



## Healthcare System Country Notes Asian Region

# Taiwan

*The purpose of the IMSA National Health Insurance (NHI) web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This series of Country Notes is a collation of material submitted by independent researchers who are willing to place their research notes in the public domain. The collated notes, together with other studies found in the public domain are presented as a service to researchers, policy-makers and stakeholders who are looking at health reforms around the world.*

### A. Research Notes on Taiwan

#### Context

- Taiwan has a population of 23 million people, who live on a major and several smaller islands. By late 1990's the GNP was \$13 000 per capita.
- The country has a free-enterprise economy, with a market-driven health care delivery system including a mix of both private (65% of beds) and public (35%) owned hospitals. 63% of physicians are employed by hospitals and are salaried, receiving performance-related incentive bonuses. The remainder are fee-for-service private practitioners practicing in private clinics and do not have admitting rights to hospitals (clinics may have around a dozen beds).
- Hospitals have large out-patient departments and affiliated primary health care clinics to maintain patient flows.
- City or county administrations are responsible for the running of public health facilities in their area.
- Overall though, the health service delivery has been described as fragmented, and lacks continuity of care. There is a laissez-faire policy towards clinical practice.
- The NHIP which came into effect in 1995 was effectively the result of merging several already existing insurance schemes which had been in existence for a long period.

#### Evolution of Health Insurance in Taiwan

- Prior to the NHIP in 1995 Taiwan had over 10 different insurance schemes, the main ones being: Labour Insurance (LI - which came into force in 1950), Government Employees Insurance (GEI - 1958), and Farmer's Insurance (FI - 1988).
- The introduction of social insurance for industrial workers followed research from the committee in the Social Affairs department in the 1940s. LI consisted of both sickness and occupational injury insurance, with the employers and employees sharing the cost (75:25 initially and later 80:20), and the government paying the monthly administrative costs. At the time there were no private insurance carriers that could administer the scheme so it was done so by government (Taiwan Labour Insurance Bureau and Department of Social Affairs). During 1950-1979 the LI changed from being a social insurance solely for industrial workers to a social insurance for workers from all categories in the private sector.
- The GEI differed from the LI and covered both health insurance and old age pension insurance for state employees. Employees and the Government contributed equally to the fund. The administration of GEI was conducted by the Ministry of Personnel, whilst the Ministry of Finance was entrusted as the insurance carrier.
- The Farmers Health Insurance Act, unlike the GEI and LI, was enacted later in 1985, after the ruling political party had been accused of overly favouring the urban wage worker. The legal entitlement to the FI was restrictive and limited only to those older than 15 years of age, and who engaged in agricultural activity for 90 days a year. The level of financing was different

for the low waged rural worker compared to the urban worker. The Taiwan Labour Insurance Bureau was entrusted as the insurance carrier. The administration of FI was done at two levels: by the Ministry of the Interior at the national level and the provincial government at the local level.

- The process of health insurance coverage extension was termed “opportunity hoarding” as different segments of the population were provided with access depending on their affiliation to the Nationalist Party. However from the 1990’s, with the advent of democracy, this policy was condemned.
- Ultimately, this fragmented set of schemes still left 40% of the population uncovered.
- Predominant fee-for-service payment mechanisms generated over-prescription of drugs and overly frequent care visits. Consequently, spending per person increased rapidly, around 2-3% above the increase in real annual incomes since 1960.

### The NHIP process

- Government committee research on making coverage universal started in 1987. The first working committee (under the Council for Economic Planning and Development) initially established 2000 as the year for implementation, due to concerns about economic viability, but this was subsequently moved forward by the governing party to 1995 (partly due to political pressures).
- The second working party (under the Department of Health) with established task teams and health experts drafted the implementation report.
- Strong economic growth averaging more than 8% a year from the 1950s to the 1980s provided a fiscal base on which the NHI could be built. And opening up of the political space to the opposition put pressure on the governing party to implement the NHIP early.
- In 1993 the Bureau of National Health Insurance (BNHI) established a task force to draft the architecture of the health insurance scheme. Following evidence from Japan, Germany and South Korea regarding multiple insurance carriers and the associated administrative cost, the committee advised on a single insurance carrier model similar to the Canadian model as being best for cost management.
- Legislation of the NHIP was delayed by decisions over the financing of the NHIP. The funding model ultimately approved by legislature required employers to pay 70%, employees 20%, and government 10%. By 1997 the contributions for different segments of the population to the NHIP varied depending on employment status and employer. Civil servants (40% employee, 60% employer), self employed (100% employee funded), low income (100% government funded) etc. The contribution rates are applied to individuals’ incomes subject to a cap.
- Substantial opposition to the NHIP from providers (hospitals and physicians) was overridden by the government in putting the scheme in place.

### The NHIP

- Under the NHIP, all the insured are entitled to uniform, comprehensive and extensive medical care benefits, which was an aspiration of the party in government at the time. The package included preventative and medical services, prescription drugs, dental care, Chinese medicine and home nurse visits.
- Providers are paid in full at preset rates. There is little balance billing permitted by providers unless patients want access to devices more expensive than those covered by the NHIP. Though providers have started charging ‘registration fees’ to supplement their income.
- There is no gate-keeping of access to highly utilised services or hospitals, through GPs for example.
- The NHIP incorporated a \$5 co-payment for outpatient clinic visits, \$8 for outpatient hospital visits, and on average a 10% coinsurance for inpatient services (which ranges from 5-30% depending on service provided). Co-payments are also capped and poor households are exempt from the co-payment.
- The BNHI is the administrator of the scheme, with six local branches covering different cities and counties. Administration fees are low.

- A sophisticated, real-time IT system is based on electronic cards issued to each insured resident, that contain data on recent treatments and diagnoses, and are used to track premium payments.
- Funding for the NHIP comes predominantly from contributions collected by the BNHI and also from sin taxes.
- The BNHI pools the funds and contracts with health facilities to deliver services, including over 90% of hospitals and clinics.
- Fee-for-service is the major reimbursement mechanism for most items, drugs and services. This is combined with a global budget approach to better manage costs. Each treatment is assigned a relative value unit (RVU) and the unit value fluctuates to ensure that spend remains within the global budget.
- The BNHI also adopted case payment (similar to DRG's) for fifty of the most common diseases and treatments as a means to control health expenditure. Hospitals have a financial incentive to discharge patients early as they are reimbursed a fixed amount. The case payment method assisted with cost management especially at private hospitals. However it was less successful at non profit and public hospitals that were financially supported by government funding or philanthropic donations.
- Pay for performance payments are also used for some chronic conditions, like diabetes, asthma, hypertension, etc. And global budgets have been instituted for highly discretionary services like dentistry, Chinese medicine and clinic office visits.

### Impact of NHIP

- Patients had the freedom to choose their providers. Access was limited initially as there were few facilities in the rural areas. As a result, the BNHI provided incentives for providers to relocate.
- Since implementation the proportion of the population covered increased quickly, and by December 2001, NHIP provided coverage for 96% of the population. Despite the broad access, high out of pocket payments mean that the NHIP accounts for only 53% of national health spending.
- Equity in healthcare financing also increased with the reform according to the WHO Fairness in Financial Contribution index changes over the period. Other studies have suggested that the NHIP improved health outcomes for those who were most vulnerable and least healthy. However, demand for access to more or better services still exists for those who can afford to pay for it, and the 'registration fees' charged by some providers is said to now be generating a 'two-tiered' system.
- It is not clear what changes have occurred in the quality of care provided since there is little measurement of clinical performance, patient outcomes, adverse events, etc.
- Provider payment approaches had unintended consequences including for instance, very short average consultation times of 5minutes (focusing on symptom management). Inappropriate physician payment incentives distorted provider selection of specialisation versus requirement to meet the needs of the population.
- Attempts to progressively separate provider prescribing and dispensing were slow and the compensation given to providers for whom the dispensing function was removed were enough to outweigh any potential savings.
- Lack of gate-keeping means that patients (and therefore NHIP money) tends to flow more to well-equipped, large hospitals rather than smaller facilities.
- Low copayments for outpatient visits has driven increased utilisation with patients having on average 14 physician visit per year. Hospital admissions have also increased. In response a series of approaches have been developed. For instance, to encourage referrals rather than direct access to higher level facilities, using differential co-payments are applied to people voluntarily go a referral route. And a progressive sequence of analytic and communication approaches have been developed to handle frequent users of the system in a way that is clinically appropriate.
- With the NHIP patients out of pocket payments were reduced from 48% to 30% of national health spend, and not totally removed. Increasing cost sharing in the form of copayments

and coinsurance have been increasing in recent years reaching 37% of total health care spending in 2007.

- The effect of providing insurance coverage to a large section of the population drove a spike in health spending per person but then increases in this spending fell below pre-NHIP level of annual increase.
- The lower increases in spend post-NHIP were partly due to internally aggregation to a single payer system and offering a single benefit package, which reduced administrative costs and improved efficiency for both the insurance entity and providers. The system also provided comprehensive information which allowed profiling of patients and doctors over-utilising services or committing fraud.
- However by 1999, the NHIP was in debt due to increasing medical costs associated with an aging population, technology and pharmaceutical price increases. Seven years later the BNHI was able to manage costs more effectively. Cost containment measures included: discounted payments or different payment mechanisms to providers as described above, and increased out of pocket payments for devices and medications not covered by NHIP.
- By 2008, health-spend remained at 5-6% of GDP, with good overall levels of key health indicators (life expectancy, infant mortality) relative to spend. Public satisfaction with the system is also high.
- There is a risk that the insurance mechanism may in the long term channel funding from high payoff public health interventions towards consumer driven curative treatment.
- However, the long term sustainability of the NHIP is not certain, with 2008 health care budget shortfalls, increasing national debt, and political reluctance to raise contribution levels.

### Lessons for South Africa

- Taiwan achieved universal coverage through progressively extending health insurance to segments of its population over a 45 year period. By 1995, prior to the NHIP, 60% of the population already had health insurance provided by state agencies.
- Taiwan's economy was considered advanced at the time of implementation, with a GNP of \$13000 per capita, and a large formal employment sector. As such, the BNHI could collect NHIP contributions from a broad contributory base and the government had sufficient revenue to subsidise coverage of the poor, veterans, and farmers.
- Both the central and local levels of government had the experience and organisational ability to manage a NHIP scheme, partly built up by nearly fifty years of managing similar large scale schemes.
- The NHIP lacked sufficient regulations to monitor and measure quality of care and the impact on demand and supply of different payment and cost-sharing approaches.
- Ability to enforce payment mechanisms on providers relied on the system not being short of these providers.
- Taiwan's experience in health reform impresses the importance of adequate consideration to financing and adopting a holistic view of the interacting components health system, paying attention to performance matrices and being sufficiently responsive to manage unintended consequences

### References

Lu JR, Hsiao WC. Does Universal Health Insurance Make Health Care Unaffordable? Lessons from Taiwan. *Health Affairs* 2003; 22:77-88.

Davis K, Huang AT. Learning from Taiwan: Experience with Universal Health Insurance. *Annals of Internal Medicine* 2008; 148:313-4.

Son AHK. Taiwan's path to National Health Insurance (1950-1995). *International Journal of Social Welfare* 2001; 10:45-53.

Lin H, Tung Y, Chen C, Tang C. Relationships between length of stay and hospital characteristics under the case payment system in Taiwan: using data from vaginal delivery patients. Taipei: Graduate Institute of Health Care Administration, National Taiwan University, 2002.

Cheng T-M. Taiwan's National Health Insurance System. Six Countries, Six Reform Models: The Healthcare Reform Experience of Israel, Netherlands, New Zealand, Singapore, Switzerland and Taiwan. World Scientific, 2010.

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## B. Medi-Clinic Research Notes: The Healthcare System of Taiwan

### Background:

- Public health insurance programs were created from 1950 to the mid 1990s, and most of them were employment related. Up to February 1995, there were 10 such programs covering approximately 59% of the population.
- In March 1995, the government launched the NHI with the aim of universal coverage.
- The NHI incorporates the health insurance coverage provided by the 10 former public health insurance programmes and further extends to citizens previously not covered by health insurance.
- The NHI is administered by the Bureau of NHI of the DOH.
- The insured, employers and the government are all required to make mandatory contributions to the NHI.
- The Bureau of NHI contracts health care facilities to provide health care services for the insured and reimburses the health care providers from the NHI contributions.
- Since its establishment, the major challenge faced by the NHI is the imbalance between revenues and expenditures.
- The Bureau of NHI implements the NHI through its six local branches. Each of them covers a number of cities or counties.
- In addition, each of the 25 city/county governments has a health bureau which is responsible for the operation of public health centres under the guidance of the DOH.
- In 2007, the NHI expenditure was about 6.2% of GDP.
- 99% of the population is covered by the NHI.

### Financing:

- In accordance with the NHI Act, the insured and employers are required to make contributions to the NHI and the government is required to pay premiums for some of the insured.
- Premiums are set based on each person's ability to pay and the pooling of resources to help support those lacking the financial means to participate in the insurance program.
- Premiums are calculated as a percentage of an individual's income, capped at NT\$131,700 per month, and shared by the individual, the individual's employer or other insurance registration organizations, and the government.
- The shares of premiums receivable among the insured, employers and the government in 2004 were 38.1%, 35.5% and 26.4% respectively.
- For those employed in the private sector, the employee pays 30 percent of the premium, the employer 60 percent and the government 10 percent.
- The government foots the bill for low income individuals.
- To help the disadvantaged groups government provides partial subsidy for the disabled, the elderly, and the jobless and offers several relief measures such as premium instalments, interest free loans, and charity organization donations.
- When the new system came into effect in 1995, the Bureau feared that employers might discriminate against individuals with a high number of dependents to avoid paying premiums on their behalf. So it established a system where employers' contributions would be assessed

based on an average number of dependents per employee that is promulgated by the Bureau and is generally lower than the actual average.

- All contributions are collected by the Bureau of NHI.
- Other revenues come from outside sources, such as fines on overdue premiums, public welfare lottery contributions, and the health surcharge on cigarettes, all of which supplement the system's income after meeting the mandated reserve fund's basic funding needs.
- Patients are required to make a co-pay for the health care they consume.
- For outpatient services, the co-pay is between NT\$50-107.
- For inpatient services, the co-pay for each hospital stay is between 5-30% of the cost, depending on the type of wards they stay in and the duration of hospitalization.
- Co-pay ceilings for hospital care and exemptions for certain groups (e.g. low income) are prescribed by law.

#### **Benefits and Pooling:**

- All funds are pooled in a single fund of the Bureau of NHI.
- The Bureau of NHI then allocates the global budget among health care services and among regions for that particular financial year.
- The Bureau of NHI is also then responsible for contracting health care facilities to deliver health care services.
- As at June 2005, 98% of the hospitals in Taiwan were contracted by the Bureau, and the corresponding percentages for clinics and dentals clinics were 86% and 95% respectively.
- The National Health Insurance system offers a comprehensive and uniform benefits package to all those covered by the program, including foreigners.
- No gatekeeper and no waiting lines.
- There is no gatekeeper in the system due to the fact that the public is strongly against this idea.

#### **Purchasing:**

- The fee-for-service mechanism, which covers more than 4,200 medical service items, 6,400 medical devices and materials, and 16,000 drugs, remains the main system used by the Bureau to reimburse providers under the global budgeting scheme.
- But other payment methods have been introduced, such as per case payment and performance-based payment systems.
- The pay-for-performance system, first introduced in 2001, is currently being used for breast cancer therapy, diabetes, asthma and hypertension treatment.
- The per case payment method, now covers 54 categories of health services. Health care providers must demonstrate that their patients with chronic conditions have remained in good health based on certain predetermined criteria to claim reimbursement.
- Under the global budgeting and fee-for-service system detailed above, some providers complained that certain procedures were reimbursed at below cost. An RBRVS (resource-based relative value scale) system was adopted in 2004 to address the problem. Under the RBRVS system, relative values are assigned to medical services, with the value of a specific service being assessed based on the medical resources used to provide it.

#### **Provision:**

- Hospital ownership can be broadly classified into two groups; public and private.
- Almost 90% of hospitals are private and 70% of beds are private.
- Public hospitals play a key role in providing medical care in remote areas.
- While all medical facilities must be non-profit by law, most private hospitals are owned and controlled by physicians.
- These hospitals are managed to maximize profits similar to other profit seeking organization.
- Since public hospitals are an operational unit of government funds, they typically do not have to assume the risk of profits or deficits.
- Physicians are primarily salaried by hospitals.

**Problems with the NHI:**

- Since the implementation of the NHI program, the rate increase in revenues has been significantly less than the increase in expenditure.
- Furthermore, premium adjustments are quite rigid due to the required authorization of Legislative Yuan.
- The vested numbers of Legislative Yuan will not agree to an increase in the premium due to their interests of getting re-elected.
- As a result, the NHI fund has been experiencing a growing gap between revenue and expenditure, and the NHI Bureau is facing an emerging financial crisis.
- The implementation of the NHI program has resulted in a misallocation of healthcare resources.
  - The insured has complete freedom to choose their health care provider and they prefer to visit the well equipped medium-to-larger size hospitals (no gatekeeper). Since the money follows the patient, more money flows to these well equipped medium-to-large sized hospitals at the expense of clinics and small sized.
- Second, the payment scheme may cause a serious shortage of doctors in some divisions. For example, the current payment system for surgery is generally low, and the NHI Bureau is reluctant to adjust it due to budget constraints. It is expected that there will be a shortage of doctors in the near future as current medical students prefer not to choose surgery as their 'major', due to low reimbursement rates. The NHI Bureau is the regulator and the insurer. This leads to a conflict of interest.
- The NHI Bureau is a public organization, thus it lacks an adequate supply of qualified personnel.
- The premium is regulated by Legislative Yuan. The members of Legislative Yuan have a tendency to vote against premium increases. This voting structure will make it very difficult for the NHI Bureau to balance its budget.
- Taiwan is rapidly discovering that their population is unwilling to adjust and will not accept a price hike for their care. As a direct result of this, many Taiwanese citizens are choosing to turn to private health insurance schemes to ensure that in the future they will have the best medical care available. This also ensures that these individuals are able to receive medical treatment at private hospitals not associated with the NHI, cutting down on waiting times and receiving a higher standard of treatment than is the norm.

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**C. "How can Taiwan rescue its bankrupt NHI?"**

"How can Taiwan rescue its bankrupt NHI?"

7 August 2009

<http://www.chinapost.com.tw/commentary/the-china-post/joe-hung/2009/08/07/219471/How-can.htm>

Yang Chih-liang, newly installed minister of health, had started tongues wagging against him before he was sworn in to take over from Yeh Chin-chuan. Yeh quit on Monday to run for magistrate of Hualien. The new head of the Department of Health promised to raise national health insurance premiums, a no-no for the past nine years, and dunned Taipei for its arrears topping NT\$34.7 billion as a debt collector.

He is a brave man. He told the truth about the bankrupt NHI system, which Taiwan cannot afford, and he pledged an all-out effort to keep it afloat. That is a Quixotic charge on the windmill. He will be stepping on a landmine, demolished as cannon fodder. The trouble is no government official is responsible.

It is former President Lee Teng-hui who decided Taiwan should have a national health insurance plan like the ones in advanced countries, such as in the United Kingdom or even Italy. Remember even the

world's only superpower, the mighty and rich United States, has no health insurance for all its citizens.

When Lee brought up the NHI idea at a Kuomintang central standing committee meeting in the early 1990s, all the members in attendance opposed it. But when they met reporters after the meeting, every one of them promised insurance across the board would be made available in no time.

It was. It was destined to go bankrupt unless, just as former premier Hau Pei-tsun insisted, "the users have to pay for the service." He is another brave man.

The premier is the father of current mayor of Taipei Hau Lung-bin, who is trying what he can to avoid a head-on collision with President Ma, who started accumulating the arrears while he ruled the capital from 1998 to 2006. The younger Hau is risking the danger of a boycott by a city council, where opponents demand he not pay the debt Ma owes. Whether President Ma will help out remains to be seen.

Premiums haven't been raised for seven long years. They have to be hiked because medicines and services have become more expensive. And many of the insured, as well as service renders, haven't tried to restrain from wasting the dwindling resources. Many see doctors though they shouldn't, while doctors prescribe unnecessary medicines and perform unnecessary surgery to produce a better track record.

Yang wants to raise the premiums of the rich. Well, he wants to milk the rich for the poor. The rich, of course, are displeased. On the other hand, he plans to let the government pay 70 percent of the increased premiums of the poor, who have to share the remaining 30 percent. Even a small hike is a hike, which no one likes.

For that reason alone no health ministers have dared try to hike NHI premiums in the past. Of course, the government may raise taxes to cover all the expenses for the national health insurance service it cannot afford. The United Kingdom and Italy do so. Northern European countries initiated the scheme.

It won't work in Taiwan, where politicians dare not offend the taxpayers. Every president popularly elected has to promise there won't be any tax hike. Even worse, they promised tax rebates or cuts to stimulate the sagging economy. Yang is in a no-win predicament. Clear-thinking people can only wish Yang luck. But they are afraid he may not last long. He may have to count himself lucky if he can keep swine flu at bay and bow out.

Accessed March 2010.

## D. Extracts from Press Reports on Taiwan in 2010

### **"National Health Insurance rates sure to rise this year"**

28 January 2010

<http://www.chinapost.com.tw/taiwan/national/national-news/2010/01/28/242594/National-Health.htm>

The nation's top health official yesterday reiterated the need to bump up National Health Insurance (NHI) rates this year to salvage the cash-strapped program, before adding that premiums for half the population will not be raised....

### **"Rate may not affect most wage earners"**

4 March 2010

<http://www.chinapost.com.tw/taiwan/national/national-news/2010/03/04/246784/Rate-may.htm>

The Department of Health (DOH) will raise the National Health Insurance (NHI) premium rate in April at the earliest, but as many as 75 percent of wage earners will probably be spared the increase based on an instruction from Premier Wu Den-yih, DOH Minister Yaung Chih-liang gave yesterday.

Note from Alex van den Heever: It is also worth noting in addition to the story below, that the value of co-payments in both Taiwan and Korea, both of which have single payer NHI's, exceed per capita health spending in SA's public system. Both countries roughly have per capita GDPs in excess of 2.5 times that of SA.

### **"Wu again rejects Yaung's NHI proposal"**

10 March 2010

<http://www.taipeitimes.com/News/taiwan/archives/2010/03/10/2003467678>

The government's plan to adjust National Health Insurance (NHI) premiums remains unchanged despite the health minister's sudden resignation the day before, Premier Wu Den-yih said yesterday. Wu told a question-and-answer session on the legislative floor that the plan to raise premiums was "necessary to ensure the financial integrity of the NHI system." "The government will make a reasonable adjustment while proposing supplementary measures," Wu said.

Department of Health (DOH) Minister Yaung Chih-liang surprised many on Monday by tendering his resignation two hours before he was scheduled to brief Wu on the department's premium adjustment scheme. Yaung told a press conference that he resigned because he could not fulfil Wu's request that 75 percent of those insured not be affected by the planned increase.

### **"Revamping the insurance system"**

17 March 2010

<http://www.taipeitimes.com/News/editorials/archives/2010/03/17/2003468210>

There is a consensus that the National Health Insurance (NHI) system cannot be allowed to go bankrupt. Currently, most discussion on the topic revolves around the differences between alternative rescue plans proposed by the Cabinet and the Department of Health. We must point out that even if the health department's more rigorous version were adopted, it would only keep the program's income and expenditure balanced for one year. ....

The problem must be tackled on two fronts. Insurance premiums must be adjusted as soon as possible to prevent the NHI system's deficit from growing even bigger in the short term. Concurrently, the legislature must speed up deliberations on amending the National Health Insurance Act to overhaul the system and lay the foundation for a sustainable health insurance program in the medium and long term. ...

The NHI program employs a single-insurer system and a single-payment structure, making it relatively easy to exert financial control. This system also generates the biggest possible risk-sharing group. This accounts for the success of the NHI, relative to some other countries, in achieving equity in health provision and in giving access to the underprivileged. Another feature of the single-insurer system, however, is that it ties everyone's interests together. This can easily lead to "collective irresponsibility" because it is hard to pinpoint financial responsibility. To break this "collective irresponsibility" — this cycle of blame and denial — transparency is required. Measures to enhance -transparency would make it clear whether and when increases in NHI premiums are justified.

Accessed March 2010.

### **E. Commercial Times Analysis of NHI "Attend first to health insurance basics"**

<http://taiwantoday.tw/ct.asp?xItem=96381&ctNode=426>

To translate loosely from the "Analects of Confucius," "With attention to the foundation, the rest will follow." While this saying originally applied to filial piety and fraternal duty, over time it has come to emphasize how in any undertaking, only if the groundwork is well laid can the whole matter be brought to fruition. Without a strong foundation, any design and its implementation will be ineffective and wasteful. The situation now faced by Taiwan's National Health Insurance is a case in point.

NHI is compulsory social insurance. Part of the current controversy over NHI results from a confusion between social insurance and social welfare.

Social insurance is a form of insurance, differing from private insurance in that its purpose is not to make a profit, but rather to achieve a policy objective. In the case of NHI the objective is clearly set out in the National Health Insurance Act, Article 1: "This Act is enacted to promote the health of all nationals, to administer national health insurance . . . and to provide health services."

Since NHI is insurance and not social welfare, it should revert to the nature of insurance. Insurance pools resources, with each participant contributing a small amount of capital, so as to compensate some participants for accidental or serious losses. The key point here is that the compensation must be for accidents or severe losses.

"Accidental" events are those that under normal circumstances are unpredictable or unpreventable; "serious" events are those of a scale or protractedness that the victim cannot bear alone, necessitating drawing on the pooled resources. For this reason, frequently occurring or minor damages must be borne by the individual participant (the policyholder), and no claim settlement should be awarded.

The present range of NHI coverage includes everything, from the frequently occurring common cold to rare or previously unknown diseases, and from small fees most people can afford to horrendously expensive cancer or chronic illness treatment that can break a family economically. When one considers the extent of insurance coverage in relation to the current premiums, no fancy calculations are required to see that there is no way the premiums could cover the huge costs. It is inevitable that NHI should suffer a deficit.

Given the great scope of present NHI coverage, to proceed with no hike in premiums would be like trying to squeeze water from a stone. It is pointless to argue about how to implement a raise in fees, and whether the health minister should resign over the issue. It would be better to explain clearly to the populace how NHI should cover only adventitious illnesses but not frequently occurring ones, and only severe conditions but not everyday ones.

This approach would save money, instead of trying to create new sources of funds. Surely the eloquent Wu Den-yih Cabinet can make the people see how one cannot have one's cake and eat it, too.

This attention to basics is quite likely to bring on even greater political controversy. But this would be a policy debate, with the long-term sustainability of NHI at stake. No responsible political party could avoid taking a stand on the fundamental nature of NHI. High-ranking officials in the Cabinet and Legislature should work to go down in history for looking after the greatest benefit of the people.

As NHI is returned to the realm of insurance, the current social welfare benefits it includes should be taken over by the Ministry of the Interior and related agencies, so the fewest people possible will be affected and social order maintained. It could be argued that in this way the government's finances will not actually be improved, with NHI's deficit just being moved to other agencies, but this is another important reason for advocating that NHI operate as insurance.

When the hidden benefits of NHI are transferred to other government bodies, the administration and Legislature will have to put the social welfare costs out in the light for all to see, so the people will be able to judge the appropriateness of the present distribution of resources, as a basis for future adjustments. Only in this way can there be a strong foundation for long-term social welfare.

Since NHI is insurance, let it function like insurance. Social welfare should not be hidden within NHI, with all health conditions of whatever degree of seriousness covered. The foundation of NHI should be coverage of adventitious and severe illnesses. (THN)

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These notes have been collated for IMSA from submitted research material. The material has not been independently reviewed, checked or verified.

**Professor Heather McLeod**

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