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Wayne Soon and Mohammad Bin Khidzer

The health insurance systems in highly developed East and Southeast Asian nations have been praised by journalists in the United States as universal, accessible, and equitable (Goldrick 2020; Reid 2008; Scott 2020). Journalist T. R. Reid's PBS documentary *Sick Around the World* (2008) has been used widely by scholars in classrooms across the United States. The documentary illustrates how the state-led communitarian Japanese and Taiwanese health insurance system ensured healthcare equity, in contrast to the United States' market-driven health insurance that covers too few patients at too high costs. Similarly, Dr. William A. Haseltine (2013), a public intellectual and former professor at Harvard Medical School, wrote a book praising Singapore's ability to balance public expenditures on healthcare and to ensure a robust healthcare market that allows competitive healthcare providers to provide excellent private care for those who can pay.[1] Likewise, the World Health Organization (2020) has specifically linked South Korea's initial success at managing the COVID-19 pandemic with its development of universal health care.

Conversely, journalists and scholars in East and Southeast Asia have typically used the United States healthcare system as a negative example, exhorting fellow citizens to ensure that their healthcare and health insurance system remains robust and superior to the American healthcare system. In the words of Singaporean healthcare journalist and critic Salma Khalik (2020), "The health insurance scene in Singapore needs major tweaks to ensure costs do not spiral out of control—the way they have in countries like the United States." In a recent event held at Johns Hopkins University Bloomberg School of Public Health

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[1]Also see George P. Shultz and Vidar Jorgensen (2020).

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(2023), a public health physician provided a blurb for his talk that stated that "over 90% of Indonesia's total population has access to universal health coverage, greatly reducing out-of-pocket healthcare spending," in contrast to the "approximately 64% of people living in the United States with private healthcare insurance, with public schemes limited to certain population [sic]." Furthermore, the physician added that "Indonesia is benefited by a single-payer national healthcare insurance, offering access to wide range of services to all population." Persistent challenges with health insurance in China make it difficult to claim comparative value to the US health insurance system, but even so, the University of Southern California US–China institute (2020) noted that "it is striking that life expectancy in the U.S. is only slightly longer than in China, despite America's much higher per capita GDP and per capita health spending."

Certainly, some scholars attribute comparatively better health outcomes (including higher levels of life expectancy) in East and Southeast Asian nations compared with the United States to a more robust health insurance coverage (Erlangga et al. 2019; The Commonwealth Fund 2023). But this binary approach—where Asian observers look at the United States as a negative example and the US observers see some Asian nations' solutions as a panacea—obscures the very real challenges faced by doctors, patients, and states in the region. Moreover, the assumption of an inclusive Asian system driven by beneficent state intervention in contrast to an alleged heartless capitalistic healthcare system in the United States obscures the facts that demonstrate that the state also contributed to many healthcare problems in East and Southeast Asia.

Furthermore, the mainstream media in East and Southeast Asia (and the United States) were generally critical of other healthcare systems in the West, especially of the United Kingdom (UK) and Canada. The media preferred to highlight the British and Canadian's chronic underfunding of their healthcare systems and long waiting lists for patients to see their preferred providers (Bivins 2022; Druzin 2016; Goren 2020; Paperny 2022; Raphael 2023; Straits Times 2022). Scholars, in contrast, view the British, Canadian, and other similar systems in the West with more nuance. Their approaches range from a sympathetic coverage of historical actors who sought to preserve this universal healthcare system to those who are more attuned to actors who desired market-based reforms to existing healthcare systems (Cohen 2020; Gorsky 2008; Jones et al. 2022; Marchildon 2012; Webster 2002). Such critical histories of universal healthcare systems provide broader inspirations for the authors in this special issue who research into cases of health insurance in East and Southeast Asia.

1 Beyond East–West Binaries: Why Histories of Health Insurance in Asia Matters

This special issue thus contends that the state-led development and reforms to healthcare and health insurance in East and Southeast Asia were filled with societal, political, and economic promises, tensions, perils, and negotiation. The issue comprehensively highlights regional healthcare actors' heterogeneity in the postwar and contemporary period (1945 to the present). It builds on existing work that frames the history of health insurance as "welfare politics." We recognize that

the politics of welfare vis-à-vis the state and society is central to our narrative and highly productive for our research (Jacobs 2000; Kwon 2009; Luk 2020; Wong 2018). Yet, we insist that health insurance, as it relates intimately to the history of risk pooling, actuarial science, developmental state, biopolitics, labor politics, medical associations, reorientates welfare policies and politics towards many more aspects of society beyond "welfare." In some cases, we contend the recipients and others excluded from health insurance programs did not see health insurance programs as "welfarist" but instead as expensive, exclusionary, and discriminatory programs. We show that the *affect* of health insurance configured and appropriated existing societal, economic, geopolitical fissures, problems, and historical issues. We contend that shortfalls in health insurance coverage and payment were not simply a result of an increasingly capitalistic or democratic society or the legacies of authoritarian and one-party governance.

These contradictions were very much embedded in the *longue durée* of the societal negotiations over different forms of health insurance and healthcare systems over time and space: changes, continuities, and contingencies matter, as this volume demonstrates. As John P. DiMoia articulates, the contemporary South Korean state drew many lessons from its authoritarian past in privileging the healthcare needs of particular societal groups. Yone Sugita describes how the contentious and patchwork effort to re-establish the universal healthcare insurance system in postwar Japan drew inspiration from its hugely successful wartime implementation of universal healthcare. Meanwhile, Wayne Soon demonstrates the problems associated with the full access and use of national health insurance cards in the immediate post-1995 period in Taiwan, drawing from earlier problems of a medical consultative sheet known as *Menzhendan*. Mohammad Bin Khidzer traces the origins of Singapore's winning universal healthcare formula, which engendered political rhetoric in the early 2000s directed towards minority racial groups, whose sickly bodies were deemed to be detrimental to the national insurance pool. Dimas Iqbal Romadhon and Tunggul Puji Lestari's piece highlights how Indonesian fund-collecting based its national health insurance system upon the philosophically unstable ground of *gotong royong*, which has been used primarily by Indonesian elites in the past to mobilize the masses and to allocate the efforts at nation-building among the citizenry. Among other societal and political tensions, wealthy Indonesians who pay high premiums challenged the government's granting similar benefits to members who pay less, calling this concept "communist-socialist." Finally, as Rachel Core discusses, reform-era People's Republic of China's dismantling of some of its health insurance programs led to some tuberculosis patients delaying care seeking, while under the high socialist era, they would have sought expedient care.

Our special issue illustrates the centrality of health insurance in shaping medical practices and patients' choices in the region in the postwar period in Asia. By considering health insurance, we challenge the idea that medical treatment, training, and choices were inadequate *and* inexpensive in Asia (and other countries in the developing world) because of the perception of economic underdevelopment of these polities in contrast to wealthy Western Europe and the United States, whose complex societies deserve their histories of health insurance. In other words, although some Asian healthcare systems are perceived as excellent

by contemporary media (and often attributed to borrowing from the West), their past remains enigmatic, understudied, and underappreciated by scholars across different disciplines. As Honghong Tinn (2023) has shown, economists in the United States thought that input–output analysis used for Western and Soviet economies was inapplicable when planning and interpreting the economy and industrial production of "underdeveloped" polities such as Puerto Rico. Alexandre White (2023: 16–17) has argued that in the supposedly post-colonial present, "the repression and controls over ways of seeing the world are still dominated by a certain coloniality of knowledge that recognizes the voices and ways of seeing in the West against epistemologies in the rest of the world." Such coloniality was termed by White as "epistemic orientalism." We see similar healthcare rhetoric towards developing countries in the 1970s. Oscar Gish (1979), a US public policy expert, was deeply critical of healthcare in developing countries in postcolonial Asia and Africa in the 1970s and 1980s. While Gish partly attributed contemporary problems to the colonial exploitation of resources, he also criticized the overly ambitious efforts of the postcolonial governments. Gish called the healthcare projects in these countries extensive, underfunded, and tended to hinge on specific vanity projects. He noted that more often than not it was the prestigious hospital plan that was thus singled out, and not the health centers, rural clinics, or preventive programs. The rhetoric of the plans was, and still is almost always at sharp variance with proposed expenditures.

Contemporaneous health experts shared Gish's approach. Experts who waged successful health campaigns, such as malaria eradication, of their own in "developing countries" turned around to criticize other nations who failed to do so. As Bogdan C. Iacob (2022) reveals, "once socialist countries joined the rest of malaria-free Europe, Eastern European expertise touted the region's civilizational superiority over post-colonial spaces struggling with the disease." Iacob added that "Eastern Europeans relished overcoming their subaltern status in world hierarchies by way of disease-conquering socialist modernity." Iacob noted that "their global gaze however was quasi-colonial—the resilience of disease in the South signalled deficient civilization." Health analysts did not always accept such rhetoric—Lucy Gilson (1988) of the London School of Hygiene and Tropical Medicine, for example, critiqued Oscar Gish's "inappropriate" assumptions in 1987 that healthcare financing was inadequate in Swaziland. But the civilizational ethos, which premised the West as having a *history* of health insurance, has perhaps denied equivalency or serious research on how health insurance worked in Asia and how people were not simply victims of lousy healthcare, but demonstrated a desire to want, to critique, and to overcome health insurance deficiencies.

The ideal approach is not simply the theorization of an alternative notion of Asian health insurance that claims superiority over the West, but rather, as in Howard Chiang's (2021: 9) work, to enable the construction of "new historiographical practice" oriented toward "building bridges" with dominant Western scholarship, "rather than walls". In pursuing this goal, our articles do not center the claim individually or collectively to evaluate the efficacy and performance of health insurance solutions in "developing" nations. While we certainly understand and acknowledge the importance of such an approach, which has been comprehensively dealt with by health policy scholars around the world (Carrin, Waelkens and Ciel 2005; Lagomarsino

et al. 2012), including those interested in Latin American countries (Drechsler and Jutting 2007: 504–8), the overarching agenda of our special issue is primarily to complicate this dichotomous narrative of East versus West in the scholarship of healthcare studies.

We illustrate how people in Asia cared deeply about accessing good healthcare when they were sick, and how *both* capitalist and socialist states in the region responded by providing different health insurance programs. Each country's health insurance system *directly* shaped healthcare behaviors and the choices of their citizenry, which has not been widely considered in previous scholarship. Health insurance acted as an intermediary between the government and its citizens and a critical actor in influencing individual and societal outcomes. Such a social history of health insurance provides a rich cultural insight into patient–doctor relationships in the region. In South Korea, John DiMoia shows, the first MERS patient (a Korean businessman who traveled overseas) spread the virus in a crowded room of four beds in 2015; such wards were directly designed in the post-1980s context so that government insurance programs could reimburse patients and hospitals. Underpinning DiMoia's paper is the broader story of how South Korea eventually managed to contain MERS and consequently did well in fighting COVID-19. In mainland China around 2010, some tuberculosis patients preferred to be hospitalized rather than simply receiving outpatient care, as their insurance would not cover the latter, only the former. Yet, Core (2023) also shows in her book how TB patients consistently sought care from the 1950s, believing that insured care would help them get better. Indonesian citizens sought better-insured care, wanting their government to live up to its rhetoric of *gotong royong* when persuading them to pay premiums into the universal program. In Taiwan, insured workers skipped insured care if they could not obtain one or more signed consultation sheets (*menzhendan*) from their employers, as hospitals required the sheets to provide care for insured workers. In Singapore, the emergent "insurance imaginary" shaped what it meant to be responsible and healthy citizens.

This volume shares characteristics with East and Southeast Asian films and documentaries that explore the wide-ranging societal impact of health insurance in shaping healthcare at the individual and community level in the region (AJI Indonesia 2019; Ku 2008; Kurosawa 1952; Song 2011; Tay 1998; Wen 2008). As fiction and film amply show, many encounters with health insurance and healthcare were intrasocietal, rather than simply interactions between state and society. Sometimes, high politics and local maneuvers mattered, and at other times, geopolitics, localism, and developmentalism became more critical factors in shaping the history of health insurance and society at specific periods in different contexts. Hence, our articles on Asia provide a fuller range of historical and cultural nuances that, for example, would encourage scholars of health insurance who predominately work in the West to consider how infectious diseases and epidemics, race and ethnicity, colonialism and post-colonialism have shaped the studies of health insurance, medicine, and society. Some work has been done on this front by Beatrix Hoffman (2006) and David McBride (2018: 111–184), but the existing field was still overshadowed largely by the dominance of institutional, legal, and economic approaches towards health insurance.

2 Bio-Geopolitics

This special issue also highlights a new concept of bio-geopolitics to describe the cultural and geopolitical ramifications of the production and management of health insurance in the region. We argue that biopolitics in Asia, particularly as it relates to population management, needs to consider health insurance more seriously (Borovoy and Li 2017; Gottweis 2009; Huang 2016; Langlitz 2011). However, health insurance systems are not necessarily "contained" within the boundaries of the nation-state. Conceptualizations of health insurance systems and what they mean in the contexts explored here are also inflected by geopolitical factors, both real and imagined.

Biopolitics, defined as "the mechanisms through which the fundamental biological aspects of the human species are politicized" (Foucault in Hull 2013: 324), plays a pivotal role in optimizing productivity in a nation's population. This is achieved through governmental techniques such as social or national insurance, which are designed to manage national health. The concept of national health encompasses the imperative to prevent excessive healthcare expenditure, which not only signifies a nation with poor health (and therefore, low productivity), but also implies a misallocation of capital where potential investments and returns are lost. These concerns form the basis of biopolitics (see Villadsen 2021), a framework that prioritizes the economy in political practice (Hull 2013).

Yet, governing populations in this manner requires a fair bit of geopolitical savvy and statecraft, particularly because the "nation" and governmental practices exist relationally within a larger, competitive global landscape. Kivela and Moisio's (2017) study on the bio-geopolitics of healthcare in post-war Finland points to a combination of biopolitical and geopolitical considerations in the creation of a welfarist healthcare system; the Finnish state was not just concerned with the social consequences of ill health and the creation of a national identity under a coherent and centralized social system, it was also wary of the rapidly expanding Swedish and Soviet economies that posed a threat to its own national progress.

The notion of inter-state competition and national identity introduced by Kivela and Moisio (2017) presents an excellent segue to our examination of East and Southeast Asian bio-geopolitics. We expand on these elements of bio-geopolitics by highlighting the importance of nation-building narratives and imaginations of healthcare systems elsewhere that contribute to the material formation of healthcare systems and insurance systems. In particular, we draw from this interface between biopolitics and geopolitics to illustrate how Cold War East and Southeast Asian nations' changing relationships with the United States, China, and other major powers shaped their experiences in managing healthcare systems. In other words, Japan, South Korea, Taiwan, Indonesia, and Singapore's competition and collaboration with their capitalistic and communist counterparts shaped their notion of healthcare financing over time and space.

The articles in this issue thus highlight the regional and global influences that animate the geopolitics shaping healthcare in the region. DiMoia highlights the impact of the brain drain and the loosening of immigration restrictions in the US that led to the shrinking supply of biomedical doctors and their subsequent empowerment in South Korea's healthcare landscape. The power of Korean medical labor

during COVID hints suggestively at the ongoing labor struggle by physicians in South Korea (Lee 2024). Sugita points to the postwar democratic aspirations of the Japanese public, derived from the United States, that contributed to a form of national insurance that leaned heavily on values of fairness and egalitarianism. Soon also illustrated the influences of the International Labor Organization (ILO) and connections to the Republic of China that shaped differentiated access to universal healthcare in Taiwan. Bin Khidzer points to Singapore's aversion to a liberal cradle-to-grave model of health welfare that supposedly devastated European countries, paving the way instead for the current national insurance model sustained by notions of collective responsibility. Romadhon and Lestari describe how the memory of the transnational histories of communist-socialism in Indonesia haunts the implementation of the national health insurance program. Core reveals how China often consulted international norms (such as the effect of International TB Day, the use of X-ray protocols, and types of TB treatments) while implementing its policies towards mitigating tuberculosis among the population.

Geopolitical considerations combined with domestic biopolitical consolidations resulted in many citizens falling through the gaps of existing health insurance and healthcare systems. These citizens were often ethnic, racial, and class minorities. As Takashi Fujitani (2013) shows, the creation of a wartime state in Japan and the United States during the Pacific War involved disciplining and mobilizing racial minorities, often through state-directed medical care, biopolitical comfort, and control of the body. As Bin Khidzer shows, Singaporean parliamentarians socially constructed an insurance-specific articulation of sickly, idle, and risky minorities in the context of debates of how healthcare should be financed in Singapore. With more significant discussion of universal coverage, those deemed at higher risk in the growing risk pool became infused with moralizing language that stressed racialized responsibility and accountability in fighting diabetes. Similarly, DiMoia revealed that rural residents have historically received less coverage than white-collar workers associated with large firms, especially those in major urban centers such as Seoul and Busan. Soon argues that the early Chinese Nationalist (*Kuomintang*, KMT) government in Taiwan favored its core constituency—government employees—over laborers in expanding its health insurance program. Because KMT politicians and government officials retreated from China to Taiwan in 1949, they favored fellow mainlander Chinese government employees over ordinary Taiwanese laborers, many of whom grew up under Japanese colonial rule and were generally ambivalent about KMT's control over the island. Romadhon and Lestari show how 43% of national health insurance system members in Indonesia struggled to keep up with their monthly premiums. Core demonstrates how employees of key state-owned enterprises had better access to tertiary facilities than those from collective and workshop enterprises during the Maoist period, creating an occupational class difference even within a society that pledged egalitarianism.

The creation of a postwar developmental and disciplinary state drew not only from prewar and wartime precedents; postwar East and Southeast Asian states' discrimination against disadvantaged groups in societies also emanated from, and was broadly reflective of, the postwar geopolitics of health insurance and healthcare. The approach of bio-geopolitics has its challenges. While synthesizing biopolitics and geopolitics represents an innovation, it tends to reproduce the notion of an

encompassing state, giving rise to the question of what can exist outside the ambit of a bio-geopolitical state. We draw upon research such as T. D. Hà and Mohammad Bin Khidzer (2021), who have explored how bio-geopolitics manifests on the ground as communities contend with the reinvigoration of ethno-racial and ethnonational identity narratives in Vietnam and Singapore engendered by biopolitical national scale genome sequencing projects. More critically, the juxtaposition of societal cleavages at a local level and bio-geopolitics at an (inter)national level reminds us of Warwick Anderson's (2012) broader project of considering the "form of heuristic possibilities of Asia as method," opening up possibilities for multiple fields—the history of geopolitical East Asia, the history of health insurance and medicine, and the history of doctor–patient and state-society relationships.

3 New Directions in Social Histories of Healthcare: Access, Minorities, Capital(ism), and Geopolitics

By highlighting gaps in coverage and access to healthcare, this special issue makes the case that *access* to healthcare should be a more significant component of the medical histories of the region. Studies of modern medicine and society in East and Southeast Asia have provided excellent analyses of the role of colonial and post-colonial medical education, the role of revolution and post-revolution medical institutions, traditional medicine vis-à-vis biomedicine, gender and medicine, the politics of medical practices and institutions, disease construction, and mental health histories.[2] These studies have described the medical landscape for doctors and patients in Asia, including new hospitals, clinics, mental health facilities, and medical training facilities. However, as our articles have shown, access to these medical facilities and resources was not simply an outcome of whether the state or medical provider wanted the populace to participate. Such an assumption of a developmental, mobilization, and perhaps altruistic paradigm embedded in medical accounts in Asia could be further augmented by considering whether patients can afford to be part of these new facilities, as well as the consideration of whether the state can implement and represent its medical will on the population. The trajectory, too, is not linear: Rachel Core shows how the post-Maoist period, with the retreat of the state, meant that some Chinese citizens did not have access to the TB treatment landscape that appeared on the books as they would have had in the previous Maoist period.

Finally, considering health insurance in medical histories can also shed light on how insurance programs interact with traditional and western medical practices, especially among indigenous populations. Besides Takakazu Yamagish's (2022) discussion of the growing dominance of western medicine over Chinese medicine (*kanpo*) in the modern Japanese socio-economic medical landscape, Judith Farquhar and Lili Lai (2021) have also examined how minorities in Southwest China engaged with the evolving health insurance programs in the region. In the North American

[2]Rather than list all the authors with their single-authored monographs, we point you to the contributors in these edited volumes: Pols, Thompson and Warner (2017); Chen Lincoln, C. Michael Reich and Jennifer Ryan (2017); Leslie Charles and Allan Young (1992) and Leung and Furth (2010). Also see Lei (2014) and Bay (2012).

context, David H. DeJong (2011: 176) argues that Native American communities complained that "insurance companies refused to pay for services in tribally operated facilities even though they would in IHS (Indian Health Service) facilities." One could envision how future research could consider how health insurance shapes the healthcare of indigenous communities in East and Southeast Asia. In sum, we assert that a fuller consideration of the economy of medical histories can enrich the medical histories and anthropologies as much as historical and ethnographic studies of (post)colonialism, (post)revolution, traditional medicine, and politics have.

Moreover, highlighting these gaps in coverage and access adds to the emerging research on the history of new capitalism, labor, and medicine. The articles reveal the salience of class, ethnicity, and geopolitics that became implicated with broader questions of capitalism in the Cold War period. This issue adds to historian Christy Ford Chapin's effort in the *Bulletin of the History of Medicine* by considering the myriad agents of medical and healthcare markets (health insurance companies, government, associations, patients, and others) that shaped medical practices, ideas, and knowledge. Bringing together the holistic approach toward medicine and society as well as the new history of capitalism, Ford (2020) makes a case for drawing on the "mechanics of market operations to incorporate religious beliefs and cultural ideologies, gender, and race—the full range of lived experience as it has related to economic exchange." Likewise, we argue that new capitalism, as manifested in the developmental state in East and Southeast Asia, grappled with issues of class, ethnicity, and geopolitics in the configuration of healthcare in East and Southeast Asia.

In sum, by truly historicizing health insurance and society, we move beyond the existing studies of Asian medicine, welfare, state intervention, and East–West binaries. We show how the agency of diverse actors reveals the processes of truth-making, crafting the rhetoric of benevolent governance, population management, and resistance in East Asia. We demonstrate how patient-centered narratives of health insurance negotiations reveal a contested medical landscape for residents in the region. We show the promise of interrogating the role of insurance and healthcare in the region as it relates to critical gaps in developmental nation-building. The promises of overcoming economic scarcity in developmental states remain central to the myth of state-building in the region. But as our articles show, the ethnic, class and geopolitical challenges of coverage and equity became more pronounced with the gradual expansion of health insurance. Filling the healthcare coverage gaps, reducing healthcare inequity, and reorientating welfare towards the truly disadvantaged remained a critical challenge, even for wealthy East and Southeast Asian nations.

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