existing institutional conditions and are shaped by these conditions. Alternatively, there is some consolation in that there is no one best way, and a variety of means can be adopted to address similar policy problems. Indeed, sensitivity to and reflective knowledge of both field and context provide agency in developing innovative, even hybrid solutions, to complex policy problems and fields (Marmor 2007). The Asian countries here under study have set out to develop, universalise and reform their health care arrangements in a later phase to most western countries. Furthermore, there are histories of authoritarianism suggesting reformers may be unfettered in their pursuit of change. These conditions present respectively potential learning opportunities enabling Asian reformers to defy their institutional inheritance in health policy, as well as political opportunities for change. Drawing from propositions of the institutional literature, we briefly examine further the extent to which institutions have mattered in our cases under study. While we recognise (western) institutional concepts are simplified and may have only limited applicability to Asian contexts, we nevertheless apply them here to organise our analysis and examine their leverage.

A first proposition draws from the European health care literature regarding the distinction of National Health Service systems (NHS—Beveridgean systems) and National Insurance Systems (NHI—Bismarkian systems). These represent different kinds of institutional landscapes whereby NHS systems are tax-funded, and imply universal coverage, public ownership of health care facilities and salaried medical staff (Freeman 2000, p. 6). They present governments with more direct levers to control expenditure. By contrast, insurance-based (Bismarkian) systems are financed through premiums paid into funds organised by occupation, corporation or region. NHI systems have been characterised by greater decentralisation, greater use of private providers and more widespread use of ‘fee for service’ payment to practitioners. They have been associated with emphasising choice as opposed to universalism and to less supply-side control of the volume of services. Furthermore, the reimbursement of fees and enrolment of payees in NHI systems is associated with higher administrative costs. While these are ideal types and a mix of arrangements is more often the rule, the proposition examined here is that Asian cases with early adoption of NHS systems demonstrate greater capacity for cost control compared with NHI systems.

A second institutional proposition is that unified political administrative systems (and polities) present reformers with more opportunities to legislate and enforce policy change with little compromise or delay (Immergut 1992). This proposition recognises that more centralised and unified systems are able to pursue health care reforms unfettered by opposition at political or administrative levels. While the first proposition is about managing health administration and costs, this second proposition concerns the capacity for reform change and adaptation. Degrees of centralisation touch upon different aspects of the policy context wherein health reform is pursued. It includes formal political centralisation as reflected in executive dominance and the ability to pass legislative changes concerning finance and provision of health care. It can also relate to (less formal) centralisation at the level of the bureaucracy as reflected in the ‘degrees of horizontal coordination’—that is, the extent...
to which central administrators can ensure other parts of the bureaucracy pull in the same direction (Pollitt & Bouckaert 2000). Federal systems are deemed less centralised than unified systems, and more averse to uniform, broad scope and speedy (health care) reforms because of numerous veto points, whereby reforms can be rejected, compromised or implemented in diverse ways (Immergut 1992). Health care reforms and debates in these contexts tend to be more politicised when paired with ethnic, linguistic or socio-economic diversity. Similar fragmentation of authority can also characterise decentralised unified systems. The consequence is that reformers in more decentralised contexts experience greater constraints in their pursuit of uniform change and oversight.

3. The Cases

Among the cases here under study, Singaporean and Malaysian represent health care finance and provision features developed in a context of similar NHS systems, while Taiwanese and South Korean arrangements occurred in a context of NHI systems. These institutional features have historical origins whereby Singapore and Malaysia were initially one country and former British colonies inheriting legacies from England. By contrast, Taiwan and South Korea developed health insurance schemes for particular, industrially strategic, employees. This was not initially motivated by social protection but rather selective compensation for functions that would enhance the authoritarian developmental state (Wong 2004). South Korea was historically influenced by Japan in the organisation of health insurance (Jeong & Niki 2012).

In both pairs of similar cases, there are distinctions in degrees of centralisation, although this has changed over time, particularly in South Korea and Taiwan. In the cases of Singapore and Malaysia, the federation of Malaysia is politically more decentralised. It is characterised by an ethnically fragmented political and administrative elite that can be disruptive for reforms, including the unified pursuit of health care reforms and regulation (see Ramesh 2007; Chee 2008). Nevertheless, the United Malays National Organisation (UMNO), a ruling coalition party, has been in power since independence. It maintains political legitimacy and oversight, also in health care policies, by responding to the diverse needs of rural and urban areas (Barraclough 2000). By contrast, as a city-state with a well-organised authoritarian regime, reformers in Singapore can pursue change and adaptation with less opposition. Among the four cases here examined, Singapore has remained the most centralised political administrative context over time.

Political centralisation in South Korea and Taiwan was a characteristic of their authoritarian developmental states; however, the administration of health financing and provision was historically decentralised to particular industries. This allowed for variations across regions and industries, particularly in South Korea. Democratisation in these countries fragmented central political authority, although at a different pace over time and with different consequences for the scope of health care reform. Taiwan’s shift to universal health care insurance in the 1990s occurred in a context of greater political centralisation than that of South Korea. The Kuomintang had maintained executive dominance at the time of democratisation providing latitude to plan significant structural reform and have it adopted by a fragmented minority opposition within the Legislative Yuan (Wong 2004, pp. 81–2). There was also careful political leadership with President Lee using the universalisation of health care reform as a means to cut across ethnic cleavages (Wong 2004, p. 75). By contrast, South Korean reformers were constrained by stronger opposition in the legislature and increasing disagreement between groups in civil society (Wong 2004, pp. 69–70; Kwon & Chen 2008).

In the following sections, similarities and differences in health care financing and provision are briefly elaborated upon against the background of these institutional propositions. The purpose is to both organise the analysis through an institutional lens and consider their relevance to the diversity in arrangements and transformations observed.
4. Health Care Financing

Singapore and Malaysia inherited British-style NHS and continue to finance a portion of health care costs from general revenues. This presents governments with a direct way to influence public expenditure on health. Indeed, in both cases but particularly Singapore, the stable governments have maintained a strong and activist role in structuring the health care system. Both countries, but most extensively Singapore, layered on a more elaborate diversified financing system through legislating compulsory savings funds. This was without opposition and followed the implementation of the Medisave scheme through the National Health Plan. In considering the sustainability of their health care system, Singaporean policy-makers were cautious of international trends in health care, weighing up domestic options with the knowledge of experience elsewhere. They developed the famous medical savings accounts (Medisave), which finance individuals and family units with virtually little risk-pooling to the collective (Okma et al. 2010). But NHS legacies continue to be robust as build-up of the Medisave accounts and increasing user charges contributed towards greater cost-sharing. The addition of Medisave accounts to financing health expenditure was a Singapore invention.

The health funds evolved into Singapore’s distinctive 3-M health care financing system consisting of three types of funds: Medisave, Medishield and Medifund. Medisave (1984) is compulsory—it builds on monthly employee’s contributions (6–9 per cent monthly income) and can be drawn upon to pay for medical expenditure. Medishield (1990) is more equivalent to a social health insurance system, although it has an ‘opt-out’ feature with greater voluntary insurance to cover catastrophic illness. It was introduced to back up the limitations of Medisave for bigger bills, while Medifund (1990) is a state-funded safety net for those who are unable to pay for their hospitalisation costs. More recently, Eldershield (2002), a low-cost social insurance scheme for long-term care services for the elderly, has been introduced.

Malaysia tried establishing a separate fund for the treatment of serious illness (Account III) in the Employees Provident Fund. It included proposals for greater medical savings, but has been torn between the options of shifting towards a social health insurance. The default has been an increasingly mixed health care financing system with expansion of the private sector. Leaders of the ruling UMNO party have demonstrated greater ideological capture regarding health care privatisation in Malaysia as compared with Singapore, and there is evidence of cronyism in the way this has been pursued (Barraclough 2000). Malaysia’s privatisation had the consequence of diluting direct government control over health care expenditure, such as private sector expenditure on technology, particularly because of fragmented regulation (Phua 2007). Furthermore, an oppositional public accustomed to a dominant government role in health care has emerged, constraining further Malaysian privatisation efforts (Barraclough 2000). Differential user charges have been introduced in both Singapore and Malaysia, although this is predominantly in Malaysia’s urban area. Malaysian rural public health facilities, important to the key Malay constituency of the UMNO, are almost free (with nominal charges of RM1 ringgit for outpatient and RM5 for specialist fees) and the majority of hospital beds are in third-class wards with nominal fees.

The Singaporean government does and can quite swiftly continue to fine-tune its health financing system. Recently, concerns about the inadequacies of the 3-M system are being addressed with the expansion of the Medishield to a new compulsory Medishield Life plan in 2015. Medishield Life offers lifelong coverage of catastrophic illness and greater government financing for the poor and aged with the Pioneer Generation Package. Malaysian government exhibits less capacity to act as swiftly or uniformly as that of Singapore—its recent push for the 1Malaysia social health plans (1Care) was scuttled in the last elections. Nevertheless, the NHS legacy in both countries appears to have kept health care expenditure growth contained (Table 1).
South Korea and Taiwan host National Health Insurance systems whereby (mandatory) enrollees pay income-based premiums for their coverage. These evolved from selective health compensation systems provided by strategic industries. They were pluralistic systems, although to different degrees, with South Korean non-government insurance societies exceeding 350 in 1998 and Taiwanese societies amounting to 10 by the 1990s (Cheng 2003; Kwon 2003). The income and employer contributions of insurance systems were deemed economically advantageous, as compared with an NHS approach, since it minimised direct government funding (Kwon 2003). It left a legacy of dependence upon insurance societies to ensure prudent purchasing of medical care in a context of fee for service. Furthermore, prior to the introduction of universal insurance, there were concerns about the equality of these systems, both with respect to how contributions were set and risk-pooling across societies (Kwon 2003).

In order to obtain greater cost control (and equity), both countries moved to a single payer system. This occurred in 1995 in Taiwan and in 2000 in South Korea (Cheng 2003; Wong 2004; Jeong & Niki 2012). While health care expenditure in these countries is low by OECD standards, it is nevertheless higher than Singapore and Malaysia and is growing more rapidly (see Table 2). This is despite the administrative costs of the single payer systems being extraordinarily low (Cheng 2003, p. 64; Kwon 2003, p. 82). Expenditure increases have been attributed to insufficient supply-side controls—a recognised vulnerability of NHI systems (Lee et al. 2008; Jones 2010).

As in Singapore and Malaysia, there are co-payments made by users. This has been considerably high in South Korea, particularly given the initially quite limited benefit coverage. An OECD report notes that public contributions to health spending have been increasing, rising to 55.5 per cent in 2008 compared with 44.5 per cent from private contributions (Jones 2010, p. 7). The highest portion of private spending comes from patient payments for non-covered services and co-payments. Taiwan’s user fees are reported to be lower and their benefit coverage more generous, but direct

| Table 1 Statutory Health Financing Arrangements in Singapore and Malaysia |
|----------------------------------|-----------------|-----------------|-----------------|
|                                  | Government financed | Compulsory savings | Social insurance |
| Malaysia                         | Subsidised public hospitals—varies by class of ward; subsidised public primary health clinics; free public primary health centres in rural areas | Account III in Employees Provident Fund | Medishield (Plus) |

| Source: Adapted from Ramesh and Holliday (2001) and other sources. |

| Table 2 Overview Health Expenditure Data and Provision in Singapore, Malaysia, Taiwan and South Korea |
|------------------------------------------------|-----------------|-----------------|-----------------|
|                                                 | Singapore       | Malaysia        | Taiwan‡          | South Korea     |
| Total health expenditure as share GDP (2012)    | 4.0%            | 4.4%            | 6.2%‡           | 6.9%            |
| Public share expenditure health (2010)          | 36.3%           | 55.5%           | 65%‡            | 59%             |
| Out of pocket spending (% total private expenditure) | Over 80%       | Over 70%        | (34% of total spending)‡ | Over 70%        |
| Annual average growth rate (2000–2010)          | 8.1%            | 6.2%            | 34%             | 8.4%            |
| Public hospital ownership†                      | 72%             | 75%             | 34%             | 10%             |

| Sources: OECD (2012), †Leong et al. (2012), ‡all figures 2005 from Okma et al. (2010). |

GDP, gross domestic product.

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patient co-payments constituted approximately 31 per cent of total health expenditure (Okma et al. 2010). Both countries boast freedom of choice for provider, although user charges act as a barrier to choice and are meant to limit use.

Taiwan moved boldly in one step to their single payer system in 1995, while South Korea integrated their multi-payer system over numerous phases to a single administrative pipe in 2000 (Wong 2004). In Taiwan, this change was informed by careful examination of international experience. Incremental pursuit of change in South Korea was a consequence of political opposition, thus less degrees of centralisation. Democratisation has continued to fragment centralised political authority, reducing the capacity of both governments to simply push through reforms. Interest group cleavages in the South Korean context have continued to present greater barriers to government reforms with increasing opposition from the medical profession presenting deadlocks in attempts to introduce greater supply-side controls (Kwon & Chen 2008). In Taiwan, by contrast, there has been the introduction of a global budget system to contain costs, although it is controversial (Cheng 2003).

Both governments were nevertheless successful in layering further social protection into their health systems, also because this had support from constituents, such as rural constituents in South Korea (Kwon 2003). In Taiwan, the government subsidises (up to 100 per cent) some groups of enrollees, e.g. low income or unemployed, for their premiums (Cheng 2003). In South Korea, there is a means-tested Medicaid program for the unemployed, which complements the employment-based contributory system. Medicaid is funded by government revenue and managed by local governments (Kwon 2003) (Table 3).

5. Health Care Provision

There is a stark contrast between public and private provision of health care services in the former British colonies of Singapore and Malaysia, as compared with the National Health Insurance systems of Taiwan and South Korea. According to recent data, public ownership of hospitals in both Singapore and Malaysia is in excess of 70 per cent (respectively 72 per cent and 75 per cent), while it is approximately 34 per cent in Taiwan and just 10 per cent in South Korea (Ramesh & Wu 2008).

In both Malaysia and Singapore, there have been moves to privatisation, as well as experimentation or policy proposals for further privatisation of hospitals. These stalled due to inherent limitations and opposition, and as a consequence of negative public opinion (Okma et al. 2010, p. 87). The legacy of a strong government role in health care provision has created widespread societal support for maintaining the status quo in these countries. An exception has been the growth of private hospitals to serve the growing market of medical tourism, but again there are limitations due to adverse effects on the health systems (Chee 2008; Pocock & Phua 2011). Outpatient services such as primary care medicine in urban parts of Malaysia and throughout Singapore are predominantly privately provided, although as noted above government clinics are public facilities in rural areas of

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Malaysia. Furthermore, Singapore has government polyclinics that receive substantial subsidies (Phua 2005). While Singapore did not opt for major privatisation of its hospital facilities, it did pursue substantial reforms of public hospitals granting them the status of corporations. In order to reign in the negative aspects of this reform (as a consequence of competition between individual hospitals), all corporatised hospitals were regrouped into just two competing clusters (see Okma et al. 2010, p. 88). Among the counterproductive effects of competition was the loss of medical staff to private organisations. This continues to be a significant problem for public hospitals in Malaysia, where regulation of the private sector has been fragmented (Chee 2008).

The provision landscape is entirely different in Taiwan and South Korea, where private provision of medical services has a much longer history (Wong 2004). Moreover, private provision increased in both countries since the 1950s, although public provision was already limited at that time. There is more substantial public ownership of hospitals and clinics in Taiwan compared with South Korea, although competition among providers in both countries is described as fierce (Cheng 2003). The limited number of publicly owned hospitals in South Korea offer cheaper services and have a larger share of Medicaid patients. The emphasis upon competition, as opposed to coordination, between hospitals has been identified as a problem that increases costs rather than improve quality or even decreasing costs (Kwon 2008, p. 66).

4. Conclusion

This article has sought to provide an overview of the health policy landscape in (East) Asia through a comparative institutional lens. It has illustrated unique diversity across the countries, but has also shown that propositions regarding institutional constraints apply to these contexts. We have drawn from conventional categories in comparative health systems literature to make ‘broad brush’ observations. Undoubtedly, a closer micro analysis, together with a more detailed understanding of the public–private divide, would present more refined understandings of their institutional trajectories. Nevertheless, we pose three general observations.

First, commonalities across the countries include the innovative and hybrid ways in which the reforms in the different paired cases have sought to mitigate inherent vulnerabilities in their existing health infrastructure. For example, the savings funds in the NHS systems (of Singapore and Malaysia) and the shift to single payer systems in National Health Insurance systems (Taiwan and South Korea) respond, respectively, to the tendency for limited sources of funding (and choice) in health services and the administrative inefficiencies attributed to social insurance systems (Freeman 2000). While the mere existence of such structural changes does not of themselves ensure the desired effects, they remain fascinating innovations to the foreign observer. Such layering can be expected to introduce new dynamics within these systems, although how this occurs requires further investigation. Ironically, they also challenge conventional categories, such as NHS and NHI systems.

Second, the health reforms in all of the countries here under study, and particularly Taiwan, South Korea and the most recent Singapore reforms, have brought about significant extensions in welfare protection and consolidation (see Kim 2008). This is diluting some of the residual characteristics previously associated with these countries and presents system challenges with respect to demographic changes in the region. It has also increased expectations for health care among constituents in these countries. The capacities of governments to pursue reforms have been dependent upon degrees of political centralisation, which has been decreasing, particularly in South Korea. This presents future challenges to any attempts at retrenchment.

Third, there are significant patterns of similarities and differences noted in the four countries and particularly as reflected in the paired countries of Singapore and Malaysia vis-à-vis Taiwan and South Korea. On the one hand, the legacies of NHS systems in Singapore and

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Malaysia, and with it direct policy levers to influence health expenditure, would seem to have contained costs in these countries as compared with the NHI systems of Taiwan and South Korea. Most striking has been the cognizance of the reformers in most of these countries, both with respect to assessing foreign models in relation to local context, as well as in seeking balance between the different institutional logics that inhabit the complex health sectors. This will continue to aid reformers in managing their institutional constraints.

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