The Politics of Health Policy Maintenance

- The Formation of Health Care Governance and Its Breakdown in the United States and South Korea

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Abstract

In this paper, I present a theoretical framework by which a self-undermining mechanism of health care governance is analyzed. The governance where policymakers define the proper reach of health care providers' power may have two modes: an organizational control and fiscal control. In examining the American and South Korean case where each health care system (Medicare in the US and the National Health Insurance in Korea) is usually considered to perform well, I argue that a variety of health care reforms employed in pursuit of two controls, whether coverage expansion, delivery system rearrangement, or payment tools, have in fact contributed to undermining the way the very governance is effective, thereby weakening its administrative and regulatory authority over providers. This is mainly because these two modes of the governance are, in reality, not supposed to work on tabula rasa; instead, once set in motion, they would be immediately forced to be embedded in "a dense array of existing policies that have themselves become established institutions" or what is called policyscape. It is thus necessary to analyze how the existing arrangements affect two controls of the governance.

An important contribution of this study lies in the fact that it identifies specific causal mechanisms of governance breakdown in each country. For one thing, fostered by the insurance company model, which serves as the US policyscape, administrative and regulatory delegation by private entities on the one hand and the regulatory capture by the Relative Value Scale Update Committee (RUC) on the other have put the governance in jeopardy. In Korea where the low-taxation state model works, policymakers' co-optation with big business, combined with physicians' distrust of them, has made their reputation much more fragile. As a result, the end-mechanism of health care breakdown is termed hollow-out (US) and detraction (Korea), respectively.

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This formulation sheds new light on both the American welfare state and Korean developmental state literature. By pointing out that the way governance is weakened in the health care field, I rebut the revisionist argument that American state can be still effective in a unique manner. I also suggest the reason why the Korean government has failed to have physicians trust on it, thereby debunking a conventional wisdom that the Korean state is "strong."

Keywords: health care governance, organizational and fiscal control, policyscape, mechanisms of governance breakdown, hollow-out, detraction, United States, South Korea

Theoretical framework: governance, policyscape, and politics of health policy

– An endogenous theory of governance breakdown

The rule of the bourgeois democrats, from the very first, will carry within it the seeds of its own destruction.

(Karl Marx. 1850. Address of the Central Committee to the Communist League)

The world is cluttered with good health policies gone wrong. They are adopted but badly executed, or produce unintended effects, or fall prey to corruption and ineptitude. Sometimes the trouble is political, and sometimes it is financial, but sometimes it is in the way things are done – in governance.

(Scott L. Greer, Matthias Wismar, and Josep Figueras. 2016. Strengthening Health System Governance)

As political scientist Lawrence Brown adroitly pointed out, despite implying something "desirable more or less by definition," the *real* reform defies simple diagnosis and solutions. This is in large part attributed to the fact that not only is "consensus on the content of policy change uncommonly elusive," choices among means for that are also "uncommonly encumbered by conflicts of values and interests." (Brown 2012, 587-588) Health policy is one such area, where how to supply and maintain health care requires the state to engage in a variety of activities in which it is supposed to deal with a series of challenging tasks arranging from payments of the services to its quality care. For instance, how (much) public expenditure is spent depends on the way policymakers and the public see its legitimacy and effectiveness when applied. Moreover, although there may be a shared conception that fairness should be a basis for the spending, how to use it also varies according to what kind of institutional and ideological arrangements are open to policy options available at the moment. What makes things more complex is that policymakers' efforts to do better are often hindered and even undermined by the very

commitments that they did in prior periods. This dynamics of self-undermining fundamentally shapes contents and means with which to transform a health care system.

In this paper, I aim to identify those "failed" policy efforts and their long-term consequences to understand why health care reforms often produce results that they do want initially intended. In order to answer this, I pay special attention to health care governance by which policymakers manage and coordinate stakeholders within the health care system to pursue stable, equitable and affordable provision of the services. It pushes one to explore an intriguing relation between the state and market. This study thus begins with a critical question of classical political economy: How is a market created in the first place? The thrust of the political economy literature is that it is necessary to see the market as an institution in order to understand this dynamics. (e.g., Polanyi 1944) To put it simply, a state is deeply intertwined to establish a market. The question is now reformulated as follows: How does a state utilize the market force to supply welfare – health care services in this case – at the national level? By examining the core pillar of the American and South Korean health care system where private sector predominates in service provision, Medicare and the National Health Insurance (NHI) respectively, I first investigate the institutionalization of the national health care governance in both countries. Yet it is not true that, once established, the institutions are supposed to work as designed. While some do well to maintain themselves and run their business successfully, others often fail. In other words: The institutions need "upkeep," which requires a set of policy tools to govern them. (Mettler 2016) And if so, health outcome would be significantly different depending upon the upkeep and maintenance. It thus leads to the key question I would address**: despite a series of efforts to improve it, why and under which conditions does health care governance that the state employs become self-undermining? And what causal mechanisms would be in explaining this paradox?**

Drawing resources from the policy feedback and political economy of taxation literature, I present an endogenous theory of governance breakdown. In health care, it is imperative that policymakers within the state make provision of the service affordable and keep its cost manageable. The concept of governance thus implies a relation between the state and stakeholders in the health care system. When reforms occur, such as coverage expansion, or delivery system rearrangement, or new payment initiatives, they therefore generate a series of

conflicts among them. The state's tasks have to do with their management of stakeholders. I propose two modes of state's control over them by which policymakers try to ensure service provision in health care affordable and accessible as well as its quality: an indirect control through organizational transformation and a direct control with budgetary regulation. On the one hand, the first mode is set to enable them to modify an institutional environment in which providers produce and deliver services, thereby creating a new relationship among health care actors like physicians, hospitals, and other private entities including insurers. On the other, the second mode has to do with payment policies. As this fiscal control directly determines providers' profit, it plays an important role in altering their clinical and business practice in a way consistent with what policymakers want to pursue. It encompasses capitation, salary, per diem, global budget, bundled payment as well as a predominant method such as fee-for-service.

Yet policymakers are "heirs before they are choosers, who spend far more time living with the consequences of inherited commitments." (Mettler 2016, 372.) The policyscape, the policy commitments inherited from the previous periods, thus shapes specific modes of controls policymakers can take. (ibid.) I conceptualize the "insurance company model" (Chapin 2015) and the "low-taxation state" (Kim 2018) as the health care policyscape in the US and South Korea (hereafter Korea), respectively.

What is derived from these feedback effects is examined with respect to both controls. The distinct policy arrangement in two nations shapes the way both organizational and fiscal control operates. It subsequently begets distinct politics of health policy, which ends up undermining the function (and thus goal) of the controls themselves. Four types of result are analyzed in explaining why each mode of governance is undermining or even fails to achieve what it is originally supposed to work. For the first mode of governance, the insurance company model in the US most likely results in deepening delegation with which private entities exert much more influences over public interests, while the low-taxation state in Korea likely pushes policymakers to co-opt with big business and major universities for supplying health care services. When it comes to the fiscal control, the US health care policyscape has high likelihood of producing regulatory capture. The Korean counterpart would have not succeeded in obtaining its regulatory legitimacy over providers.

The final part of this chapter discusses the end-mechanisms of governance breakdown. They are understood as a combination of the results of both controls. While the weakening emerges as the hollow-out of the governance in Medicare, detraction from policymakers' reputation would be the key feature of the breakdown in the NHI.

1. Literature review: A tale of two (welfare) states

There is virtually no comparative work to date exclusively on the US and Korean health care system. It pushes one to develop a new theoretical framework to explain our substance of interest, which will be elaborated in the next section. Nonetheless, each topic has generally been part of the welfare state literature as a whole, which is thus worth examining before I address health care in its own right.

As a subfield of political science, American political development (APD) has developed a wide range of studies on the American welfare state. Debunking the liberal conventional wisdom that generally describes the modern American state as "exceptional, laggard, incomplete, backward, uneasy, maternalist, and reluctant," a group of revisionists has in particular demonstrated that the American state is neither weak nor small but a *different* one. (Novak 2008, 756; see also Sheingate 2009; 2014; King and Lieberman 2009; Balogh 2009) They advanced a new thinking of how the state actually works, proposing varieties of its modus operandi. One of these venues includes a public and private relation. (Novak 2008) For example, Jacob Hacker emphasized that distinctness of the American welfare state should not lie in "the level of spending" but in "the source." (Hacker 2002, 7) In examining the development of retirement pension and health insurance, he thus argued that American welfare regime is not just consisted of "the network of direct-spending social programs" such as Medicare, Medicaid, Social Security, but also of "the constellation of more indirect or hidden government interventions" like tax breaks as well as "private social benefits and the public policies that subsidize and regulate them." (Hacker 2002, 11-12, xiii) This is why he argued that the American welfare state is *divided*; it cannot be thus properly understood without *both* public and private benefits. In a similar vein,

Christopher Howard also pointed out that, to figure out US social policy, the *hidden* welfare state, whose core lies in "tax expenditures with social welfare objectives" other than direct expenditure, needs to be taken into account. (Howard 1997) In sum, both of them pointed out that the social policy version of American exceptionalism is attributed not to the fact that "social spending is distinctly low in comparative perspective," but to that "so much of that spending comes from the private sector." (Hacker 2002, 16)

The invisible attribute of the American governance has also gained lots of attention in the American welfare state literature. Back in 1997, Howard already proposed the metaphor of the "coral reef" which "lies beneath the surface, hard to see unless one knows exactly where to look" to figure out the importance of tax expenditures (Howard 1997, 188-189) Hacker also pointed out that the politics of private social benefits is "subterranean" in the sense that it is "far less visible to the broad public, far more favorable to the privileged." (Hacker 2002, xiii) Mettler later furthered this insight in citizen's perspective. In this invisible governance, she argued, citizens "are ill-positioned to form and articulate opinions about them, or even to understand what is at stake in reform efforts." (Mettler 2011, 27) As a result, politicians can "deter direct government spending, both by reducing revenues and by appeasing those who might otherwise be vocal opponents." (ibid., 18)

These formulations enable us to have a more nuanced understanding the way the American welfare state works yet their theoretical considerations, for our purpose, remain insufficient. First, at the heart of building blocks employed is path dependence, which means "social process characterized by *self-reinforcement*, in which the cost of reversing an existing course of institutional or policy development increases over time." (Hacker 2002, 53; Pierson 1993. Emphasis added.) Yet the point I would make here is, as discussed in the next section, to theorize how governance in a policy domain put itself in jeopardy. Second, critical junctures are also utilized here as "moments of political opportunity when significant new policy departures may be put in place or when the forces for change are strong enough to cut into the ongoing path-dependent development of an existing policy and alter its trajectory." (Hacker 2002, 59; but also see Capoccia and Kelemen 2007) Exploring a causal linkage between strategies the government pursues and the consequent modes of governance breakdown, I would instead focus

on ongoing political process over inherited commitments rather than emphasizing timing and sequence of governance as traditional historical institutionalists argue.

The third, and arguably most problematic issue is that this revisionist scholarship obscures other critical aspects of American welfare state. Let me make two points here. First, in a distinction Hacker made between direct-spending social programs and hidden government interventions, public health insurance like Medicare and Medicaid falls under the former. Yet what I would explore in this study is how private actors (such as HMOs and PBMs) penetrate into a public program and why deepened reliance upon them causes governance breakdown in the long run. It is thus an interaction between the public and private *within* public programs (not the distinction itself as he suggested) that matters. Second, this literature tends to emphasize the way American state is effective in a defensive yet positive manner. King and Lieberman's work is suggestive here. They present five modes of it: the administrative, standardized, fragmented, associative, segregating state. For example, in their formulation, in contrast to professional (in a Weberian sense) and "elite bureaucrats who presided over centralized power" in Western Europe, the American state has "bureaucracy that relies on alternative mechanisms (like networks and democratic roots in civil society) to be effective." (King and Lieberman 2009, 569-571; 2017, 180-181) Yet this argument like 'it is different nonetheless works as much as do others' does not apply to all policy domains. Health care is such an area. Here I do not just highlight the fact that the United States has no universal health insurance that almost all advanced economic societies have. As Prasad correctly pointed out, what is really unusual in the US is "the lack of decline of private welfare state," about which "no one has explained why." (Prasad 2016, 195) In a comparative perspective, what needs to be examined is thus why "the US government codified private welfare by increasing support for it" and it is exactly what I try to uncover. (ibid.)

My reading on the extant health policy literature also shows why a new perspective is called for in addressing the question above. Following Theodore Marmor's book (1970) on Medicare, usually considered as a foundation in the study of American health politics, Jonathan Oberlander explored important dimensions of the politics over Medicare, such as benefits, financing, and regulation. (Oberlander 2003) A remarkable contribution he made in this book is the claim that the operation of Medicare from 1965 to 1994 was characterized by "a politics of consensus." By this he argued that "federal health insurance for the elderly should be provided

through a universal government program went relatively unchallenged," but it ended in 1994 when the Gingrich Revolution began, which unleashed the new politics of Medicare. (Oberlander 2003, 156) Despite rich in details on the policy development, his theoretical framework is nonetheless quite thin. Although his work is conductive to rethinking the American exceptionalism by arguing that in the case of Medicare "federal policymakers have often acted independently and pursued policies against the interests of private groups associated with the program," he did not elaborate this line of reasoning further. (ibid., 14) Similar problems are found in works on Medicaid. Focusing on the role of governors in health policy making at the state level, Shanna Rose provided a comprehensive study on the Medicaid reform and fiscal federalism that drove it. Her framework is largely based on the policy feedback literature to demonstrate that "policy feedback effects on the political mobilization of government elites" such as governors "have been understudied." (Rose 2013, 14) Addressing this critical issue, however, she spent only three pages, which also proposed no specific causal mechanisms unfolded in the Medicaid policy development. Furthermore, more importantly, path dependence is considered the same as policy feedback in her explanation (ibid.), which is not the case as will be shown in the next section.

For the Korean counterpart, there are to date very few works on the welfare state from a *political science* perspective.[2] Huck-Ju Kwon arguably presented the first analysis of why the Korean authoritarian regime utilized social policy tools. He showed that the making of social policy in Korea has been primarily determined by the politics of legitimation, where, as the "normative grounds of the overarching institutional framework of polity are usually challenged, those in power attempt to defend it by the use of political measures such as social policy." (Kwon 1999) In other words, the government provided core groups like civil servants and industry workers with welfare benefits, thereby inducing them to support the regime. Specifically, the Park Chung Hee government found it useful "to stay in power, to be able to govern and to execute rule effectively, and to promote economic growth." (Ringen et al 2011, 23) Stein Ringen and his collaborators later furthered that social policy as a hidden dynamics contributed to the Korean political and economic development at the outset. (ibid.) For instance, land reform during 1946-1955 was a crucial step by which absentee ownership was mostly abolished and the overall class structure was transformed. As a consequence, it not only led to "a new class of self-owning

[2] For an overview of regional-specified approaches on the Korean welfare state development, see Yang (2017), 5-8.

class" but also increased agricultural productivity, enabling farmers to educate their young generation. It paved the way for the young nation to initiate the later economic development. (ibid. 11, 111) Meanwhile, Jae-jin Yang took another perspective on the origins of the small welfare state in Korea. Asking why the Korean welfare state is underdeveloped despite successful industrialization and democratization, he argued that legacies of the developmental state prevented unions, as a core change-agent, from supporting welfare state building. Specifically, his reasoning goes as follows: "the pre-existence of statutory retirement allowances, a generous income-and-working year-related lump sum benefit paid by employers, weakened Korean union leaders' interests in redistributive income maintenance programs such as old-age pensions and unemployment benefits." (Yang 2017, 15; 2013) Let me note that works discussed above deal with some aspects of my interest. For instance, Yang's observation that "the Korean developmental state was interventionist in the market but minimalist in its commitment to social welfare" would be critical to me as well. (ibid., 14) Nonetheless, the literature generally addresses social welfare policy, whose logic and dynamics is not the same as health care.

Other than the welfare issue in general, the health policy literature also fall short of full development. (For exceptions, see Kwon 2005) To be sure, a series of pioneer works by Byong Hee Cho on Korean medical sociology are noteworthy. (Cho 1994; 2000; 2003; 2006) Yet despite tracing how medical professionalism, as a distinct form of general practitioners (GPs) from that in other countries, was historically developed, neither he systematically theorize a relationship between this issue and health care governance, nor explore causal pathways linking them. Finally, among comparative scholarship is Wong's study on the transformation of the health care system in Korea and Taiwan. (Wong 2004) His book still remains the only one available to the English-speaking readership on this topic to date. Yet it only presented an inductive (not deductive) framework which traces two paths leading to universal health insurance. It also addressed the effect of globalization on the health care system in each country, which is not relevant to my study. To summarize, the extant literature both on the American and Korean welfare state calls for another framework needed for exploring the formation and weakening of health care governance.

2. Theoretical Framework

(1) Health care governance and its two controls

The literature review above reveals that there are only a few studies that pay systematic attention to dynamics of governance breakdown in the (comparative) health care field. In order to fill in this gap, this paper pursues to understand why and how health care governance ends up undermining itself despite a series of reforms to improve it.

Ensuring health care is a critical task for policymakers in many respects. The first and foremost reason should be found in the fact that it has to do with people's lives. Unless properly provided, it may have a direct and devastating effect on health of citizenry in a country. (e.g., Oliver 2006; Carpenter 2012) At the macro level, a domain of the governance thus lies in a task of remedying "health care market failure both through regulation and resource allocation." (Brinkerhoff 2004, 373-374) For policymakers to fulfill this task, defining "the proper reach of medical power" is critical. (Giaimo 2002, 9) They have a responsibility to determine the extent to which providers exert their clinical and financial autonomy.

The organizational control

I propose that they are equipped to employ two modes of health care governance: organizational and fiscal. The first mode facilitates an organizational transformation of the overall health care system. The distinction between systematic and programmatic retrenchment Pierson made in the analysis of the politics of welfare retrenchment in the United Kingdom and United States helps us make sense of how it works. In his account, compared to programmatic retrenchment which results from "spending cuts or a reshaping of welfare state programs," systematic one refers to "policy changes that alter the broader political economy and consequently alter welfare state politics." (Pierson 1994, 15) In health care, this effort is expected to change a relation between policymakers and providers as well as that among providers themselves.

The organizational control can be achieved through at least two pathways. For one thing, as the economy develops and technological innovation advances, medical demand is highly likely to increase over time. In response to this need, policymakers may induce new stakeholders to enter a health care market. For another, policymakers may seek to alter interaction patterns of the established relationship among actors within the health care system.

The fiscal control

The second mode of governance that policymakers employ has to do with payment policies to providers. As this control determines the way they get reimbursed (and thus earn money), it may also have a regulatory effect on them. As the largest payer, Robert Field argues, the government can exert "tremendous influence over what it pays for without resorting to direct regulation." As a result, payment policies "have grown to include substantial regulatory powers that in many instances were not originally anticipated." (Field 2007, 74-75) More importantly, this instrument also may help policymakers take a firm grip on physicians' behavioral and financial incentives. For example, a prospective payment method can in principle send providers a clear signal to be more cost-efficient, thereby granting policymakers a stronger budgetary control over them. (Brown 1992; Smith 1992; Oberlander 2003; Mayes and Berenson 2006) The fiscal control can take a wide array of forms. It arranges from salary, capitation, per diem, RBRVS, bundled-payment like DRG, prospective payment system such as global budget to fee-for-service, the most traditional and predominant method. Let me take a few among them. For example, the DRG refers to a payment policy by which standardized health prices are in advance set according to a type of disease. Providers are consequently encouraged to efficiently supply their services to patients. (Lee 2003, 49) As DRG is the most typical payment method among various case payments, it is just called case payment as well.[3] The global budgeting is one of the cost-containment policies by which the government prospectively sets total health expenditure for a given period and induces providers to supply their services within the expenditure. It thus implies a relatively strong policy intervention to manage the total amount of the costs. The global budgeting usually has two types: expenditure cap (hard cap) and expenditure target (soft cap). The former is a method that allots a total expenditure for services and drugs offered by providers

[3] For more details about a comparative study about various payment policies including DRG, see Cashin et al. 2005.

for a given period and that reimburses them within the budget. The latter is a more flexible way by which both providers and payers shoulder a deficit when total costs exceed the targeted expenditure. (Choi and Shin 2003; Moon et al. 2008, 207; Chung et al. 2011, 38) In any case, global budget is understood as a policy by which a government (as a payer) may have a firm control over national health care costs. (Chung and Lee 2010, 37-38; Yang 2006)[4]

(2) Policyscape

To be sure, these two modes of health care governance are, in reality, not supposed to work on tabula rasa; instead, once set in motion, they would be immediately forced to be embedded in a complex array of exiting institutional and policy arrangements. Political scientists have developed a variety of conceptual tools for understanding this social phenomenon. This scholarly tradition usually falls into so-called policy feedback research. It dates back to E. E. Schattschneider (1935) and Theodore Lowi (1964) well-known for their thesis that "new policies create a new politics" and was later elaborated by Theda Skocpol (1992) and Paul Pierson (1993; 1994; 2000; 2004; 2007).[5] Prior to discussion on the tradition, however, it would helpful to distinguish it from institutionalist theories for conceptual clarification. Both enterprises began with a common interest of why, once in place, an institution or policy continues to be as it is, and then moved to ask why it may change despite its tendency of inertia.

For one thing, the institutionalist approach has a long tradition which dates back to the 1980s, yet from a perspective of comparative historical analysis (CHA) in general and American political development (APD) in particular, a critical shift of interest is detected since the 2000s. Previous work in the CHA/APD field tends to focus on how a given institution sustains itself over time. As it concerned why an institution is increasingly being non-malleable once it established, the analysis of this "path-dependent" process was its main task. (David 1985; Arthur 1994; Skocpol 1992; Pierson 1994) Yet as it faced a critique that its theoretical orientation is ill-equipped to explain a change, a large number of these approaches found it useful to employ a

[4] According to the OECD's Health Systems Institutional Characteristics, only four states (Korea, Japan, Austria, and Switzerland) did not implement global budget among 29 countries covered in the 2010 survey, except the United States who did not participate in the survey. This shows that global budgeting is a quite general means to administer the health care system in the advanced societies. (Chung et al. 2011, 51-53)

[5] For a good overview of policy feedback research in general, see Beland (2010) and Beland and Schlager (2019)

model of punctuated equilibrium, originally from paleontology. (Gould and Eldredge 1977; Krasner 1984; Baumgartner and Jones 1993) For those who would present alternatives to this model, however, it has at least two drawbacks. First, within this framework, a change only appears to happen when external shocks intervene to break down a preexisting equilibrium. That is actually what "punctuated" means. Second, as a result, a change is seen as a real change only when its process is abrupt and its result is discontinuous. In this understanding, it is difficult to capture the fact that an incremental process of change also causes a (albeit gradual) transformation of the institution, or that the abrupt process of change can rather lead to a survival of the institution, not its replacement or breakdown. (Streeck and Thelen 2005, 4-9) To address these issues, Wolfgang Streeck and Kathleen Thelen (2005), one of the important agenda-setting works in the field, argued that institutionalists need to go "beyond continuity" of institutions and instead delve into how they change despite their inherent tendency of path dependence. (For their precursor, see also Thelen and Steinmo 1992, 16-18) Building on insights from a variety of pioneers (esp. Schickler 2001 on layering and Thelen 2003 on conversion), they shed new light on institutional dynamics by suggesting five modes of institutional change: drift, conversion, layering, displacement, and exhaustion. (Streeck and Thelen 2005, 18-33) Thelen and her collaborators later elaborated on these dynamics by focusing on characteristics of the targeted institution and those of political context surrounding it. They argued that the level of discretion (low and high) in enforcement or interpretation of the institution and the degree of veto possibilities (weak and strong) derived from political contexts can jointly produce four different modes of institutional change. (Mahoney and Thelen 2010) More recently, they furthered to propose two modes among four—drift and conversion – very common and consequential patterns, thereby seeking to generalize their arguments. (Hacker, Pierson, and Thelen 2015)

Despite sharing a starting point of why and how a policy in question sustains over time, the policy feedback research advanced a distinct theoretical development. To be sure, it is true that it also started with an observation that a policy produces positive feedback. For example, Pierson (1993; 1994) asked why social welfare programs are resilient to retrenchment efforts that the conservative government sought to make. Andrea Campbell (2003; 2012) and Suzanne Mettler (2006) also showed that how political behavior like interest group mobilization can be self-reinforcing. Campbell's work analyzed how social welfare program like Medicare prompted senior citizens' political participation by focusing on the ways in which programs bolster their

own bases of political support and endure or even expand it over time. In contrast to institutionalist theories which devoted to elaborating specific modes of institutional change, however, this line of reasoning realized that a policy in question not only produce this positive feedback but also *negative* one.[6] More recent works have thus developed an array of menus to explore the dynamics of self-undermining feedback. To be sure, this interest dates at least back to Skocpol (1992) where she analyzed why the achievement of premature welfare program (Civil War veteran's pension) paradoxically contributed to building a welfare laggard by making policymakers "associate the pension with corruption in patronage politics, which dampened their willingness to embrace other types of social provision in the early twentieth century." (Mettelr and SoRelle 2016, 153) Yet one of clear catalysts in promoting toward this direction may be found in Avner Greif and David Laitin's work. In the 2004 seminar paper, they advanced a theory of "endogenous institutional change." In crafting a concept of quasi-parameter, they theorized how an institution can be self-undermining as well as self-reinforcing. (Greif and Laitin 2004; Grief 2006) Whether explicit or implicit, subsequent works on negative feedback effects were significantly influenced by their work. For example, Alan Jacobs and Kent Weaver presented three types of self-undermining feedback mechanisms: "the emergence of unanticipated losses for mobilized social interests, interactions between strategic elites and loss-averse voters, and expansions of the menu of policy alternatives." (Jacobs and Weaver 2015) Weaver, along with Jonathan Oberlander, also formulated another way of understanding policy feedback effects in which socio-political, fiscal, and administrative effects are examined and thereby conditions exacerbating self-undermining effects are explored. (Oberlander and Weaver 2015)

Another important line of research which develops a theory of negative feedback should be found in Eric Patashnik's work. As early as in 2008 (but see also Patashnik 2003), his book advanced an important thinking of why an enactment may *fail* even after its passage. While recognizing the fact that policy reform is a "political project," he emphasized three factors which come into play when "the politics of reform unfolds over time." (Patashnik 2008, 26) Among political structures, market forces, and policy feedback effects which he considers generate the

[6] Let me note here another difference between them: Compared with the institutionalist approach, the notion of policy feedback implies endogeneity of change. Whether positive or negative, the feed-back itself thus originates from within.

politics, he particularly stressed that the third one "matters most of all." (ibid.) In the book, he presented a hypothesis about "the general conditions under which reforms will be most sustainable" and its specific kinds of post-reform dynamics. (ibid., 31) Two factors are critical in his formulation: a relevant interest group's identities and affiliations (stable or fluid) on the one hand, and its investments (modest or extensive) on the reform on the other. Depending upon the mix (i.e., a 2 by 2 matrix), one of four different reforms consequently occurs. For example, when a group identity is fluid yet its investment modest, the reform may be eroded.[7]

Later his reasoning on negative feedback further developed in a coauthored article. Still building on a critical distinction between the enactment and postenactment phase, he suggested three mechanisms undermining positive feedback: resource effects, interpretive effects, and institutional supports. (Patashnik and Zelizer 2013) For instance, with respect to resource effects, benefits that a welfare program provides can fail to generate a political support from beneficiaries when the benefits are too low at the point of policy design. And equally, if the benefits are not sufficiently augmented, policymakers may still fail to maintain the policy even after it was implemented. To put it simply, policies are not always self-reinforcing.

While building on these insights on the dynamics of negative feedback, I employ another concept to develop my theorization on an endogenous breakdown of governance. The conceptual innovation I would highlight from the literature is policyscape. Theorized by Mettler, it basically means one that is "densely cluttered with public policies that were established by lawmakers at earlier points in time, which now structure the political order." (Mettler 2016, 370) Like infrastructure (e.g., highways, bridges, public transit, etc.), the maintenance and even update of policyscape is emphasized as a fundamental task of policymakers to keep its function as it is originally designed to. The variation in upkeep also depends, she argues, on the fit between "the demands of the policyscape" and the attributes of the political context at that historical moment, as well as on their governing expertise. (ibid., 375) In her rendering, management of policyscape is thus understood as governance responding to its demand. In other words, governance here is the equivalent of policy maintenance.

While adopting the concept, I make some revisions to advance my argumentation. First, the idea is still crucial that, for governance to be effective, upkeep of it matters. Yet compared to

[7] In his analogy, this type of reform accounts to "death by a thousand cuts" or "smothering." (ibid., 32)

her theory where policyscape is the very object of the maintenance effort, my take on it focuses on the way the existing set of policies affect health care governance. Put simply, the upkeep of policyscape does not account to governance; what would be maintained is instead governance itself, and it refers to as a set of controls (organizational and fiscal) by which policymakers set the proper reach of medical power as discussed earlier. Second, as a result, its dynamics of negative feedback should be different from one Mettler considered. In her explanation, policy decay occurs when the policy generates its consequences, such as policy design effects, unintended consequences, and lateral effects. Unless properly responded to changes in policies themselves as well as ones in environment (and thus updated), the policy (higher education policy in her formulation) would be derailed or deteriorated by the effects it produced over time. (ibid., 374-375) In this study, I suggest *two steps* of understanding mechanism linking causal chains between policyscape and the results of governance breakdown. (cf. Hall 1993) The first-order mechanism concerns the way policyscape affects governance. The contrast to Pierson's argumentation would be helpful here for clarification. He examines how welfare state institutions (e.g., pension, housing, or income-support) can be resilient to retrenchment efforts and thus path-dependent (Pierson 1994). His focus thus lies in why those reforms fail to undermine the existing institutions. Meanwhile, I examine how policymakers repeatedly appeal back to a *problematic* policy arrangement when they face policy issues like rising costs or coverage expansion. My focus consequently lies in why those attempts fail to improve the policyscape. In the sense that the policyscape persists despite its problematic feature, my take may be called a *reversed* form of self-reinforcement.

Put differently, under the first-order mechanism, I focus on how inheritance from policies established at earlier point in history plays a critical role in shaping "the parameters of government action." (Mettler and SoRelle 2014, 160) What I mean by this is specifically as follows: As a predominant policy arrangement embedded in the specific setting, a policyscape understood in this way have served for policymakers as the cognitively "last-instance" solution to whatever policy problems they faced. As they have been accustomed (if not tailored) to interests of relevant actors as well as institutional-cultural adaptation processes, they do not need to be optimal in terms of economic efficiency. This formulation helps me depart from other approaches. First, they are not just barriers to the subsequent reforms; for policymakers, they rather should be understood as an alternative with which to utilize among many available options.

In that sense, they are also not the same as "cognitive scripts" or "cultural templates" as sociological institutionalists claim. (DiMaggio and Powell. 1991; Hall and Taylor 1996) Second, as the policyscape equally imposes accountability to improve governance upon policymakers under both conservative (Republican) and liberal (Democrat) administrations, neither ideological orientations nor cultural influence solely determines how it works. In a similar vein, its operation also does not depend upon politicians' short-term horizon due to political (electoral) competition. (Pierson 2004; Jacobs 2011) Third, in contrast to some theorization on self-undermining feedback effects by which policy menu expansion (e.g., individual mandate) contributes to relaxing opposition (whether politicians or interest groups) to a reform (e.g., the ACA) and helping it enacted, a theory presented here suggests that, despite policy options increased, a reform may face the opposite fate: a failure. (Jacobs and Weaver 2015)

While the first-order mechanism would reveal why policymakers take the existing policy arrangement (despite its limitations and ineffectiveness), the second-order mechanism traces how the governance (influenced by the policyscape) consequently develops, thereby producing its own weakening. This logic explains that the way by which the governance put itself in jeopardy despite policymakers' efforts to make it better. As these processes are embedded in the specific environment, however, the results from them are also context-sensitive. What I mean by this is twofold. First, in cases of interest, four different types of result-mechanisms are detected: delegation and capture (US) on the one hand, and co-optation and distrust on the other (Korea). These types are examined in the next section. Second, as I pay special attention to the process by which the governance operates over time, the politics around its implementation as well as design would be of great interest.

From this re-formulation, I consequently suggest three added values. First, these conceptual arrangements empirically reveal that the effects of existing policyscape persist. To be sure, it could be termed a reversed version of path dependence as mentioned above. Second, the theory I advanced not only explains how the policyscape shapes the operation of governance (the first order) but also the political process by which the governance generates a specific type of its own weakening (the second order). Third, as a result, this setup enables me to analyze causal mechanism regarding each mode of governance (presented above) as well as overall mechanisms

of governance breakdown found in the US and Korea: hollow-out and detraction, both of which will be presented in the last section.

(3) The specific policyscape in the US and Korea

The insurance company model in the United States

Let me now turn to the specific policyscape in each country. In the United States, what I term the insurance company model (following Chapin 2015) has developed. In this model, she argues, insurers afford to "decide which services and procedures qualify for policy coverage, influence physician pay and hospital revenues by setting reimbursement fees, and shape medical practices by requiring that health care providers follow treatment blueprints to obtain compensation." (Chapin 2015, 2)

Prior to the postwar periods, two episodes are noteworthy in shaping later policy developments. First, in early 1910s, as part of the Progressive movement, the American Association for Labor Legislation (AALL) pursued legislation for national health security. Unlike the proponents' expectation that the success of workers' compensation will be "a good guide" to establishing of compulsory health insurance, however, it faced strong opposition from almost all groups around the reform, including "employers, commercial insurers, and local medical societies." (Hacker 2002, 195-196; Oberlander 2003, 18-20; Starr 2011, 29-35) Second, during the New Deal, there were several efforts to create a national health insurance along with a public pension program, which will be Social Security. Reformers considered "public and nonprofit health insurance as a response to growing medical needs as well as rising medical costs." (Starr 2011, 37) Yet fearing that both reforms (on pension and health insurance) would be threatened by businesses and physicians (represented by the AMA), FDR in the end chose to drop the national health insurance proposal. (Hacker 2002, 206-212)

Because of these failures, however, physicians increasingly felt greater pressure from rising costs and were forced to craft their own reform proposal. They consequently embraced the role of insurers in financing health care services, yet strictly defined the jurisdiction of the latter.

Specifically, insurance companies were required to "reimburse the services of individual physicians rather than medical groups; compensate practitioners for each service or procedure provided (e.g. on a fee-for-service basis); and allow doctors to practice medicine as they saw fit, free from supervision or interference." (Chapin 2015, 2) Put simply, despite significant organizational and fiscal changes within the health care system, "professional security" or "physician sovereignty" mattered most for them. (ibid.)

The Eisenhower administration paved the way for consolidating this insurer-oriented arrangement. It did so by crafting tax policies that "encouraged businesses to purchase insurance for workers and a massive health benefits program for federal workers yoked the insurance company model to employer provision." (ibid., 59) Specifically, two measures were crucial that the federal government facilitated the employer-sponsored insurance (ESI). First, as employer-provided benefits grew over time, the administration wanted to expand health care coverage through workplaces. Although employer contributions to health benefits had previously been considered nontaxable (i.e., "tax breaks"), it officially made a codification that clarified "the tax status of employer-sponsored health insurance" and expanded "the individual medical expense deduction." (Hacker 2002, 239-243; Starr 2011, 42; Chapin 2015, 60-64) As a result, the Internal Revenue Act of 1954 helped expand a space where private insurers would play a critical role in operating the ESI. Second, the administration also created the Federal Employees Health Benefit Program (FEHBP) in 1959. With this program, the government was now required to purchase private insurance for federal workers. In so doing, it in large part "replicated" the existing voluntary market, instead of having the government bear the risk of costs. (ibid.) As the Act of 1954 did, the FEHBP not only contributed to private insurers' penetrating into workplaces (as a new market) but also "setting a norm for private sector benefits." (Chapin 2015, 63)

And with the passage of Medicare under the Johnson administration, this practice finally reached another domain, "federally funded aged insurance." The end-result of long, fierce legislative battles was so-called "three-layered cake" where hospitals and physicians are paid (through Part A and B, respectively) while health care services for the poor are also reimbursed (through Medicaid). (Marmor 2000; Oberlander 2003; Morgan and Campbell 2011, Barr 2016) Despite difference in policy details, however, the thrust of the legislation lay in the fact that the government came to "outsource claims payment to the insurance industry." (Starr 2011, 48) As a

consequence, the government designated private insurers "semiformal appendages of the state," which in turn made their practice of delegation (and thus the role of fiscal intermediaries) much more embedded in both private and *public* health insurance program. (Chapin 2015, 230) Its effects not only will endure but extend the boundaries into other areas such as prescription drug benefits.

The low-taxation state in Korea

Unlike the US case, as the policyscape in Korea has to do with political economy of taxation, some background on that is necessary. To understand "why particular states settle on particular tax policies," two dimensions of taxation should be examined: the tax level and the tax structure. The former indicates the extent to which a government levies. It is measured by total tax revenue as a percentage of GDP. The latter means the way tax burdens are distributed among social actors. Specifically, taxes are usually composed of direct and indirect ones, and the tax structure is measured by the share of direct taxes as a percentage of total tax revenue. The direct taxes typically include capital and labor income taxes, while consumption taxes and value-added taxes (VAT) fall under the indirect ones. (Martin, Mehrotra, and Prasad 2009; Kim 2009; Steinmo 1993)

For the Korean case, I propose two variables for the tax level and the tax structure, respectively: extractive capacities of the government and its developmental strategies. (cf. Mares and Carnes 2009, 109; Haggard and Kaufman 2008; Ahlquist and Wibbels 2012) My justification for this formulation relies upon a fundamental goal of the Korean state in an era of economic development: "a mission of modernization, epitomized as industrialization." (Ringen et al. 2011, 17) That is, the tax system of the Korean state depended on how to mobilize and accumulate capital for industrialization. As early as the late 1950s, Albert Hirschman suggested a developmental strategy distinct from that followed by conventional wisdom at the time. For him, development depends "not so much on finding optimal combinations for given resources and factors of production as on calling forth and enlisting for development purposes resources and abilities that are hidden, scattered, or badly utilized." (Hirschman 1958, 5) At an early stage of state-building, the Korean government continuously suffered from the lack of capital. This was exacerbated by the Korean War, through which a large number of state infrastructures were

destroyed. Policies for large tax exemptions were also continued to boost economic development. This low extractive capacity of the state explains the low level of taxation in early period.

When it comes to tax structure, more discussions are needed. In explaining the relation between welfare state and regressive taxation, Kato argues that the timing of the VAT introduction is critical for its adoption. The VAT is "a flat-rate regressive tax on a broad base, when implemented, has a strong revenue-raising power." (Kato 2003, 27) The countries in which the VAT was introduced before the governments experienced chronic budget deficits became welfare states, while the countries in which the VAT was introduced after they had experienced deficit finances came to have small welfare states (i.e., welfare state laggards). (ibid., 28-34) This is because the public of the former countries, "with no experience with budget deficits, had no way to oppose the new tax" and accepted it evitable. In contrast, the public who already suffered from a budget deficit "tended to suspicious of increasing tax only to solve deficits" and opposed it. (ibid., 27; Kim 2010) In discussing Korean case where the VAT was introduced at the middle stages of their industrial development, she attributes its early adoption to policy diffusion effect. That is, it could "fully enjoy outside help, including learning from the experience of the European countries and consulting with economists from international organizations." (ibid., 189) This advantage of backwardness made possible the introduction of the tax in Korea. (cf. Gerschenkron 1962) What is less highlighted in her account is, however, the role of the VAT in promoting economic development. To be sure, she points out critical features of the VAT, such as "efficiency, discouragement of tax evasion, and revenue-raising capability." (Kato 2003, 188) I also take them seriously yet also pay attention to its effect of reducing capital income taxation. In this regard, Cathie Jo Martin's work would be helpful. As she illustrates, employers play an important role in building revenue (and thus tax) systems in coordinated market economies. In this role, the invisibility of indirect taxes is crucial for achieving their preferable form of taxation. They can subsequently seek a tax system in which labor and consumption taxes are much levied than capital taxes. (Martin 2015) In case of developmental states in East Asia, such as Korea, however, a corporatist counterpart was underdeveloped. The role of employers therefore has to be replaced by that of the government in my analysis.

To summarize, let me note two considerations. First, the Korean government (instead of business) developed tax policies to reduce tax burdens on capital. In other words, tax policies in

Korea also served as industrial policies in order to stimulate economic development. Due to low extractive capacities of the state and the nature of its developmental strategies, i.e., export-oriented industrialization, the Korean government sought to transform the tax structure without changing the tax level. Second, as a result, compared to the share of capital and property taxes which likely stifle economic growth, consumption taxes' share (including the VAT) increased more. How then does this political economy framework affect health care governance? That is a task I would tackle in the next section.

(4) Results from the controls: Theoretical expectations

United States

Given the specific policyscape in two nations, it is theoretically plausible to see that what result the governance would produce under each policyscape. For one thing, in the US insurance company model, the organizational control is expected to result in a deeper delegation of administrative and regulatory accountability to private entities. What I mean by "deeper" is twofold. First, policymakers delegated much more authorities to the HMOs and PBMs. Second, private actors' business scope has further extended into Medicare Part C and Part D.

Although the HMO Act was enacted in 1973, a practice of managed care was not widespread throughout the field of health care until the mid-1980s. (Brown 1983; Gray 1997; 2006) The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) paved the way for the HMOs to convert non-profit, local organizations into profit, national ones. Being now "different animals," they grew significantly. (Kelly 2015; 2016, 332) Despite so-called "managed care backlash" and Bill Clinton's failed initiative to pursue comprehensive health coverage, its rationale of the third party delegation continued to influence policymakers. (Skocpol 1996; Blendon et al. 1998) The Balanced Budget Act of 1997 (BBA) and the MMA later provided "a major boost in government contributions to private plans" (i.e., MA), thereby consolidating the role of HMOs in the Medicare system. (Berenson and Dowd 2008, w32; Kelly 2016) The MMA also created a new prescription drug benefits. The Part D is fully administered by private insurers and PBMs. (Seeley and Kesselheim 2019) As a consequence, insurers and PBMs now have

become “risk-bearing entities” that not only administer a large part of Medicare itself but also manage its costs and benefits. (Gingrich 2015, 17) This substantial delegation of governance would have high likelihood of producing a series of governance crises. For the MA, it is not hard to expect that a need of transparency (due to fraud) will be a perennial issue. (Morgan and Campbell 2011) In Part D, in addition to transparency, PBMs’ business practice like rebates and spread pricing as well as inefficient government support (e.g., reinsurance) likely will critical problems for sustainable governance of health care.

For another, the fiscal control is likely to produce another problem. This is mainly because increasing reliance upon the third party (inherent in the insurance company model) made the government’s grip on physicians much loose. The lack of direct control over them will be evident in a regulatory capture of the RUC and failure of the SGR. (Carpenter and Moss 2014) After the passage of Medicare and Medicaid, in response to rising costs, the federal government began to steer health care governance from one accommodating providers to one regulating them more. In the 1970s, the efforts to impose controls (both behavioral and budgetary) the program were at the state and local levels. For example, the PSROs are voluntary organizations of physicians and its roots are local. (Brown 1992; Smith 1992) During the 1980s, a set of centralized initiatives were made. For both hospitals and physicians, reimbursement became standardized and prospective. While the PPS and DRG were established in the hospital sector, the RBRVS was also created for the physician fee schedule. (Mayes and Berenson 2006) As a cap on total health expenditure, the VPS was also set. These federal moves are significantly weakened by physicians, however. Absent direct government intervention, the AMA (its specialty societies, to be exact) virtually took over the RUC, thereby securing their profit (a fee increase). (Laugesen and Rice 2003; Laugesen 2009; Laugesen, Wada, and Chen 2012) In terms of VPS (replaced by the SGR in 1997), their lobbying on the Congress successfully stopped it from cutting a rate of fee. (Laugesen 2016) This means that, despite within the insurance company model, physicians’ power still will be preserved and even re-consolidated at least in the fiscal control of governance.

Korea

In Korea, it is expected that the way the low level of taxation (and its indirect-oriented structure) shaped the unique form of economic development has significantly influenced how health care governance works. When it comes to the organizational control, the efforts of resource mobilization hugely limited social welfare revenues. As a result, even though the government passed the Medical Insurance Act in 1963, it just remained a paper without effect for a long time. Yet the Second Amendment of the Act in 1976 required every firm with over 500 employees to provide them with medical insurance. Accordingly, 485 employer-sponsored medical insurance associations were also established. (Cho 2008) One of critical effects that this measure activated should be found in the fact that as it created a massive volume of medical demand. This is because, supported by the insurance, they were now able to purchase medical services that otherwise could not received. (Cho 2009) In response to increasing demand of the services, however, a bunch of infrastructural arrangements that afford to address the demand were required. The government that has put its top priority on economic development turned to private actors to find a solution. It induced large companies and major colleges to invest and even participate in the health care market. During the 1980-90s, big businesses (like Hyundai and Samsung) as well as universities (such as Seoul National Universities and Yonsei University) consequently established their own hospitals and branches with a large number of beds. (Cho 1994; 1997; Sung 1995; Yoo 2007)

Yet this co-optation with market actors likely made the government seed its own governance breakdown. Two issues will be salient: First, due to poor investment in health care, the generosity of the insurance is more likely to be weakened. And as a trade-off, it is also possible to see a remarkable growth of private health insurance. Second and more importantly, under the current health care system, primary care doctors who does not serve as gate-keepers but as individual practitioners will be forced to directly compete with large-sized hospitals for patients. In addition to low fees, the changed situation from which they find themselves more difficult to earn money will likely make their discontent about the current governance widespread and deeper.

Combined with this discontent, the fiscal side of the governance will lead to aggravate physicians' distrust of the governance even further. The catalyst would be the mandatory separation of drug prescribing and dispensing enacted in 2000. As this measure prohibits

physicians from dispensing, it is designed to remove one of critical practices from which they profit. It sets the stage for physicians' first strike in Korean history. (Cho 2003; Cho 2008) A series of these episodes will form a reference with which they would fathom out policymakers' intention of pursuing subsequent health care reforms. The combination of growing discontents (from the fierce competition) and the creation of the "reference" will likely cause another weakening of governance. Two points are important: First, under the low-fee condition, the government's attempt to fully implement a new payment reform (K-DRG), whose prospective design further constrains their profit, will be not just hard to succeed but also make physicians' distrust much worse. It will help us understand why, among three health care reforms in the early 2000s, the financing reform (the merge of all health insurance societies into a single insurer) and pharmaceutical reform (the separation mention above) succeeded, while the provider payment reform did not. (Kwon and Reich 2005) This is in large part attributed to the fact that the first two has little to do with an effort to transform the low-taxation state model. (The first reform aims to improve coverage inequity among beneficiaries and the second one would rearrange a service delivery structure.) Put differently, these reforms do not pursue to increase health care revenues. Second, as a consequence, despite a voluntary (and thus partial) implementation of the K-DRG, physicians' distrust of the current governance will deepened. Specifically, HIRA, the government agency that utilizes the payment method to review and assess their medical claims, is most likely to be their target. The administrative and regulatory authority that the institution is supposed to hold will consequently continue to be under attack.

The end-mechanism of governance breakdown in the US and Korea

Taken together, it is also possible to predict an end-mechanism of governance breakdown caused by a combination of these results discussed above. Although both crises yield a negative effect on the proper (i.e. designed) function of the governance, a mechanism of doing so is distinct in each case. In the US, it is highly likely that deepened delegation to private actors (derived from the organizational control) and regulatory capture of the RUC (from the fiscal one) jointly produce a breakdown of health care governance. In the sense that these moves have deprived the governance of its substantive authority (administrative and regulatory), I would call

this form of governance breakdown a *hollow-out*. To be sure, this term was previously used by other scholars to describe similar conditions. For instance, as early as in the 1990s, R. A. W. Rhodes employed the word of hollowing out to provocatively suggest that "the (British) state is being eroded or eaten away." This is because, he argued, it was losing its functions due to privatization of public service delivery, Europeanization, and the shrunk discretion of public servants through the new public management. (Rhodes 1994) In the context of Medicare administration, Morgan and Campbell also pointed out as follows: "the antipathy of policy-makers toward bureaucratic power not only led to the delegation of program governance to private actors, but also hollowed out the agency charged with overseeing these private actors." (2011, 151) Nonetheless, many of these attempts ended up attributing hollow-out of governance to privatization itself or just paid unsystematic attention to it. Linking two undermining effects resulting from the organizational and fiscal control, I put this notion on the front to advance my claim that the government has handed its authority (much of which is supposed to be publicly hold) over to others, thereby hollowing itself out.

In Korea, the mechanism that puts health care governance at risk takes another mode. While policymakers' co-optation with big business and major universities will help them respond to increasing demand of health care, it also will constrain parameters of physicians' profit-making. Blended with a long-standing complaint with low fees they reimbursed, this likely causes their discontent about the current governance. Moreover, a new payment reform such as K-DRG is highly likely to worse physicians' distrust of the governance, already catalyzed by their strike (followed by the separation of drug prescribing and dispensing). This will not only lead them to refuse the reform but also to unwilling to accept its legitimacy as a payment method. As a result, this distrust will also be applied to an institution in charge of payment review and assessment, the HIRA. Together, the results from the organizational and fiscal control cause a breakdown of governance. In the sense that despite having substantial (and "strong" in a sense) authority, its legitimacy has been dismissed by the very policy constituency (i.e., physicians) upon which it is supposed to impose, I would call this form of breakdown *detraction*. In other words, when physicians are not willing to embrace the legitimacy, the governance may be self-undermining.

The argument developed so far is summarized in a table below.

<Table 1> Summarization of the argument

		Medicare (USA)	NHI (South Korea)
	Policyscape	*Insurance company model*	*Low-taxation state model*
Modes of health care governance	organizational control (object / venue)	- managed care through HMOs (Part C) - PBM (Part D)	- market competition by big business
	the result of control	**delegation**	**co-optation**
	fiscal control (object / venue)	- RUC - SGR	- HIRA - K-DRG
	the result of control	**capture**	**distrust**
Mechanisms of governance breakdown	end-result (from a combination of both controls)	"hollow-out"	"detraction"

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