

## *The State, health policies and Asian Women*

**by Ito Peng**

**Professor of Sociology, University of Toronto, Canada**

I have been asked to present a paper on the state, health policy and Asian women. I will focus on four East Asian countries that I know the best: they are Japan, Korea, Taiwan, and China. I hope the underlying message of my presentation will also have some resonance with other Asian countries and Asian women so that, at the end, we will be able to share ideas and thoughts and begin to think about common issues from different contexts and perspectives.

I will start out by outlining my two main ideas. First, many East Asian countries, such as Japan, Korea, Taiwan and China, have been going through some radical social, economic and political changes during the last few decades. These changes have created tremendous pressures on the state to rethink their social policies, which include health policies. My second point is that for women, these structural and political shifts may create opportunities for positive changes. But we also have to be very vigilant and critical about monitoring and analyzing the implications of these changes. I will use health care policies to illustrate the areas of positive changes and the areas of new concerns.

Let me start with social, economic and political changes. Over the last couple of decades, countries such as Japan, Korea, Taiwan and China have gone through huge social, economic and political changes. On the social front, these countries have seen huge changes in relation to population aging, declining fertility, individualization of the family, or what some people call the defamilialization, and increasing women's and particularly married women's labor market participation rate. For example, in all these countries, the demographic aging has been proceeding at a rapid pace partly because of the increased longevity but also partly due to a decline in the total fertility rate. China's one-child policy notwithstanding, both Japan and Taiwan have seen the fertility rate decline to around 1.3, and in the case of Korea, it has dropped to 1.17 in the last couple of years.

In the area of family and gender relations, these countries are also witnessing steady shifts towards greater individualization. For example, in Japan, Korea, Taiwan and China, the proportion of three or more generation households has been declining on the one hand, and on the other hand, the proportion of single-family households has been increasing. Divorce rates and marriage rates have also increased quite dramatically over the past couple of decades. Women's labor market participation rates have also increased. Even though we know that women's unpaid labor has been very crucial for the family, what we are witnessing is that now not only women's unpaid labor is crucial for the families but also women's paid labor is crucial. Women in that sense are burdened much greater economically and in terms of care.

These demographic, family and gender factors have forced the state to rethink their social policies. The reason for this is not simply because of the immediate and short term implications of these societal changes and its impact on social security systems such as health, pension and elderly care, but also because of much longer term implications of what these changes mean for the nation, particularly in relation to labor shortage and economic slowdown. In short, what I'm trying to say is these social transformations have been creating tremendous pressures on the state to rethink and force policy changes.

But in addition to these social and structural factors, there have been very important political and economic changes in these countries. For example, both Korea and Taiwan went through political transitions from authoritarianism to democracy in the late 1980s and then further followed by political regime shifts after the Asian economic crisis in 1997. In the case of China, the internal political changes and decentralization process have been proceeding along with shifts from centrally planned to market economy. Even in Japan, the

collapse of the bubble economy in the early 1990s has been followed by political regime shifts and the end of one-party dominance.

These political changes have had profound effects not only on the political processes but also in terms of policy competitions and new policy innovations, and in turn these political and economic changes have had a significant impact on social and health policy reforms in these countries. They have also been a main driving force behind the shift in state paradigms about social policies. Although the political and cultural contexts of these countries are very different, what we see is the common theme of the state and policies in transition. What is important here is that the state paradigm processes change. What shape these changes take is yet to be seen.

This takes me to my second point, which is the implication of these changes for women. For women, this state of disequilibrium may provide actually some important openings for positive changes. We have to be careful in monitoring and analyzing the implication of these changes. Let's take the example of health policies to look at the implications of the changes. In Korea and Taiwan, one of the most profound outcomes of the democratic transitions since 1980 has been the mainstreaming and expansion of social welfare. An area that has shown a huge expansion in these two countries was the expansion of health insurance. In both Korea and Taiwan, the consolidation of old health insurance schemes and the establishment of a single national health insurance meant that almost all the population was covered by health care. For women, this was an important step forward because previously health insurance in these countries was occupationally separated and tied to employment status. Coverage was also quite uneven. Many women did not have access to health care on their own because they were less likely to be employed, and if they were employed, they were also less likely to be in standard full time employment. For many women, their access to health care was really through their husbands and fathers. In many cases, the health insurance coverage for dependents was not as generous for the dependents as compared to the main insured. In that sense, the introduction of universal health insurance was a positive change for women.

But we also know that despite the universal health care, there are still noticeable gender differences in terms of mortality, disability, patterns of illness, and use of health services and financial and social resources. These are of course not just unique to Taiwan and Korea; it is quite a universal phenomenon. Even with universal health care, while women for example live much longer compared to men, they spend much longer time living in disability.

It is also evident that women are less likely to use health care services as compared to men, particularly if their family income is low. Access to health care is not only gender biased but also dependent on individual financial and social circumstances. In other words, the unequal access to health care even in the best situation is structured along gender and class lines. In Korea, there is universal health insurance but the co-payment for medical service is quite high. In this case, people with low income, and particularly low income women, are selectively disadvantaged. Therefore, the gains made by universal health care are partially offset by unequal access and distribution of financial resources.

In the case of Japan, the 1990s has also seen some remarkable expansion in health care particularly in terms of long term care insurance for the elderly. While this insurance has universalized elder care and perhaps commoditized the hitherto unpaid care work provided by women in the family, the introduction of this long term health insurance scheme has also coincided with reforms of national medical insurance.

This reform of national medical insurance in Japan involves attempts to control and reduce the rising costs of health expenditures. As a result, health insurance contributions and co-payments have been raised in the case of Japan. Also, many of the provisions have been delisted from the medical insurance coverage. So what we see here is a case of positive expansion in one sector of health care carefully balanced by restraint in another.

Finally, in China, health care has been downloaded to local and regional levels, and different regions have been experimenting with various forms of health insurance. The collapse of state enterprise has led to fragmentation of social security systems including pension and health care. In big cities like Shanghai, there has been some radical reform in the recent years. In Shanghai, the old labor insurance, such as *gongwei* and *laobao*, which was insurance for employees of state enterprise and public sectors, has been restructured into basic health care insurance for urban employees. These were supposedly positive responses to the shift to market economy and the decline of state enterprises.

In this new health insurance scheme, the problem is that it's been completely employment based. And as well, it only covers registered urban workers who are employed in formal sectors. Again, women are discriminated because of employment barriers. There were a large proportion of women who were not covered, because they were not able to find full time employment in the private sector. New insurance also has coverage based on income so again women are discriminated because of pay differentials. Furthermore, the new health insurance excludes coverage for dependent family members, which means that many women who are dependents of men who have the insurance are still denied the health care access. And finally, because this insurance is limited to urban employees who have the residential registrations with the city government, it excludes completely the so-called floating population, of which there are about 3 million in Shanghai and the majority of which are also women.

What these suggest is that we need to carefully examine all aspects of changes and implications of these changes. What the cases of health policy advances in Japan, Korea, Taiwan and China suggest are two things: first, that social policy changes have in fact created some important openings and opportunities for women but these changes are far from uniform. A move forward may be countered by more moves backward at the same time. Secondly, we also need to pay closer attention to how health policy creates new lines of inequality. A new policy developed to address one issue, whether it be the universalization of health care in Taiwan and Korea or extension of health care to the elderly in Japan or the introduction of insurance to urban employees, as these policies emerge to address one set of issues, they also serve to redraw new lines of inequality. Whether these lines are along the lines of gender, class or employment status or all of the above, we therefore have to be constantly alert about where and how new demarcations of inequality emerge.