

Political Determinants of Compulsory Social Health Insurance:
the Cases of Israel, Korea and Switzerland

By
Ivan Polynin

Submitted to
Central European University
Department of Political Science

In partial fulfillment of the requirements for the degree of Master of Arts in
Political Science

Supervisor: Professor Judit Sandor

Budapest, Hungary
(2015)

Abstract

This comparative study analyzes the three most important healthcare reforms that introduced Universal Health Coverage (UHC) through the mandatory Social Health Insurance (SHI) in the three countries: Switzerland, Israel and South Korea. The main aim of this research is to find the key actors participating in the political struggle over the SHI reforms and the mechanism behind their implementation. The primary analysis is concentrated on the preferences of political parties in these countries in relation to organization and equity of their respective health systems. The main methodological contribution of this study is the adaptation of the veto-player theory for the analysis of the mandatory SHI reforms. The work reveals a number of consistent patterns between the official positions of political parties and implementation of the mandatory SHI reforms, and it also challenges a conventional approach associating the introduction of UHC exclusively with the labor movement.

Acknowledgements

This study was partially supported by the research grant of Central European University. I want to thank CEU Budapest Foundation for financing my trip to Switzerland, where I acquired data and information highly valuable for this research. I also express my deep gratitude to the Department of Political Science of CEU, which accepted me to the Master of Arts programs in the first place, provided me with a scholarship and made the creation of this research possible.

I thank my supervisor: Professor Judit Sandor, for her guidance through the entire process of thesis writing. Her advice helped me to make this study much more conceptual and academic.

I also wholeheartedly thank Professor Dietmar Braun of the University of Lausanne. Even aside the fact that my research actively draws from his methodology, I deeply appreciate his help and consultation that he gave me on the matter of veto-player theory during my research trip to Switzerland.

My special thanks go to the Manifesto Project that provided me with the very rare political platforms of all of the Korean parties for 1996 essential for my study. Even though these materials were not yet presented at the website of this research organization, the members of the Manifesto Project answered my help request and sent me these valuable materials.

I want to express my deepest gratitude to Darya Vashuk and Chang Bog Lee, who helped to translate the manifestos from Hebrew and Korean. Also, I thank my friend Cory M. Cox for the proofreading of the final version of this thesis.

In the end, I want to thank my wife Liudmila Polynina for her active moral support during the thesis writing and my parents: Olga Polynina and Sergey Saraykin for their practical insight on the functioning of a health system.

Table of Contents

Table of Contents.....	i
List of Figures	ii
List of Abbreviations	iii
Introduction	1
Chapter 1. Theoretical framework.....	4
1.1 Primary concepts and definitions	4
1.2. Literature review.....	8
1.3 Methodology and Variables.....	14
Chapter 2. Switzerland.....	20
2.1. Before the SHI reform	20
2.2. The discourse of the reform	21
2.3 The reasons of success.....	24
Chapter 3. Israel.....	26
3.1 Before the SHI reform	26
3.2. The discourse of the reform	29
3.3 The reasons of success.....	36
Chapter 4. South Korea.....	37
4.1 Before the SHI reform	37
4.2. The discourse of the reform	40
4.3. The reasons of success.....	45
Conclusions	46
“The actors involved in the healthcare reforms”	47
The reasons of success and similar features of the mandatory SHI reforms in Israel, Korea and Switzerland.....	48
References	50
Appendix 1. Coding peculiarities.....	56
Appendix 2. Switzerland	57
Appendix 3. Israel.....	61
Appendix 4. South Korea	64
Appendix 5. The formulas retrieved from the previous research.....	67

List of Figures

Figure 1. The preferences of the Swiss political parties in relation to the status quo and the proposed reform, adapted from Uhlmann and Braun (2009, p.229) using original data set and analysis.

Figure 2. The preferences of the Israeli political parties in relation to the status quo and the proposed reform.

Figure 3. The preferences of the Korean political parties in relation to the status quo and the proposed reform.

List of Abbreviations

CVP – Swiss Christian-Democratic party

FDP – Swiss Liberal-Democratic party

GNP – Grand National Party of Korea

LAmal/ KMG – Swiss Federal Law on Health Insurance

NCNP – National Congress for New Politics

NHI – National Health Insurance law of Israel

SHI – Social Health Insurance

SP – Swiss Social-Democratic party

SQ – Status Quo

SVP – Swiss People's Party

UHC – Universal Health Coverage

ULD – United Liberal Democrats

Introduction

The public and academic interest in the Universal Health Care (UHC) has been persistent and robust over the last decade. This concept includes a widely-shared set of values, such as equity, access and a provision of high quality healthcare to citizens, regardless of their ability to pay. Usually political debates about the introduction of UHC in a country are located within a state-market dichotomy. The competing sides argue over the optimal roles of the government and business sectors, distribution of costs and benefits between them and ways of organization and financing of healthcare. All of these broad themes include more peculiar and as a consequence more controversial issues such as: “is healthcare a person’s right or liability?”, “is it appropriate to have a health system organized on competition?”, “should the ill and healthy pay the same contributions?”, “what is the optimal level of public expenditures and health sector regulations?”, “how heavy should be the financial burden put on the patients’ families” etc. Therefore, there is small room for doubt that talking about adoption of UHC in a certain country we speak about different political circumstances that shape a debate and determine the decision making process, that results in implementation of Universal Health Coverage. Despite that fact, “although much has been written about the mechanics of expanding health care coverage and its consequences for levels and distribution of health and financial contributions, much less has been written on the power and politics behind choices to expand healthcare access.” (Stuckler D., et. al, 2010, p. 4)

This study is concentrated on process-tracing of the most important healthcare reform in the recent history of three countries: Israel, Korea, and Switzerland – introduction of the Universal Health Coverage through the mandatory Social Health Insurance (SHI). I want to focus on the proximal roles of interest groups in the implementation of and resistance to the introduction of SHI in these countries. My research questions are:

- Who were the actors involved in the healthcare reforms in Israel, Korea, and Switzerland?
- Why the proponents of the mandatory Social Health Insurance in these countries succeeded?
- What similar features do these countries share in regard to adoption of mandatory SHI?

When I started this research, I initially undertook the task of developing a new methodology for the assessment of the healthcare efficiency in order to understand why some countries perform better than others. Utilizing the UN classification, I refined the total population of 258 countries and selected 68 of the largest countries with the longest life expectancies and the highest GDPs per capita. I explained my results through the percentage of public spending of total health expenditures and the corruption perception in those countries. These findings helped me to delve deeper into the problems of healthcare efficiency and formulate the puzzle for this research.

The formula for the healthcare efficiency developed in my previous research (Appendix 5) yields a logical and consistent distribution of efficiency scores which could be explained by the economic, political and at times even the geographical features of the country. It formed four groups: countries with healthcare systems that are 1) most efficient, 2) good, 3) moderate, and 4) the most inefficient. Among the countries with the most efficient healthcare, I discovered four outliers: Korea, Israel, Switzerland, and Singapore (Table 1. below)

All of these countries share a similar feature: each has a highly efficient healthcare system, but spends a rather low percentage of public funds toward the total healthcare expenditure. The preliminary research shows that three of these four countries have Universal Health Coverage and Social Health Insurance. The remaining countries can be classified as one of two scenarios: 1) mostly financed by general tax revenue and 2) countries with the institutionalized SHI. Yet

in both cases, high public expenditures are observed (see the table below). This suggests SHI alone cannot sufficiently explain the high-quality, low-expenditure outcomes of these four cases.

Table 1. Outliers among the most efficient healthcare systems (SHI states)

Country	Efficiency	Expenditures
Korea Rep.	0.97	54.43
Israel	0.87	61.69
Switzerland	0.86	61.67
Singapore	0.79	37.60

Table 2. Countries with the healthcare financed by the general revenue

Country	Efficiency	Expenditures
Sweden	0.91	81.70
Denmark	0.85	85.54
UK	0.78	82.51
Finland	0.78	75.42

Table 3. Countries with the institutionalized SHI but high expenditures

Country	Efficiency	Expenditures
Japan	1.00	82.49
Germany	0.92	76.28
Austria	0.84	75.55
Belgium	0.84	75.91
France	0.80	76.95

Singapore, having 37.6% of public expenditures is an outlier among outliers. Moreover, though the SHI system there is national it is not mandatory (refer to Theoretical Framework). Due to these and other reasons explained in the theoretical framework of this study, I want to concentrate on the peculiarities of adoption of UHC in Israel, Korea and Switzerland. I believe that by answering my research questions, namely who the actors behind the reforms were, why they succeeded and what changes in SHI are similar to all of the cases, I will prepare the ground for the future research that will be able to determine the connection between the low public expenditures and mandatory SHI systems in these countries.

Chapter 1. Theoretical framework

1.1 Primary concepts and definitions

Universal Health Coverage (UHC) There are variances in the understanding of this concept: for example, WHO gives a rather broad definition: “UHC is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”¹.

The vast movement towards the introduction of Universal Health Care Coverage was started approximately in 1970s. At that time the international public health community and most of the governments worldwide agreed that UHC should become a main goal of the health policy. (Frenk J., 2009, p.7). The most important commitments of international actors on the global level were made at the conferences in Alma Ata (The Declaration of Alma-Ata, 1978) and, subsequently in Ottawa (WHO, 1986). The participants of both of the conferences expressed their intentions to fight the existing inequalities in provision of the health services to the people within their own countries and on the international arena as well. (Ibid.) Also, they declared that the current situation with the low equity of healthcare across the globe is unacceptable in any regard: be it political, social, or economic inequity. Hence, all of the countries should guarantee UHC in order to facilitate equity of their health systems. (The Declaration of Alma-Ata, 1978, p.1) Nevertheless, decades later the progress in this area is not evident. A number of international organizations such as: OECD, the World Bank, WHO, and various groups of medical professionals argued that many countries, which did not have sufficient resources for the introduction of UHC, instead promoted a model of “Selective Health Care”, which relies

¹ See the website of WHO. “What is universal Health coverage?” Accessed: 3.06.2015.
http://www.who.int/health_financing/universal_coverage_definition/en/

on the number of economic techniques employed for decreasing the cost of healthcare in a country. “This partial model, with substantial private-sector involvement, continues to dominate the development of health systems in resource-poor settings”. (Stuckler D., et. al, p. 7)

There are three most important problems in implementation of Universal Health Coverage. The first one is the obtainability of financial means. Healthcare traditionally requires a substantial part of a governmental budget, which is especially true when the health system aims to provide a universal access to the health services and the instant health delivery. Also, in this case we face a problem with the size of the minimal package of available services and the government’s financial ability to sustain it. This problem is even more difficult to overcome for poor or developing countries, which do not have sufficient tax revenue.

The second obstacle to UHC is a common for most of the health systems tradition to receive direct payments right after the treatment. These include nonprescription payments for drugs and out of pocket expenses of the general public on medical procedures and consultations. “The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal (under the table) basis – prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment.” (WHO, 2010, p.9). This problem becomes even deeper if the health system is oriented on the palliative care, which is usually not included in the minimal insurance plans, which results in the situation when people contribute to the inpatient care services of the health systems, which they rarely use. However, the reverse situation is also possible if a health system is concentrated on the inpatient care, it leads to the overuse of these services (for example, unnecessary hospitalization) and returns us to the first problem of availability of financing.

The third problem, which hinders the implementation of UHC is the inefficient and unfair use of resources. According to WHO the inconsiderate healthcare spending in many countries results in an enormous financial waste, estimated from 20 to 40 percent of the total spending. (WHO, 2010, p.9). The more responsible approach to this problem would significantly increase the efficiency of health systems (see Appendix 5), namely its ability to deliver health services to the population. Better efficiency improves the outcomes of healthcare, releases additional funding for improvement of health systems and makes the process of the healthcare budgeting much more transparent.

Social Health Insurance (SHI) is one of the main methods of administration and financing of health system in addition to general tax revenue (UK, Sweden, Denmark, etc.). Guy Carrin and Chris James – researchers affiliated with WHO and concentrated on the historical transition of health systems towards UHC – claim that “at least twenty-seven countries have established the principle of universal coverage via Social Health Insurance” (Carrin G., James C., 2005). Among those countries, we can find: Israel, Korea, and Switzerland (Carrin G., James C., 2004). Carrin and James did not include Singapore in their classification, though the research was already completed in the beginning of 2000s and was devoted to SHI systems internationally. That made me doubt whether Singapore has UHC, and as I found out later, there were sufficient reasons for my doubts. Verifying my sample I discovered that Singapore has “Medishield” - a public insurance scheme, which is national, but not compulsory. Medishield does not include people older than 90, you can always opt out from it, and under certain conditions you cannot rejoin this scheme. Moreover, it covers only 92% of Singaporeans.²

² See the website of the Singaporean Ministry of Health, answer 1. Accessed: 3.06.2015.
https://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2012/medishield_coverageofpopulation.html

According to the classification of Garin and James that I use in this study, one of the integral parts of SHI is a compulsory membership for everyone on the basis of citizenship. (Carrin G., James C., 2004). All types of working population including industrial workers, businessmen, government employees, and civil servants must contribute a part of their salary to a certain type of SHI endowment. The level of employee's income determines the amount of payments. Freelancers have to pay whether flat contributions or the ones calculated out of the estimated income. A government can also provide mean-tested subsidies for the poorest members of the society, who cannot pay their premiums by themselves, for example temporarily unemployed people. There are three most popular ways to organize SHI. The first is to establish some sort of state insurance agency. The second way presumes to work with accredited public and private health care insurers to create competitive products that conform to state requirements. The third option is to use a mix of the previous two options, because even within a governmentally administered SHI system, private institutions better known as "sickness funds" can perform some of the functions. (Ibid.)

However, even though SHI is an efficient way to organize a financing of a health system, it will not necessarily raise additional funding for health. The success of the funding depends on the design of contribution systems. If you offer a social health insurance to people who usually pay for the services of medical providers out of their own pockets, then the overall health expenditures might skyrocket, fall, or remain the same depending on a multitude of criteria. Nevertheless, the main aim to substitute most of the direct over-the-counter payments with health insurance contributions is generally meant to provide a social guarantee to the people who in the case of illness can get free access to health services without the fear of going bankrupt after the treatment is over. On the whole, SHI is hardly a way to ensure an increase in funding for health, but it definitely alters the timing of payments giving the patients more time to absorb the costs. (Doetinchem O., Carrin G., Evans D., 2010, p.4).

Mixed health-financing systems – systems with the dominance of Social Health Insurance combined with general tax revenue (Japan, Germany, Austria and Belgium). These hybrids offer a universal coverage through the mixed approaches of the automatic membership in a national health service and voluntary health insurance schemes for certain social groups (for example, the special public health insurance for civil servants in Germany). The latter kind of insurance programs might also be offered by health insurance companies or sickness funds and therefore function similarly to SHI schemes.

On the whole it is very important to say that all of the healthcare financing options, mentioned above give a substantial room to be filled by private health insurance. Sometimes it just pays for extra medical services, which are not included in a standard package of benefits. Ultimately, as some researchers claim (Carrin G., James C., 2004) and as we can see from the World Bank database on the percentage of public expenditures,³ today there is no health system which can be hundred percent classified as SHI, general tax revenue-financed, or even mixed. Still, this classification is useful for identifying the most essential features of administration, financing, and the ways of achieving Universal Health Coverage.

1.2. Literature review

Today, the vast majority of the literature on UHC is concentrated primarily on the origins of Universal Health Coverage: namely why it arises in a certain country and how it is generally implemented. There are three main groups of authors cited in the background paper for the global symposium on health system research “The Political Economy of Universal Health Coverage” (Stuckler D., et. al, 2010):

³ See the dataset at the website of the World Bank: “Health expenditure, public (% of total health expenditure)”. Accessed: 3.06.2015. <http://data.worldbank.org/indicator/SH.XPD.PUBL/countries?display=default>

1. **Public-health policy analysts**, who put the emphasis on the influence of power groups (such as medical professionals, hospitals, academics, insurance companies, etc.) on health-policy reform process. Among the authors, who represent this scholarly tradition we need to mention Marmor T. (1983), Anderson O. (1985), Starr P. (1983).

Navarro (1989) emphasizes that even though these authors offered a substantial contribution to the UHC research by providing an in-depth descriptive analysis of health systems, the explanatory and analytical value of their studies is rather limited (Navarro., p. 889). Navarro attacks their most questionable popular choice assumptions, and questions the viability of their methodological approach. His main criticism towards public-health policy analysts is that the interest groups on which these researchers primarily focus, do not in fact set the agenda for health policy. Navarro claims that the interest groups have an only one achievement: they catch the wave of the proposed reforms and become the only visible actors influencing health policy. Therefore, public-health policy analysts undeservedly overlook the role of non-visible actors such as social classes, which include interest groups, empower them, and provide those groups with a specific set of values. This fact provides a basic explanation for the rules upon which the power groups act, compete, and shape the discourse for the health reforms. That is why Navarro concludes that due to the excessive concentration on the visible actors, the public-health policy analysts fail to justify their interpretation of introduction of UHC in a country. (Ibid., p.889)

The strongest emphasis of the public-health policy analysts is placed on the process tracking of health system changes, such as for example the legal initiative to implement the mandatory Social Health Insurance. The problem is that in most of the cases they focus solely on the influence of organized groups of medical specialists over the health reforms.

This bias can be partially explained by the fact that most of the literature is written by medical professionals, who have a very specific academic background. Moreover, “there are also historic tensions between the medical field and public health practitioners, reflected in the identification by some scholarship of the medical profession as an impediment to reform”. (Stuckler D., et. al, p. 20). However, even though this interpretation reflects UHC debates in certain countries, such as America or Switzerland, where the medical professionals opposed the introduction of SHI, it does not present the full picture and fails to explain why the SHI reforms were finally passed in these countries.

So, due to that fact and the other aforementioned limitations of this approach, it has a limited value for this study. Moreover the preliminary research shows that the institutional framework at least in Israel and Korea is different and therefore the power of the medical professionals does not influence the decision making in these countries as much as in the US and Switzerland.

2. **Development economists** assert that there two most important factors which determine the decision to introduce UHC: the first one is the economic growth and the second is democracy. The adherents of this approach rely on the cross-country analyses mostly based on the quantitative data, see (Fuchs V., 1986), (Evans R.G., 1985).

The development economists share a number of important assumptions regarding economic development such as the “convergence hypothesis”. The hypothesis states that there is a correlation between the wealth of nation expressed in GDP per capita and the coverage offered by a health system. Accordingly, the higher a country’s economic capacity, the better chance it will converge with the already developed countries and as a consequence will introduce the Universal Health Coverage. (Stuckler D., et. al, p. 20)

Another assumption of the development economists is the pluralist hypothesis, which connects the success of the UHC introduction to the public will. It asserts the decision makers at the national level, particularly parliamentarians react directly in accordance with the wishes of their constituents, who tend to demand a better health coverage and a bigger basket of basic services. In this sense, the adoption of UHC becomes the ultimate result of the people's will. However, a number of researchers criticized this approach as too simplistic and not entirely correct. (Ibid.) For example, the absolute majority of Americans have been speaking in support of Universal Health Coverage for more than last thirty years, but the final decision to introduce Obamacare and its further implementation met a significant political resistance that was highly difficult to overcome. So, the public support is important, but it does not always influence the adoption of UHC directly.

3. **Political scientists**, who focus on the interplay of power groups and political institutions responsible for producing Universal Health Coverage. These scholars prefer qualitative methods with the emphasis on comparative historical analyses and case-studies, for example: (Navarro V., Shi L., 2001), (Coburn D., 2004), (Uhlmann B., Braun D., 2009), (Immergut E.M., 1992), etc. The common tendency for this researchers is to connect the notion of healthcare with the expansion of welfare state. Most of the analyses are based on the classical work on welfare regimes: "The Three Worlds of Welfare Capitalism" by Esping-Andersen (1990). He identified the three types of social welfare systems: liberal (or Anglo-Saxon), corporatist-statist (or conservative) and social-democratic (or Nordic). Esping-Andersen argued that all of these types are oriented on the well-being of their citizens and promote the equality, but each of them holds a different approach in the redistribution of wealth and the costs for

the high standards of living. (Esping-Andersen G., 1990) According to Esping-Andersen the main determinants of arising of a certain welfare regime in a country are:

- The level of decommodification defined a process of introduction of modern social rights, which are supposed to make the workers less dependent on the free market, by changing the status of labor from a commodity to a valuable asset with a number of social guarantees. (Ibid., p.23)
- The degree of dependence on family in covering the social costs (Ibid., p.28)
- The fusion of welfare and work or the governmental commitment to the full employment (Ibid.)

A significant number of political scientists, conducting their analyses of Universal Health Coverage, rely on the classification of Esping-Andersen. For example, Vincente Navarro studies the influence of political parties on social and economic inequality in health care (2001). According to Navarro: “the major social force behind the establishment of a national health program has always been the labor movement and its political instruments – the socialist parties” (1989). Navarro concludes that UHC is very difficult to implement in a country, which does not have a well-organized labor movement backed up by some social-democratic parties. He claims that the US failed to implement Universal Health Coverage primarily due to the anti-labor orientation of the American government, which policies undermined the legislative power of labor unions. Being aware of its weak political stance the American labor movement initiated some changes within itself, which could help to regain a certain economic and political power, but nonetheless it was not successful. (Ibid., p.897)

Even though Navarro takes the Esping-Andersen’s classification as a starting point he proceeds further into ideology and introduces several other factors important for understanding what determines a type of UHC implemented in some country. The first

factor is the ruling political party, representing a majority in government (or a coalition of such parties). In his studies Navarro makes a very strong assumption that a number of years a political party stays in power directly corresponds with a number of indicators reflecting the overall situation with the welfare and particularly healthcare system in a country such as: poverty rate, income inequality, infant mortality and etc. (Navarro.V., Shi L., p.490) The second factor in his opinion is the representation of class interests by political forces. As it was mentioned earlier, in contrast with the public health policy analysts, Navarro goes beyond the notion of interest groups, because he considers them only “visible actors” which are parts of broader “invisible” entities such as social classes. (Navarro.V., 1989, p.889). The third factor of Navarro is the force of labor movements and the social democratic parties. Considering this variable, he makes another strong assumption that the presence and the power of these political forces in a country determine its commitment to redistributive policies, which in their turn lead to the improvement of health outcomes, for example Navarro insists that social-democratic policies will necessarily reduce the infant mortality. (Navarro.V., Shi L., p.490) He proceeds even further with this claim and states that the liberal welfare regimes with the weak labor and left-wing parties have much worse health indicators, than the social-democratic welfare regimes, exactly because of their lack of commitment to the policy of redistribution (Ibid.)

Navarro’s conclusions are very similar to the ones of Esping-Andersen, particularly in respect to corporatist-statist welfare regime. He argues that the conservative welfare regimes tend to produce better health indicators than the liberal ones and worse than Social-democratic. Again Navarro explains through the inclination towards redistribution, he claims that the secret of a good performance of a health system lies within the compromise between the Christian-democrats and leftists. The most

important difference of these states from the Nordic type is in the more significant role of the family in sharing the healthcare costs, which is Navarro's opinion much stronger than the role of state or market. In other words, Navarro concludes the presence of the strong labor unions and dominance of certain political parties in a country determine not just the fact whether this country has Universal Health Coverage, but also the type of health system in this country and the quality of health delivery. (Ibid.)

1.3 Methodology and Variables

Concerning the analysis of healthcare reforms in Israel, Korea and Switzerland, I follow the methodology of Uhlmann and Braun (2009), who lean on the veto-player theory analyzing the political struggle over the introduction of Social Health Insurance in Switzerland in 1990s. They explained the Swiss transition to the Universal Health Coverage by the drastic changes in ideological positions of main Swiss parties. They claimed that the ideological preference of these political parties, namely their perception of solidarity and aspiration towards more equal health system allowed the introduction of mandatory SHI system in Switzerland in 1996. (Uhlmann B., Braun D., p.205). I do not expect all of the countries to have the outcomes similar to Switzerland, but I consider this methodology appropriate for the analysis of Korea and Israel as well, because all of these countries are proven liberal democracies and have advanced and stable party systems. So, my **dependent variable** is the introduction of mandatory Social Health Insurance in in Israel, Korea and Switzerland.

In this study I also apply the measuring technique of Uhlmann and Braun (2009), who in their turn lean on the taxonomy of OECD, which classifies health systems on a scale of inclination towards the free market or towards the state (OECD, 1987). I adjust this methodology to the partisan struggle in Israel, Korea and Switzerland. A number of studies (Carrin G., James C., 2005), (Stuckler D., et. al, 2010), (Uhlmann B., Braun D., 2009) show that usually the debate

around introduction of UHC usually unfolds over two main issues: first, whether a country has to persist in organizing its health system as a free market where private insurers compete with each other; and second what is the best way to evenly allocate the costs and benefits among the general population. That is why in order to visualize the healthcare preferences of the political parties and present the degree of the transformation of health systems in in the countries of my sample, following Uhlman and Braun, I quantify the said preferences and use **two independent variables**: organization and equity.

The first variable “**organization**”, represents the way a health system is managed. This variable consists of the three components; each component has four options and runs on a scale from 0 to 1. So the maximum score that a health system can get on the scale of organization is 3, and a minimum is 0.

The first component of the organization variable is “managing organization”. (Uhlmann B., Braun D., p.233), it can be classified as one of the alternative options:

- a. Governmental agency that provides a mandatory health insurance, collects and distributes money for provision of UHC (1)
- b. Not competitive system offering a choice between multiple insurance endowments (0.67)
- c. A system of competitive insurance agencies (0.33)
- d. Free market system (0)

The second component of the independent variable outlines the “way of financing” of a health system. (Uhlmann B., Braun D., p.233), it can be classified according to the following criteria:

- a. General tax revenue financed (1)
- b. Compulsory income-related contributions to the social security system (0.67)

c. Individual premiums with additional state subsidies (0.33)

d. Individual premiums with no governmental participation (0)

The third component of the organization variable is the public expenditures as a percentage out of total expenditures on the scale from 0 to 1.

The second variable is **equity**; it represents the fairness and equality in provision of the medical services to the population. It consists of three dimensions: access, benefit distribution, and risk protection. The maximum and minimum scores that a health system can get on the scale of equity are the same as on the scale of organization: 3 and 0 accordingly.

The first component of the equity variable is the “Access” to a health system. It can be divided into 4 types. (Uhlmann B., Braun D., p.234)

a. Mandatory participation for all citizens in the health system without a choice of a provider (1)

b. “Mandatory participation in a health insurance scheme, but with freedom to choose across alternative schemes” (OECD, 2004: 9). (0.67)

c. Insurance system based on the voluntary membership with a state regulation of the market (0.33)

d. Voluntary membership insurance system with the liberalized fees (0)

The second component of this independent variable is the “benefit equity”, it can be determined on the following criteria. (Uhlmann B., Braun D., p.234)

a. Mandatory health insurance, with a vast basic package (1)

b. A compulsory health insurance offering an average number of benefits (0.67)

c. The membership is voluntary, but the insurance agencies are required by a state to offer a few numbers of services (0.33)

d. No mandatory insurance and no regulations (0)

The third component of the equity variable is “risk protection”. It can be classified into 4 categories. (Uhlmann B., Braun D., p.234)

a. The same percentage of size of SHI contributions for all of the members (1)

b. The premiums differ on a few categories, but not according to a risk group (0.67)

c. Differentiation on a large number of factors from an age to a chronic illness (0.33)

d. No state-imposed compensation to risk groups (0)

The aforementioned criteria will help me to understand the similarities and differences not just in the political process of adoption of UHC in Israel, Korea and Switzerland, but also the similarities and differences between the mandatory SHI systems in those countries. The “mandatory” component in this sense becomes essential. Hence, OECD suggests that it does not matter for UHC whether the health system is based on a public or private component, but the experience shows that countries, which did not enforce the compulsory SHI failed to achieve the full national coverage. Thus, OECD experts conclude that in order to reach UHC in a country the acquiring of insurance must become obligatory. (OECD, 2004, p.71)

For the purpose of tracking the change in the independent variables, I am considering the veto player framework in Israel, Korea and Switzerland, using the veto-layer theory of Tsebelis (2002). There are two kinds of veto players relevant for this work’s analysis. The first kind is institutional veto-players, which are generally determined by country’s legislation for example the chambers of parliament, president or referenda. The second kind of veto player is the

“partisan veto player”, which are formed within the institutional veto players by the struggle of different political forces. (Tsebelis, p.79). For this study, partisan veto players are the ones that constituted the majority in the federal parliaments of Israel, Korea and Switzerland on the period of transition to the Universal Health Coverage.

There are two principle differences between the approach of Tsebelis and my adaption of it. First, the „indifference curves“ used by Tsebelis for mapping the partisan actors’ preferences are defined by the distance between the preferred position of actor X at time point Y from the SQ at time point Y. (Tsebelis, p.38). The logic behind it is that the larger the aforementioned distance is, the greater the circle becomes and accordingly the more other views can be contained. For the purposes of this study I use the “interest circles”, which define the variation of the opinions within the party on the moment of the reform determined by the fact whether the party supported or did not support the previous status quo. Second, while the indifference curves of Tsebelis are always cutting through the SQ point, the interest circles do not, because the ideological disagreement of the parties with the previous SQ is the primary reason why the SQ is changed.

The main elements of the veto theory are the ideological preferences of political actors. (Uhlmann B., Braun D., p.207) For this study I am interested in those preferences, which concern the administration of health system in a country. A successful UHC reform needs a majority of partisan veto-players, or the political parties, which ultimately will produce the legislation and promote its implementation. Expanding the approach of Uhlman and Braun, I think that analyzing the partisan veto-players which dominate the political system of Israel, Korea and Switzerland, I will understand why the health reform was passed and why the subsequent attempts to avert it were not successful.

I am aware of the competing explanation of public-health policy analysts, who would in this case put the emphasis on the influence of power groups (such as medical professionals) on health-policy reform process. I also know that some other political scientists, specifically those, who are concentrated on welfare politics would focus on the role of labor in introduction of mandatory SHI in Israel, Korea and Switzerland. However, I think that the methodology that I choose for this study is the most appropriate, because it captures the smallest changes in the dependent variables of organization and equity and allows us to make an apparent connection to the independent variable: the change in healthcare preferences of political parties of the countries in my sample, thus providing sufficient evidence to causality.

My data on party positions and the actual shift in the Health systems of the countries of my sample is based on party manifestos, research articles quoted in this study, and the overviews of the Swiss health reforms by WHO and CIVITAS. The collected data was then analyzed on a scale of preferences towards the organization and equity of the health system.

Chapter 2. Switzerland

2.1. Before the SHI reform

The Swiss health care system in many aspects is a reflection of its political system that can be characterized by federalism and liberalism. State intervention in health care at the federal level was never extensive and much of the responsibility for financing, organizing, and delivering health care has always been located at the local level of cantons, private insurers, and private hospitals. The system of health care had not undergone too many major reforms. That was mainly a result of the strong reliance of the Swiss political system on referenda, which makes any comprehensive reforms difficult to pass into law. “The system evolved largely in [a] fragmented and uncoordinated fashion”. (WHO, 2000, p.77)

Before 1996 the Swiss Health system was voluntary and financed mostly from patient's premiums, which varied greatly on the multiple categories such as age, gender, risk group and canton. The level of social protection was low: nominal premiums were not income related, though the federal and regional governments compensated some of the expenditures to the poorest and the most disadvantaged citizens. Also, there were serious problems with competition between the insurers. For example, if a sickness fund accumulated a significant number of chronically ill or old patients, it had to increase the premiums for all of its customers forcing the young and healthy to choose another fund. In these conditions the free insurance market could not effectively function and the insurers always remained with three options: to compete for the healthiest, merge with the other sickness funds or to go bankrupt. Thus, it was extremely hard to achieve solidarity not just between the people from the different risk groups, but also between insurance companies. All of these factors combined with the fact that about ten percent of Swiss citizens remained uninsured, made the reform necessary. (WHO, p.77)

There is strong evidence to suggest existing path dependence. Namely, before the reform was realized, the two previous attempts to implement universal SHI in Switzerland (the referenda in 1974 and 1987) both failed. One of the main reasons for these failures was the substantial political opposition to the most important provisions of the reforms, namely: cost control, the benefit package, maternity insurance, and compulsory insurance. This opposition was possible due to the last element of the veto-system in Switzerland – the referendum, which facilitated the negative votes much more often than the positive ones, therefore posing a serious threat to any reform that aimed to change the status-quo.

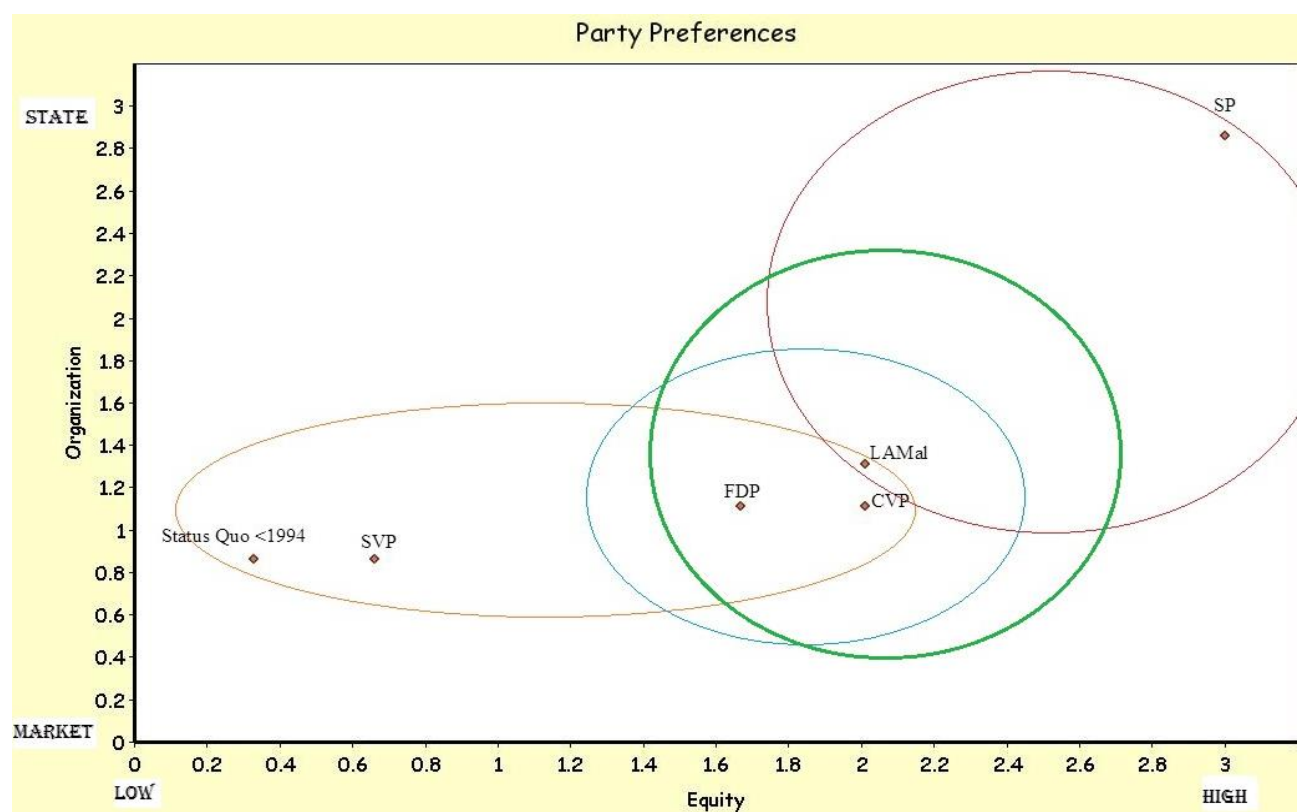
Though, Uhlman and Braun successfully trace the process of adoption of LAMal (KMG) and the failures of subsequent health reforms, they do not sufficiently explain the mechanism of referendum, which in fact significantly reduces the role of interest groups in the promotion of legislation in Switzerland. For example, the Swiss doctors, who opposed LAMal due to the fear of disruption of the insurance system, never needed to go on strike; because they could easily threaten to hinder the law during a referendum. (Immergut., p.68). That mechanism created a serious obstruction to any interest group, which tried to promote laws instead of opposing it. That could be an explanation to the question of why Swiss trade unions did not play such a tremendous role in introduction of mandatory SHI in their country, as it would be expected by the scientists, who consider unions as a decisive force in implementation of UHC, such as Navarro.

2.2. The discourse of the reform

In order to make a substantial change of the healthcare system a potential law had to accumulate the preferences of the four major Swiss political parties. During the period of reform, the relative power of the four parties in terms of parliamentary seats varied. From 1991 to 1995 in the National Council the FDP and the SP were the strongest parties at the time (44 and 41 seats

of 200), with the CVP and the SVP following (35 and 25 seats). In the Council of States the balance of power was slightly different: (FDP:18, CVP:16, SVP:4, SP:3) (Nohlen D., Stöver P., 2010, p.1955). Therefore, the “agenda-setter”, namely the Christian-Democratic Minister of Health making the reform proposal, had to account for the aforementioned distribution of power and the preferences of each of the political parties.

Figure 1. The preferences of the Swiss political parties in relation to the status quo and the proposed reform, adapted from Uhlmann and Braun (p.229) using original data set and analysis.



* Points – official preferences of the Swiss parties, declared in their manifestos. Interest Circles – degrees to which they agreed to extend their positions: Hazel – SVP, Blue – FDP, Green – CVP, Red – SP.

As we can see from the Figure 1, in 1994 all of the parties aspired to the change from the status quo. (Appendix 1). FDP and CVP made up a nucleus of the winning coalition, because the initial demands in their programs were the closest to the proposed reform (LAMal). The declared position of SP was the most remote from the LAMal point, but the initial status quo was even farther; so social-democrats were ready to make a compromise on the issue of

organization in order to increase the equity of the healthcare system. SVP was the most reluctant to the change. Several years after the LAMal was passed they tried to avert it, namely by trying to revoke the mandatory status of the health insurance, liberalizing prices, and reducing the benefit package. However, dating back to 1994, SVP supported the bill in both chambers of parliament, even though it was on the edge of their preferences.

The proposed bill did not significantly differ from the actual law. So, let us take a look at its main propositions and evaluate the changes that were brought into the system:

1. The status of the health insurance was changed from voluntary to mandatory⁴
2. Uniform premiums per capita became the main way to finance the universal SHI (Gubb J., Dailey C., 2013, p.3)
3. The basic package of benefits was extended and divided into three categories: Sickness Insurance, Maternity Insurance and Accident Insurance (WHO, 2000, p.21);
4. Individual cantons were obliged to provide tax-financed, means-tested subsidies directly to those who unable to afford the basic package⁵ (Gubb J., Dailey C., p.2);
5. The risk was equalized solely on the basis of sex and age (Ibid., p.6);

As we can see the Swiss Health System moved from its previous status quo (Equity – 0.33, Organization – 0.86) to the new status quo suggested by LAMal (Equity – 2.01, Organization – 1.31). The change of the score Equity (1.68) is more than three times greater than the change in the score Organization (0.45). Thus, by this reform FDP, CVP, and SVP managed to reach the consensus with SP on the grounds of enhancing equity for the general Swiss Population without sacrificing the competitive insurance market to the state. However, SP was not a loser

⁴ For the full version of LAMal, see the website of the Swiss federal government:

<http://www.admin.ch/opc/de/classified-compilation/19940073/index.html>

⁵ According to the Federal Office of Public Health the amount of the individuals requiring this kind of financial assistance in 2009 was 30.5% out of the total insured population:

<http://www.bag.admin.ch/themen/krankenversicherung/01156/index.html?lang=enn>

of the reform because, even though the market persisted, the equity of the Swiss healthcare increased and the influence of the state on the Organization scale was enhanced as well.

2.3 The reasons of success

Thus, there are three significant factors that explain who the actors of the reforms were, and why the proponents of LAMal succeeded. First, the main actors of the reforms were the Swiss political parties, because of their status as partisan veto players in both of the chambers of the Swiss parliament and their significant influence over the general population during the referendum. Unlike Uhlmann and Braun, I conclude that the Swiss trade unions played an important role in the law making process due to their affiliation with SP and a great influence over a significant part of the electorate. However, the role of trade unions was not major due to the Swiss framework of institutional veto players, which facilitates the negative votes and creates a serious obstruction for those groups, which try to promote legislation instead of opposing it.

Second, like Uhlman and Brown, I think that the proposers of LAMal won because they managed to accumulate the preferences of all of the four biggest parties during the debates in parliament. Then, during the referendum the reform was supported by FDP, CVP, and SP, which was sufficient, despite the fact that SVP mutinied as it was the smallest party among the top players. The proposers of LAMal succeeded in the accumulation of preferences, because of the failed referenda of 1974 and 1987 and the discontent with the previous status quo of the healthcare system, which failed to achieve solidarity between insurance companies and address the problem of a highly unequal approach to the evaluation of risk premia, which excluded a significant number of people out of the health system. These factors prepared the ground for a more extensive consensus, while the changes of the health care system were substantial enough to create a core out of FDP and CVP and include Social-Democrats (SP) and the most

progressive members of SVP. However, unlike Uhlman and Braun, I find that the unpredicted growth of the public health expenditures became the main reason of the failures of the subsequent SHI reforms, because none of the parties except SP, was initially ready to increase government spending.

Third, even though I agree with Uhlman and Braun that the consensus was achieved more on the ground of “equity” than on the “organization” scale, I think that they underestimated the importance of the increase of the state involvement into the Health System. All of the parties agreed that the access has to become universal, the benefit package should be expanded and the risk protection has to be enhanced. Thus, the Swiss Health System moved from its previous status quo (Equity – 0.33, Organization – 0.86) to the new status quo suggested by LAMal (Equity – 2.01, Organization – 1.31). So, though the movement on the scale of Equity (1.68) was more than three times greater than the movement on the scale of Organization (0.45), the Swiss federal state for the first time in history assumed the role of a supervisor of the Health System. On the whole, the increase in equity and the limited organizational change which preserved the free market insurance system can also serve as an explanation of the consensus achieved by the Swiss main political parties.

Chapter 3. Israel

3.1 Before the SHI reform

The history of the implementation of mandatory SHI in Israel has a much stronger resemblance to the theory of Navarro than the Swiss healthcare reform, which I considered in the previous chapter. As it was emphasized in the theoretical framework, Navarro argues that the necessary preconditions for successful introduction of UHC in a country include a presence of strong labor movement, which has to be organized politically through labor unions and socialist political parties. Accordingly, due to the struggle of Jewish labor for better social protection, the health system of Israel started to develop, even before the actual state of Israel had arisen. Namely since the beginning of the 20th century it has been evolving around the completion of the four large insurance endowments, often called “sick funds” or “health plans”.

The key difference between the sick funds and ordinary insurance agencies common around the world is that sick funds were also healthcare providers, aside of being mere insurers or administrators. It is notable that the first sick fund called “Clalit” was established in 1911 by the groups of agricultural day laborers, and then it went under control of “Histadrut” (General Federation of Israeli Labor). This health plan was later accompanied by three others: Maccabi, Meuhedet and Leumit, however Clalit still remains the biggest, even though the amount of the people it insured, went down from around 80% of the total Israeli population in 1980s to about 55% nowadays. (WHO, 2009a, p.13,) The long and uncontested dominance of Clalit, directly administered by Histadrut and politically backed up by the Labor Party of Israel in many aspects determined the direction of evolvement of the Israeli Health system.

Before 1995 all of the four major Israeli sick funds offered a voluntary health insurance to 95% of the population, however its private nature and the excessive control by the labor movement gave birth to many problems in the Israel’s healthcare. In order to investigate what these

problems are and how to deal with them, the government of Israel decided in 1988 to convene the Netanyahu Commission, which concentrated on the issues of quality and efficiency of the Israeli healthcare system. The report produced by the Netanyahu Commission described a number of problems concerning both organization and financing of the health system in Israel, which I will sum up in the three points.

First, the Israeli Health Ministry (MOH) had an unclear role in the country's healthcare. On the one hand, it was a service provider in charge of a major part of the national hospitals and about 40% of the hospital beds (WHO, 2009a, p.110). On the other hand, MOH was supposed to be the health system administrator responsible for regulating the provision of medical services by the health funds, which led to the excessive centralization and bureaucratization of the process. Also, the law did not clearly separate the health delivery responsibilities between the Ministry of Health and sick funds. Moreover, MOH did not have the authority to set the insurance premiums, which consequently did account for the healthcare costs. (Ibid.). Hence, this dual role of MOH was a serious obstacle for its efforts in establishing a coherent national policy concerning healthcare operation and management.

Second, another circumstance that weakened the MOH was the excessively strong power of the Ministry of Finance (MOF) in healthcare budgeting. The main concern of MOF was cutting down everything that was potentially seen as unnecessary expenditures, therefore the healthcare budget was produced without sufficient medical expertise, and as a consequence it did not account for the population ageing, increase in chronic illnesses or a need to modernize equipment. Thus, MOH regularly faced budget deficits and could not allocate enough resources for improvement of the preventive medical services, health promotion, health education and information systems. The underdevelopment of the aforementioned spheres significantly reduced the performance of the Israeli Healthcare. (Ibid.)

Third, the over-privatized medical services in Israel-failed to satisfy the expectations of the general population. Poor management and superfluous amount of physicians resulted in the long lines at hospitals and emergence of a black market of medical services, when doctors provided care in the public medical facilities, but off the books. At the same time, the strong affiliation of the health workers with the labor movement encouraged strikes as a main method of sending the political message to the Israeli government, and as a consequence it frequently resulted in stoppages of provision of medical services to the public. (WHO, 2009a, p.110).

As we can see the Israeli case is different from the Swiss one, because aside of the dissatisfaction with the equity of healthcare (as in Switzerland), there was a serious discontent with its organization as well. However, even at this level we can observe certain similarities. For example, before the successful introduction of the mandatory SHI in Israel, the previous healthcare reform attempts from 1990 to 1993 were overthrown by organized groups of medical professionals. Nevertheless, even in this regard there is still a difference between Israel and Switzerland, because in their opposition to the reform efforts, Israeli medical workers teamed up with the labor movement represented by Histadrut. The reason for such a partnership was in the shared reluctance to replace the existing system of 4 competing sick funds with the single provider, which again reveals a very interesting phenomenon totally uncommon for Western Europe: the Israeli labor movement, which has its own political party:

- distances from the party of social-democrats (Meretz, the explanation of the ideological preferences is presented in Appendix 3)
- opposes the attempt to introduce a socialist type of UHC, financed by a general-tax revenue

3.2. The discourse of the reform

Mandatory SHI in Israel was successfully introduced in 1995 through enactment of National Health Insurance Law (NHI). The law was supposed to alleviate the problems of the Israeli healthcare revealed in the report of the Netanyahu Commission, enhance the manageableness of the health system, increase its equity by banning the “cream-skimming” insurance policy of the sick funds and guarantee the comprehensive health insurance to the entire population of Israel. The main fact that indicates that this universal health coverage reform was structural is that after the enactment of NHI, there were no fundamental changes in the Israeli health system. Some researchers even observed a gradual decrease in the public satisfaction by the health services (preceded by the active encouragement during the 2 years right after the reform), and a period of health policy stagnation, which was most likely caused by the budget erosion (Hart J., 2001 p.10). However, before we will delve deeper into the explanation of actual changes brought by the NHI law, let us take a look at the veto players, essential for understanding of the political struggle over the UHC debate in Israel.

The most important institutional veto player in the political system of Israel is the unicameral national parliament – Knesset, it adopts the national budget and has the two committees directly related to the functioning of healthcare in Israel: Finance and Health Committees. Before Israeli parliamentarians discuss the annual budget, it is comprised and submitted by the government with the primary role given to the Ministry of Finance, and as we can infer from the report of the Netanyahu Commission until 1995 the budget failed to meet a number of health costs due to the lack of a sufficient medical expertise of the Ministry of Health. The similar situation could be observed in the Knesset as well, where the Finance Committee was much more important, than the Health Committee in determining the actual annual budget of the Ministry of Health. Also, the role of government in Israel is much larger than in Switzerland. For example, one of the key compromises for the 1995 law was achieved between the ministers of

health and finance, because the minister of finance stated that he would not oppose the NHI bill, if the minister of health would approve a number of measures for the containment of costs of mandatory Social Health Insurance in Israel. Thus, the influence of the Israeli executives over the legislative process goes far beyond the agenda-setting as in Switzerland.

Nevertheless, the role of government officials in passing the NHI law does not overshadow the role of primary partisan veto-players: Israeli political parties. Historically these parties did not concentrate on the social issues in their programs, preferring to address the immigration and foreign policy (with a special attention to Arab-Israeli relations). However, the 1992 elections were a prominent exclusion out of this rule, because during this campaign along with the discussion of the potential Oslo accords, the major political debate unfolded over the introduction of National Health Insurance law and the corruption scandal around the main sick fund Clalit and its inalienable supervisor Histadrut (JTA, 1995)

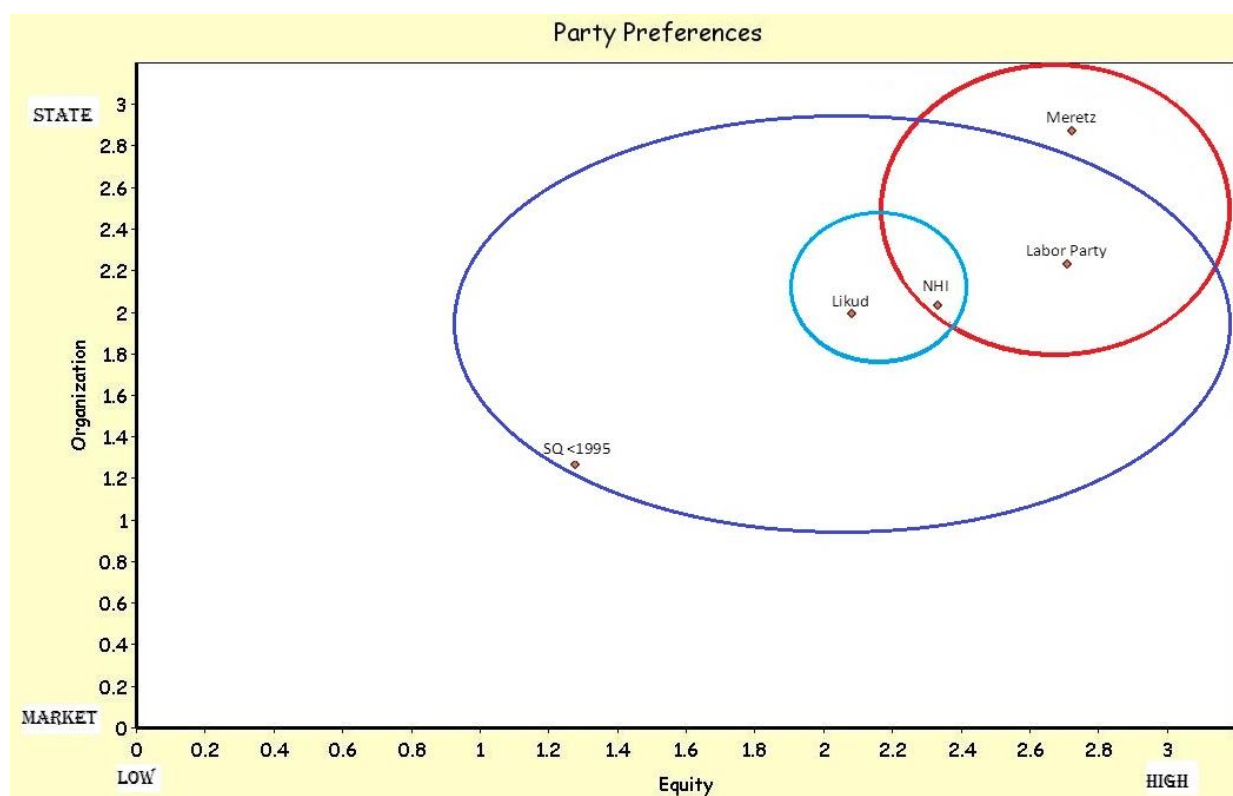
There were three main partisan veto players in the Knesset. The first one was the Labor party of Israel, which provided a political back up to Histadrut and actively resisted the introduction of a nation-wide united health service, which would endanger the absolute dominance of the national labor federation. In contrast with that, the second veto player or namely the centrist party Likud (and its predecessors) opposed any laws that could organize the UHC system on the base of Histadrut, which would ensure the superiority of the rival Labor Party. The third player, Meretz was not in the game until 1992, and it was formed as a coalition of three leftist political parties. Meretz pursued a social-democratic political agenda, which determined their cooperation with the Labor party.

There were in total 120 seats in the Knesset. The mandates of the political parties were distributed in the following way: first of all, the major share of votes was taken by the Labor party, which occupied 44 seats (or 34.7% of the total). The second place was taken by Likud

with 32 mandates (or 24.9% of the total). The third place went to Meretz, which being at that time a newborn political party, still managed to gain 12 seats in the parliament (or 9.6% of the total). (Nohlen D., et al, p. 128) The fourth place was occupied by Tzomet – a right wing political party, which gained its votes thanks to a hard position on the Arab-Israeli conflict, demanding from the Palestinians to abandon their territory claims and an immediate cease-fire. However, the party was rather unstable and lacked ideological homogeneity, also it failed to join any coalition and fell apart by the next elections, so it did not significantly influence the political debate over healthcare in 1994 in which we are interested. Thus, for a successful winning coalition the reformers needed cooperation between the Labor Party, Likud and Meretz.

As we can see from the Figure 2, the official position of the Israeli political parties concerning the Universal Health Coverage issues were much closer to each other, than in the Swiss case. However, it did not prevent a rivalry between the Labor Party and Likud, which as well as in previous reform attempts could not agree on the main organizational issue, namely on how strong should be the influence of Histadrut over the biggest sick fund Clalit. In this debate, Meretz took the side of the Labor Party due to the close ideological ties and similar attraction to socialist ideas, so Likud demonstrating the closest preferences to the National Health Insurance Law played an auxiliary role due to the lack of allies necessary for reversing the situation. Thus, the destiny of the NHI bill had to be determined within the Labor party itself.

Figure 2. The preferences of the Israeli political parties in relation to the status quo and the proposed reform



* Points – official preferences of the Israeli parties, declared in their manifestos. Circles – degrees to which they agreed to extend their positions: Indigo – Labor Party, Blue – Likud, Red – Meretz.

The agenda setter – the Health Minister Haim Ramon was a member of the Labor Party, whose task was to convince his fellow party members to support his NHI bill as the main compromise between the Labor Party and Likud. That was essential for the success of the reform, because even though, both Likud's and the Labor Party's manifestos reflected the same appeal, specifically – transformation of the sick funds into non-competitive endowments, which would unite the functions of insurers and providers of health services (See the Appendix 2, managing organization component for Likud and Labor Party), still the Israeli Labor Party was the only one which partially embraced the status quo. The reason for that embracement was the specific wing of the Labor Party, which was directly affiliated with Histadrut and Clalit (making the Labor Party's preference circle the widest, see the Figure 2). That wing successfully opposed

the NHI law at the plenum of the Labor party in January 1994. So, the only way to overcome this resistance for the health minister Ramon was to resign from his position and win the post of general secretary of Histadrut. Thanks to the pressure of Ramon from his new office and the threat of more radical SHI bills promoted by Likud, the Labor Party finally reached the internal agreement on the issue and voted in favor of NHI along with the majority of Likud's and Meretz's members in June 1994 (Chernichovsky D., Chinitz D., 1995, p. 139)

So, what were the main changes brought about by the NHI reform? In contrast with the Swiss case, viewed in the previous chapter, the Israeli healthcare experienced a significant change in regard to the way the system is managed. Even though the main sick funds did not undergo a structural transformation and preserved their initial structure, they lost a considerable part of their autonomy. Namely, before 1994 the sick funds were free to pursue a cream-skimming policy or to set up their own insurance premiums in the way that would attract the young and healthy and would put a major part of the financial burden on the elders and people with chronic illnesses. With the introduction of the NHI law the health plans stopped this unfair policy and what is more important became non-profit organizations managing their own hospitals. Due to the reform, the government acquired new powers over the sick funds in defining how much funding they require, setting up health taxes and contributions and defining the size of the benefit packages. All of these factors allow us to speak about the shift on the organization scale concerning the “managing organization parameter” from 0.33 (a system of competitive insurance agencies) to 0.67 (not competitive system with multiple insurance endowments).

Another notable change on the organization scale comes from the introduction of the new way of healthcare financing brought about by the NHI law. The system of the individual premiums with the state guarantees for urgent treatment (0.33 – financing) was replaced with the special payroll health tax levied by the National Insurance Institute (NII). Israeli citizens with the income equal to a half of the country's average national salary contribute about 3.1% of their

wage to NII, while the citizens with the higher wages are obliged to pay up to 4.8% of their income. The groups which are exempted from the NHI taxes are: poor people, pensioners and people with the salary 5 times bigger than the national wage. The financing of the providers is calculated out of a parsimonious capitation formula, which encourages the sick funds to attract those who are old or chronically ill. (WHO, 2003, p.23) Nevertheless, in this case we cannot assign the new system the financing score of 0.67, because the health tax, which is in fact a compulsory income-related contribution to a social security system is supplemented by the general tax revenue in order to form the Israeli healthcare budget. Hence we have a hybrid system combining the general tax revenue with the mandatory health contributions, which receives financing score of 0.87, because, to assign it a score of 0.67 or 1.00 would be to underestimate the peculiarities of formation of the Israeli healthcare budget.

Again in contrast with the Swiss case, the level of public expenditures as a percentage out of total expenditures does not allow us to capture the trend of the increase of the government participation in the health system. While in Switzerland, since the introduction of UHC the percentage of public expenditures since 1996 to 2005 and 2010 grew significantly (from 53% to 65% from the year 1996 to 2010, though with small occasional declines), the Israeli government demonstrated a notable decline in its spending (from 67% in 1995 to 60% in 2005 and 61% in 2010). Thus in fact allowing us to subtract 0.08 from the final reform score on the scale of organization and also providing us with additional evidence towards the claim of Doetinchem, Garrin, and Evans, presented in the theoretical framework of this thesis (2010, p.6) that SHI is not a way to ensure an increase in funding for health, because its major aim is to evenly spread the healthcare costs among the population and not to reduce them.

The equity dimension was not as controversial as the organizational one: all of the parties unanimously agreed that the access to the universal healthcare should be guaranteed through the system of existing sick funds. However, the debate took place over the size of benefit

package and risk protection, where Likud took a stance of the compulsory insurance with the limited benefit package (Benefit Equity: 0.67) and premiums varying on the criteria of age, sex, and etc. (Risk protection: 0.67) for the reasons of the health costs containment, while its opponents: the Labor Party and Meretz argued in favor of a vast basic package of services (Benefit Equity: 1.00), and the same percentage of SHI contributions for all (Risk protection: 1.00). Ultimately the parties agreed to accept the recommendations of the Netanyahu Commission (compromise in favor of a higher equity of the system), firstly because it was politically neutral and presented multiple political opinions, and secondly, because Likud was notably outnumbered to come up with a more favorable alternative for itself.

I argue that with the implementation of NHI the equity of the Israeli health system concerning the offered benefit package remained at the same place (0.67). Even though along with the vast hospitalization package, NHI included into the obligatory medical services the preventive medicine (immunization, treatment at community clinics etc.) and a large discount for medication for Israeli citizens, there is still a notable difference in the access to the provision of these services for the Jewish and Arab populations. (WHO, 2003, p.122). Nevertheless, concerning risk protection provided by NHI, all of the parties agreed to go beyond elimination of the cream-skimming in the sick funds, to a system which reduces the financial burden of the most vulnerable groups and allocates the financing to the sick funds with the most amount of weaker people, therefore receiving 1.00 for the risk protection.

A number of scientists assert that the general role of the ministry of health did not drastically change through the reform. They justify their opinions by stating that the ministry of health failed to completely transgress from the role of provider to the role of administrator and that it still executes the same dual functions as before. I think that this claim is only partially true, because even though MOH still manages approximately half of Israel's emergency room hospital beds (WHO, 2009a, p. xx), and as a consequence retained some of its old functions, it

achieved an uncontested superiority over the planning and formulating of the national health policy of Israel. That was not true before the reform when the sick funds had unclear responsibilities not only to the patients but also to the MOH itself.

3.3 The reasons of success

So, why did the proposers of the NHI bill succeed? First, regarding the central controversial issue of affiliation of Histadrut and Clalit, there was a movement within the labor party itself, which aimed to break this link. The political will of the health minister Ramon played a significant role in the passing of the bill through Knesset, but if he had not be backed up by the progressive wing of his own Labor Party and would not include the preferences of Likud into the final version of the NHI bill, the law would probably never be adopted.

Second, the stated ideological positions of all three of the key parties were much more far from the SQ than from the NHI law. Also, only the conservative faction of the Labor Party, which led Histadrut since the day it was founded, embraced the SQ. Thus, the success of the reform was determined much more by the undermining of the political power of organized labor, than by achieving a consensus between the parties, which mostly agreed about the major issues of the reform, such as the necessity to increase the equity of the Israeli health system, which underwent the primary change of SQ (more than 1.01 on the equity scale).

Third, in contrast with Switzerland, Israel had no strong, populist, market-oriented oppositional party, such as Swiss SVP. That also explains a considerable movement of SQ on the scale of organization (0.80), which is less than the movement on the Israeli equity scale, but is still almost twice greater than the movement of the SQ on the Swiss organization scale (0.45), where SVP and FDP strongly opposed any attempt to bring “more state” into the health system.

Chapter 4. South Korea

4.1 Before the SHI reform

The history of the introduction of Universal Health Coverage in South Korea is very special. Primarily, because of a long period of gradual extension of SHI, which some experts (Lee. J.C., 2003), (WHO, 2009b) consider took 12 years: from 1977 to 1989. The other experts, such as Carrin & James (2004) go even farther and claim that implementation of SHI in Korea took more than 26 years in the period of 1963-1989. (Ibid., p.8). Nevertheless, usually political scientists with a focus on UHC agree that South Korea managed to achieve Universal Health Coverage by 1989. (WHO, 2009b, p.19). I do not agree with this widespread convention and criticize it in this work for the two reasons.

First, even though the SHI in Korea became mandatory for rural residents in 1988 and for the urban ones in 1989, it was still quite difficult to enforce it in the remote regions, due to the lack of the governmental control over the health care services and multiple funds providing the insurance to the local population. (Lee. J.C., p.50). Moreover, some other facts presented by WHO-affiliated scientists provide sufficient evidence to my claim stating that back to 1989 at least a 4 percent of the population of South Korea was not covered by the National Health Insurance (WHO, 2009b, p. xvii.).

Second, the political manifestos of the Korean Parties for 1996 reflect the multiple calls to expand the national health insurance coverage and increase the number of hospitals in order to make the healthcare affordable not only on paper. (Liberal United Party, p. 47, 1996). Hence, this and many other problems connected to the organization and financing of the South Korean health system (explained further on in this work) determined the necessity of the introduction of the Unified Health Insurance Act of 1999, UHIA, sometimes called National Health

Insurance Act), which I consider as the start date of the introduction of a truly universal health coverage in South Korea.

The health system, which existed in South Korea in the period from 1977 to 1999 was initially considered by its creators (namely the government of President Park [1962-1979]) as an interim step towards a fully voluntary system of health insurance. From 1977 to 1981 it expanded the insurance coverage on employment basis, starting from state employees and finishing with industrial workers. Since 1981 to 1997 the coverage was step by step extended on the regional basis until it was supposed to embrace the whole country. The Park government and its direct successors adopted the gradual approach, because back to 1977 they did not possess the sufficient financial resources to provide the entire nation with access to healthcare. Moreover, any kind of national health service was considered as an unnecessary luxury, which would do nothing, but put a put an unbearable burden on the state budget. (Lee. J.C., p.49). That is why, the Korean government until the end of the 1980s not only lacked the administrative capacities necessary for managing the mandatory Social Health Insurance on the national level, but did not even have the plans to form a governmental body capable of this kind of regulating.

The framework of institutional veto players in South Korea includes the National Assembly – a unicameral federal legislature and a Korean president who has a power of veto and sometimes plays a crucial role in the lawmaking process. For example, the first initiative to establish an integrated system of Social Health Insurance appeared in the end of 1980s, when the main Korean oppositional parties (such as the Democratic party, the Party of Peace and Democracy and the new Democratic Republican Party), sharing a liberal ideology, managed to push through the National Assembly a bill, which was supposed to integrate all of the existing insurers into a unified governmentally-administered funding scheme. Nonetheless, even though the bill was adopted almost unanimously in the parliament, it was vetoed by President Woo (1988-1993). (WHO, p.30, 2009b). Thus, the mandatory publically managed mandatory

Social Health Insurance was not implemented in South Korea in 1989, because of the pressure of the executive branch.

I see two reasons why the reform was not passed in the end of the 1980s. First, for a long time Korea had been a state with an authoritarian political regime, with overpowered executives, where the will of the government meant much more than the opinions of the parliament. For example, after the introduction of the mandatory Social Health Insurance for certain groups of employees in 1977, the subsequent coverage for a number of other social groups was expanded by the executive orders of President Park and his successors (Chun et. al, p.19) Moreover, as it will be shown further in the text, the Korean party system suffered from this authoritarian legacy until the beginning of 2000s and even then the legislature was often considered by the Koreans as a “handmaiden” of executive power. (Oh K.D., p.61, 2000). Second, in the period from the 1980s to the 2000s the Korean Party system was too unstable itself to be an effective independent veto player. An abundance of new parties grew up before every election and relatively old parties regularly collapsed or changed their names in order to represent a new political alliance formed with the defectors from other parties. For example, the biggest partisan veto player of the Korean Parliament, which I consider in this work: Grand National Party or GNP (now it is called Saenuri since 2012) was formed in 1997 by merging with the United Democratic Party, when it won the elections as the New Korea party in 1996, being the result of unification of the Democratic Justice party and Peaceful Democracy Party (Ibid., p.220). Thus, as we can see even by the end of the 1990s, the Korean Party system was not fully formed. Also as we will see later in the text it was rather fluid, because the number of members in the parties could vary dramatically from the beginning to the end of the parliamentary term.

4.2. The discourse of the reform

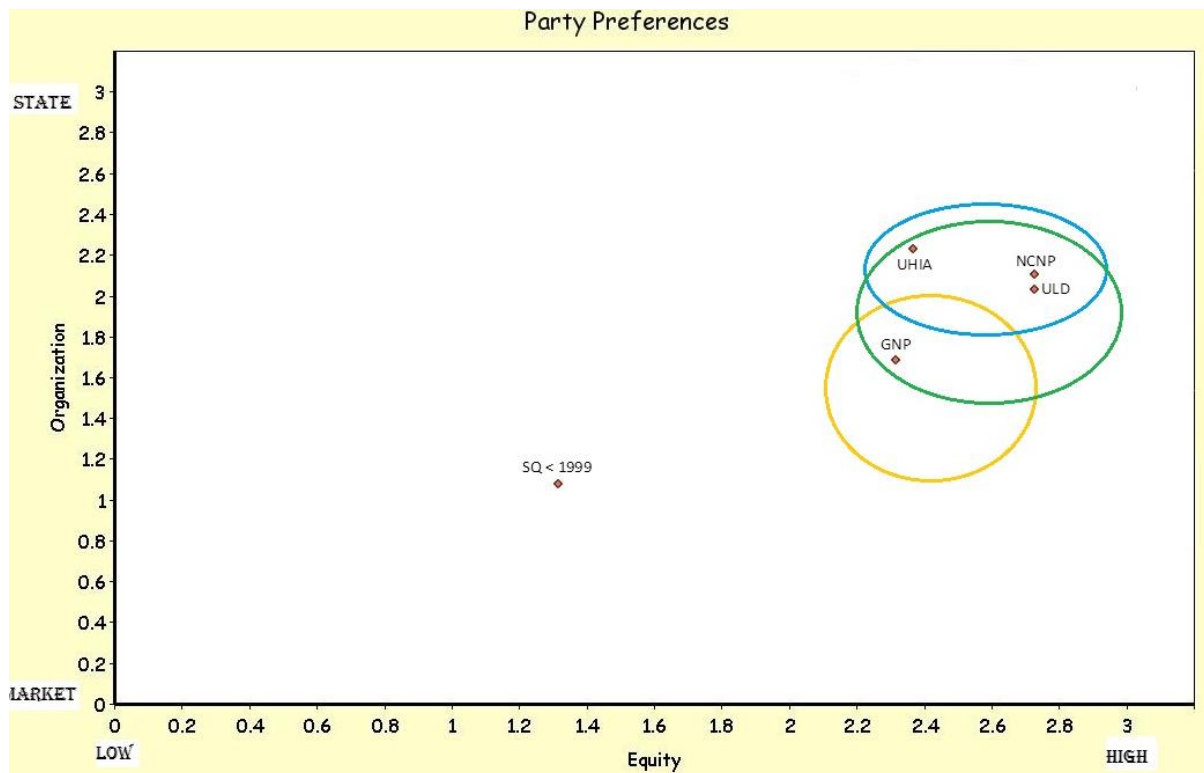
So, let us consider the dispositions and ideological preferences of the main partisan veto players before the adoption of the Unified Health Insurance Act in 1999. First, as it was mentioned earlier the Grand National Party (GNP) was the largest party in the National Assembly; right after the elections of 1996, it held 139 seats, but subsequently lost the majority. (Nohlen et. al., p.420, 2001) GNP's ideological preferences can be characterized as conservative, moderate-right, anti-communist views. The members of this party were traditionally considered as free-market supporters calling for less governmental regulation of business. (GNP, p. 101, 1998). Second, the party which took the second place during the elections was National Congress for New Politics (NCNP) with 79 seats. (Nohlen et. al., p.420) The adherents of this party tended to express the liberal and statist ideas, arguing in favor of a better governmental control over the free market. (NCNP, p. 5, 1996). Third, the United Liberal Democrats (ULD) took 50 seats at the elections of 1996 making them the third largest political party in the Korean National Assembly. (Nohlen et. al., p.420). Even though some Western researchers, such as Helgessen G. (2002, p.90) or Bluth (2008) consider ULD as a right-wing party (which collapsed in 2006 and its members fled to GNP), at the moment of voting for UHIA in 1999, they formed an alliance with NCNP, expressing similar ideas of increasing the governmental control over the national economy, particularly over the health insurance market. (ULD, p. 47, 1996).

The central debate between GNP and NCNP in coalition with ULD unfolded over the major approach to the organization and financing of the Korean health system. GNP insisted on the program close to the initial plan of President Park, namely a slow transgression to the decentralized health system with multiple private insurers providing UHC to the population. Being main proposers of decentralization, members of GNP believed that a unification of the Korean Health System would lead to skyrocketing insurance premiums for the population, place the major financial burden on small businesses and freelancers, and increase the public

expenditures on healthcare. The primary opponents of GNP – NCNP had completely opposite convictions. They advocated unification of a Korean health system as an answer to the 1997 healthcare budget deficit, arguing that by creating a single governmental unit responsible for collecting and administering insurance premiums, Korea would alleviate the inequality in the insurance contributions, enhance the class solidarity and would manage to finally contain the rising healthcare costs.

So, in 1990, the agenda-setter – President Kim-Dae Jung (a member of NCNP) had to take into account a stalemate, which formed in the Korean Parliament around the UHIA reform. As we can see from figure 3, even though none of the parties were satisfied with the SQ, UHIA was outside the circle of preferences of GNP, because of its reluctance to let “more state” into the health system. Meanwhile, their opponents NCNP even in coalition with ULD did not have enough votes to reverse the situation in their favor. So, on the one hand GNP supported the health system based on the 4 semi-competitive endowments, financed by a certain percentage of employees’ salaries going to these agencies as contributions. (GNP, p.135). Therefore, GNP offered some kind of an organizational hybrid of the existing system, though much more inclined towards the market (Managing Organization: 0.57, Financing: 0.67). On the other hand, NCNP and ULD shared the same opinion that it was necessary to create a new governmental agency responsible for collecting the income-related premiums and administering the mandatory SHI in Korea. (NCNP, p.178), (ULD, p.47). Thus they offered an alternative to GNP’s plan suggesting a similar way with GNP of financing, but with a unified governmental organizational structure as a managing organ. (Managing Organization: 1, Financing: 0.67).

Figure 3. The preferences of the Korean political parties in relation to the status quo and the proposed reform



* Points – official preferences of the Korean political parties, declared in their manifestos. Circles – degrees to which they agreed to extend their positions: Yellow – Grand National Party, Blue – National Congress for New Politics, Green – United Liberal Democrats.

Concerning the equity dimension NCNP and ULD also demonstrated almost identical preferences, advocating the mandatory participation for all citizens without a choice of provider. (Managing Organization: 1.00). (NCNP, p.178), (ULD, p.47). GNP in their turn supported the idea for mandatory participation for everyone, but also claimed that it would be a terrible mistake to take away from the citizens the opportunity to select one of the alternative insurers. (Managing Organization: 0.67). (GNP, p.135). It is also notable that the positions of all of the three major parties in respect to benefit equity and risk protection, are identical to the degree when it is almost impossible to make a quantitative difference out of them. (Benefit Equity: 0.67, Risk Protection: 1.00). (Ibid, p.135), (NCNP, p.178), (ULD, p.47).

This surprising unanimity between the rival parties could be explained by one main factor. All of the parties had a populist political orientation. For example, the website of the Manifesto Project indicates that none of the parties despite the market orientation of some of them support the welfare state limitation or cutting of the welfare benefits in any way.⁶ In contrast, each of them devotes a significant portion of their political platforms to the various suggestions to achieve the welfare state expansion, namely: GNP for 121 times, NCNP for 285 times and ULD for 53 times⁷. Thus, all of the parties competed for each other's portion of the electorate promising to give more welfare benefits to the constituents. Moreover, as we can see from the actual example set by the government of President Kim and his party NCNP, these promises were not always kept, for example: the promise to transfer 50% of the regional health expenditures to the federal level. (Lee. J.C., 2003, p.49)

With the introduction of UHIA, the Korean health system became much more equitable than it was before, primarily due to the transformation from a system with multiple private providers to the single state insurer (Access: change from 0.67 to 1.00). The benefit package was extended through the guidelines of the Korean Ministry of Health and Welfare (Chun et. al, p.73) (Benefit Equity: change from 0.33 to 0.67). Finally, with the merging of the private insurers into a single NHIC, they lost the ability to vary the insurance premiums on such factors as risk groups, guaranteeing an enhanced risk protection to the Korean patients. (Risk Protection: change from 0.33 to 0.67).

Among the three health systems considered in this work, the health system of South Korea is the only one, which underwent a much more significant change on the scale of organization

⁶ See Volkens A., et. al. (2015) for:

NCNP: https://manifestoproject.wzb.eu/election_parties/3357

GNP (back to 1996 New Korea): https://manifestoproject.wzb.eu/election_parties/3357

ULD: https://manifestoproject.wzb.eu/election_parties/3367

⁷ Refer to the previous references for the figures.

(1.09) than on the one of equity (1.01). When UHIA went into power in 1999 it organizationally (and partially financially) integrated the public and private health insurance endowments into the National Health Insurance Corporation (NHIC) giving absolute control over the mandatory SHI to the Korean government, thereby upgrading SHI in Korea from a system of competitive insurance agencies (Managing Organization: 0.33) to a governmentally-administered insurance system (Managing Organization: 1.00). Accordingly the primary source of financing of the mandatory SHI in Korea was also changed from individual premiums (Way of financing: 0.33) to compulsory contributions with a fixed percentage depending on your income. This fact makes Korean SHI rather similar to the one of Israel allowing us to assign Korea a financing score of 0.77. The percentage of public expenditures also raised from 48% in 1998 to 53% in 2005 and 56 in 2010%, indicating a much stronger involvement of federal money into the healthcare financing, than was before the UHIA reform.

In contrast with the Israeli case, the organized labor in South Korea was hardly a significant or independent actor. It did not play an important role in the introduction of mandatory SHI in Korea due to the underdevelopment of the political system there, where even political parties did not exert influence greater than executives. However, the main peculiarity of the organized Korean Labor was that it did not have a uniform opinion on the issue of organization of healthcare. Namely, on the eve of the UHIA reform there were two Korean labor unions holding opposite opinions on the matter. The first one was the Korean Confederation of Trade Unions, whose members were strongly in favor of the unification of healthcare and supported the alliance of NCNP and ULD. The second organization: The Federation of Korean Trade Unions gave its support to GNP, advocating decentralization of healthcare as the only way to reach a greater equity of the system and protect the self-employed from the pooling of insurance premiums. So, the labor in South Korea was clearly divided and its activity could hardly be

separated from the politics of the Korean parties, which makes their role insignificant for this work. (Lee. J.C., 2003, p. 50)

4.3. The reasons of success

On the whole there were two main factors that allowed the agenda setter to form the winning coalition in the Korean parliament and get the UHIA law passed. First, we have sufficient evidence to suggest that ULD as a political party had a very opportunistic character, probably following in the wake of NCNP due to its direct affiliation with President Kim and the hazards of being oppositional due to the unfinished transition of the South Korean political regime to democracy from authoritarianism. Second, being unable to reach the consensus with GNP on a number of issues, including healthcare, the government of President Kim used its administrative resources and through the general prosecutor's office initiated a number of investigations, accusing GNP's leadership of corruption. It resulted in multiple defections from GNP to NCNP and ULD, because many of the GNP members tried to find a refuge from the legal persecutions. Thus, Kim Dan Oh (2000) claims that from May 1998 to March 1999 almost 29 members of GNP fled the party to join its opponents, which subsequently deprived GNP of its status as the largest party in the Korean Parliament. (Ibid, p.64) At the same time the number of members in NCNP and ULD increased dramatically, which allowed them to overpower GNP in the National Assembly and finally pass the UHIA law.

Conclusions

This work presents the reviews of the introduction of Universal Health Coverage (UHC) through the mandatory Social Health Insurance (SHI) in Switzerland, Israel and South Korea. The main focal point of the analysis was how the preferences of the political parties in these countries frame the political struggle, which leads to implementation of mandatory SHI. The preferences were measured on two scales: organization and equity, adapted from Uhlman and Braun (2009), and then analyzed using the adjusted version of the veto-player theory of Tsebelis (2003). Following Navarro (2002) I also paid a special attention to the role of organized labor in decision making. Thus, my theoretical framework mostly included the political scientists conducting their research in the sphere of UHC (refer to the Literature review section for the full explanation).

The causal mechanism of how the political parties' preferences, being measured on the scales of organization and equity (independent variables), influence the introduction of mandatory SHI in a country (dependent variable) has five main characteristics. First, for the successful introduction of mandatory SHI the official positions of the major political parties, declared in their manifestos have to be closer to the new SQ, than to the old one. Second, if the party's position incudes SQ, it will oppose the new law. Third, the adoption is more possible (yet not a hundred percent guaranteed), if the new SQ is situated in the intersection of the interest circles of most of the major parties. Fourth, if the opinions of the parties were extremely polarized and/or the passed law was outside of the intersection of the interest circles, the stalemate was solved with the interference of the executive branch. Fifth, the consensus is more easily achieved by virtue of equity than on the grounds of organization, and as a consequence: most of the interest circles will have an oval shape and a reform will be less controversial and will go easier in parliament, if it brings less organizational change.

So, let us consider the answers to the research questions, which I found conducting the primary analysis for this work.

The actors involved in the healthcare reforms

The main actors during the reforms, whose debate and ultimately the agreement resulted in adoption of mandatory SHI in a country were political parties. The secondary role was played by agenda setters: members of the executive branch, usually health ministers, and in the Korean case: presidents. The level of influence of agenda setters over the debate about the introduction of UHC is usually determined by the maturity of the party system. For example, the lowest level influence of the health minister on the adoption of mandatory SHI could be observed in Switzerland, which has the oldest and the most stable party system among all of the countries considered in this work.

In contrast with the Swiss case the Israeli party system is much younger, and as a result, the role of the executive branch in the lawmaking process was much higher there. That is why the political will of the health minister Ramon, namely his compromise with the Ministry of Finance and his successful occupation of the post of general secretary of Histadrut became a tie-breaker allowing the NHI reform to be implemented in Israel.

Korea, which back to 1999 had the least developed party system (among the three considered in this work) demonstrated the highest level of interference of agenda-setters into decision making, that shifted the balance of power in the Korean National Assembly in favor of the coalition of NCNP and ULD, resulting in passing the UHIA reform.

Another important conclusion of this work is that Navarro's hypothesis that organized labor in combination with socialist parties always stand behind the introduction of mandatory SHI does not always prove itself to be true. On the contrary: in all of the cases observed in this work the organized labor did not play a major role in the introduction of UHC, and in the case of Israel,

it (represented by Histadrut) even was a major oppositional force hampering the NHI reform. I assume that such a role of organized labor in the countries of my sample is determined by the institutional veto players. For example, in Switzerland labor was excluded out of a decision making because of the referenda, in Israel it was too much satisfied with the previous SQ and in Korea the labor was not independent enough,

The reasons of success and similar features of the mandatory SHI reforms in Israel, Korea and Switzerland

First, in all of the three cases the official positions of the main partisan veto-players were much farther from the old SQ, than from the one suggested by the UHC reforms. Second, in all of the cases the parties, which excessively stretched their interest circles lost the political struggle. Third, in two out of three cases (excluding Korea) the new SHI law was in the intersection of the interest circles of all of the major players. The Korean case is an exception, because one of the major players boycotted the voting because of the administrative pressure of the executive branch. Fourth, in two out of the three cases the political struggle was alleviated by the absence of representatives of all of the ideological spheres. For example, in the Israeli case there were no representatives of the radical right parties, which would try to privatize the healthcare management and cut down the benefits. In the Korean case there were no socialist parties, which would try to boost the equity of the system and advocate a creation of a national health service. Fifth, in all of the cases the reforms were passed right after the main consensus was achieved on the matter of organization of the healthcare.

In the end, I would like to discuss the limitations of this study and the perspective of future research in the area of UHC. The methodology used in this study is good for capturing: the actual changes in the health system, the environment of the decision-making and a retrospective explanation of the mandatory SHI adoption. However, with this methodology it is hard to depict the position of the agenda-setter on the preference map and account for the actions of the

charismatic members of the executive branch. Moreover, even though this study visualizes the political struggle over UHC and allows us to make certain causal claims, the predicting value of the approach is yet to be tested. Also, even though the public health expenditures helped to describe the level of a government involvement into a health system, they did not help to find any trend, connected to the introduction of UHC in a country (in the case of Switzerland and South Korea the expenditures grew, but in Israel they decreased) supporting the hypothesis of Carrin (2004, p.4) that mandatory SHI hardly increases the health funding. Nevertheless, this research area has a great potential for development and future elaboration. This study gives us an additional insight into the parliamentary political struggle and could be very useful for specialists in party politics. Also, a solid theory describing the mechanism of adoption of Universal Health Coverage could be very helpful for the political practitioners who are planning to reform the health systems in their countries.

References

- Anderson O. (1985). *Health Services in the United States. A Growth Enterprise Since 1875*. Michigan: Health Administration Press.
- Braun D., Uhlmann B., (2009). Explaining Policy Stability and Change in Swiss Health Care Reforms. *Swiss Political Science Review*, 15 (2), 205-240.
- Bluth C. (2011). *Crisis on the Korean Peninsula*. Washington D.C.: Potomac Books.
- Christlichdemokratische Volkspartei der Schweiz (2004). Parteiprogramm der CVP Schweiz. http://www.cvp.ch/fileadmin/Bund_DE/downloads/partei/Parteiprogramm-dt11.pdf
- Carrin G., James C. (2004) Evaluating social health insurance: Key design features in the transition period (Health Financing Policy Issue Paper). Geneva, World Health Organization, Department of Health System Financing, Expenditure and Resource Allocation (PER).
- Carrin G., James C. (2005). Social health insurance: Key factors affecting the transition towards universal coverage. (Health Financing Policy Issue Paper). Geneva, World Health Organization, Department of Health System Financing. Expenditure and Resource Allocation (PER).
- Chernichovsky D., Chinitz D. (1995). The political economy of healthy system reform in Israel. *Health economics*, 4 (2), 127-141.
- Coburn D. (2004). Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Social Science & Medicine*, 58, 41–56.
- Cutler, D. M. (2002). Equality, efficiency and market fundamentals: The dynamics of international medical-care reform, in *Journal of Economic Literature*, September, 40 (3), 881–906.

Doetinchem O., Carrin G., Evans D. (2010). Thinking of introducing social health insurance? Ten questions. WHO Background paper, 26. Retrieved from:

http://www.who.int/health_financing/documents/cov-pb_e_09_04-10qshi/en/

Esping-Andersen G. (1990). The three worlds of welfare capitalism. NJ: Princeton University Press.

Evans R. G. (1985). Illusions of necessity: evading responsibility for choice in health care. Journal of Health Politics, Policy and Law, Fall, 439-465.

Frenk J. (2009). Strengthening health systems to promote security. Lancet. 373 (9682), 2181-2182.

Freisinnig-Demokratische Partei. (2001). Gesundheitspolitik.

<http://www.fdp.ch/images/stories/Dokumente/Positionspapiere/gesundheitspolitik.pdf>

Fuchs V. (1986). The Health Economy, Cambridge: Harvard University Press.

Gubb J., Daley C. (2013). Healthcare Systems: Switzerland. Civitas, Health Reports.

Hart J. (2001). Reform of the health care service system in Israel 1995-2000. World Hospital and Health Services, 37 (3), 9-11.

Helgessen H. (2002). Imported democracy: The South Korean experience. Globalization and Democratization in Asia. Edited by Kinnval C. & Jönsson. Routledge.

Immergut E.M. (1992). Health Politics. Interests and Institutions In Western Europe. NY: Cambridge University Press.

JTA. (1995). News Analysis: Labor Party Faces New Problems As Histadrut Comes Under Investigation. The website of JTA, the Global Jewish News Source. Retrived from:

<http://www.jta.org/1995/03/07/archive/news-analysis-labor-party-faces-new-problems-as-histadrut-comes-under-investigation>

Labor Party of Israel. (1992a). Summary of the Political Platform. Manifesto Project.

Volgens, Andrea / Lehmann, Pola / Matthieß, Theres / Merz, Nicolas / Regel, Sven / Werner, Annika (2015): The Manifesto Data Collection. Manifesto Project (MRG/CMP/MARPOR). Version 2015a. Berlin: Wissenschaftszentrum Berlin für Sozialforschung (WZB). Retrieved from: https://manifestoproject.wzb.eu/election_parties/2369

Labor Party of Israel. (1992b). Political Platform (in Hebrew). The Israel Democracy Institute. Retrieved from: <http://en.idi.org.il/tools-and-data/israeli-elections-and-parties/political-parties/labor-party/>.

Likud (1992). Summary of the Political Platform. Manifesto Project. Volgens, Andrea / Lehmann, Pola / Matthieß, Theres / Merz, Nicolas / Regel, Sven / Werner, Annika (2015): The Manifesto Data Collection. Manifesto Project (MRG/CMP/MARPOR). Version 2015a. Berlin: Wissenschaftszentrum Berlin für Sozialforschung (WZB). Retrieved from: https://manifestoproject.wzb.eu/election_parties/2460

Lee J.C. (2003). Health Care Reform in South Korea: Success or Failure? American Journal of Public Health. 93 (1), 48-51.

Marmor T. (1983) Political Analysis and American Medical Care Essays. NY: Cambridge University Press.

Meretz (2015). Political platform of the party. Healthcare. (in Russian). Retrieved from: <http://elections.meretz.org.il/rus/2015/03/08/%D0%B7%D0%B4%D1%80%D0%B0%D0%B2%D0%BE%D0%BE%D1%85%D1%80%D0%B0%D0%BD%D0%B5%D0%BD%D0%B8%D0%B5/>

Navarro V., Shi L. (2001). The political context of social inequalities and health. Social Science and Medicine, 52, 481-491.

Navarro V. (2002). The World Health Report 2000: Can Health Care Systems Be Compared Using a Single Measure of Performance? *Am. J. Public Health*, January, 92(1), 31-34.

Navarro V. (1987). Why some countries have national health insurance, others have national health services, and the US has neither. *Social Science & Medicine*, 28 (9), 887-898.

New Korea (1996). Political Platform (In Korean). Retrieved from:

https://manifestoproject.wzb.eu/election_parties/3363

NCNP. (1996). Political Platform (In Korean). Retrieved from:

https://manifestoproject.wzb.eu/election_parties/3357

Nohlen D., Stöver P. (2010). *Elections in Europe: A Data Handbook*. Oxford: Oxford University Press.

Nohlen D., Grotz F., Hartmann C. (2001). *Elections in Asia & the Pacific – A Data Handbook*, London: Oxford University Press.

Oh K. (2000). *Korea Briefing: 1997-1999 : Challenges and Change at the Turn of the Century*. NY: An East Gate Book.

OECD (1987). *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*. Paris: OECD.

OECD (2004). *Towards High-Performing Health Systems. The OECD Health Project*.

Retrieved from:

<https://books.google.hu/books?id=r6MLakbHnEQC&pg=PA71&dq=OECD+mandating+insurance+coverage+purchase+or+providing+compulsory+cover+appears+necessary&hl=hu&sa=X&ei=wiRnVYX4HcGTsgHx84DIAQ&ved=0CCkQ6wEwAA#v=onepage&q=OECD%20mandating%20insurance%20coverage%20purchase%20or%20providing%20compulsory%20cover%20appears%20necessary&f=false>

Sozialdemokratische Partei der Schweiz. (1982). Parteiprogramm. <http://library.fes.de/pdf-files/ialhi/90031/pp-1982-d.pdf>

Stuckler D., Feigl A.B., Basu S., McKee M. (2010). The Political Economy of Universal Health Coverage. Background paper for the global symposium on health systems research. First Global Symposium on Health Systems research.

Swiss People's Party. (2011). SVP – the party for Switzerland. Party Manifesto. http://www.svp.ch/de/assets/File/positionen/parteiprogramm/svp_parteiprogramm_e.pdf

Starr P. (1983) Social Transformation of American Medicine. NY: Basic Books.

The website of Singaporean Ministry of Health. (2015). Costs and Financing. https://www.moh.gov.sg/content/moh_web/home/costs_and_financing.html

The website of WHO. (2015). What is universal Health coverage? http://www.who.int/health_financing/universal_coverage_definition/en/

Tsebelis, G. (2002). Veto Players: How Political Institutions Work. Princeton: Princeton University Press.

ULD (1996). Political Platform (in Korean). Retrieved from: https://manifestoproject.wzb.eu/election_parties/3367

Volgens, Andrea / Lehmann, Pola / Matthieß, Theres / Merz, Nicolas / Regel, Sven / Werner, Annika (2015): The Manifesto Data Collection. Manifesto Project (MRG/CMP/MARPOR). Version 2015a. Berlin: Wissenschaftszentrum Berlin für Sozialforschung (WZB).

World Bank (2015). “Health expenditure, public (% of total health expenditure)” dataset. <http://data.worldbank.org/indicator/SH.XPD.PUBL/countries?display=default>

WHO. (2000). Health Care Systems in Transition. Switzerland. European Observatory on Health Care Systems. Retrieved from:

http://www.euro.who.int/_data/assets/pdf_file/0003/96411/E68670.pdf

WHO. (2003). Health Care Systems in Transition. Israel. European Observatory on Health Care Systems. Retrieved from:

<http://dosei.who.int/uhtbin/cgisirsi/V7esfQa1nk/113780013/5/0>

WHO. (2009a). Israel. Health System Review. Health Systems in Transition. Vol. 2 (2).

Retrieved from: <http://www.hspm.org/countries/israel25062012/countrypage.aspx>

WHO (2009b). Republic of Korea. Health System Review. Health Systems in Transition.

Vol. 2 (7). Retrieved from: <http://dosei.who.int/uhtbin/cgisirsi/V7esfQa1nk/113780013/5/0>

Appendix 1. Coding peculiarities

Coding scheme employed by Uhlmann and Braun was adapted as follows:

- The income equity component of the “organization” measure was removed as it was deemed redundant.
- The health expenditures component is an original measure added to “organization” measure.
- All defined scale scores were adopted as employed by Uhlmann and Braun, with the original public health expenditure component using a similar logic.
- Uhlmann and Braun presented composite standardized scores only for Switzerland and did not present the data that was coded to arrive at these scores. As a result, my findings reflect an original selection of party texts for analysis of all of the countries including Switzerland (both in English and translated from German, Korean and Hebrew to English)

Appendix 2. Switzerland

“Organization”

	SP	CVP	FDP	SVP
Managing organization	1	0.33	0.33	0.33
Way of financing	1	0.33	0.33	0
Public Expenditures	0.86	0.55	0.55	0.55

“Equity”

	SP	CVP	FDP	SVP
Acess	1	0.67	0.67	0.33
Benefit Equity	1	0.67	0.33	0.33
Risk Protection	1	0.67	0.67	0.33

SVP

Organization

“SVP supports competition in the healthcare sector, which guarantees high-quality healthcare throughout the country” (Swiss People's Party, p.85) Also, “Private providers of insurance solutions should not be discriminated against in favor of state insurance schemes through the payment of benefits that are not financed or the implementation of extraordinary restructuring operations”. (Managing organization: + 0.33)

“The 1990s were the era in which the dam burst; it was a truly «socialdemocratic decade», with burgeoning government expenditure, debt mountains, tax takes, fees and premiums. Hand over your money!»... “for maternity insurance, childcare centres, day schools, early retirement, premium reductions”... (Swiss People's Party, p.124). (Way of Financing: 0, Public expenditures: we observe the discontent with the current level of health expenditures, therefore assign the Status Quo level – 55%)

Equity

SVP “favours the abolition of compulsory basic health insurance in the longer term” (Swiss People's Party, p.85). (Access: +0.00)

SVP “demands a slimmed-down list of services provided under basic health insurance, and a list based on positives” Ibid., p.85). (Benefit Equity: +0.33)

SVP “demands the immediate abolition of the officially imposed upper limit for the voluntary deductible in compulsory health insurance, so that those who pay the premiums can take responsibility for deciding on the scope of their insurance coverage and react to the trend of massive increases in premiums” (Ibid., p.85). (Risk equity: +0.33)

SP

“Die medizinische Versorgung muss für jeden im Krankheits- und Unglücksfall gewährleistet sein. Deshalb muss eine Kranken- und Unfallversicherung geschaffen werden, die obligatorisch und solidarisch, universell und entsprechend der Einkommensstärke finanziert wird, ohne differenzierung nach Geschlecht und Risiko. Die Krankheitskosten müssen gesenkt werden. Massnahmen im Bereich der Ärztehonorare, Medikamentenpreise sowie neue Formen der Krankenpflege sind unabdingbar”. (Sozialdemokratische Partei der Schweiz, p. 49). (Managing Organization: +1.00, Financing: +1.00, Access: +1.00, Benefit Package: +1.00, Risk equity: +1.00. The aforementioned features match the English NHS, so we assign the Public health expenditures at 86%, so +0.86)

CVP

“Wir verbessern die Kostenkontrolle im Gesundheitswesen. 3.14. Wir stehen hinter dem Grundsatz, dass sich die Spitäler aus einem Kanal finanzieren (monistisches System). Die Mitwirkung der Kantone in der Spitalplanung bleibt sichergestellt. Wir verankern dieses

System im Gesetz und setzen es bis 2009 in Kraft” (Christlichdemokratische Volkspartei der Schweiz, p.21). (Managing organization: +0.67, Way of Financing: +0.67, + SQ level of public expenditures 55%)

“Mit der obligatorischen Krankenversicherung (KVG) soll jeder Bürgerin und jedem Bürger der Zugang zu einer angemessenen Grundversorgung garantiert werden. Den Versicherten sollen qualitativ hochstehend und wirtschaftlich erbrachte Leistungen zustehen”. (Thesen aus der Gesundheitspolitik der CVP, p.4) (Access: +0.67)

“Wir unterstützen die Prävention und Gesundheitsförderung. Die Eigenverantwortung der Versicherten sowie ihre Sensibilisierung für die Gesundheitsförderung müssen gestärkt werden (Empowerment)” (Christlichdemokratische Volkspartei der Schweiz, p.20) (Benefit Equity: + 0.67)

“2.7. Wir ermässigen die Krankenkassenprämien entsprechend der wirtschaftlichen Leistungsfähigkeit – insbesondere die Kinderprämien reduzieren wir markant” (Christlichdemokratische Volkspartei der Schweiz, p.16) (Risk Protection: +0.67)

FDP

“Die FDP meint aber auch, dass das Gesundheitswesen erschwinglich bleiben soll – langfristig und für die ganze Bevölkerung. Allerdings geht es nicht ohne einschneidende Korrekturen. Nötig sind sie im Gesundheitssystem, aber auch bei der individuellen Einstellung aller Beteiligten. Die FDP empfiehlt einen liberalen Lösungsweg – mit mehr Selbstverantwortung, Wahlfreiheit und Wettbewerb. Dieser der Weg führt am ehesten zum Ziel – viel eher jedenfalls als weitere Flickschusterei am heutigen System oder der Irrweg in eine sozialistische Planwirtschaft” (Freisinnig-Demokratische Partei, p.3) (Managing Organization: +0.33, Access: +0.67, Benefit Equity: + 0.33)

“Finanzierung der obligatorischen Krankenversicherung durch Kopfprämien; höhere Franchisen. Prämienbemessung unabhängig von Einkommen und Vermögens. Die obligatorische Krankenversicherung ist weiterhin durch Prämien der Versicherten zu finanzieren. Die gezielte Prämienverbilligung für wirtschaftlich schwächere Personen ist beizubehalten. Die Prämienverbilligung ist Sache der Kantone. Um das individuelle Kostenbewusstsein und Anspruchsverhalten gegenüber der Krankenversicherung wirksam zu steuern, ist sie auf die tatsächliche Bedürftigkeit der einzelnen Versicherten und nicht auf die Gesamtkosten in den jeweiligen Kantonen oder Regionen auszurichten”. (Freisinnig-Demokratische Partei, p.16), (Financing: +0.33, Risk Equity: +0.67, +SQ Health Expenditures).

Appendix 3. Israel

“Organization”

	Likud	Meretz	Labor Party
Managing Organization	0.77	1	0.67
Way of Financing	0.67	1	0.87
Public Health Expenditures	0.67	0.86	0.77

“Equity”

	Likud	Meretz	Labor
Access	0.67	0.67	0.67
Benefit Equity	0.67	1	1
Risk Protection	0.67	1	1

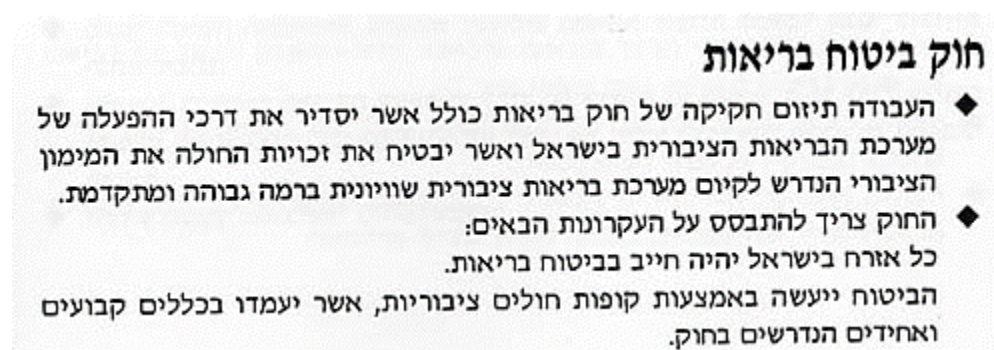
LIKUD

“The National Health Insurance Law would provide complete cover for the entire population, free of all connections with sectoral interests and without relation to financial means of the patient. The National Insurance Institute would collect all the health dues without adding any staff for this purpose. The health services would be provided in practice, on the basis of agreements between the state and the existing medical bodies, whose independence would not be affected. The possibility of setting up a national hospitals authority would be examined” (Likud, 1992), (Managing Organization: +0.77, Financing: +0.67, Access: +0.67, Benefit Package: +1.00, +SQ public health expenditures).

LABOR PARTY

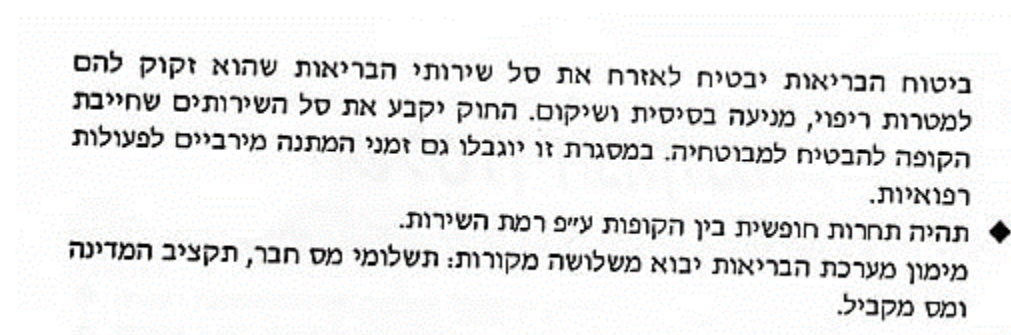
“A new Health Insurance Law must be enacted, different from the one which passed its first reading in the Knesset recently to guarantee equal facilities for all, but through the medium of the existing health funds. More public money must be invested in the broader facilities

nowadays required, while savings and economies must be sought simultaneously through rationalization, not by cutting down services” (Labor Party, 1992) (Benefit Package: +1.00, Public health expenditures: +0.77)



(Labor party,

p.23, 1992), (Managing Organization: +0.67, Access: + 0.67) .



(Labor

Party, p.24). (Financing: +0.87), (Risk Protection: +1.00)

MERETZ

“Закон о государственном медицинском страховании, действующий с 1995 года, гарантировал полный набор медицинских услуг для каждого гражданина Израиля. Однако в стране все еще существует значительный социальный разрыв в уровне предоставления медицинских услуг, связанный с классовой и этнической принадлежностью, а также с проживанием в центре страны и на периферии. Предоставление услуг в сфере здравоохранения, вопреки принципам, заложенным в

законе, не является равноправным”... (Meretz, 2015) “МЕРЕЦ настаивает на принятии следующих мер”:

– “формирование национальной программы, направленной на сокращение социального разрыва в предоставлении медицинских услуг”. (Meretz, 2015). (Managing Organization: +1.00, Access: +1.00, Financing: +1.00)

– “отмена финансового участия пациентов в оплате визита к врачам-специалистам и приобретении лекарств, находящихся в корзине медицинских услуг”. (Meretz, 2015) (Benefit equity: +1.00, Risk equity: +1.00, Public Expenditures: +0.86).

Appendix 4. South Korea

“Organization”

	GNP	NCNP	ULD
Managing Organization	0.57	1	1
Way of Financing	0.67	0.67	0.67
Public Health Expenditures	0.48	0.5	0.48

“Equity”

	GNP	NCNP	ULD
Access	0.67	1	1
Benefit Equity	0.67	0.67	0.67
Risk Protection	1	1	1

GNP (New Korea back to 1996)

5. 4대 사회보험체계를 완성하여 노령·질병·실업·산업재해 등 사회적 위험으로부터 국민생활이 보호되는 전국민 사회보험시대를 실현한다.

가. 이미 실현된 전국민의료보험에 이어 '98년부터는 국민연금제도를 도시지역 주민에까지 확대하고 공평·적정하게 발전시킨다.

○ 여성의 연금권확보를 위하여 배우자의 노후소득보장대책을 보완하고 부부간의 연금분할제도 도입을 추진한다.

○ 국민연금, 군인연금, 공무원연금 등 공적연금간의 통산제도를 도입하여 합계 20년이상 가입하면 누구나 연금을 받을 수 있게 제도를 개선한다.

나. '99년부터 산재보험을 5인미만 사업장까지 확대 적용한다.

다. 고용보험제도는 '98년부터 10~29인 사업장까지 2000년부터 5~9인 사업장까지 단계적으로 확대한다.

(New Korea, p.135, 1996)

(Managing Organization: +0.57, Financing: +0.67, +SQ Public health expenditures, Access: +1.00, Benefit Equity: +0.67, Risk Protection: +0.67).

NCNP

207. (통합의료보험 실시) 보험료 인하, 보험급여 확대 및 질높은 의료서비스를 제공하기 위하여 3개로 나뉘어 있는 의료보험조합을 통합·운영한다. 그리고 보험급여기간을 365일로 연장한다.

(1) 현황 및 문제점

지역·직장·공무원 및 사립학교 교직원등 3종류로 분리된 현행 조합주의식 의료보험방식은 관리운영비의 낭비, 지역조합의 재정불안정, 요양급여 및 보험급여 제한 등으로 요약할 수 있다. 지역의료보험에 보건복지부의 예산은 '90년 이후 지속적으로 증가하여 '96년에는 보건복지부 예산의 거의 절반에 가까운 9,270억원이 지원되고 있으나 현재 4조원에 육박하는 직장의료보험조합과 공무원 및 사립학교교직원의료보험조합의 적립금규모는 준비금의 성격을 넘어 일종의 기금으로 축적되는 양상을 보이고 있다. 특히 여기서 지적될 수 있는 것은 빈약한 보험급여를 확대할 수 있는 막대한 금액이 적립되어 있음에도 불구하고 이것이 급여확대로 이루어 지지 않고 있다. 즉 본인부담금이 입원시 60%를 넘는 등 보험급여율이 매우 낮은 상태에서 본인부담금의 인하나 비급여 부분의 보험급여 포함 등의 조치가 이루어지지 않고 적립금이 지속적으로 누적되어 사회보험의 근본취지에 어긋나게 시행되고 있다.

(NCNP, p.135, 1996), (Managing Organization: +1.00, Financing: +0.67, + 0.50 Public health expenditures, Access: +1.00, Benefit Equity: +0.67, Risk Protection: +1.00).

ULD

가. 기본방향

우리당의 사회 공약은 6개부문 34개항으로 작성했는데 그 기본방향은

- (1) 사회적 소외·취약계층에 대한 최저 생활권과 자
활권을 보장하며 영세사업장에 대한 사회보험의
확대적용과 통합의료보험의 실시 등 충실한 사회
보장제도를 확립하여 복지사회의 기반을 조성하
며

504

(ULD, p.11, 1996). (Access: +1.00)

(5) 의료 서비스의 질적 향상을 도모한다.

- 현재의 240일 보험급여 제한기간을 점진적으로 개선하
여 수급자 중심의 의료보험제도가 정착되도록 한다.
- 통합의료보험제로 전환하여 지역의료보험의 재정을 안
정시키고 의료보험료를 평준화한다.
- 의료보험급여 범위를 확대하여 병원 이용율을 증대시
킨다.
- 농어촌의 부족한 보건의료시설을 확충하기 위해 보건
소, 보건지소, 보건진료소 등을 신·증축하고 의사, 한
의사, 간호사 등 의료요원을 증원한다.

504

504

504

504

(ULD, p.47, 1996). (Managing Organization: +1.00, Financing: +0.67, +SQ Public health expenditures, Benefit Equity: +0.67, Risk Protection: +1.00).

Appendix 5. The formulas retrieved from the previous research

$$\text{Efficiency} = \text{Quality} - (\text{Cost} * 0.2)$$

$$\text{Quality} = \text{Nurses and Midwives} + (1.5 * \text{Physicians}) + \text{Hospital beds} + \text{Life Expectancy} + \\ (\text{R\&D_GDP} * 1.5) + \text{Medical School rate} + (1 - \text{Infant Mortality}) * 2 + (1 - \text{Adult Mortality}).$$

Cost is the amount of money in international dollars reflecting the total health expenditures of the countries in the year 2012