Adapting to Democracy: Societal Mobilization and Social Policy in Taiwan and South Korea*

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Democratic transition and institutional change do not necessarily guarantee greater political inclusion, particularly when it comes to the policy influence of civil society groups. Rather, political inclusiveness requires strategic adaptation among societal actors. Actors need to seize upon opportunities endemic to political change. This article provides a comparative analysis of health care reform in democratizing Taiwan and South Korea, focusing on two social movement coalitions, the National Health Insurance Coalition in Taiwan and Korea's Health Solidarity. Both movement coalitions were critical in shaping welfare reform trajectories in Taiwan and South Korea during the late 1990s, despite having been shut out from earlier episodes of health care reform. I argue that these groups (1) strategically adjusted their mobilization strategies to fit specific political and policy contexts, (2) benefited from broad-based coalition building, and (3) effectively framed the issue of social welfare in ways that gained these movements ideational leverage, which was particularly significant given the marginal place of leftist ideas in the postwar East Asian developmental state model.

The global spread of democracy has been one of the most important developments of the postwar period. Despite the introduction of new democratic institutions in many parts of the world, the promise of democracy has significantly come short in meeting widespread political and socioeconomic expectations. Evelyne Huber, Dietrich Rueschemeyer, and John Stephens describe this as the paradox of formal democracy. One expects that democratic transition "makes deepening toward more fully participatory democracy and progress toward increasing equality *possible*" (1999: 168 [emphasis added]; Przeworski, 1999: 40). However, the empirical evidence suggests that this promise has yet to be realized in much of the democratizing world (Birdsall, 1998). This significant gap between expectations and reality is not trivial. The quality of democratic performance and ultimately the

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survivability of democracy are dependent upon meeting somewhat these social, economic, and political expectations.[1] To that end, the comparative study of democratic transitions has begun moving toward evaluating democratic performance, focusing on the processes of institutionalizing formal democratic institutions and beyond that, substantively deepening democracy in terms of social reform and fostering participatory inclusion (Weyland, 1996; Kapstein and Mandelbaum, 1997; Goodman et al., 1998; Encarnacion, 2001).

This article builds on the concept of democratic deepening in the East Asian context and examines the related politics of democratic inclusion and social policymaking in Taiwan and South Korea. Specifically, I look at the process of healthcare reform in democratizing Taiwan and South Korea during the 1990s, and how civil society actors gained entry into the policy process. As a redistributive social policy, healthcare reform captures political contestation across a swath of social, economic, and political cleavages. The stakeholders in health policy outcomes are numerous, and because there are winners and losers in redistributive social policy, actors are often in conflict with one another. In this respect, examining the politics of healthcare reform in Taiwan and South Korea allows us to evaluate the extent to which social policymaking processes, and democratic practices generally have become more or less inclusive of divergent interests and their activist interlocutors.

The stories of healthcare reform and deepening democracy in Taiwan and South Korea are distinctive because they reflect the specific contexts of the two cases. I highlight the nuanced differences between the two East Asian experiences throughout the article; still, I contend that the political dynamics of societal inclusion and the broadening of participatory politics in Taiwan and South Korea are roughly similar and have occurred at around the same time. Grassroots activists in both places played particularly instrumental roles in shaping equitable health policies during the late 1990s, despite having been shut out of earlier efforts in healthcare policymaking. Moreover, inclusion in the policy process in both Taiwan and South Korea were not automatic and was not solely the consequence of the introduction of formal democracy *per se*. Rather, societal actors strategically adapted to democracy in Taiwan and South Korea and, in so doing, forced their way into the policy process. In other words, their actions squared what Huber and her colleagues view as the paradox of formal democracy.

The first section of the paper offers an analytical framework through which we can delineate the processes of strategic adaptation among civil society actors in Taiwan and South Korea as well as groups' impacts on social policymaking. Here, the discussion centers on open political opportunities, actors' mobilization of political resources, and their adaptation to specific policy contexts. Section 2 provides an account of healthcare reform in Taiwan and Korea during the period of democratic consolidation. In addition to the empirical details of policy reform, this section illuminates how societal actors were initially shut out of social policymaking processes, despite the introduction of democratic institutions.

The remainder of the paper focuses on the 1990s, the period when social movement coalitions ably penetrated previously closed policy networks and significantly steered the course of recent healthcare reform. In these sections, I highlight how societal actors (1) adjusted their mobilization strategies to fit specific political and

policy contexts, (2) engaged in the process of broad-based coalition building, and (3) effectively framed the issue of social welfare in a way that gained these movements important bases of ideational leverage, which was particularly significant given the historical antipathies toward the welfare state idea throughout the postwar period in East Asia. The conclusion elaborates on what I see to be the "learning" processes inherent to the politics of democratic deepening.

Analytical Framework

Kenneth Roberts defines democratic deepening as the "inject[ion] of greater social content into the democratization process." He adds that democratic deepening entails "both procedural and substantive connotations, ranging from popular participation in the policymaking process to re-distributive socio-economic reform" (1998: 3; Wong, 2003). Inclusive political democracies, such as those that bring societal actors into the political and policymaking arenas, promote fairer political economies. The politically excluded in democratizing Latin America, Eastern Europe, and Asia have tended to mirror those who are socioeconomically marginalized. A major concern among practitioners and scholars of democratic change therefore lies with the rejuvenation of civil society and its reconnection with the larger political arena. This inclusive ideal is difficult to achieve. There is no guarantee that actors born out of an effective oppositional civil society from during the pre-democratic period will persist as efficacious political and policy advocates in the post-transition order (Smolar, 1997).

Democratic Inclusion

This article looks to explain how civil society actors such as the National Health Insurance (NHI) Coalition in Taiwan and Health Solidarity in Korea gained entry into the health policy process during the late 1990s. As the dependent variable, inclusion here refers to the substantive role played by societal actors during deliberations about important healthcare reforms. In particular, I am interested in those actors that have historically been excluded from such decision-making processes, such as labor and other socioeconomically marginalized sectors of society. Democratic deepening and political inclusion require that such actors not only participate in the policy process, but also that their roles be instrumental in shaping health policies. In the case of Taiwan, for instance, the NHI Coalition was crucial in resisting the government's efforts to privatize and marketize Taiwan's health insurance system during the late 1990s, thus preserving the redistributive integrity of universal care. The Health Solidarity Coalition in South Korea compelled the Kim Dae-Jung government to financially integrate medical insurance, resulting in greater risk and financial pooling across disparate households. Simply put, democratic inclusion and democratic deepening, as they are conceived here, are centered on both societal actors' impact on health policies and how much these reforms in Taiwan and South Korea promote greater redistributive equity.

This is an inductive study of societal mobilization; it does not look to evaluate specific hypotheses for explaining democratic inclusion in social policymaking. Rather, this article endeavors to inductively generate causal explanations about how

groups can gain entry into highly contested social policy areas, such as in healthcare. As alluded to above, the introduction of formal democracy is not enough. While democratic transition in Taiwan and South Korea was initiated during the late 1980s, as the empirical sections here will recount, societal actors continued to be excluded from health policymaking, a pattern not dissimilar to the earlier authoritarian period. Though democratic transition legalized associational life, societal actors were ineffective in gaining inclusion. Healthcare reform continued to be directed from the top-down, driven by the heavy handedness of the state and through a process of insulated elite decisionmaking. It was not until the late 1990s, roughly ten years after the initiation of democratic reform, that societal groups successfully forced their way into the health policymaking process in Taiwan and South Korea.

The "open" politics of democracy, even as a theoretical ideal, does not necessarily equate political inclusion, so the cases of democratizing Taiwan and South Korea are not unique. As Philippe Schmitter points out, the legacies of state corporatism in Latin America and East Asia, where associational life was sanctioned and constrained by the authoritarian state, stunted the development of autonomous civil society in many consolidating democracies (Schmitter, 1997: 257–258). Carlos Vilas, in his review of democratization in Latin America, similarly contends that the unequal distribution of power and resources within democratizing societies undermined the representation of, and participation by, social movement groups in policymaking. He suggests that new democracies "lack specific space for social movements" and, as a result, societal activists have tended to be "reduced to roles as outside pressure groups" (Vilas, 1997: 33). I contend that inclusive social policymaking is determined to some extent by the institutionalization of democratic rules, but more important, democratic deepening is determined by the ability of societal actors to strategically adapt to the new political game.

Explaining Adaptation

To make sense of this adaptive process, I focus on three dimensions of adaptive societal mobilization. First, political adaptation among societal actors depends upon *open opportunities* for strategic mobilization. Democratization creates new strategic contexts or political playing fields that in turn facilitate or constrain opportunities for new modes of political organization and mobilization. Strategic adaptation on the part of societal actors involves seizing opportunities inherent to democratic politics and turning them to their advantage. Effective mobilization goes beyond simply groups' "adherence to the specific rules" (Diamond, 1997: xvii). Some of these opportunities are endogenous to the political institutions that structure a society's democratic practice: electoral institutions, political party systems, and bureaucratic reform, shape the ways in which actors adjust their mobilization strategies. Yet in other instances, exogenous events—such as the 1997 Asian financial crisis—interact with these institutional variables and the political logic of democratic competition. Such events also create unexpected though no less important opportunities that social movement groups can exploit and thus assert themselves into the policymaking arena. The key point here is that societal actors must seek out and make the best of their strategic opportunities.

Second, taking advantage of strategic opportunities requires societal actors to ably mobilize resources in exchange for their inclusion in policymaking and for groups' interests to be taken seriously by decisionmakers. Simply put, social movement activists need *political currency* that they are able to exchange for policy influence. Political resources, or what I see to be political currency, are vague, but they must be available to societal actors and, more important, they must possess some value to policy decisionmakers. In this respect, effective exchanges between elites and societal activists are context specific. They vary from case-to-case and over time. As the evidence from Taiwan and South Korea demonstrates, societal groups strategically leveraged their political (primarily electoral) support, their policy expertise, and their normative legitimacy in gaining entry into policymaking. In other words, the NHI Coalition and Health Solidarity offered something that health policymakers valued.

Third, the processes of strategic adaptation by societal actors are shaped by the *specific goals and objectives* of activist groups. Strategies for democratic inclusion are contingent upon what the social movement groups seek to achieve in terms of policy agenda setting, decisionmaking, and implementation. Appropriateness is critical. For instance, if societal actors seek to raise awareness about certain policy issues, they may be less inclined to devote resources to gain the attention of bureaucratic policymakers and more likely to tailor their mobilization tactics toward a publicity campaign or to win the attention of key legislators. Different goals and objectives require different strategic adaptations. As the evidence will show, social movement groups in Taiwan sought to veto policy initiatives made by the government during the late 1990s, which required a different course of action than the one taken by Health Solidarity in South Korea, which aimed to steer the policy agenda towards policy change. Though their motivations were in principle similar (i.e., greater redistribution in healthcare), the NHI Coalition in Taiwan and Health Solidarity nonetheless pursued different adaptive strategies when it came to gaining entry into the health policy process.

All three of these considerations—opportunities, exchangeable currency, and policy objectives—illuminate how societal groups adapt to the democratic game and how they seek entry into previously closed policy networks. Before turning to the empirical sections of the article, I should introduce one last analytical consideration. Though democratic transition is often conceptualized to be a moment of radical institutional change, and a moment during which a new political logic of electoral contestation is introduced, I think it necessary to stress that the democratization process, in empirical reality, is never a one-shot deal (Di Palma, 1990; Friedman, 1994; Linz and Stepan, 1996; Schmitter and Santiso, 1998). Democratic reform involves a dynamic process of change. Constitutional crafting, partisan realignment, electoral reform, and the cultivation of civil society string together several crucial moments over a period of time.[2] Consequently, political contexts and strategic opportunities for broader political inclusion emerge along a temporal plane, certainly not all at once. Furthermore, because actors are able to learn over time—indeed, political adaptation often involves learning from past mistakes and gaining new knowledge—reinforces this temporal dynamism inherent to the politics of democratic deepening. These last points are developed more fully in the article's conclusion.

Democratization and Healthcare Reform

During the late 1980s, newly elected President Roh Tae-Woo universalized medical insurance in South Korea. Health insurance schemes were first extended in 1988 to rural self-employed workers, comprising mainly farmers, followed by a second wave of expansion to self-employed urban workers in 1989. In Korea, the universalization of healthcare was achieved with the addition of 255 self-employed workers insurance scheme. By 1990, there were more than 400 different health insurance societies (HIS) or funds. Though administratively decentralized, the total coverage rate of the various funds reached nearly 100 percent of the population. In Taiwan's case, planning for the National Health Insurance (NHI) program began in 1988, though it was not until 1994 that the program was passed in the Legislative Yuan. The NHI program was implemented the following spring. Unlike the decentralized structure of health insurance coverage in South Korea, the KMT-led government in Taiwan designed an integrated insurance system administered by the central Bureau of National Health Insurance. The NHI covered 97 percentage of Taiwan's population.

Healthcare Reform in the 1990s

Though the universalization of healthcare coverage in South Korea and Taiwan were important social policy achievements in their own right, the insurance programs nonetheless confronted significant challenges early on, demanding immediate solutions. In South Korea's case, the decentralized organization of HIS or medical insurance funds mitigated redistributive transfers among different wage-earning and risk groups. Due to the smaller size of each HIS—for example, the average number of enrollees in rural funds was about 45,000 in 1990—financial redistribution and risk pooling was limited (NFMI, 1999). Furthermore, because there were no mechanisms for interfund transfers or equalization payments among the different HIS, disparities among occupational groups were exacerbated. The ratio between contributions made and benefits received among the different health insurance funds was skewed in favor of government employees, and at the expense of self-employed workers (see Table 1). In 1993, self-employed workers paid the largest amount in insurance contributions making on average 3.66 medical insurance claims per person that year. Meanwhile, government employees, typically higher wage earners in lower-risk occupations, paid much less in insurance premiums, though made on average 4.46 claims per person (NFMI, 1999).

The idea of integrating or consolidating Korea's disparate HIS funds had long been discussed among policymaking officials, National Assembly lawmakers, and social movement groups; actually, the idea dated back to the 1980s. It was only in 1999 that the Kim Dae-Jung government successfully legislated the integration of the medical insurance system under a single, publicly managed, financial and administrative organization. The newly created National Health Insurance Corporation (NHIC) consolidated Korea's health insurance schemes and aimed to promote greater redistribution in inter-wage group and inter-risk group transfers. Despite great opposition from entrenched interests, such as employers and even from some actors within the state bureaucracy, the 1999 reform was a major step toward pro-

Table 1
Benefits and Contributions in South Korean Health Insurance Societies (in Korean Won)

	Government Employees Insurance	Industrial Employees Insurance	Self-Employed Workers Insurance (rural and urban)
Yearly Contributions per Person	127,002	137,412	138,345
Yearly Benefits per Person	186,180	153,372	144,514
Ratio of Benefits to Contributions	1.47	1.12	1.04

Source: NFMI 1999

moting greater socioeconomic equity in social policy. The health insurance system was administratively integrated in the summer of 2001 and financial consolidation was completed in July 2003.

Taiwan's NHI program also faced challenges, albeit different ones, shortly after the program began operating. In terms of redistributive equity, the NHI scheme was successful. After its implementation, medical care utilization rates increased fastest among lower- and middle-income households (Chiang and Chen, 1997: 92). Tung-Liang Chiang also found that the value of health insurance contributions paid by high-income households was greater than the value of medical care benefits received by them, whereas the value of medical care received among low-income households was nearly double the amount expended by such households, leading Chiang to observe that "the poor pay less but get more; the rich pay more but get less" (2000: 143).

In terms of fiscal health, the NHI program was threatened by rapidly escalating expenditures. Table 2 shows that the NHI posted a fiscal deficit in 1998 and its reserve fund had been drained the following year. When the NHI's performance was reviewed during the late 1990s, health policymakers stressed the need to contain costs and to put the program's precarious financial situation in order.

Financial instability in the NHI, combined with criticisms of the government's mismanagement of the national healthcare system, compelled state leaders in Taiwan to propose in 1998 the privatization and marketization of medical insurance provision. The reform would allow private sector insurance carriers to enter the

Table 2
Finances of the NHI in Taiwan, 1995–1999 (in millions of NT dollars)

Year	NHI Revenue	NHI Expenditure	Surplus/ Deficit	Reserve Fund
1995	199,150	161,671	37,479	—
1996	247,463	229,409	18,054	25,145
1997	256,843	250,810	6,033	5,680
1998	269,481	271,043	–1,562	3,376
1999	300,362	300,351	—	–21,528

Source: BNHI, 2000.

healthcare market. Though the carriers would be heavily regulated—for instance, they would be mandated to offer the same basic benefits to all enrollees and they could not turn any potential enrollee away, irrespective of the individual's health profile—private sector insurers could offer supplemental benefits for additional premiums. Furthermore, they would be responsible for organizing their own networks of healthcare providers, the logic being that they could more effectively contain provider-side costs than the existing single public insurance carrier. It seemed that there was a fortuitous opportunity for the government's reform idea. Despite what appeared to be an emerging elite consensus around the multiple-carrier proposal, he idea was blocked by a hesitant legislature. Many feared that the reform would result in a multitiered healthcare system and the retrenchment effort was consequently abandoned shortly thereafter.

Democracy's Paradox

It is significant that both the Taiwanese and South Korean experiences ran counter to global trends in welfare state retrenchment. Equally interesting about these two episodes of healthcare reform is the tremendous policy influence gained by civil society groups. The Health Solidarity Coalition in Korea was a key actor that pushed the Kim regime to pursue the medical insurance integration reform. In Taiwan, the National Health Insurance (NHI) Coalition was instrumental in undermining the state's retrenchment efforts. It needs to be stressed again that the inclusion of societal actors in social policymaking was not typical of past practices in South Korea and Taiwan, even after democratic transition had been initiated in both places. Societal groups were emphatically excluded from healthcare reform processes in the immediate post-transition period. During the late 1980s, President Roh Tae-Woo led healthcare reform in Korea by executive order and with little societal input (Lee, 1993). In Taiwan, the executive branch of the state planned the NHI program, a process that was similarly insulated from outside influence (Lin, 1997). In other words, during the early stages of democratic transition in Korea and Taiwan societal groups were either nonexistent in, or marginalized from, unequivocally state-led efforts in healthcare policymaking.

Looking back specifically at the cases of South Korea and Taiwan, several factors help explain why societal actors were excluded from social policymaking during the late 1980s and early 1990s. First, even though social movement activists were pivotal in sparking democratic breakthrough—such as those who made up the *minjung* alliance in Korea or the *tangwai* movement in Taiwan—these grassroots alliances collapsed shortly thereafter. Prospects for coalition building within civil society were slim and fragmentation undermined societal actors' political leverage (Chu, 1992; Mo, 1996; Kim, 1997). Politically, social movement groups looked incapable of delivering unified political support for the governing regimes in Taiwan and South Korea. Labor movements in particular broke away from their former civil society allies and increasingly mobilized on their own and solely around worker related issues. As it turned out, labor's particularistic demands and its subsequent exclusion from mainstream civil society were politically costly, both to workers' welfare and to broad-based grassroots activism more generally. I will return to this point later.

Second, societal actors lacked the policy expertise with which to effectively participate in serious policy discussion. Because healthcare was a relatively new policy area for most grassroots activists, they were without the policy capacities needed for them to be taken seriously by elite policymakers. The complexity of healthcare policy was prohibitive in terms of effective participation and representation in health policy debates. As a result, social movement groups were not viewed by policymakers to be important sources of policy knowledge and expertise during both the Roh Tae-Woo and KMT regimes of the late 1980s. Though movement leaders were then adept at mobilizing in the grassroots, societal actors were nonetheless perceived, quite rightly at the time, to be weak policy advocates. They had little expertise to offer health policy decisionmakers.

Third, social groups enjoyed few linkages with state-level policymakers. Access into the political and policy processes was restricted and connections had yet to be made. In both Taiwan and South Korea, bureaucrats remained insulated from bottom-up pressure, a continued legacy of the authoritarian developmental state. Parties, and by extension national legislatures, were also out of reach for social movement groups, particularly as elected politicians in Taiwan were preoccupied with capitalizing on the ethnic divide among Chinese "mainlanders" and ethnic "Taiwanese"; in Korea, regional cleavages and personal loyalties to party leaders (Cotton, 1997; Rigger, 1999). So long as politicians could mobilize voters through regional networks and ethnic ties, and so long as civil society as a whole remained fragmented and unable to deliver large voting blocs to incumbent parties, social movement activism was relegated to the political sidelines. Simply put, health policy reform advocates from within civil society did not enjoy any significant opportunities to engage governing policy decisionmakers.

Things had changed by the late 1990s. According to elite survey data collected in 1999 and 2000 (comprising health policy bureaucrats and national level legislators), 96 percent of respondents in Korea (n=132) and 74 percent in Taiwan (n=109) indicated that they perceived societal group influence to be on the rise. Only 2 percent of Korean respondents (three of 132) and 6 percent of respondents in Taiwan (seven of 109) felt that group influence was declining.[3] The stories of healthcare reform during the late 1990s confirm this reappraisal of civil society's role in public policymaking. In contrast to earlier episodes of social policy reform, societal actors such as the NHI Coalition and Health Solidarity were pivotal in determining healthcare policy outcomes during the late 1990s. They emerged as key actors in the policymaking process and their roles were decisive in healthcare policies. How can we explain this change? The remainder of the article offers an explanation.

Strategic Adaptation

Though the goals of the Health Solidarity Coalition in Korea and the NHI Coalition in Taiwan were not dissimilar—both groups sought to preserve or deepen socioeconomic redistribution in healthcare—the specific strategies for political inclusion employed by the two social movement organizations proved to be different. Two considerations shaped each group's mobilization strategies: their policy objectives and the political-institutional settings in which they maneuvered. Health Solidarity's

primary objective was to ensure that health insurance integration was legislated. In short, it sought to *make policy*. To do this, Health Solidarity allied itself with President Kim Dae-Jung, his ruling party, and the centrally controlled executive apparatus tied to the presidency. In Taiwan, on the other hand, the NHI Coalition's main concern was to block the passage of the executive's privatization reform. In other words, the coalition looked to *veto policy*. To achieve this, the NHI Coalition took advantage of the increasingly fragmented legislature and fomented deadlock among elected lawmakers. Unlike Health Solidarity, the NHI Coalition pursued no partisan alliances and instead petitioned all legislators, regardless of partisanship. These two stories of reform are developed more fully below.

Making Policy in Korea

The 1997 Asian financial crisis created an important political opportunity for social policy reform advocates in South Korea. Rapid unemployment and increasing poverty resulting from the crisis exposed severe weaknesses in Korea's existing social safety net. With year-end presidential elections already scheduled, social policy advocates mobilized around opposition candidate Kim Dae-Jung and shaped his platform regarding social welfare reform. Kim needed the votes, especially since his was then the opposition party. During the presidential election campaign, Kim promised Health Solidarity that his administration would integrate the health insurance system. Soon after his electoral victory, Kim made good on his promise when he brokered the Tripartite Commission in early 1998, bringing together labor, business, and the government. It was here that important trade-offs were made and the government subsequently affirmed its commitment to strengthen Korea's welfare system by expanding the pension system and by integrating the finances and administration of medical insurance.

To see these social policy reforms through, President Kim was forced to recentralize policymaking authority in the state to within a exclusive network of actors (Moon and Kim, 2000: 164). He marginalized those in the Ministry of Health and Welfare (MOHW) who were opposed to the integration reform. Lee Sang-Yong, a Kim ally, was subsequently appointed head of the health insurance division in the ministry. To administratively oversee the reform process, President Kim named Cha Heung-Bong, a long-time proponent of medical insurance integration, to be the Minister of Health and Welfare in 1999. Another Kim ally, Kim Yoo-Bae, was appointed to head the Blue House (office of the president) Secretariat for Labor Affairs and Social Welfare, solidifying executive backing for the integration reform. All of these individuals were intimately involved in the integration reform process and they all wielded a great deal of administrative authority.

President Kim Dae-Jung was similarly thorough in reworking the National Assembly to his advantage. During the first year of his presidency, Kim was able to cobble together a legislative majority (153 of the 299 seats) through *ad hoc* alliances with key opposition legislators. As party leader and president, Kim Dae-Jung imposed tremendous discipline over his party rank-and-file. Even though several opposition legislators sitting on the National Assembly's Health and Welfare Committee were opposed to the reform idea, they remained silent for fear of alienating

key electoral constituents, and particularly those voters represented by the broad-based Health Solidarity Coalition (Oh, 2000). In effect, President Kim could have his way in the National Assembly.

The centralization of authority among like-minded reformers and political allies of the president facilitated healthcare policymaking in Korea under the Kim administration. Decisionmaking was centered in the MOHW and the office of the presidency, and then approved by the National Assembly in early 1999. Health Solidarity was a key actor in this exclusive policy network. In fact, Health Solidarity's leadership was invited to a part of the policy formulation process from the beginning. Seoul National University (SNU) medical school professor Kim Yong-Ik, one of the leaders of the Health Solidarity movement, served on several executive-level committees within the state. Other high-level Health Solidarity affiliates—including key reform proponents such as SNU professor Bong-Min Yang, grassroots activist Jung-Sung Yoo, and labor movement leader Young-Gu Huh—also served on and advised President Kim's executive committees tasked with overseeing the integration reform (Wong, 2004). In other words, Health Solidarity not only intimated a formidable show of force in the grass roots and quieted potential opponents of the reform bill in the legislature, its leaders also enjoyed privileged positions within the centralized core of health policy decisionmakers.

Vetoing Policy in Taiwan

In the face of financial crisis in healthcare, the government in Taiwan and the ruling party (KMT) leadership proposed to privatize and marketize the national health insurance (NHI) program. A reform bill prepared by the Department of Health (DOH) was subsequently approved by the executive branch and then delivered to the Legislative Yuan in February of 1998. Public debate ensued, which enabled bottom-up mobilization.

Soon after the bill's introduction into the legislature, a publication criticizing the government's reform proposal was circulated to all legislators, DOH officials, and social activists. This pamphlet was prepared by the NHI Coalition, an umbrella organization comprising some 200 different social movement groups. The coalition argued that the proposed bill would create a multitiered healthcare system wherein the wealthy and large private-sector providers benefited disproportionately (NHI Coalition, 1998). Its efforts to veto the reform did not go unnoticed. The coalition sparked debate among policymakers over the potential effects of the DOH proposal. By the fall session of the 1999 legislature, 14 different members' bills had been introduced, in addition to the reform bill presented by the DOH. Six proposals were from opposition Democratic Progressive Party (DPP) members, one was from the New Party, two bills were submitted by independent legislators, and quite surprisingly, five proposals came from out of the ruling KMT (Bulletin, 1999). The DOH bill was challenged from all sides of the political party spectrum, including the ruling party of the day, and predictably, it failed to pass. Though the reform bill was not technically defeated in the legislature, it was mired in a sea of competing proposals. It died because of legislative deadlock and policy indecision.

By the late 1990s, the Legislative Yuan no longer functioned as the rubber stamp assembly of years past. However, unlike in South Korea where President Kim cen-

tralized authority in the executive and through the National Assembly, the Legislative Yuan in Taiwan became increasingly fragmented and legislative decisionmaking increasingly individualistic. Parties themselves were unable to build internal consensus over important social policy matters, let alone across party lines. Three reasons account for legislative fragmentation in Taiwan and the system's proneness to social policy deadlock.

First, internal factionalism within Taiwan's parties eroded party leaders' authority over its members and weakened their ability to foster consensus within the legislative arena (Gold, 1996; Chao and Myers, 1998). Second, the political party system in Taiwan was not conducive to intra-party coalition building in social policy. Because ethnic conflict had been so central to Taiwan's politics (Wachman, 1994), socioeconomic cleavages were marginalized from the party system, meaning that there lacked a programmatic basis upon which party leaders could discipline their party rank-and-file when it came to social policy reform. Third, Taiwan's multimember district electoral system institutionally undermined political party unity, particularly as candidates from the same party were forced to contest one another within the same district. Party labels and party platforms were less meaningful (Hsieh, 1996). Instead, legislators tended to rely on ties with societal groups and local political factions rather than on party patronage (Lin, 1998).

With healthcare reform during the late 1990s, the fragmented legislature in Taiwan was the optimal arena in which the NHI Coalition could veto the executive's marketization proposal, or as it turned out, to *force a political stalemate*. This strategy worked for several reasons. The broad-based support enjoyed by the coalition gave it political leverage *vis-à-vis* vote-seeking legislators. The NHI Coalition also played an important educative role for politicians who themselves tend to be underinformed about complex policy matters such as healthcare reform.[4] Societal actors exchanged their expertise, policy knowledge, and their electoral clout for a voice among legislators. Finally, the NHI Coalition completely disregarded partisanship, unlike the Health Solidarity in South Korea. The Taiwan legislature was not neatly divided along party lines about healthcare reform. Disagreements about health policy reform emerged between parties and within parties themselves. The NHI Coalition exploited this division and targeted its campaign to all parties and to every legislator, creating legislative deadlock (Wong, 2004). Though its tactical strategies differed from those of Health Solidarity in Korea, the NHI Coalition similarly adapted its mobilization strategies to fit the specific policy and political realities that it confronted.

Coalition Building

Health Solidarity and the NHI Coalition were broad-based movements, comprising several activist groups that themselves cut across important political cleavages such as social class, ethnicity (in Taiwan), and regionalism (in Korea). Their eventual success in gaining entry into the health policy process notwithstanding, the fact that these encompassing coalitions were able to form at all was relatively unexpected, especially considering how few cooperative linkages existed among social movement groups in the immediate post-transition period when groups rarely worked together. Students mobilized on campuses while workers took to the streets and

marginalized labor from mainstream civil society activity. Middle class activists gravitated toward the task of ensuring their voice in electoral politics and staked their political fortunes in the formal political arena. Parties in democratizing Korea and Taiwan looked to win over moderate voters and were less concerned about societal mobilization on the margins. During the immediate post-transition period, groups went their separate ways, and not surprisingly, civil society activism failed to be incorporated into the mainstream political arena. Fragmentation weakened civil society's capacities to mobilize political resources.

Lessons Learned

The case of Korean farmers is instructive. The idea for health insurance integration in Korea emerged as early as 1989 when farmers organized around structural reform. Because farmers were considered to be self-employed, their medical care benefits were far less generous than those enjoyed by urban-based industrial workers. Their insurance premiums were also higher on average than industry employed workers. The farmer's movement organized on its own, yet because their grassroots base was so narrow and their political weight so slight, farmers were unable to compel the government to integrate their medical insurance funds with those of industrial workers.

Farmers failed to build an effective coalition, although one might have expected the labor movement to be a natural coalition partner. The reality was that workers were less concerned about health policy issues at the time; workers already gained disproportionately from the then existing medical insurance arrangements. For their part, farmers were also unwilling to ally with labor. They saw the labor movement as being too radical, too outside the political mainstream. From the perspective of the farmer's movement, labor was viewed as a strategic disadvantage. In the end, coalition building failed to occur and President Roh Tae-Woo easily quashed the insurance integration idea by vetoing it unapologetically in the spring of 1989 (Wong, 2004). Roh had nothing to gain by supporting integration as farmers alone had few resources to exchange. Added to that, the ruling party of the day already enjoyed voter support in the countryside due to other pork-barrel side payments. Appeasing farmers would be redundant for the Roh regime.

The failure of Korean farmers to be taken seriously during the medical insurance integration debate of the late 1980s did not go unnoticed in the subsequent development of social movement politics, especially within the area of social policy reform. Activists in democratizing South Korea learned that if civil society remained organizationally fragmented they would continue to have only a marginal voice in policy deliberations. Civil society's fragmentation weakened groups' abilities to mobilize the resources that could be exchanged for their input into the policy process. The Health Solidarity Coalition, which formed during the mid–1990s, comprised a broad-based and cross-class membership. Health Solidarity leaders reactivated social movement networks dating back to the minjung-democracy movements of the 1970s and the late 1980s. The Health Solidarity coalition initially began in 1994 as an alliance that combined the earlier farmer's movement and other urban-based activist groups. Many social movement leaders from the predemocratic period had come to occupy important leadership positions in progressive social

movement groups during the 1990s. Moreover, Health Solidarity actively sought the inclusion of the independent labor movement, notably the Korean Confederation of Trade Unions (KCTU), into the health policy coalition. By the mid–1990s, farmers were increasingly willing to ally themselves with industrial workers, a corrective to their strategic mistakes of the late 1980s.

Taiwanese activists underwent a similar learning process. Not unlike the situation in democratizing Korea, civil society in Taiwan fragmented soon after the introduction of democratic reform. Ethnic conflict, partisan affiliations, and even personal enmity held over from the predemocratic era undermined prospects for meaningful coalition building. As in Korea, fragmentation resulted in civil society's continual exclusion from policy deliberations. Elite policy decisionmakers lacked the incentive to engage civil society. Beginning in the 1990s, social movement leaders in Taiwan realized that their inclusion in the political and policymaking processes required a renewed strategy of alliance building from the bottom-up, from within civil society. Differences needed to be put aside and consensus building around common policy interests had to be cultivated.

In the run-up to the 1995 legislative elections, 50 activist groups came together to forge a common policy platform and to form the Social Movement and Legislation Coalition (*she hui yun dong li fa lian meng*) (Hsu, 1999; Kuo, 1999). According to both legislators and social movement leaders, the 1995 coalition was successful in steering the policy agenda in the legislature and in rejuvenating nongovernmental activism within the mainstream political arena. The lasting importance of the coalition stemmed from lessons learned: broad-based coalitions were taken seriously by vote-seeking politicians, and the degree of political power and policy influence groups brought to bear on policymaking correlated with strength in numbers. These lessons were the bases upon which the NHI Coalition formed only a few years later.

In both Taiwan and South Korea, civil society actors were taken seriously by elite health policy decisionmakers during the late 1990s, in part because they were able to demonstrate a formidable show of political strength and electoral resources. Government policymakers could no longer summarily dismiss societal actors, nor could they take advantage of civil society's fragmentation as President Roh so easily did with Korean farmers during the late 1980s. Yet, I want to stress that the inclusion of Health Solidarity and the NHI Coalition into the health policymaking process during the late 1990s was not solely due to their large sizes, but also because they comprised a *broad range* of social movement groups, from farmers to industrial workers to medical care professionals. They effectively cut across important political cleavages that further compelled government elites to engage civil society. In other words, the state could no longer rely on a strategy of "dividing and demobilizing" civil society.

Health Solidarity leaders, for example, enlisted the leadership of moderate "civic groups," most notably the Citizen's Coalition for Economic Justice (CCEJ) and People's Solidarity for Participatory Democracy (PSPD). Both the CCEJ and the PSPD are regarded as pioneers in the new generation of social movements in Korea and, according to public opinion data, are considered to be the most "trustworthy and influential" actors in political and policy matters (Seong, 2000: 92; see also Dalton and Cotton, 1996; Kim, 2001). These groups are made up of middle class

activists, professionals, academic and policy experts, as well as other marginalized socioeconomic organizations, such as farmers. The NHI Coalition in Taiwan formed in response to the government's proposal to privatize and marketize the national health insurance system. Fears about the *potential* redistributive implications of this reform resonated with a broad range of social activist groups. The NHI Coalition thus boasted a membership of over 200 social movements, including groups representing labor, children, the aged and disabled, aboriginal groups, women, and different medical care professional associations.

Reappraising Labor

Particularly interesting about the emergence of Health Solidarity and the NHI Coalition was the incorporation of labor into each social movement coalition. On the face of it, the inclusion of labor might not appear all that counterintuitive. After all, Korean workers benefited from medical insurance integration through the redistribution of healthcare resources. Labor also anticipated spillover from the integration reform efforts, with the hopes that welfare deepening in health policy would affect other social and labor policy areas. In Taiwan, the goal of preserving the public health insurance system benefited wage earners, compelling labor unions there to join the NHI Coalition. In both cases, workers' interests were represented.

Surprising were the concerted efforts of Health Solidarity and the NHI Coalition to actively enlist the cooperation of labor since workers in Korea and Taiwan were earlier thought to be poor coalition partners. As suggested above, workers were initially seen as a political liability among social policy activists, especially during the immediate post-transition periods in Taiwan and Korea. The absence of labor parties in either place meant that workers had to mobilize "in the streets." Consequently, labor movements were considered too radical in their mobilization tactics and they quickly alienated other civil society groups. Workers were also seen to be too militant. In 1987 alone, more than 3,700 labor disputes were recorded in Korea. Labor was also perceived to be too particularistic in their policy demands, as labor leaders tended to focus their attention almost exclusively on wages and workplace related issues and with little concern for other progressive social policies (Mo, 1996; Chu, 1998).

Worker movements in Taiwan and South Korea were also politically fragmented. There was little unity among labor movement groups, making workers less attractive as potential alliance partners. In Korea, for instance, the independent Korean Confederation of Trade Unions (KCTU) historically harbored suspicions about the Federation of the Korean Trade Unions (FKTU) because of the latter's ties to the authoritarian regimes of Korea's predemocratic period. It feared the FKTU had been co-opted by the state. Similar conflicts emerged in Taiwan's labor politics. The China Federation of Labor (CFL), for example, was shunned because of its earlier corporatist links with the authoritarian KMT party-state. In addition, the two main independent labor organizations in Taiwan, the Committee for Action on Labor Legislation (CALL) and the Taiwan Labor Front (TLF), were themselves embroiled in a longstanding conflict over official and unofficial partisan ties. Simply put, labor in Taiwan and South Korea failed to present itself as a viable strategic partner for coalition building.

Why, then, were workers actively pursued by Health Solidarity and the NHI Coalition to be alliance partners during the late 1990s? Why would Health Solidarity leader Hung-Jun Cho say in 2000, "we knew that labor was an absolutely critical ally for the 1990s" (Cho, 2000)? Essentially, labor had changed. Labor movements in Korea and Taiwan began to undergo a process of reinvention during the mid—to late 1990s. Workers similarly learned that they needed to adapt to democracy, and that they too could take advantage of the opportunities presented by democratic rules of the game (Cho, 2000; Kim, 2000). In short, they reacted strategically.

Labor groups in South Korea and Taiwan began to shed their "radical" image. They presented themselves as being less ideologically rigid by abandoning their revolutionary impulse in exchange for their inclusion in the policy process. Labor also moderated its image by reworking its mobilization strategies. Groups like the KCTU in Korea and the TLF and the CALL in Taiwan learned to compromise with other social movement groups and with government policymakers rather than holding inflexibly to their hard-line positions. Labor movements also became much more professional, bolstering their expertise in labor policy details and social welfare policy. Most important, workers increased the scope of their policy goals and issue areas in an attempt to alter their image of being too particularistic in their policy objectives. As a result, labor groups became more willing to cooperate with other groups. They began to actively seek out partnerships with other social movement groups, provided their interests converged. Woo-Hyun Yoon of the KCTU explained that "the KCTU continues to represent and fight for the basic rights of workers. That has not changed since the late 1980s. However, we also welcome cooperation with the civic groups on these larger, more national issues, like corruption, industrial policy and social welfare, including the integration of health insurance" (Yoon, 2000). Liang-Rong Lin, the outreach officer of the Taiwan Labor Front, echoed a similar strategic shift in worker mobilization in Taiwan:

> After the passage of the Labor Standards Law [1984], we wanted to broaden the scope of the independent labor movement. Labor activism should no longer have been about negotiating solely with management or on the shopfloor, but rather, the labor movement needed new leadership in order to cooperate with other groups, and together, negotiate with government in important labor and social policy matters (Lin, 1999).

By the late 1990s, labor was less likely to battle politically on its own, and other social movement groups reciprocated. The reappraisal of labor among moderate groups and middle class activists, and the subsequent reconnection among workers and other mainstream civil society groups, were absolutely crucial developments in strengthening the policy influence of Health Solidarity and the NHI Coalition.

Policy Learning

Health Solidarity and the NHI Coalition were not only broad-based grassroots movements, they were also above all else policy oriented movements. They were very specific in their policy mandates: healthcare reform. Health Solidarity and the NHI Coalition engaged the health policy debates of the late 1990s in South Korea and Taiwan with well-defined and articulated policy positions. Due to their single

policy focus, both social movement coalitions, through a process of continual policy learning, cultivated expertise in healthcare reform. They comprised "expert activists" (Wong, 2004), narrowing the information and expertise gap between civil society actors and elite policy decisionmakers.

Information, knowledge, and expertise are important sources of power in policymaking. They constitute political currency (Atkinson and Coleman, 1992; Sabatier, 1988). As we know, societal actors in democratizing Taiwan and South Korea were excluded from earlier healthcare policy reform episodes, partly because they lacked the policy expertise with which to gain influence in shaping policy outcomes. State policy decisionmakers enjoyed an expertise monopoly, and they tended to not value input from civil society. More recent evidence from the late 1990s suggests that through a process of policy learning—or the gradual acquisition of expertise over time—social movement groups were elevated to a position of more equal footing with elite policymakers. Groups gained expert resources to exchange for a voice in policymaking. Health Solidarity leaders in Korea were invited into President Kim Dae-Jung's exclusive core of healthcare reformers from the early stages of the integration reform effort. The NHI Coalition in Taiwan played an educative role regarding the impact of medical insurance privatization throughout legislative debate.

Policy learning was a conscious political strategy pursued by societal activists in South Korea and Taiwan. During the 1990s, social movement groups began to set up their own policy research divisions. They proactively recruited university academics and outside policy experts. One of the key figures in the NHI Coalition in Taiwan, for instance, was a high-ranking official in the government's Department of Health.[5] Labor groups such as the Korean Confederation of Trade Unions and the Taiwan Labor Front retain permanent staffs of policy analysts and researchers. Broad-based coalition building also facilitated information exchange between social movement activists. Groups shared data, ideas, technical skills, and policy expertise, building up their stock of policy knowledge and strengthening their position *vis-à-vis* government policymakers. Bringing together actors with different interests and perspectives on healthcare reform enabled both Health Solidarity and the NHI Coalition to engage the entire health policy debate, rather than advocating for particularistic demands seen only to serve specific group interests. In sum, both movement coalitions politically unified disparate social activist networks and pooled together their expert resources.

Ideational Leverage

Health Solidarity and the NHI Coalition effectively portrayed the idea of social welfare as a normative good, muting historically entrenched hostilities toward social policy initiatives in Taiwan and South Korea. Throughout the postwar period, Taiwan and Korea were welfare laggards. The limited social policy programs that had been put into place were initiated only during times of political crisis and motivated by the authoritarian state's need to ensure social stability (Ku, 1997; Kwon, 1999). These programs targeted the relative well-to-do, leading Ian Holliday (2000) to observe the "productivist" orientation of social policy reform in authoritarian East Asia. Notions such as redistributive equity and universal social citizenship, the

core principles of the modern welfare state, were nonexistent. In the cold war context, the idea of social policy reform was equated with communism and demonized in mainstream politics; antigrowth social policy was even thought to be unpatriotic. Simply put the idea of the welfare state failed to resonate among elite policymakers.

An important strategy for groups such as Health Solidarity and the NHI Coalition was the deradicalization and mainstreaming of the welfare state idea. They effectively portrayed social policy as a universal public good, rather than as a divisive political wedge between social classes and between the goals of growth and equity. This mainstreaming process, in turn, helped legitimate their positions as health policy advocates and their reform goals. Theirs was no longer a marginal message. As we know, changes in dominant ideas, values, and norms reconstitute the terms of policy debate, the dynamics of policy decisionmaking, the range of actors involved in the policy process, and the scope of policy reform (Hall, 1989; Sabatier, 1993). Privileging the normative place of the welfare state in contemporary, mainstream politics afforded Health Solidarity and the NHI Coalition the ideational leverage—an important political resource—with which to gain entry into the health policy process.

Public opinion data from Taiwan and South Korea suggest that progressive social movement coalitions such as Health Solidarity and the NHI Coalition were successful in effecting this ideational transformation, and consequently in building a broad normative consensus around the desirability of the welfare state (Peng and Wong, 2004). In 1998, 83 percent of Koreans indicated that the government, and not the individual or their families, should take on the responsibility of social protection and economic security (Shin and Rose, 1998: 35). Data from Taiwan indicates that in 1994 only 20 percent of the population was satisfied with the government's commitment to social welfare. The overwhelming majority of respondents believed that the state, rather than other nongovernmental organizations, should be the provider of social protection (Academia Sinica, 1994: 108).

Government policymakers also shared these beliefs, a marked departure from their earlier attitudes toward the idea of the welfare state. According to my elite survey data, more than 80 percent of legislators and bureaucrats in Taiwan and South Korea ($n = 243$) agreed that "public welfare is a fundamental characteristic of democracy." Specifically about health, 85 percent of elite respondents ($n = 241$) agreed that "universal healthcare is a democratic right." Moreover, the majority of legislators and bureaucrats disagreed with the assertion that economic growth alone promoted an equitable distribution of wealth, which was a rejection of the high-growth ethos shared earlier among the postwar authoritarian developmental states.

As suggested above, Health Solidarity and the NHI Coalition were key agents in facilitating this process of ideational change. Their adaptive strategy entailed repackaging the idea of the welfare state in ways that broadened its appeal in contemporary Korean and Taiwanese society. For example, Health Solidarity and the NHI Coalition exploited the 1997 Asian financial crisis by highlighting the socioeconomic vulnerabilities confronted by all in the current era of globalization. In the face of growing unemployment and economic insecurity, groups like Health Solidarity and the NHI Coalition portrayed the social safety net as a universal good. The financial crisis affected broad sections of society—irrespective of gender, social class or wage group, region, ethnicity, and so on—and further legitimated these

groups' claims that universal and redistributive social policy, such as healthcare, benefited everyone. The cross-class bases of both Health Solidarity and the NHI Coalition reinforced this conception of social policy as being, at least politically speaking, *class blind* (Koo, 1997: 97). They effectively tempered the zero-sum implications of redistributive welfare policy and brought the idea of the welfare state into the political mainstream.

Health Solidarity and the NHI Coalition also deradicalized the idea of social welfare by stripping it of its conventional ideological connotations. This was a purely strategic move by the social movement coalitions. They were keenly aware of the historically marginalized place of the left in mainstream political discourse and in the formal political arena. One social movement leader recounted that her group intentionally "tries very hard not to be labeled as a 'leftist' organization." She went on to add that it is important that groups such hers "avoid this leftist label" if they are "to maintain their influence in mainstream politics" (Lee, 2000). By strategically eschewing ideological labels, Health Solidarity and the NHI Coalition were able to legitimate their progressive social policy goals. Social welfare reform, and healthcare policy reform in particular, was not understood to be specifically about farmers' grievances, labor agitation, or a leftist political cause. The idea of redistributive social policy was portrayed by Health Solidarity and the NHI Coalition as a universal right of citizenship and a set of policy arrangements that cut across, rather than exacerbate, social, political, and economic divisions. Again, since both Health Solidarity and the NHI Coalition comprised cross-class constituencies themselves, they lent even greater legitimacy to this normative appraisal of the welfare state idea.

Conclusion: Adapting to Democracy

As I have argued in this article, democratic transition in Taiwan and South Korea failed at least initially to deliver greater political inclusion. Healthcare reform during the late 1980s was unequivocally state-led. Societal participation was negligible, even though both Taiwan and Korea had begun to undergo democratic transition. Herein lay the paradox of formal democracy. It was not until the late 1990s that civil society groups gained entry into the social policy process—a decade after democratic breakthrough.

I do not mean to suggest that the structural features of formal democracy necessarily inhibit or delay societal inclusion in democratic practices. Nor is it my claim that democracy's paradox is necessarily difficult to reconcile. Democracy's virtue is precisely the possibilities, at least theoretically, for greater participation in policymaking and politics. In this regard, that Health Solidarity and the NHI Coalition effectively penetrated during the 1990s what were once closed social policymaking networks is also not the point of this article. Rather, the arguments developed here illuminate how previously excluded societal actors have adapted to the democratic game in Taiwan and South Korea, which in the end afforded them the power and influence to impact social policy outcomes. This article is about *explaining* democratic inclusion.

Societal actors adapted by mobilizing valued sources of political currency, which they exchanged with elite policymakers for a voice during healthcare policy delib-

erations and ultimately for influencing policy outcomes. They seized opportunities by leveraging their political, policy, and ideational resources *vis-à-vis* elite policymakers. For example, Health Solidarity and the NHI Coalition similarly created broad-based coalitions to strengthen their political position, as well as to foster an image of cross-class inclusiveness. The reconnection among social movement groups with labor was crucial in this respect. Societal activists also acquired health policy expertise over time and effectively used this specialized knowledge throughout healthcare policy deliberations, whether within the executive branch in South Korea or the legislature in Taiwan.

The similarities in these adaptive strategies notwithstanding, Health Solidarity and the NHI Coalition nonetheless tailored their tactics for inclusion in ways that reflected their specific policy and political-institutional contexts. The challenges of making policy in Korea during the late 1990s meant that Health Solidarity needed to form an alliance with the Kim Dae-Jung administration. In Taiwan, the objective of vetoing policy compelled the NHI Coalition to eschew partisan alliances and to instead attack and exploit the fragmented legislature. The lesson here is that coalition building and policy learning could only bring them so far; groups also needed to attend and adapt to specific policy, political, and institutional contexts.

The role of labor in the politics of democratic inclusion in Taiwan and South Korea deserves a more integrative discussion here, particularly given the centrality of the working class thesis in more conventional theories of the Anglo-European welfare state (Korpi, 1983). On the one hand, we must not overstate our case about the role of labor in the current politics of social policy reform in Taiwan and South Korea. Labor was not the decisive social actor that facilitated medical insurance integration in Korea and the defeat of government-led retrenchment efforts in Taiwan. Rather, it was the *cross-class* nature of social movement mobilization during the late 1990s that was crucial for steering social welfare reform. Consequently, labor's integration into each coalition and civil society activism, was a necessary though far from sufficient condition for deepening democracy and for winning a policy voice among societal actors. On the other hand, we should not understate our case either. As I have argued throughout, the re-inclusion of labor into Health Solidarity and the NHI Coalition was due in part to the entrepreneurialism of middle class and rural-based activists who intentionally sought out a renewed alliance with workers. The tactical shift among mainstream social movement groups reflected the strategic reinvention of labor politics, a process that was initiated by labor movement leaders themselves. Workers moderated their image, their mobilization tactics, their policy concerns, and positioned themselves to seek allies from within civil society. In this respect, labor movements in Taiwan and South Korea were important agents in facilitating social movement coalition building and in reconfiguring civil society. They learned to adapt to the related imperatives for, and politics of, democratic inclusion.

Adaptation and learning are themes that have continually emerged and reemerged throughout the foregoing analysis of healthcare reform in Taiwan and Korea. Institutional openings that come with political reform tell only a part of the story of democratic inclusion. Democratic deepening and the practice of participatory democracy depend as much on the ability of actors to seize upon openings and to adapt their mobilization strategies in ways that effectively take advantage of such

opportunities. In short, political agency matters very much. By drawing on and building upon the analytical framework developed in the first part of this article, this comparative study of Taiwan and South Korea reveals for us three important assertions about the place of agency in the process of democratic adaptation., I anticipate that these assertions should provide the bases for the broader comparative analysis of democracy building in other parts of the world.

First, societal actors develop—often through trial and error—a repertoire of mobilization strategies. They also adapt these strategies to fit certain policy, political, and institutional contexts. Mobilizing "goodness of fit" involves political learning. As the stories of Health Solidarity and the NHI Coalition demonstrate, employing adaptive strategies successfully requires that actors learn from earlier and often failed efforts at gaining inclusion in both the political and policy processes. Second, societal actors acquire policy expertise and knowledge, resources that can be leveraged and exchanged for their inclusion into previously closed policymaking networks. This too involves a process of policy learning. Third, the politics of adaptation takes time. Agents must learn from past mistakes, adapt to opportunities as they emerge, and acquire gradually new bases of policy expertise and knowledge, all of which require the passage of time. The practice of participatory democracy is not automatic, and developing effective political agency can be frustratingly slow. I maintain that only through an appreciation of political agency and the development of effective political entrepreneurship over time can social movement activists on the ground, and the scholars who analyze them, begin to square the very real paradox of formal democracy.

Notes

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1. Juan Linz and Alfred Stepan point out that without "some alleviation of gross inequality, democracy would not be sustainable" (1996: 13; Przeworski et al., 1996).
2. Regarding the Taiwan case, see Higley, Huang, and Lin 1998; Chao and Myers 1998. For Korea, see Brady and Mo, 1992; Kim, 1997.
3. Bureaucrats from health and welfare-related ministries (and agencies) and all legislators in Taiwan and South Korea were asked to complete a self-administered survey comprising over 60 different attitudinal and role-based questions. The total sample size of usable responses numbered 243 respondents.
4. Over 80 percent of elite survey respondents (n=111) disagreed with the statement: "After policy bills have been introduced into the Legislative Yuan, legislators completely comprehend the policy's content."
5. This official asked that his/her identity not be revealed.

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