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# RESISTING REFORM: THE POLITICS OF HEALTH CARE IN DEMOCRATIZING TAIWAN

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## Abstract

This essay examines the failed attempt by the KMT government to marketize and privatize Taiwan's national health insurance program during the late 1990s, despite overwhelming financial, administrative, and political pressures favoring such a reform. To explain the politics of "resisting reform," this essay focuses on: 1) waning KMT authority in legislative politics, 2) the articulation of tenable policy reform alternatives by health policy bureaucrats, 3) new patterns of societal mobilization, and 4) constraints imposed by the legacies of earlier rounds of health care reform. As a case study, this essay illuminates the impact of democratization on social policymaking processes in Taiwan. In terms of its comparative implications, this essay engages crucial debates about welfare state development and the politics of retrenchment.

On March 1, 1995, the Kuomintang (KMT) government in Taiwan began operating the National Health Insurance (NHI) program. The NHI is an administratively centralized and state-operated universal health insurance system. To date, the

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NHI program is Taiwan's most celebrated social policy reform, and has helped to promote greater redistributive equity among disparate income and health-risk groups. Soon after its implementation, however, the NHI confronted a looming financial crisis. Escalating health-care expenditures set against the government's unwillingness to implement unpopular revenue-generating measures contributed to a dwindling reserve fund. The NHI was soon in a deficit situation. This health-insurance crisis in Taiwan was symptomatic of the purportedly larger welfare state crisis among advanced industrial economies wherein the costs of maintaining expensive social policy programs, both politically and economically, have begun to overwhelm the social democratic aspirations of many states.[1]

In 1997, only two years after the NHI was implemented, the KMT government initiated a second round of reform. The Department of Health, with the approval of the Executive Yuan (or cabinet), submitted a major health-care reform bill to the legislature in 1998. The KMT regime proposed a new multiple carrier structure in the provision of medical insurance. Though the government would continue to play a significant role in the regulation of health insurance and health-care provision, the centralized structure of the NHI was to be reorganized, allowing for the emergence of new private sector insurance carriers. In short, universal health insurance would be provided by competing, private sector insurers. Reformers reasoned that the injection of market-type incentives in medical care insurance would promote greater systemic efficiency, while continued government regulation would maintain redistributive equity. This proposed reform, in many important ways, mirrored the direction of health policy reform in other states similarly facing the challenge of escalating health-care

[1] See Evelyne Huber and John D. Stephens, *Development and Crisis of the Welfare State* (Chicago: University of Chicago Press, 2001); Jonas Pontusson, *The Limits of Social Democracy* (Ithaca, NY: Cornell University Press, 1992); Fritz Scharpf, *Crisis and Choice in European Social Democracy* (Ithaca, NY: Cornell University Press, 1991).

costs.[2] However, in Taiwan, the proposed reform failed to garner support in the Legislative Yuan. Myriad forces successfully resisted reform.

The politics of health care and the dynamics of resisting reform need to be understood in the context of democratic change.[3] Theoretically speaking, examining the politics of health-care reform through the analytical lens of democratization appends the broader public policy literature.[4] This essay specifically illuminates the ways in which macro-political change in Taiwan reconfigured policy networks through the inclusion of new actors, altered power dynamics within these networks, and encouraged the articulation of new policy ideas by actors from outside the elite ranks of the state apparatus. Though the KMT retained much of its policy authority in the early stages of democratic transition, and thus throughout the planning of the universal NHI program, the KMT confronted a new social policymaking context during the late 1990s.

This essay focuses on four factors. First, it highlights the political and institutional factors that have contributed to the KMT's waning authority in directing legislative matters, especially among the ruling party's rank-and-file. Second, it examines the emergence of technocratic opposition to the reform agenda from within the Department of Health (DOH) and its articulation of tenable alternatives to the multiple carrier reform. Third, it recounts the role played by social movement

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[2] For a good comparative overview, see Daniel Drache and Terry Sullivan, eds., *Health Reform: Public Success, Private Failure* (London: Routledge, 1999).

[3] See Ramon Myers and Linda Chao, *The First Chinese Democracy: Political Life in the Republic of China on Taiwan* (Baltimore: Johns Hopkins University Press, 1998); Yun-han Chu, *Crafting Democracy in Taiwan* (Taipei: Institute for National Policy Research, 1992).

[4] Michael Atkinson and William Coleman, "Policy Networks, Policy Communities and the Problems of Governance," *Governance* 5, no. 2 (1992): 172-6. For a general overview on the political-economic impact of democratic change in Taiwan, see Gerald McBeath, *Wealth and Freedom: Taiwan's New Political Economy* (Aldershot, UK: Ashgate, 1998), chap. 6; Gregory Noble, *Collective Action in East Asia: How Ruling Parties Shape Industrial Policy* (Ithaca, NY: Cornell University Press, 1998), chap. 7.

organizations in resisting reform from the bottom up. And finally, it shows how the legacies of the original NHI structured a political context hostile to health insurance reform. By drawing on theories of institutional legacies, the essay argues that opponents of the multiple carrier reform successfully transformed the health-care reform debate of the late 1990s from one about systemic efficiency to a debate over socio-economic equity and the future of the welfare state.

The story of the KMT government's failed attempt to implement health-care reform during the late 1990s is an important one. The politics of resisting reform is important both in furthering one's understanding of the dynamics of Taiwan's young democracy and for the comparative study of social policy reform more generally. Despite financial and administrative impetuses favoring the multiple-carrier reform, as well as the dominance of the KMT in policymaking processes both prior to and immediately after democratic breakthrough, the government was unable to craft a consensus for reform. Politics matters. As scholars of comparative social policy teach us, what appear to be universal pressures for reform—or in the case of the welfare state, for retrenchment—nonetheless elicit different national responses.[5] Reforming social policy is highly contested and therefore specific to national political economic circumstances.

The first section of this essay outlines the development of universal health insurance in Taiwan, a policymaking process that spanned the late 1980s to early 1990s. Here, it is argued that while political pressure intrinsic to democratic break-

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[5] See Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (New York: Oxford University Press, 1999); Paul Pierson, *Dismantling the Welfare State? Reagan and Thatcher and the Politics of Retrenchment* (Cambridge, UK: Cambridge University Press, 1994); Marian Dohler, "Policy Networks, Opportunity Structures and Neo-Conservative Reform Strategies in Health Policy," in Bernd Marin and Renate Mayntz, eds., *Policy Networks: Empirical Evidence and Theoretical Considerations* (Boulder, CO: Westview Press, 1991), 235-96.

through was the impetus for the universalization reform, the actual process of creating the NHI was dictated almost entirely by the KMT leadership and by extension, the KMT-dominated state apparatus. The second part of the essay explains how the ruling party's efforts to implement the multiple-carrier reform during the late 1990s—despite overwhelming political, financial, and administrative imperatives to enact this reform—were resisted during the legislative stage.

## The "Crisis" of Universal Health Care

Prior to the implementation of the National Health Insurance (NHI) policy in 1995, Taiwan already had a limited social insurance system in place. In this program, the provision of medical-care benefits accounted for the single largest social insurance expenditure. The gradual introduction of various employment-based insurance programs beginning in the 1950s—including labor insurance, government employees' insurance and farmers' insurance—expanded the number of those covered by some form of social insurance, though coverage remained well short of universal.[6] Because dependents and retirees were excluded from these programs, roughly 50 percent of the island's population was enrolled in any social insurance scheme by the early 1990s. The relatively decentralized administration of the various social insurance programs also contributed to significant disparities between occupational schemes, most notably in terms of the enrollees' contributions paid and the benefits received.[7] Health insurance prior to 1995, in short, was exclusionary and perceived to dis-

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[6] See Gordon Hou-sheng Chan, "Taiwan," in J. Dixon and H.S. Kim, eds., *Social Welfare in Asia* (London: Croom Helm, 1985).

[7] For example, while government employees could claim both old-age and medical care benefits upon retirement, those enrolled in the labor insurance program were forced to forfeit their medical care benefits once they had claimed old-age benefits after retirement age.

proportionately benefit certain occupational groups, particularly those in the privileged political strata.

Political pressures on the KMT party-state beginning in the mid-1980s prompted the ruling party to move in the direction of universalizing health care. The legalization of the grassroots opposition Democratic Progressive Party (DPP) in 1986, the lifting of martial law in 1987, and the continued extension of free and fair elections prompted the KMT government to launch new social policy initiatives. Reforming health care was a political strategy aimed at winning important political support. Indeed, public opinion favored the expansion of medical insurance and improved social welfare provision more generally.[8] Health-care reform was also driven by mounting challenges to the effective public administration of social insurance. State leaders reasoned that a unified administrative structure would improve coordinated decision-making and effective monitoring over the collection of insurance premiums. In short, reform was driven by both political and administrative imperatives.

In 1988, the Council for Economic Planning and Development (CEPD), a supra-advisory committee to the Executive Yuan, assembled a task force that was put in charge of initiating the reform process. The task force, comprising public health scholars from Taiwan and abroad, set out to draft the basic principles of the new health insurance program.[9] After two years of consideration and much internal debate, the task force presented its report to the Executive Yuan in 1990.[10] The challenge of "turning ideas into policy" was then given to the Department of Health (DOH), specifically to the newly formed Health Insurance Reform "small group" (*xiao zhu*).

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[8] Yun-han Chu, *Crafting Democracy in Taiwan*, 84.

[9] The core members of the task force included Professors Yaung Chi-liang, Chiang Tung-liang, and Wu Kai-hsun, all from Taiwan. In 1989, Harvard professor William Hsiao joined the task force.

[10] See the *Report on the Planning of National Health Insurance* (Taipei: Executive Yuan, Council for Economic Planning and Development, Task Force, June 1990) [in Chinese].

As one task force member, Wu Kai-hsun, explains, the DOH small group came at the health-care policymaking process from both a political and administrative perspective, working the KMT's political objectives into a feasible administrative framework.[11] Throughout this initial planning period, the KMT leadership played a supervisory role, insulating the bureaucratic policy process from outside influence.[12] With few changes made to the original task force proposal, the cabinet submitted the NHI bill to the Legislative Yuan in late 1993.

Though there was some contention over the specifics of the NHI proposal, amendments to the cabinet's bill were minor. Legislators and social movement groups were largely ineffective during legislative debates concerning the NHI. The complexity and newness of the bill prevented quick policy learning among these actors.[13] Ruling party discipline gave legislators few alternatives. While health policy planners in the DOH made great efforts to publicize the NHI program throughout the planning process, the precise implications of the NHI and the details surrounding its implementation were either left largely unexplained or simply not understood by the general

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11 Interview with Wu Kai-hsun, Chair, Health Care Cost and Arbitration Committee, DOH; member of the CEPD Task Force, November 3, 1999.

12 For example, the CEPD task force and the DOH Team were closely monitored by the Supervisory Small Group, which was made up of ranking ministerial officials and party cadres. Vincent Siew, the former deputy chair of the CEPD and senior KMT leader, convened both the Supervisory Small Group and the CEPD task force between 1988 and 1990. Siew was the key actor connecting the ruling party leadership and the inner bureaucratic circles of the policymaking task force.

13 The Committee for Action on Labor Legislation (CALL) was one of a few grass-roots advocacy groups that prepared counterarguments to the Executive's reform bill. However, this came in June 1994, only weeks before the government's bill was put to a vote. As Ku Yu-ling, the chief drafter of the CALL proposal, recounted, "We were at a disadvantage from the start. We had heard that the government was planning some new health insurance programs, but we were kept in the dark as to the details of the proposal. We had to start from the basics in order to even begin to understand the government's bill." Interview with Ku Yu-ling, Committee for Action on Labor Legislation, October 27, 1999.

public. In short, the NHI was very much a product of bureaucratic policymaking directed by the KMT party leadership.[14]

The National Health Insurance program began operating in March 1995, auspiciously one year before Taiwan's founding presidential elections. Seven years of reform planning resulted in the consolidation of the previously administratively decentralized social insurance schemes.[15] Health insurance coverage was extended to those previously uninsured, most notably to dependents of employed workers and those who were self-employed. Universal health insurance was provided for by a single, publicly-managed insurance carrier, the Bureau of National Health Insurance (BNH), which in turn fell under the jurisdiction of the Department of Health (DOH). All enrollees were subject to the same premium burdens (4.25 percent of monthly earnings) and received universally standardized medical care benefits. Patients were required to pay a flat fee copay levy at the point of service, though the actual out-of-pocket cost burden on the individual patient was not that high.[16] On the supply side of the equation, health care providers (physicians, hospitals) were compensated by the BNHI, according to a negotiated fee-for-service payment schedule.[17]

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14 Lin Kuo-min, *From Authoritarianism to Statism: The Politics of National Health Insurance*, Ph.D. Diss., Sociology, Yale University, 1997.

15 Though the labor, government employees', and farmers' insurance programs continued to operate as separate social insurance programs after the implementation of the 1995 NHI program, the portion that covered the cost of medical care was moved from each of the individual insurance schemes and integrated into one health insurance fund. Other benefits, such as disability, old-age, maternity, and death, continue to be provided for and administered by the different occupationally-based insurance schemes.

16 Patients receiving outpatient treatments at a clinic paid NT $50 (approximately US $2) out-of-pocket, while those receiving outpatient care in a large medical center paid NT $150 (approximately US $6).

17 User fees were supposed to be calculated as a percentage of the cost of the medical services received by the patient. However, due to opposition from social movements in the spring of 1995, particularly from labor organizations, the original copay scheme became a flat rate levy. The flat rate differed, depending on the size and level of the provider institution. In terms of provider reimbursement, the original NHI bill set out to institutionalize a "prospective

By the end of 1998, close to 97 percent of the island's population was enrolled in the NHI program. Access to health care provision drastically improved, especially among those who were previously uninsured.[18] The centralized structure of the NHI program, particularly its single pipe financing mechanism, promoted greater redistribution among different wage groups. Tung-liang Chiang and Shou-hsia Cheng found that, after the implementation of the NHI, the highest rates of increase in the number of physician visits were among those households from the middle (47 percent increase) and lower quartile (31 percent) income groups.[19] It should come as no surprise that public opinion toward the NHI scheme hovered around a 70 percent satisfaction rate.[20] The NHI garnered considerable

payment system" (such as the global budget mechanism). The Bureau of National Health Insurance was to allocate a set amount of funds for each medical sector/region based on the previous year's expenses. This supply-side cost containment strategy, however, was abandoned after the NHI bill was passed, due to the lack of data and some resistance by hospitals. In both cases, last minute concessions were made by the government. However, these politically motivated concessions were made *after* the implementation of the NHI program. During the planning process (1988-1994), these concerns were not systematically dealt with by the relatively insulated network of bureaucratic actors.

18 Tung-liang Chiang and Shou-hsia Cheng found that, while the utilization rate in medical services remained the same for those with some form of social insurance prior to the 1995 NHI, the rate of utilization for both outpatient and inpatient services among those newly insured under the NHI program doubled after March 1995. See Tung-liang Chiang and Shou-hsia Cheng, "The Effect of Universal Health Insurance on Health Care Utilization in Taiwan" *Journal of the American Medical Association* 278 (July 1997): 91-2.

19 Chiang and Cheng, 1997, 92. Tung-liang Chiang, in a separate study, also found that the ratio of "benefits received" to "contributions paid" was progressive across different income groups. The highest ratio of benefits to contributions was among those households from the poorest quintile (1.75) and the lowest ratio (0.96) in the richest quintile, leading Chiang to conclude that "the poor pay less but get more; the rich pay more but get less." See Tung-liang Chiang, "Taiwan's Universal Health Insurance: What Has Been Achieved? What Hasn't? And Where to Go?" paper presented at the International Symposium on National Health Insurance, Seoul, Korea, June 9, 2000, 134, 143.

20 In the author's own survey of legislators and bureaucrats in Taiwan, 70 percent of respondents (n=111) agreed that the post-1995 NHI system was more equitable than the previous health-care program.

political support for the KMT regime.

This is not to say, however, that the NHI was problem-free. Universal coverage in health insurance, combined with relatively cheap point-of-service user fees, resulted in a tremendous spike in the aggregate number of outpatient visits during the first few years of the NHI's existence.[21] On the supply side, the fee-for-service payment system gave medical-care providers an incentive to "over doctor" patients. Providers over-prescribed expensive medicines or costly and repeated treatments, while actually spending less time with each patient.[22] In other words, increasing health-care expenditures were the result of both demand-side and supply-side pressures on available health-care resources. To make matters worse, efforts at cost containment or measures to increase NHI revenues (such as raising premium rates) were obstructed by different interests at every turn.[23] For critics, the NHI program had become too politicized and prone to narrow interest group demands, from both doctors and patients, thus undermining the efficiency and long-term efficacy of medical insurance in Taiwan.

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[21] The average cost (to the NHI) for an outpatient visit in 1999 was about sixty times less than the average cost of one inpatient treatment. However, the total expenditure for outpatient care in 1998 was more than double the amount expended on total inpatient care. In most other countries, the total expenditure on inpatient treatments far outweighs the total costs of outpatient treatment. See the *National Health Insurance Annual Statistical Report* (Taipei: Bureau of National Health Insurance, June, 2000).

[22] Between 1995 and 1997, 34 percent of primary care physicians claimed to see over fifty patients per day. See the *National Health Insurance Two-Year Report* (Taipei: Department of Health, Executive Yuan, February, 1997), 130 [in Chinese].

[23] The premium rate of 4.25 percent (of monthly earnings) was based on an actuarial calculation for a five-year period. In other words, in order for the NHI program to remain financially solvent, the government should have raided the premium rate in 2000. At the time of this writing (2003), however, the premium rate continues to be 4.25 percent. Insiders tell me that the government fears the political opposition that would emerge if it were to adjust the premium rate at this time.

In its first three years of operation, the BNHI's annual surplus shrank exponentially, and by 1998, the NHI posted a deficit. In the following year, the program's reserve fund ran dry.[24] For the KMT, the NHI's financial instability represented a real political crisis. The bleak financial situation surrounding the NHI in the late 1990s cast doubt on the government's ability to effectively manage the health-care system. Media scrutiny on the financial outlook of the NHI exacerbated the perception of crisis both inside the government and among the general public. What was once a winning policy for the ruling party quickly became a political liability.

## The Multiple-Carrier Reform

State and party leaders immediately began to consider new reform ideas, particularly those that would shift the NHI's financial burdens away from central state coffers. Upcoming legislative elections in 1998 and the presidential election in 2000 compounded the sense of political urgency for the KMT regime, further prompting the government to attempt quick policy change. Politics in Taiwan had become much more competitive by the late 1990s, and the ruling KMT was increasingly uncertain about its tenuous hold on power. In short, there were important financial, political, and administrative imperatives for structural health insurance reform.

In early 1997, the Department of Health (DOH) solicited reform ideas from health-policy scholars, compiling in the end nine different proposals. The proposals ranged from those which sought to preserve but tweak the current single insurer/purchaser model, to those which advocated serious structural reform, such as the privatization and marketization of medical insurance.[25] Then Minister of Health, Chang Po-ya, was resis-

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[24] *National Health Insurance Annual Statistical Yearbook* (Taipei: Bureau of National Health Insurance, June 2000).

[25] Yeun-wen Ku, "Can We Afford It? The Development of National

tant to the market reform idea. Having been in charge of the DOH since 1990, and thus responsible for the original NHI program, Minister Chang naturally sought to maintain a significant government presence in the administration of health insurance in Taiwan.[26] The KMT leadership, however, was increasingly wary of the fiscal burden imposed by the cash-strapped health insurance program. The ruling party favored what it understood to be a more efficiency-based approach to health insurance provision. It was drawn to private sector alternatives and market-driven solutions. The cabinet was subsequently shuffled in September 1997 and newly appointed Premier Vincent Siew appointed Chan Chi-shean to head the DOH, replacing the more moderate Chang Po-ya. The new Minister Chan, a doctor from the private sector, was a proponent of completely transforming the NHI into a privatized, multiple-carrier system. Leadership changes in the cabinet, and in the Department of Health more specifically, were significant in steering health-care reform in a new direction.

Briefly, the proposed multiple-carrier system (*duo yuan hua*) would allow private sector carriers (functionally insurers) to compete. In this scheme, the Bureau of National Health Insurance (BNHI) was to become one of the many carrier options available to consumers. Enrollees would continue to pay medical insurance premiums through a single pipe mechanism to the government regulated "NHI Foundation." Funds

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Health Insurance in Taiwan," in Roger Goodman et al., eds., *The East Asian Welfare Model: Welfare Orientalism and the State* (London: Routledge, 1998), 134-5.

[26] Minister Chang Po-ya supported a "publicly administered, private sector" insurance system (*gong ban, min yi*). Under this proposed system, the role of insurance carrier was to be relinquished to the private sector, though the state would continue to play a significant regulatory role. For a more detailed analysis of Chang Po-ya's *gong ban, min yi* proposal, see *A Review of Taiwan's National Health Insurance Reform Design* (Taipei: Department of Health, internal document, April 15, 1997), 21-2 [in Chinese]. See also Cheng Min-he, "The State and the Development of National Health Insurance in Taiwan: An Examination of the State-Centered Theory," M.A. Thesis, Department of Social Policy and Social Work, National Ji-Nan University, June 1998, 126 [in Chinese].

would then be allocated to carriers on a per capita basis. These funds would, in turn, reimburse contracted providers or networks of providers, again based on a risk-adjusted capitation (per capita) calculation. All carriers were to provide a standard menu of services to ensure that all enrollees, irrespective of which carrier they joined, received the same basic health-care services. However, carriers could offer supplemental services and charge supplemental insurance premiums to their enrollees. Market competition, therefore, was to lie outside of the government-mandated basic service menu.

Prospects for the multiple-carrier reform appeared to be good. For one, the proposed policy and the rationale behind it seemed tenable. Consumer choice in carriers would encourage insurers to promote efficient practices, not only in their own administration, but also in ensuring that their contracted medical-care providers worked cost-effectively, yet without compromising health-care quality. Simply put, competition among carriers (and by extension, among their contracted provider networks) would promote both administrative efficiency and supply-side cost containment. Private sector carriers, reformers argued, would be much more efficient than the government in allocating scarce financial and medical resources. Furthermore, the proposed multiple purchaser system would shift financial responsibilities in the provision of medical insurance away from the government. Finally, the government was to continue intervening in health insurance matters, particularly in preserving the equity effects of the pre-existing NHI system. All enrollees were to receive the same basic services, for instance. Carriers would be prohibited from rejecting membership to any prospective enrollees, regardless of the risk potential of the patient.[27] Universal entitlement to

[27] Deputy Minister of Health, Yaung Chi-liang, explained that the risk adjusted capitation payment scheme to carriers would deter risk-averse selection among carrier-providers. Interviews with Deputy Minister of Health, Yaung Chi-liang, Department of Health, Executive Yuan.

medical insurance was to be guaranteed under the proposed reform.

The multiple-carrier reform emerged onto the policy agenda at a time when it appeared to be politically fortuitous for structural reform. Most importantly, as alluded to above, the NHI program was perceived to be in a state of irreversible financial crisis. Furthermore, after the 1997 cabinet shuffle, the multiple-carrier reform enjoyed the support of the Executive Yuan. Elite convergence among high-level officials in the BNHI, the DOH, and prominent Taiwanese scholars suggested that there was a substantial degree of policy consensus.[28] In the legislative arena, the KMT continued to control a majority of seats in the Legislative Yuan. Additionally, the opposition DPP was internally divided on the issue of health-care reform. The six DPP reform bills that were submitted to the Legislative Yuan in 1998 spanned the ideological spectrum, ranging from legislator Lee Ying-yuan's complete marketization proposal, to Shen Fu-hsiung's partial health insurance scheme, to labor-backed Chien Shi-chieh's proposal to eliminate insurance contributions and instead allocate government funds to finance public health care.[29] There was clearly no party consensus within the opposition. Finally, the original NHI Act of 1994 stipulated that, after the first two years of the NHI's operation (which began in 1995), the DOH was to compile a two-year report for the Executive Yuan. The report was to evaluate the NHI and to prompt renewed debates about further reform. The KMT was essentially given a ready-made

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[28] During the fall of 1999, the author interviewed all of the members of the original planning task force sponsored by the Council for Economic Planning and Development (1988-1990). With the exception of Wu Kai-hsun, all of the original members expressed support for a privatized, market-based reform package. For a discussion on the importance of elite "policy sponsorship," see John C. Campbell, *How Policies Change: The Japanese Government and the Aging Society* (Princeton, NJ: Princeton University Press, 1992), chaps. 1 and 2, especially pp. 46-8.

[29] See the *Bulletin of the Legislative Yuan*, Taipei, October 16, 1997 [in Chinese].

"window" of opportunity for health policy reform.[30]

In sum, the KMT presented a convincing rationale for reform, and toward that end, the party offered a plausible reform agenda. The political conditions also appeared to be fortuitous for health policy reform. The KMT's demonstrated ability to effectively direct health policy reform during the universalization reform process of the late 1980s and early 1990s seemed to suggest that the multiple-carrier reform was likely to be accepted. The Executive Yuan approved the multiple-carrier reform proposal in February of 1998 and the bill arrived in the legislature in March. It was expected to pass.

## Resisting Reform

By the fall session of the 1999 legislature, fourteen different members' bills on health-care reform had been introduced to the Legislative Yuan, in addition to the multiple-carrier reform proposed by the executive branch.[31] After the DOH's reform bill was referred to the Health and Welfare Committee of the Legislative Yuan, the bill was not presented back to the legislature for its second reading. The executive's multiple-carrier reform bill was not technically defeated in the legislature, as the bill was not put to a vote. However, by year-end 1999, the DOH's reform bill essentially had died in committee, and since that time, enthusiasm for the multiple-carrier reform idea has waned. The KMT failed to put together a legislative consensus in favor of the multiple-carrier reform idea. Why was the KMT government unable to craft a legislative consensus specifically, and a broader consensus for reform more generally?

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30 See John Kingdon, *Agendas, Alternatives and Public Policies*, 2d ed. (New York: Longman, 1995), chap. 8.

31 See the *Bulletin of the Legislative Yuan, Health and Welfare Committee Report*, September 1999 [in Chinese].

*Waning KMT Authority*

Weak leadership, particularly within the ruling party, undermined effective consensus building in the Legislative Yuan. In the past, efficient policymaking in the KMT party-state, even after the introduction of democratic reform, was facilitated by the ruling party's ability to discipline its legislative rank-and-file. The story of resisting reform, however, suggests that the dominance of the KMT leadership had begun to wane by the late 1990s. Though the proposed multiple-carrier reform was endorsed by some KMT heavyweights in the party leadership, several KMT legislators nonetheless voiced their opposition to the reform proposal.[32] The days of the rubber-stamp legislature seemed to be over, despite the fact that the KMT continued to "control" a majority of seats in the legislature.

Huang Chao-shun, a senior KMT legislator and vice director of the KMT Central Policy Committee (CPC), explains that legislative deliberation among KMT members remains in the CPC. However, she adds that KMT legislators increasingly have found their own policy niches and have become more vocal in CPC debates. Rank-and-file legislators have begun to seriously challenge the party leadership. It is not uncommon for KMT legislators to vote against the party and/or executive line during policy committee deliberations.[33] In

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[32] For example, KMT legislator Lin Yaw-hsing raised skepticism regarding the private-sector multiple-carrier reform when he stated: "[P]rivate carriers would only agree to participate in the health insurance market if it can guarantee a profit. Seeing as the government already subsidizes one-third of the financing for the current NHI system which operates at a deficit, can we expect private sector carriers to subsidize a money-losing enterprise? I doubt it." Shyu Jong-shyong, a KMT legislator and standing member of the legislature's Health and Welfare Committee contended that the government needed to take a slower approach to reform and first exhaust all other reform options before undertaking such a structurally radical reform agenda. Lin Yaw-hsing, KMT Legislator, December 1, 1999, and Shyu Jong-shyong, KMT Legislator, December 2, 1999, interviews by author.

[33] Interviews with Huang Chao-shun, KMT Legislator and Vice Director of

terms of the multiple-carrier health insurance reform, Huang herself expressed reservations about the proposal because of fears that the privatization of medical insurance would undermine the equity principles of universal health insurance. Some KMT legislators proposed alternative versions of health policy reform, rivaling the multiple-carrier reform in the Legislative Yuan. In fact, the party's Central Policy Committee (CPC) did not endorse the executive's multiple-carrier reform, an open defiance of KMT party leadership that was unheard of only a few years earlier.

Debate within the legislature about health-care reform was not waged among the political parties, but rather among individual legislators and between legislators and their respective party leaders. The lack of party coordination in the health-care reform debate, among both the ruling and opposition parties, fragmented the legislature and ultimately led to legislative deadlock and indecision on the issue of health-care reform. The failure of the KMT to forge a consensus in the legislative arena, even among its own members, highlights the breakdown of political parties as effective sites for consensus building and collective action in the legislature.

Intraparty factionalism has challenged party leaders' ability to steer the legislative rank-and-file during the policymaking process. Tensions surrounding the reunification (with China) versus independence debate internal to the KMT party have slowly but surely deligitimized the authority of party leaders. Factionalism in the KMT, a party with a nominally proreunification stance that finds its origins on mainland China, deepened with the ascent of Lee Teng-hui to the presidency and party leadership during the late 1980s. Lee, himself born in Taiwan, was immediately challenged by the mainlander-dominated faction of the KMT.[34] For the hardline mainlander fac-

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the KMT Central Policy Committee, November 11, 1999, and Lin Yu-hsiang, Deputy Director, KMT Central Department for Policy Research, June 10, 1999, interviews by author.

[34] Linda Chao and Ramon Myers, 1998, 156-7.

tion, Lee appeared to soften on the issue of Taiwan's independence.[35] President Lee's concessions to the opposition party, made in the interest of consolidating democracy in Taiwan, deepened the chasm between his softline faction and the KMT old guard.[36] Though factional politics in the KMT has a long history, divisions within the party surrounding the legitimacy of the party leadership became particularly pronounced in the 1990s. In short, KMT party leaders did not have the authority or legitimacy to effectively coordinate policy decisions among the party's own legislators during the health-care reform process of 1998.

Political fragmentation within parties and the inability of party leaders to foster consensus in important policy matters are also a consequence of certain institutional factors built into Taiwan's emerging democratic system. Specifically, electoral institutions have reshaped individual legislative behavior vis-à-vis their political parties. The single non-transferable vote and multi-member district (SNTV-MM) electoral system undermines party discipline.[37] Under this type of electoral system,

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[35] See Tse-min Lin, Yun-han Chu, and Melvin Hinich, "Conflict Displacement and Regime Transition in Taiwan: A Spatial Analysis" *World Politics* 48, no. 4 (1996): 456-61. See also Tse-min Lin, Yun-han Chu, Tong-yi Huang, and Bao-hui Zhang, "Elections and Elite Convergence: The Consolidation of Democracy in Taiwan," paper presented at the American Political Science Association Annual Meeting, San Francisco, August 29-September 1, 1996, 16.

[36] For example, in an effort to recast the KMT party as a moderate democratic and reform-oriented party, Lee convened two major interparty meetings during the 1990s. The ruling party compromised on several key issues with the opposition DPP. In the 1990 National Affairs Conference, Lee orchestrated an interparty agreement which forced the retirement of life-tenure parliamentarians held over from mainland elections in 1947. The 1996 National Development Conference led President Lee to proclaim that Taiwan was not a part of the People's Republic of China and that Taiwan's admission into the United Nations and other international organizations was to be actively pursued.

[37] See John Fu-hseng Hsieh, "Continuity and Change in Taiwan's Electoral Politics," in John Fu-hseng Hsieh and David Newman, eds., *How Asia Votes* (New York: Chatham, 2001); John Fu-hseng Hsieh, "The SNTV System and Its Political Implications," in Hung-mao Tien, ed., *Taiwan's Electoral Politics and Democratic Transition* (Armonk, NY: M.E. Sharpe, 1996); Shelley Rigger,

parties must field several candidates in each electoral district and candidates from the same party compete against one another.[38] Thus, party labels and party policy platforms are less meaningful. Jih-wen Lin explains that the optimal candidate strategy is to run on particularistic policy positions that are, consequently, often at odds with the party's official line.[39] Furthermore, because of the multi-member district arrangement, the minimum-winning threshold for legislative candidates is very small.[40] Personal networks, novel policy ideas, alliances with grass-roots organizations, the promise and exchange of political pork, and local ties are therefore far more instrumental to candidates' electoral success than party leadership support. Indeed, legislative candidates from the KMT have increasingly campaigned independently of their party, and in so doing, have come to rely less on party patronage for their own political survival. In sum, Taiwan's unique electoral institutions and persistent intraparty factionalism have weakened KMT party leaders' ability to coordinate and/or discipline the party's rank-and-file in legislative matters.[41] This was certainly the case in 1998.

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*Politics in Taiwan: Voting for Democracy* (London: Routledge, 1999), chap. 2; Gary Cox, *Making Votes Count: Strategic Coordination in the World's Electoral Systems* (Cambridge, UK: Cambridge University Press, 1997), chap. 13.

[38] The average number of seats contested per district in the 1998 Legislative Yuan elections was 5.68.

[39] Lin Jih-wen, "Vote Buying versus Noise-Making: Two Models of Electoral Competition under the Single Non-Transferable Vote Multi-Member District System," *Chinese Political Science Review* 30 (December 1998): 93-122.

[40] Prior to the 1998 elections, when the legislature comprised 164 seats, the minimum-winning threshold was about 50,000 votes. For example, in 1992, the lowest winning threshold in Taipei city (eighteen seats), a district with an unusually high number of winable seats, was just over 21,000 votes or 3.5 percent of the total vote. Andrew Nathan, *China's Transition* (New York: Columbia University Press, 1998), 114. After the Legislative Yuan was expanded in 1998 to the current 225 seats, the average winning threshold was only 30,000 votes for a single candidate.

[41] According to both legislators and bureaucrats surveyed in Taiwan (n=111) in 1999, legislators were considered to be the single most influential

## *The Go-Slow Technocrats*

That something had to be done to promote cost containment and greater financial stability in the NHI program was a goal that garnered general agreement. Exactly what that something should be actually was quite contested. For certain, the fiscal crisis of the NHI carried serious political implications for the ruling party. Upcoming elections in 1998 (legislature) and again in 2000 (presidential) meant that the KMT had to quickly shape up the NHI program. The party's position was reflected in the naming of Chan Chi-shean and Yaung Chi-liang to head the DOH. They both supported the privatization and marketization of medical insurance, though with continued government regulation.[42] Yet, despite the *appearance* of executive consensus around the multiple-carrier proposal, pockets of bureaucratic policymakers inside and outside of the DOH remained cautious about the more radical marketization reform idea.

Many of the ranking policymakers in the DOH during Chan Chi-shean's tenure as Minister of Health were, in fact, recruited into the bureaucracy during the early 1990s. Despite the cabinet shuffle in late 1997 that brought about a new leadership in the DOH, there still remained tremendous continuity among influential, nonpolitically appointed policymaking bureaucrats. For instance, the core of the DOH "small group," including key division leaders Lee Yu-chune and Lo Chi-ch'ong, was held over from when the NHI policy process began in the DOH in 1990. Resistance to the multiple-carrier reform emerged, therefore, among these DOH policymakers who had devoted the last eight years to perfecting the single-

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actors in the policy process, outranking the president, parties, and the bureaucracy.

[42] Chan Chi-shean was named Minister of Health in late 1997. Yaung Chi-liang, himself a member of the original task force from the late 1980s, was appointed Deputy Minister of Health in early 1999. Both were proponents of the multiple-carrier reform idea.

carrier system. For some, particularly those employed by the Bureau of National Health Insurance (BNHI), resistance to the multiple-carrier reform stemmed from their individual self-interests in sheltering the BNHI from market competition.[43] For others, the privatization of medical insurance, in effect, would undercut the government's authority to regulate the provision of basic health-care services.[44]

Politically speaking, the DOH small group, comprising the core decisionmakers in health-care policy, was increasingly less constrained by ruling party intervention. Even though the small group is officially chaired by the Deputy Minister of Health, him- or herself a political appointee, insiders say that the division leaders within the small group actually set the policymaking agenda, thus keeping the core of the DOH policymaking group insulated from party interference.[45] This was critical as key members of the DOH small group were proponents of what the author calls the "go-slow" approach to health-care reform. These go-slow technocrats worked on numerous reform alternatives that ultimately challenged, and in a way undermined, the leadership's multiple-carrier proposal.

Proponents of a more cautious approach to reform contended that the government had a wide array of policy instru-

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[43] Some of the key leaders in the Bureau of National Health Insurance publicly expressed support for the multiple-carrier system. However, many ranking bureaucrats in the BNHI privately expressed to the author during interviews concern over the reform proposal, in part stemming from the fear of job losses for the bureau staff if the bureau were to be privatized and subject to market competition.

[44] Shu-ling Tsai, director of the planning and evaluation department in the BNHI, pointed out that the privatization of health insurance was a "one chance" reform. Efforts to bring back the provision of health insurance into the public sector, should private sector alternatives prove undesirable for whatever reason, would subsequently be impossible. Interview with Shu-ling Tsai, Director, Department of Planning and Evaluation, Bureau of National Health Insurance, October 5, 1999.

[45] Interview with Julie Ma, Research Associate, DOH Small Group, Department of Health, November 11, 1999.

ments at its disposal that to date had not been utilized in resolving key structural inefficiencies in the NHI program.[46] They argued that "reform from within," and without major structural reform, could resolve the NHI's financial crisis. For example, in an effort to curtail the over-utilization of medical resources, the BNHI raised copay rates for excessive outpatient treatments and prescription drugs during the summer of 1999. Wen-hui Cheng, Director of Finance in the BNHI, forecasted a positive prognosis in terms of cost containment and reducing utilization rates as a result of this strategy.[47] Earlier in the spring of 1999, the BNHI launched a new expenditure-monitoring system whereby irregularities in service, such as over-prescribing, overly frequent follow-up visits, and large drug prescriptions, were flagged by the bureau and brought to the attention of the provider.[48] The emergence of new and reliable data has allowed the BNHI to more effectively monitor, discipline, and hold accountable the behaviors of medical-care providers.

Perhaps the most important attempt at reform from within has been through the gradual expansion of the global budget provider payment mechanism. The original NHI program mandated a prospective provider payment system (i.e., global budgets), though this scheme was abandoned almost immediately after the NHI's implementation in the spring of 1995, due to opposition from physicians and hospital administrators. Despite this, the global budget idea continued to be pushed

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46 Wu Kai-hsun, one of the original policy planners on the CEPD task force of the late 1980s, stated, "[W]e originally designed a great system. But because of political considerations, we had to make many concessions, such as dropping the referral system and abandoning the gradual introduction of the global budget program. We need to try these reforms before considering the *duo yuan* [multiple-carrier] reforms." Interview with Wu Kai-hsun, Chairman, Medical Care Cost Arbitration Committee, Department of Health, November 3, 1999.

47 Interview with Peter Wen-hui Cheng, Director, Department of Finance, Bureau of National Health Insurance, October 14, 1999.

48 Laurie Underwood, "Stronger Prescription Needed," *Topics* (April 2000): 38.

behind the scenes by policymakers in the DOH and by various professional medical associations. Professor Lee Yu-chune, director of the payment division in the DOH small group, accelerated the implementation of the global budget system in late 1998, beginning with dentists in the summer of 1999 and followed by traditional Chinese medical practitioners. Primary care physicians, the largest category of medical providers, negotiated the terms of their joining the global budget payment scheme in 2001. According to Lee, the global budget payment system has been successful in containing costs in those sectors. She anticipates that the inclusion of other providers will be effective in slowing down even further the rate of increase in aggregate health-care costs.[49] To be sure, beginning in 1999, annual health-care expenditure growth rates declined dramatically.[50]

In sum, political space afforded by the gradual depoliticization of the bureaucracy and the articulation of new alternative solutions deligitimized the KMT's reform proposal. While the go-slow technocrats did not directly factor in the multiple-carrier reform process early on, they did matter very much in giving shape to the emerging forces resisting the reform. For one, the go-slow bureaucrats in the DOH and the BNHI presented a slew of reform alternatives—alternatives which seemed to address the health-care crisis—that in the least blunted the sense of urgency within which the multiple-carrier reform proposal first emerged. Second, these alternative solutions provided ammunition for legislators opposed to the marketization reform effort. Finally, the go-slow technocrats helped new

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[49] Interview with Lee Yu-chune, DOH Small Group, Department of Health, Executive Yuan, October 2, 2000.

[50] The annual growth rate in national health-care expenditures between 1995 and 1998 averaged over 10 percent per year. In 1999, health-care costs increased by about 5 percent and in 2000, expenditures grew by only 3 percent, the first time that health-care costs did not outpace the GDP growth rate. Tung-liang Chiang and Chih-liang Yaung, "Recent Health Care Reforms in Taiwan: The Global Budget Policy," presented at the HHIP Conference, Thailand, December 5, 2001.

social movement coalitions formulate their own critiques of the multiple-carrier reform proposal.

### *Societal Mobilization*

In March 1998, just weeks after the Executive Yuan delivered the multiple-carrier reform proposal to the legislature, a short publication entitled *Big Business Health Insurance, Citizens Without Insurance* was circulated to all legislators and ranking bureaucrats in the DOH and the BNHI. The fiercely critical pamphlet was prepared by a coalition of over two hundred social movement groups, representing workers, children's organizations, the aged and disabled, aboriginal movements, women's groups, and several professional medical associations. The "NHI Coalition" opposed the government's multiple-carrier reform proposal. Members of the coalition contended that a private sector, competition-based health insurance system would lead to a multi-tiered health-care system that unjustly benefited wealthier patients and large privately-owned medical centers. The NHI Coalition also offered several different reform alternatives. For instance, members stressed the need for supply-side cost controls (such as global budgets), administrative streamlining, and a more progressive financing scheme, wherein less financially able patients paid a lower premium rate than those relatively more well off.[51]

The formation of the NHI Coalition in 1998 represented a new pattern of societal mobilization in Taiwan's politics. First, despite the initial fragmentation of social movement groups during the immediate post-transition period,[52] the formation of the NHI Coalition brought together a range of grass-roots movements. Its sheer size was unprecedented in social move-

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51 1998 NHI Coalition, *Big Business Health Insurance, Citizens Without Insurance* (March 1998) [in Chinese].

52 Yun-han Chu, "Social Movements and Democratization," in *Crafting Democracy in Taiwan*, chap. 4.

ment politics in Taiwan.[53] Second, the coalition was unique in its cross-class and cross-cleavage appeal. The broad-based, cross-cleavage composition of the NHI Coalition recast the idea of social welfare as one that was supported by the working and middle classes, as well as across genders, age groups, and occupational categories. The 1998 coalition, and its place in the health-care reform debate, transcended narrowly defined interests.[54]

Third, the NHI Coalition effectively blended legitimate policy expertise with grass-roots mobilization, resulting in what the author calls *expert-activism*. Prominent social policy scholars offered their skills and experience in drafting the coalition's manifesto.[55] Intergroup cooperation and the expanding network of policy experts within the NHI Coalition facilitated important information exchange, encouraged the sharing of ideas and proposals, and thus afforded the coalition members the opportunity to more effectively engage the policy reform process. According to the author's 1999 elite survey data, 74 percent of respondents (n=109), comprising both legislators and health-policy bureaucrats, perceived societal group influence to be increasing; only 6 percent felt it to be on the decline. Seventy-two percent of respondents (n=111) agreed that: "During the policymaking process, the government will consult with societal groups or group leaders."

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53 In the run-up to the 1995 legislative elections, fifty different grass-roots organizations formed the "Social Movement and Legislation Coalition" (*she hui yun dong li fa lian mong*). Many participants in this social movement coalition participated again in the 1998 NHI Coalition, citing that the impact of the 1995 alliance was instrumental in their decision to join the later coalition.

54 For a more in-depth analysis of new class politics in Taiwan, see Hagen Koo, "The Middle Classes in East Asian Newly Industrialized Societies: Issues, Preliminary Findings and Further Questions," in Hsin-huang Hsiao, ed., *East Asian Middle Classes in Comparative Perspective* (Taipei: Institute of Ethnology, Academia Sinica, 1999), 83-100.

55 In fact, one of the principal contributors to *Big Business Health Insurance, Citizens Without Insurance* was (and still is) a high-ranking official in the Department of Health. This official asked to be anonymous.

Social movements played an important part in determining the outcome of the multiple-carrier reform effort. The broad base of support mobilized by the NHI Coalition strengthened its influence in the policy process, especially in the legislature. Politicians, and even bureaucrats, could not politically afford to disregard the coalition. Indeed, as alluded to above, increasingly autonomous legislators take their cues from grass-roots organizations. Elite survey data show that 77 percent of legislator respondents (n=43) meet with societal group leaders at least once a month to discuss policy matters. In terms of the multiple-carrier reform effort, societal actors actively penetrated the legislature. Specifically, the NHI Coalition and its corps of policy experts played an important educative role in the Legislative Yuan, where legislators themselves were often underinformed about the specifics of any given policy.[56] Much of the opposition in the legislature to the multiple-carrier reform—from both the ruling and opposition parties—echoed many of the key arguments raised by the NHI Coalition.

### *Resisting "Retrenchment"*

What was particularly interesting about the failed multiple-carrier reform process during the late 1990s was the way in which opponents to the reform proposal transformed the *policy debate* from one about health-care efficiency into a *political battle* about social welfare. For opponents to the multiple-carrier idea, mobilization was not so much about resisting reform as it was about resisting what was understood to be *welfare state retrenchment.* This was somewhat counter-intuitive because ideological left-right conflict never was a part of the political mainstream in Taiwan. Given the absence of a left-leaning political party or a strong labor movement, it seemed

[56] For instance, 81 percent of legislators (n=47) and 86 percent of bureaucrats (n=64) disagreed with the statement, "When policy bills reach the Legislative Yuan, legislators completely comprehend the policy's content."

unlikely that mobilization in health-care policymaking would have formed around ideas such as "welfare" and "welfare state retrenchment.[57]" Nonetheless, KMT, DPP, and social movement opponents to the multiple-carrier reform similarly articulated their opposition to the proposed reform in terms of resisting retrenchment.

To understand the origins of this new political context, we must examine the important legacies left by the original NHI program. Focusing on "policy feedbacks," Theda Skocpol and Edwin Amenta suggest that it is important to "trac[e] the political consequences of *already instituted* policies or sets of policies." They go on to state that "not only does politics create social policies; social policies also create politics."[58] Put another way, pre-existing social policies redistribute resources and they also restructure politics. Paul Pierson is more specific when he argues that welfare state policies "create their own constituencies," and thus set a policy path dependent course for future reform.[59] John Kingdon contends that radical policy reform, such as the institutionalization of NHI in 1995, establishes a "new principle" in the affected policy domain, such that,

> [p]ublic policy in that arena is never quite the same because succeeding increments are based on the new principle, people become accustomed to a new way of doing things. . . . A precedent is set, so future arguments surrounding the

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57 A Labor Party did form in Taiwan in late 1987. However, the party's influence has remained minute, given its geographical base in the south and the common perception that the Labor Party is sympathetic to reunification and the Chinese Communist Party. See Wu Yu-shan, "Marketization of Politics: The Taiwan Experience" *Asian Survey* 29, no. 4 (1989): 388-9.

58 Theda Skocpol and Edwin Amenta, "States and Social Policies," *Annual Review of Sociology* 12 (1986): 149-50. See also Atkinson and Coleman, "Policy Networks, Policy Communities and the Problems of Governance," 173-5.

59 Paul Pierson reasons that "the policy induced emergence of elaborate social and economic networks" has the effect of "increas[ing] the cost of adopting once possible alternatives" and "inhibit[ing] exit from the current policy path." Paul Pierson, "The New Politics of the Welfare State," *World Politics* 48 (January 1996): 147.

> policy are couched in different terms . . . [i]nertia sets in, and it becomes difficult to divert the system from its new direction.[60]

The political effect of any redistributive policy is the formation and subsequent entrenchment of new coalitions that are resistant to change.

The NHI left its clear imprint on the structure of politics, the distribution and reshaping of interests, and patterns of political mobilization in health-care policymaking subsequent to its implementation in 1995. For instance, the creation of the central Bureau of National Health Insurance as a result of the NHI program turned bureaucratic interests toward maintaining the single-carrier model. As argued above, many staffers in the BNHI feared that market competition with private-sector carriers could potentially result in the streamlining of personnel in the central Bureau, or worse yet, the dismantling of the BNHI. Self-interested actors rarely welcome competition and the possibility of their own extinction.

The legacy effects of the NHI were most visible in the dynamics surrounding the formation of the 1998 NHI Coalition. Institutionally, the administrative integration of health insurance centralized the politics of health policymaking within a single, national, and discrete policy arena. The "nationalization of health politics" facilitated the extension of cooperative linkages between disparate groups that previously had found no common arena in which to mobilize. Simply put, the institutions that made up the NHI focused policymaking attention. Furthermore, following the logic of Pierson's argument, the universal extension of standardized benefits and the uniformity of contribution rates in the original NHI program entrenched a collective interest in preserving such an arrangement. The NHI program galvanized otherwise disparate, and in some cases, competing social movement groups around a

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[60] Kingdon, *Agendas, Alternatives and Public Policies*, 191.

single policy issue.[61] The 1998 NHI Coalition's collective interest in preventing a certain outcome (i.e., the multiple-carrier reform) overrode each member group's particularistic interests. Though each social movement group held to narrow, and thus often competing, interests in other areas of the health policy debate, the 1998 coalition of civil society actors did share a common negativist stance against the proposed multiple-carrier reform.[62] It does not take long for interests to mobilize around a preexisting policy, particularly when there is a perceived threat to that policy and its constituent interests.[63]

The 1995 NHI program also entailed an *ideational legacy* that interacted with an emerging normative view about the place of social welfare in Taiwan's young democracy.[64] The

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[61] This process of galvanizing group interests is best demonstrated in the fractious labor movement that emerged after democratic transition. Tsai Shu-ling of the Bureau of National Health Insurance explains that "before [1995], unions were diffused among different regions and sectors. Labor mobilization tended to be focused on the shop floor. The NHI, however, really amalgamated the labor movement under a single issue. It's the first time that labor unions and movement leaders actually had something to work on cooperatively." Deputy Minister of Health, Chang Hong-jen, succinctly opines that "the NHI *created* the labor movement that we see today." Interviews with Tsai Shu-ling, Director, Department of Planning and Evaluation, Bureau of National Health Insurance, October 5, 1999, and Chang Hong-jen, Deputy Minister, Department of Health, Executive Yuan, October 20, 1999.

[62] For example, primary care physicians are very much in support of a referral system based on differential copay rates. Labor and women's groups are completely opposed to any copay increases, let alone a referral system whereby only the wealthier are able to "jump levels" and directly pay for and receive more expensive care from the large medical centers.

[63] In her insightful discussion on "interests," Deborah Stone writes, "Every political goal can be portrayed both as a good to be obtained and a bad to be avoided. . . . People respond different[ly] to bads and goods. They are far more likely to organize around a threatened or actual loss than around a potential gain. They are more ready to sacrifice and take risks in order to avoid a loss." Deborah Stone, *Policy Paradox: The Art of Political Decision Making* (New York: W.W. Norton, 1997), 220.

[64] Between 2000 and 2002, the Taiwan government passed and/or implemented a new pensions program, a restructured old-age benefits package, an occupational hazards protection law, a new unemployment insurance program, and the Gender Equality Labor Law.

equity enhancing effect of the NHI helped strengthen the idea that political democracy *is supposed to* promote greater socio-economic equity.[65] Even though Taiwan enjoyed a long history of equitable economic growth, public opinion data from the early 1990s nonetheless showed that the general public viewed social welfare reform to be important, ranking it second behind the environment in terms of policy priorities for the democratizing state.[66] Political elites increasingly share this normative view. According to the author's 1999 elite survey data, of the 111 bureaucrat and legislator respondents, 97 (or 87 percent) of them agreed that, "Public provision of social welfare is a fundamental characteristic of democracy." Ninety-one percent of the elite respondents (n=111) also agreed that "universal health care is a democratic right." In short, the idea of universal health care was understood by both citizens and policymaking elites to be a normative good in Taiwan's democracy. Therefore, the notion of resisting retrenchment not only satisfied the *collective interests* of those who benefited from the original NHI, but also it resonated with the way in which opponents to the multiple-carrier reform *understood social welfare.* The language of resisting retrenchment fit well with the opposition both on normative grounds and as a strategy for political mobilization.

In sum, the legacies of the original NHI program helped structure a larger political context hostile to the government's proposed reform. The multiple-carrier proposal was understood as, and indeed, articulated as a threat to the interests and ideas of those who wanted to preserve the 1995 NHI structure. The image of the multiple-carrier reform was trans-

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65 Adam Przeworski finds, for example, that "the first connotation of 'democracy' among most survey respondents in Latin America and Eastern Europe is 'social and economic equality.'" Adam Przeworski, "Minimalist Conceptions of Democracy: A Defense," in Ian Shapiro and Casiano Hacker-Cordon, ed., *Democracy's Value* (Cambridge, UK: Cambridge University Press, 1999), 40.

66 Cited in Ku Yeun-wen, *Welfare Capitalism in Taiwan: State, Economy and Social Policy* (New York: St. Martin's Press, 1997), 190-1.

formed from one that promoted equity and efficiency into an image of welfare state retrenchment. This frustrated proponents of the reform. As legislator Shen Fu-hsiung puts it: "The government's biggest mistake was to make its first attempt at universal health care such a generous program. It is impossible in a democracy to now convince people that what is best for them is to be less generous."[67]

## Conclusions and Implications

This essay began with a puzzle. Despite powerful political, economic, and administrative pressures to restructure its universal health insurance system, the Taiwan government failed to do so. As a single case study, this analysis of resisting health-care reform (or retrenchment) illuminates a new politics of policymaking in democratizing Taiwan. It presented four interrelated arguments to explain why the KMT government, despite the ruling party's historically dominant position in the policymaking process, failed to craft a consensus in favor of the multiple-carrier reform both in the legislature and more generally.

First, though the KMT continued to control a majority of the seats in the Legislative Yuan, its ability to direct policy change from above was undermined because of intraparty factionalism and weakened party discipline resulting from Taiwan's unique electoral institutions. Second, health-policy bureaucrats convincingly articulated tenable policy alternatives which not only undercut the urgency for the government's reform effort but also provided technocratic policy ammunition for legislators opposed to the multiple-carrier reform idea. Third, the emergence of broad-based societal mobilization and the ability of the NHI Coalition to penetrate the legislative arena compelled vote-seeking legislators to challenge the proposed multiple-carrier reform. And finally,

[67] Interview with Shen Fu-hsiung, DPP Legislator, November 16, 1999.

legacies of the original NHI program constructed a political and ideational context hostile to structural reform. Despite reasoned arguments by proponents of the multiple-carrier idea that this reform would improve the efficiency of health-care provision as well as preserve distributional equity, opponents framed the policy debate as one about resisting *retrenchment.* This legacy is perhaps the most significant constraint on health-care policymakers, limiting the range of politically feasible alternatives. To be sure, no political actor presently dares to raise the issue of structural health insurance reform. There has been little will to raise the insurance premium rate from the current 4.25 percent (of monthly income), despite the fact that actuarial calculations made in 1995 forecasted a need for rate adjustment after five years in 2000.

For scholars of Taiwanese politics, the story of resisting reform during the late 1990s underscores the importance of situating policy and policymaking analyses in the context of democratic change. Studying the impact of democratic change on policymaking processes is a new and important area of scholarly research.[68] Clearly, politics, and specifically the nature of democratic politics, in Taiwan has changed over time. As this case study demonstrates, waning KMT authority in politics and the policy process highlights significant shifts in the balance of power among the contending parties as well as within parties, between leaders and their rank-and-file. The emergence of legislative deadlock challenges policymakers and signals the weakening of key political institutions like political parties. The formation of social movement alliances, the shar-

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[68] Ching-ping Tang and Shui-yan Tang, "Democratizing Bureaucracy: The Political Economy of Environmental Impact Assessment and Air Pollution Fees in Taiwan," *Comparative Politics* (October 2000): 81-99. Tun-jen Cheng, "Economic Consequences of Democratization in South Korea and Taiwan," *Journal of International Political Economy* (March 1997): 41-60. Steve Chan, "Democracy and Inequality: Tracking Welfare Spending in Singapore, Taiwan and South Korea," in Manus Midlarsky, ed., *Inequality, Democracy, and Economic Development* (Cambridge, UK: Cambridge University Press, 1997), 240-5.

ing of information and expertise among these groups, and increasing interaction between civil society and the legislature have together strengthened the position of societal actors in the policy process. This study on the changing politics of policymaking in democratizing Taiwan reminds us that democratic transformation is a process of continual change and we therefore need to account for its impact on the dynamics of policymaking *over time*.[69] Certainly social policymaking in the late 1990s was very different from patterns of policymaking of the late 1980s and early 1990s when the KMT was the principal actor, just as the nature of democratic politics in Taiwan more generally has changed over the course of the last decade.

The arguments that have been developed in this essay speak not only to the specific politics of health-care reform in Taiwan, but also to comparative debates and theories of the welfare state and welfare retrenchment. First, the resistance to health-care reform in Taiwan during the late 1990s—despite overwhelming political, economic, and administrative pressures favoring reform—reinforces the point made by others that seemingly universal pressures for change do not guarantee uniform results. Politics determines what Marian Dohler calls the "goodness of fit" between reform ambitions and extant political realities.[70] Second, the cross-class composition of the NHI Coalition in Taiwan and the absence of any workers' or explicitly left-leaning political party suggest that the politics of welfare are no longer fought exclusively along socioeconomic class lines as many earlier studies of the welfare state suggested.[71] This important point requires us then to

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[69] See Joseph Wong, "Dynamic Democratization in Taiwan," *Journal of Contemporary China* 10, no. 27 (2001): 339-62; Edward Friedman, ed., *The Politics of Democratization: Generalizing East Asian Experiences* (Boulder, CO: Westview Press, 1994), 5; Gerardo Munck, "Democratic Transitions in Comparative Perspective," *Comparative Politics* (April 1994).

[70] Dohler, "Policy Networks, Opportunity Structures and Neo-Conservative Reform Strategies in Health Policy," 236-40.

[71] Gosta Esping-Andersen, ed., *Changing Classes: Stratification and Mobility in Post-Industrial Societies* (London: Sage, 1994).

revisit our theories of the welfare state, particularly in understanding the contentious politics in emerging welfare regimes or the processes of deepening democracies among late developers,[72] as well as the dynamics of welfare retrenchment among advanced industrial states. Lastly, resisting reform in Taiwan confirms Pierson's argument that the politics of social policy retrenchment are constituted by the legacies of earlier policy decision.[73] The NHI program in Taiwan demonstrates how institutional legacies, ideational legacies and the restructuring of interest coalitions can create new political playing fields upon which subsequent attempts at major reform are played out. Indeed, what resulted from the original NHI program was a political and ideational context hostile to the retrenchment efforts of the KMT.

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[72] Huck-ju Kwon, "Democracy and the Politics of Social Welfare: A Comparative Analysis of Welfare Systems in East Asia," in Roger Goodman et al., eds., 1998; Kenneth Roberts, *Deepening Democracy? The Modern Left and Social Movements in Chile and Peru* (Stanford, CA: Stanford University Press, 1998); Douglas Chalmers et al., eds., *The New Politics of Inequality in Latin America: Rethinking Participation and Representation* (New York: Oxford University Press, 1997); Kurt Weyland, *Democracy Without Equity: Failures of Reform in Brazil* (Pittsburgh: University of Pittsburgh Press, 1996).

[73] Pierson, *Dismantling the Welfare State*, 144-7.