National Health Insurance Reform in Taiwan: A retrospective and a prospective

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NHI in Taiwan

" A car, with parts imported from countries around the world, but domestically made in Taiwan"

- Hong-Jen Chang, former CEO of BNHI

The New York Times

OP-ED COLUMNIST

Pride, Prejudice, Insurance

By PAUL KRUGMAN

Published: November 7, 2005

Taiwan model - lesson for US

Taiwan, which moved 10 years ago from a U.S.-style system to a Canadian-style single-payer system, offers an object lesson in the economic advantages of universal coverage. In 1995 less than 60 percent of Taiwan's residents had health insurance; by 2001 the number was 97 percent. Yet according to a careful study published in Health Affairs two years ago, this huge expansion in coverage came virtually free: it led to little if any increase in overall health care spending beyond normal growth due to rising population and incomes.

Before you dismiss Taiwan as a faraway place of which we know nothing, remember Chile-mania: just a few months ago, during the Bush administration's failed attempt to privatize Social Security, commentators across the country - independent thinkers all, I'm sure - joined in a chorus of ill-informed praise for Chile's private retirement accounts. (It turns out that Chile's system has a lot of problems.) Taiwan has more people and a much bigger economy than Chile, and its experience is a lot more relevant to America's real problems.

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ATLANTIC CROSSING **Uwe E Reinhardt**

Humbled in Taiwan

Taiwan's highly efficient system of national health insurance should humble and inspire the US

Tagging along with Tsung-Mei Cheng, an expert on Taiwan's health system, on her recent visit to Taiwan's Bureau of National Health Insurance, turned out to be a bit humbling for me as someone who focuses mainly on the US health system.

The bureau is the government agency that administers Taiwan's single payer national health insurance system. Its staff members fret when hospitals and walk-in clinics fail to submit completed claims within the required 24 hours after delivery of service. Private health insurance companies in the United States count themselves lucky if high priced actuaries can tell them in the middle of the year what the carrier ultimately will have to pay the providers of health care for services rendered in the previous year. Taiwan's bureau can track almost in real time what goes on in the nation's healthcare system. In the US even a vague idea of what has been going on a year or two ago can be

in Taiwan jumped from roughly 57% of the population before 1 March 1995 to virtually the entire population. For US policy makers and presidential contenders—who for half a century now have engaged in a perpetual "national conversation" on universal health insurance, only to see the number of uninsured people grow apace over the years—the speed of Taiwan's move to a national health insurance system seems downright surreal.

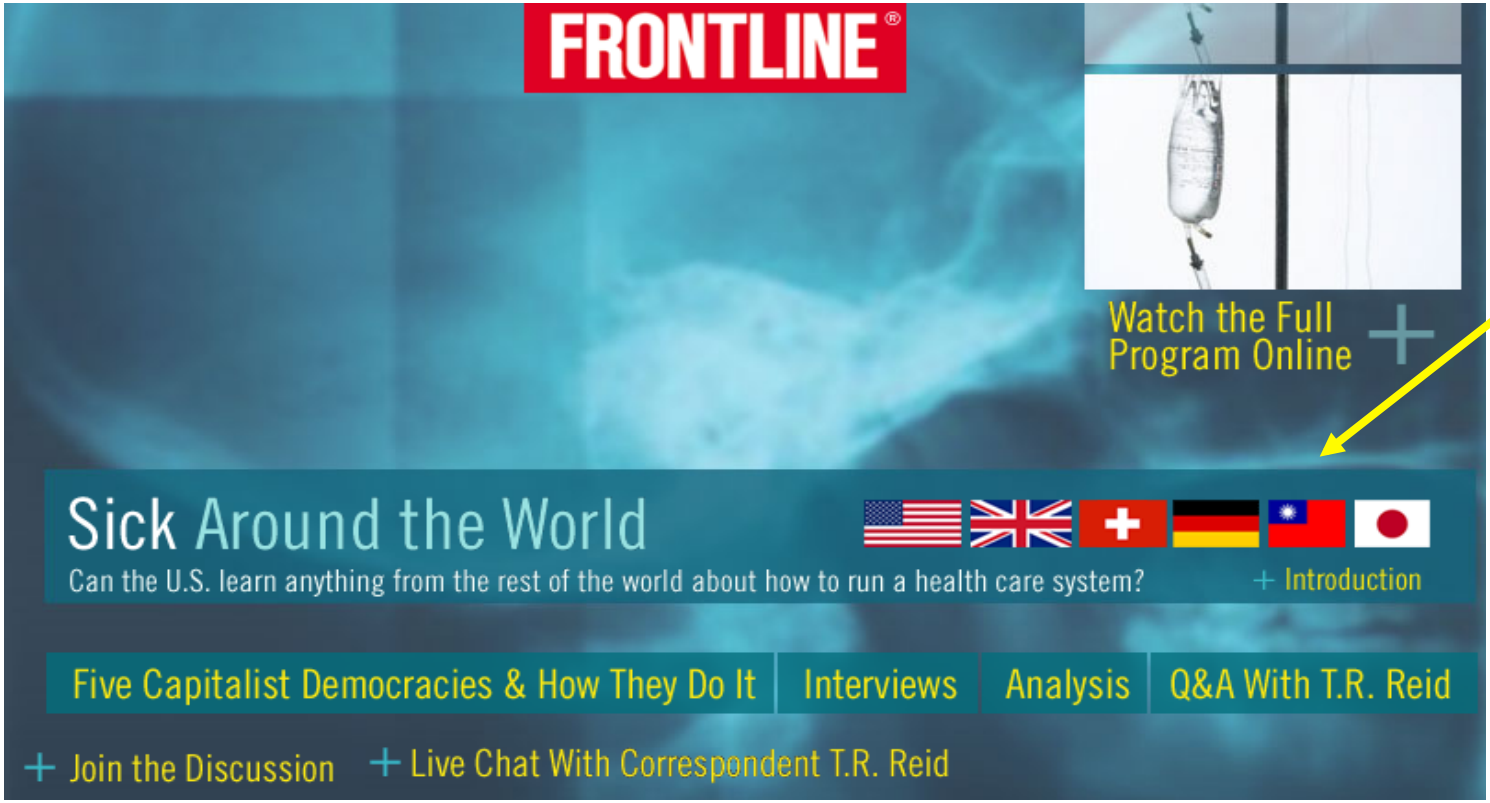
Taiwan's system is financed in roughly equal share by the government, employers, and households in a complex scheme that includes subsidies, payroll taxes, and premiums paid by self employed people. Health care is delivered by a mixed system that includes private clinics, private non-profit hospitals, and public hospitals, among which patients have full freedom of choice. The main tool for cost containment has been sectoral global budgets; while effective in the short run,

"Loss of health insurance and fear of bankruptcy over medical bills is a growing fear among millions of Americans; it has not been in Taiwan since 1995"

top tier, US style care for the rich funded by private insurance, a social insurance system for the employed middle class with highly variable quality of care, and much less or nothing for millions of uninsured poorer citizens.

Taiwan could much improve its health system by allocating an additional, say, 1-2% of its gross domestic product to health care. Some of the additional funds could be used to reduce patients' own spending, which is still higher than that in most European nations. Furthermore, much more should be allocated to the administrative budget of the Bureau of National Health Insurance, which now accounts for only an inadequate 1.5% of total spending on the health insurance system, compared with the 10% to 12% that premium commercial insurers in the US spend on administration, in addition to another 8% or so for marketing and profits. Recent research indicates that Taiwan's healthcare system devotes

A highly efficient system with low adm cost



Taiwan

PBS production by T.R. Reid, April 2008

http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/

Taiwan - 2011

- Socio-economic and demographic characteristics
  - **High-income economy**
    - GDP per capita: USD 20,139
    - 6.62% of GDP on health (2%+ since 1994)
  - **Lowest total fertility rate country**
    - TFR: 1.065 (0.895 in 2010: 1.265 in 2012)
  - **Rapid aging population**
    - Low fertility rate
    - good life expectancy
      - M/F: 76.0/82.7
    - Pop size: 23.169million

Source: DOH, "NHE in 2011", 2012;
MOIA, "Statistical Yearbook of Interior in 2010", 2012.

Reorganization (July 23, 2013)

- **Ministry of Health and Welfare**
  - Department of Health was expanded to cover social welfare
- **National Health Insurance Administration**
  - Former Bureau of National Health Insurance

Road map

- NHI in Taiwan
  - Major features
- A retrospective
  - **UHC: To be or not to be**
  - **Single-payer v.s. multiple-payer**
  - **Payroll-based v.s. household income based**
- A prospective
  - Beyond financing reform

Taiwan NHI – Major Features

- Public single-payer approach
  - Bureau of NHI (now NHI Administration)
    - Health exp payout
      - NTD 480.4 billion (USD 16 billion) in 2012
  - Direct saving through market power
    - Uniform FFS payment schedule with **4 global budgets** by service sectors
    - Uniform electronic claim filing and review system
      - Smart card
  - Avoid cost shifting and risk selection

Taiwan NHI – Major Features

- **Universal coverage**
  - Compulsory social insurance scheme
  - 99% coverage rate
- **Compulsory payroll-tax financed**
  - Government payout: 34.6%
    - subsidies + employer share
  - No less than 36% (starting 2013)

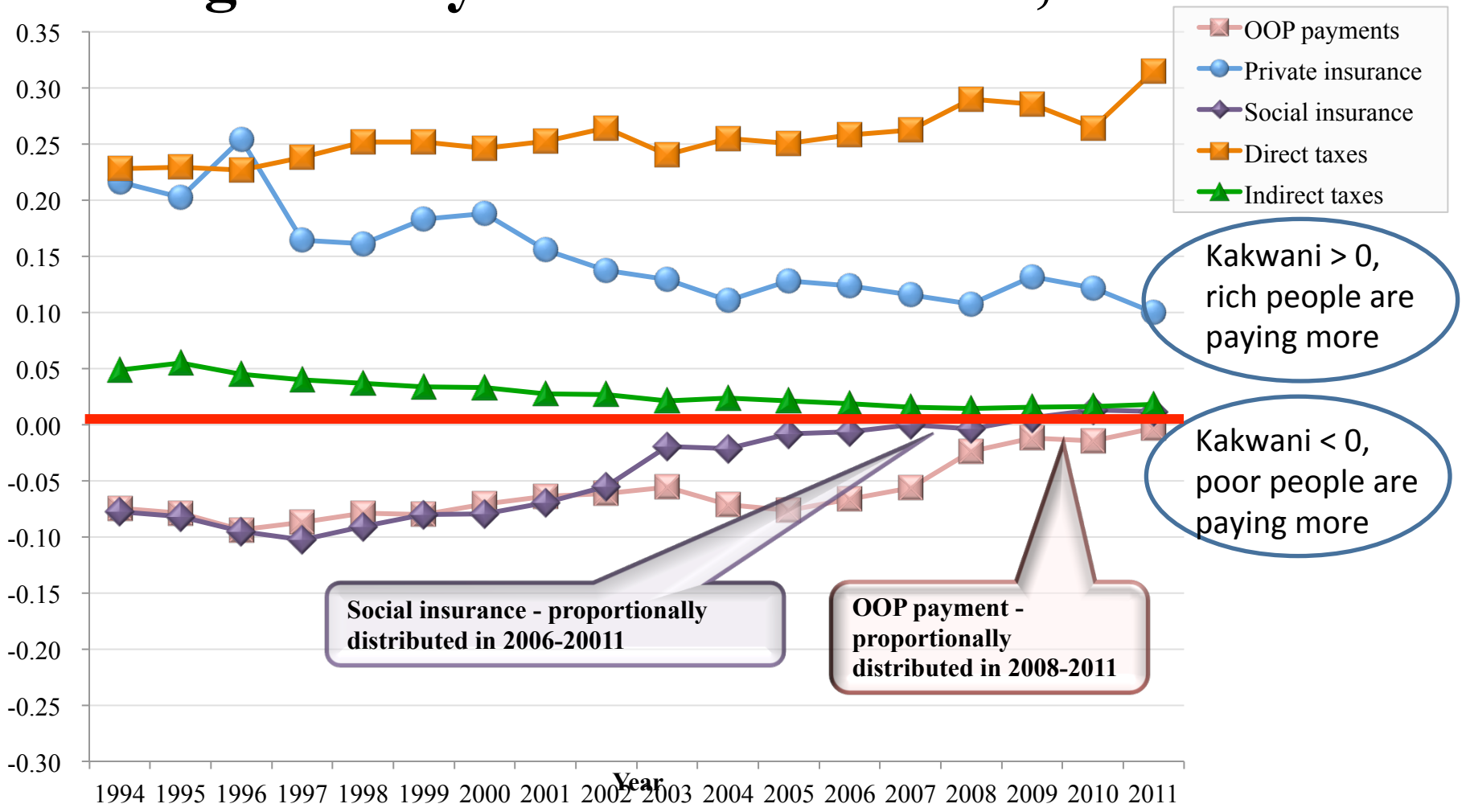
Taiwan NHI – Major Features

- Public single-payer approach
- Universal coverage
- Compulsory payroll-tax financed
- **Comprehensive service coverage**
- **Freedom of choice**

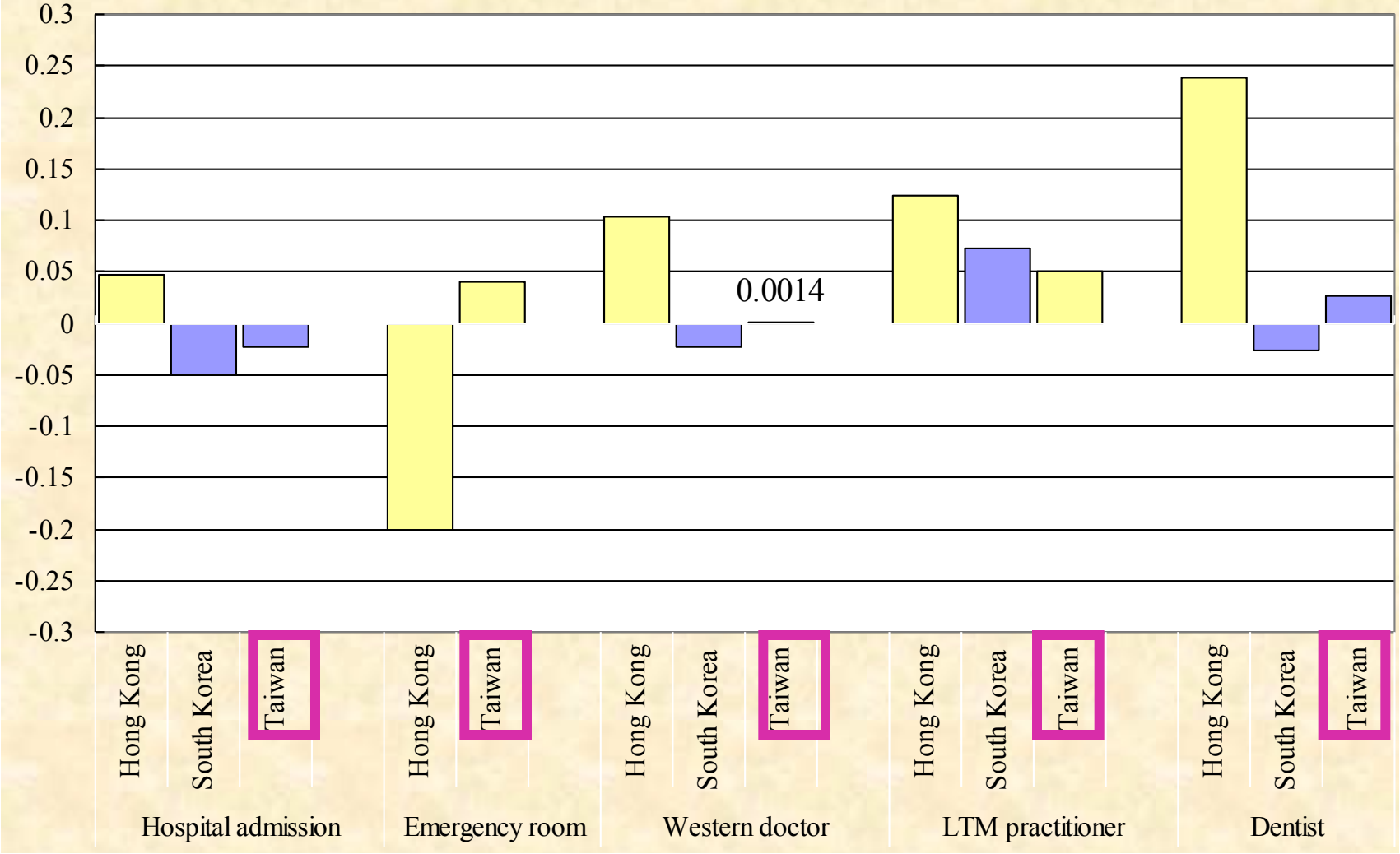
Taiwan NHI – System performance

- High public satisfaction rate
  - +70%
- Efficiency
  - **Administrative efficiency**
    - Uniform schedule, claim filing procedures
    - IC Smard card for real-time monitor
    - Adm exp: **1.51%** (total medical bill)
  - Allocative efficiency
    - Improved – remote areas
- Equity performance

Progressivity indices for Taiwan, 1994-2011

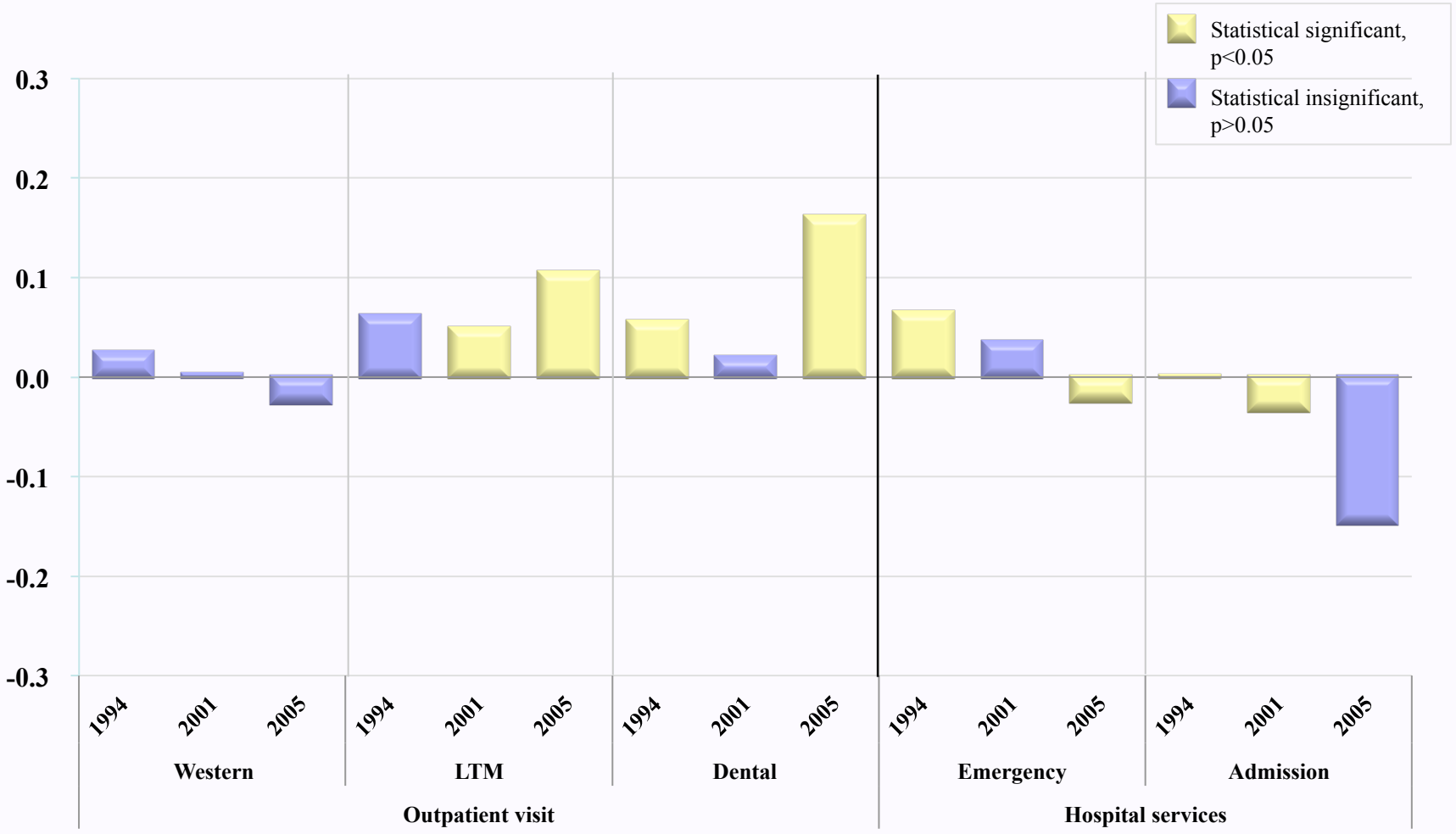


Income-related inequity in health care utilization, Hong Kong, South Korea and Taiwan 2000-2001



Source: Lu, Liang, et al, 2007.

Income-related inequity in health care uses in 1994, 2001 and 2005



A Retrospective

Universal Health Coverage
To be or not to be

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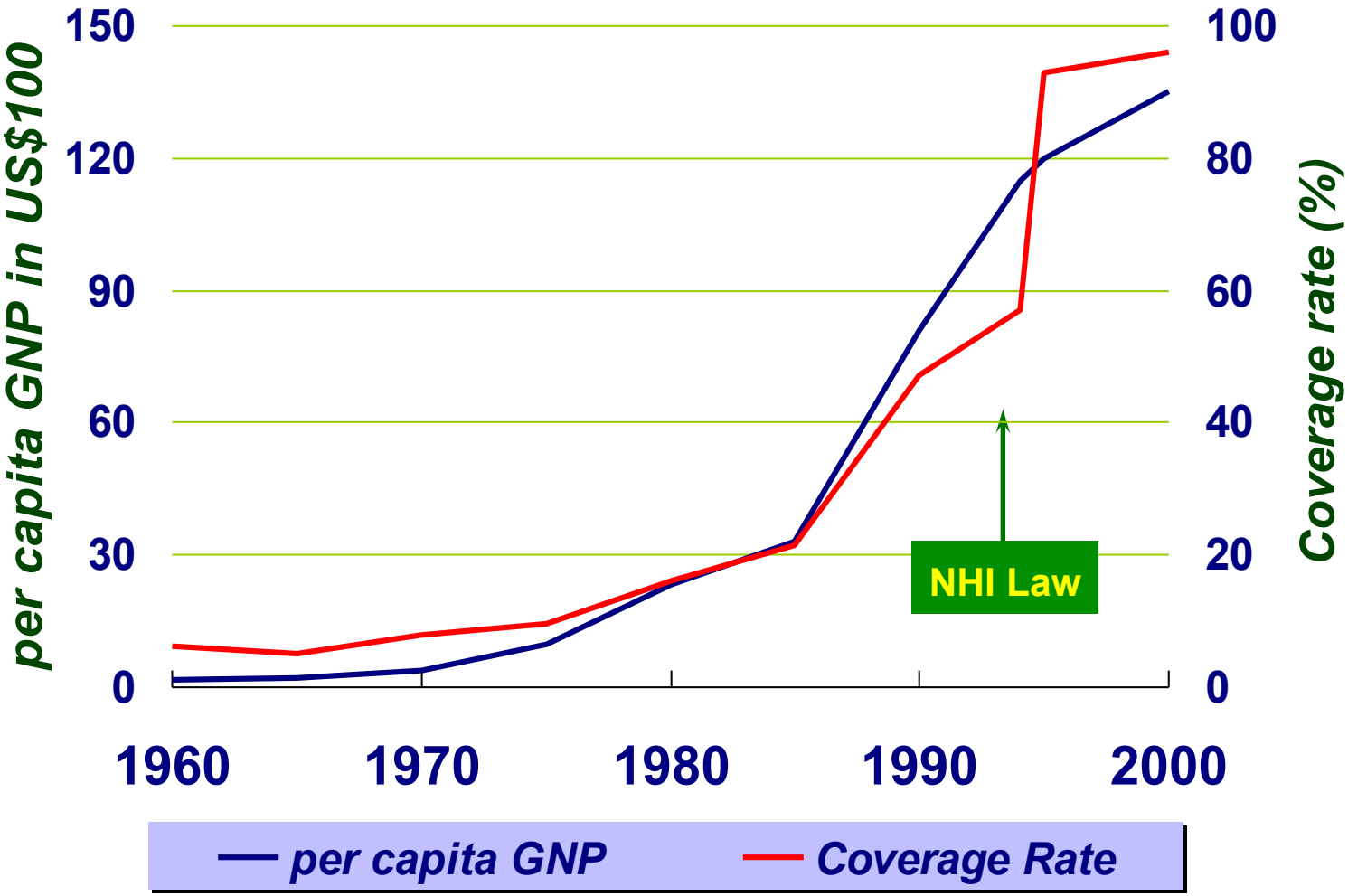
Taiwan NHI - historical development

- Taiwan implemented NHI in 1995
  - Merging three major social insurance programs
    - Labor Insurance (LI), 1950
    - Government Employee Insurance (GEI), 1958
    - Farmer Insurance (FI), 1989
    - Low-income household insurance, 1990
  - Expanding the coverage to the uninsured (43% pop), mainly the unemployed and the retired

THE BIRTH OF TAIWAN's NHI



Source: TL Chiang

What Economic and Political Forces Made NHI Possible?

- **Economic forces**
  - Miraculous economic growth in the 1980's
    - Per capita income growth: **6-8%** per year in real terms, corporate profits increasing rate: **10%** per year
  - Health expenditures was still relatively modest
    - 4.3% of GDP in 1987

What Economic and Political Forces Made NHI Possible?

- **Political forces**
  - The first opposition political party (DPP) in 1986
    - Then President Chiang Ching-Kuo legitimized his political institution by sharing political power with the opposition
  - **Social welfare programs enacted to respond to growing internal demand for a wider distribution of national wealth and power**

What Economic and Political Forces Made NHI Possible?

- **Timing of implementing NHI program**
  - Minimize potential adverse political impact
    - Legislative election campaign in Sept. 1995
    - Presidential campaign in Jan. 1996

A Retrospective

Single-payer v.s. Multiple-payer

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Single-payer v.s. multiple-payer

- Single-payer
  - Canada, Taiwan, South Korea (post-2000)
- Multiple-payer
  - Most of OECD countries, Japan, Thailand, China

Single-payer v.s. multiple-payer

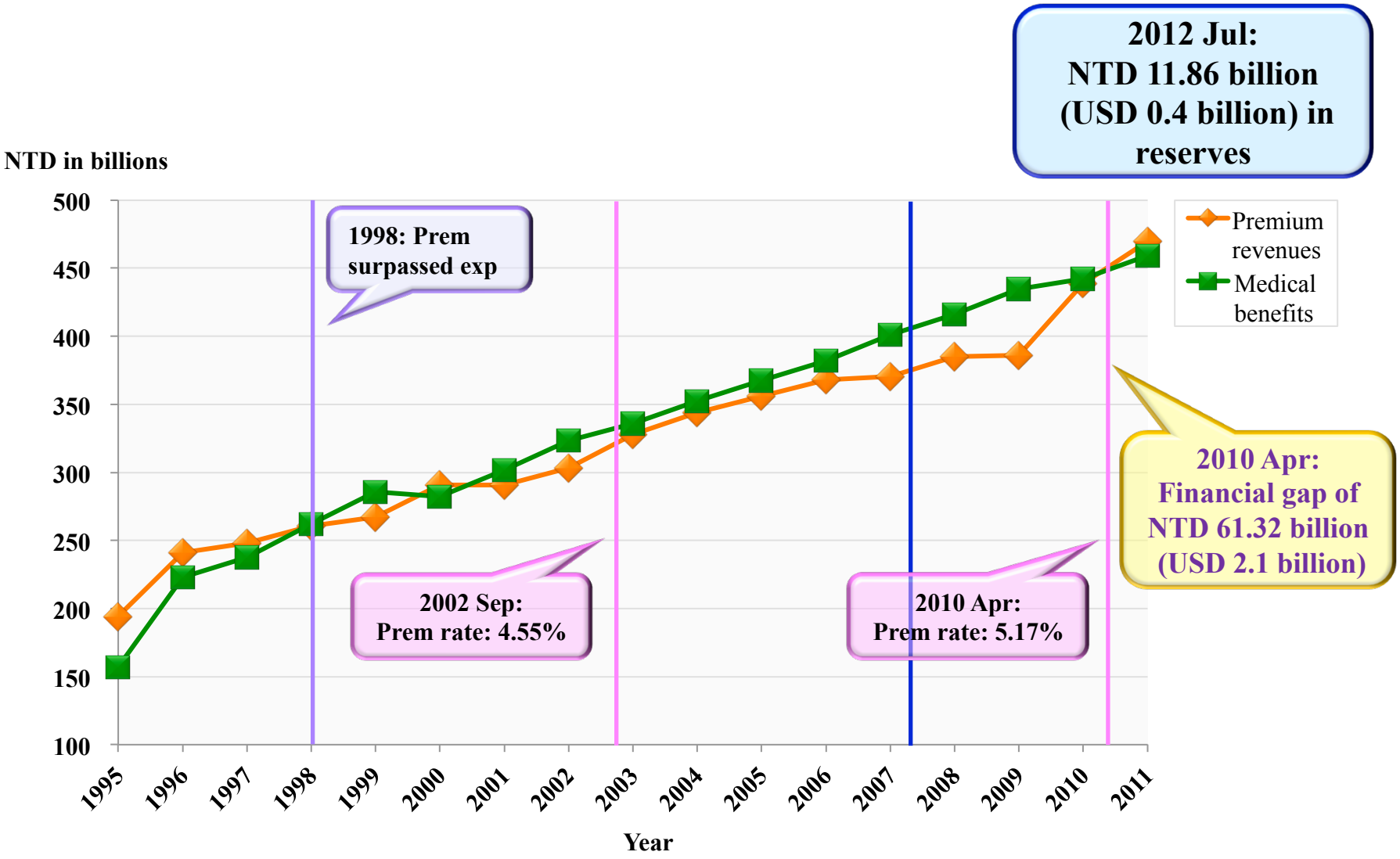
- **Economic forces**
  - Mend the financial gap of LI, GEI and FI
  - Contain cost
- **Political forces**
  - **Strong political will**
    - Opposition from bureaucrats was overruled by the political leader, former President Lee

A Retrospective

Payroll-based v.s. household income based

Financial Insolvency and Inequity

NHI premium income and medical expenditure



Source: National Health Insurance Annual Statistical Reports, 2012.

Taiwan's top fashion model, Lin Chih-ling, an unexpected driver for the birth of a new national health insurance (NHI) system

- ***Local news media has reported that Lin needs to pay only NTD 604 (USD 20) in monthly premium despite her annual income of more than USD 1.5m.***

2G NHI reform proposal

- household income based

- Goal
  - Mend the financial gap
  - Improve financial equity
- Features
  - **Expand premium base**
  - **Abolish the complicated and inequitable classification system of the insured**
    - 6 categorical groups based on employment status
  - **Lessen the financial burden of hh with more dependents**

2G NHI reform proposal

- household income based

- **Significant premium increase for middle-class households** and **singles**
- **Administrative feasibility** is highly questioned
  - Time lag and complicated tax return system
- Ruling KMT party legislators refused to support the drastic changes proposed in the reform bill
  - forthcoming elections in Jan 2012

Dual- track premium system

Premium

Basic premium

- Premium rate: 4.91%(?)
- Premium base: **payroll**

Supplementary premium

- Premium rate: 2%
- Premium base: 6 categories of **non-payroll income**

2G NHI legislation passed on Jan. 4, 2[illegible]nd implemented on Jan. 1, 2013

Health Minister resigned

- Revisions of 106 articles to NHI Law
  - Dual-track premium system
    - An increase of NTD 20.8 billion per year
  - Differential payment system
    - new drugs and medical device not fully covered by NHI
  - Health Technology Assessment adopted for benefit coverage review
  - NHI drug expenditure target

A Prospective

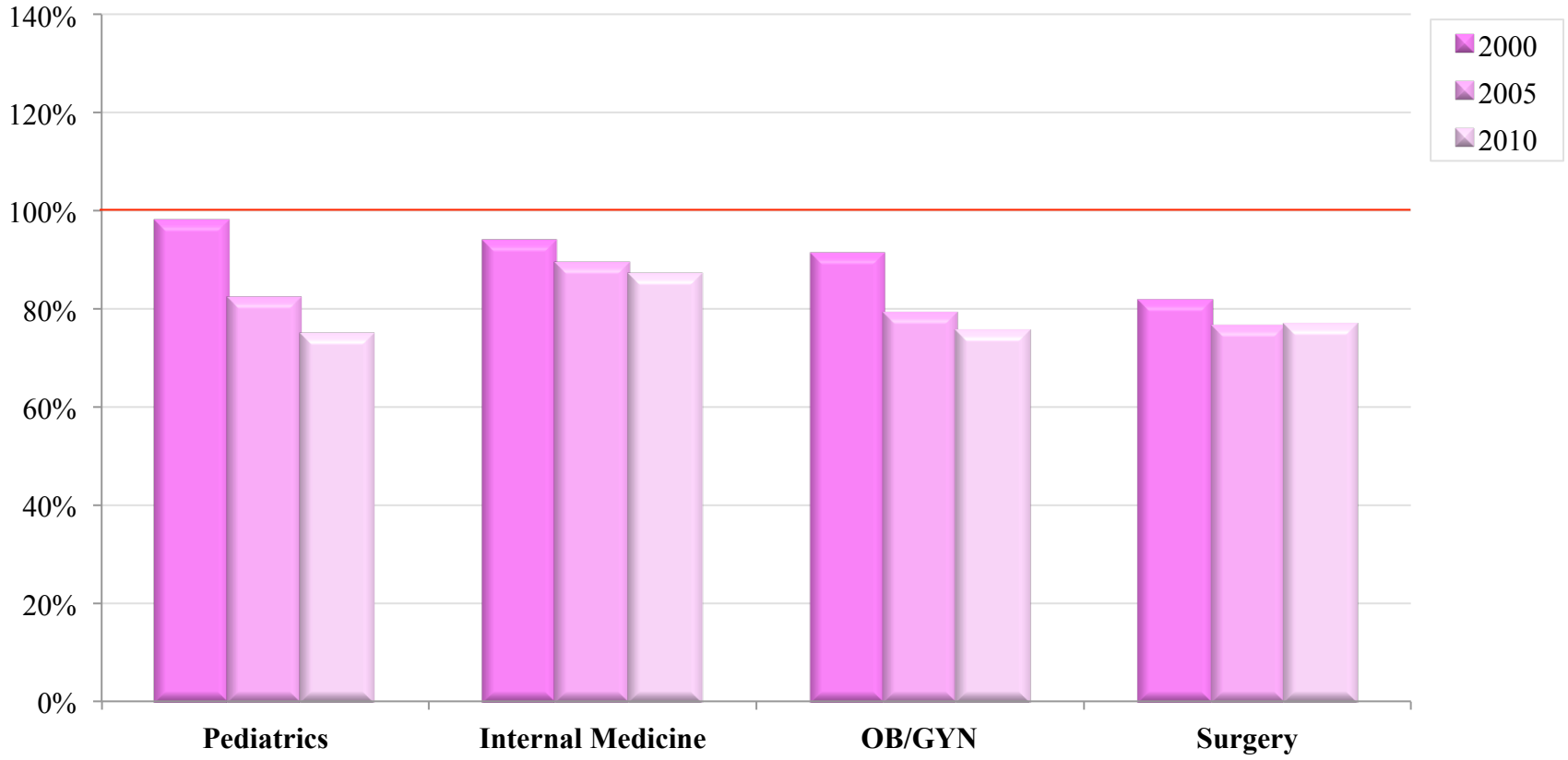
Beyond Financing Reform

Unintended system responses

- **Market-driven delivery system**
  - Dominated by **private sector providers**
    - 84% of hospitals (66% of beds) are privately owned
  - Overuse (abusive uses) of the finite sources
    - 15 OPD visits per insured per year!
    - Futile care
      - USD 2b + on renal dialysis and ventilation
- **Distortion in specialty choices**

Specialty Choices

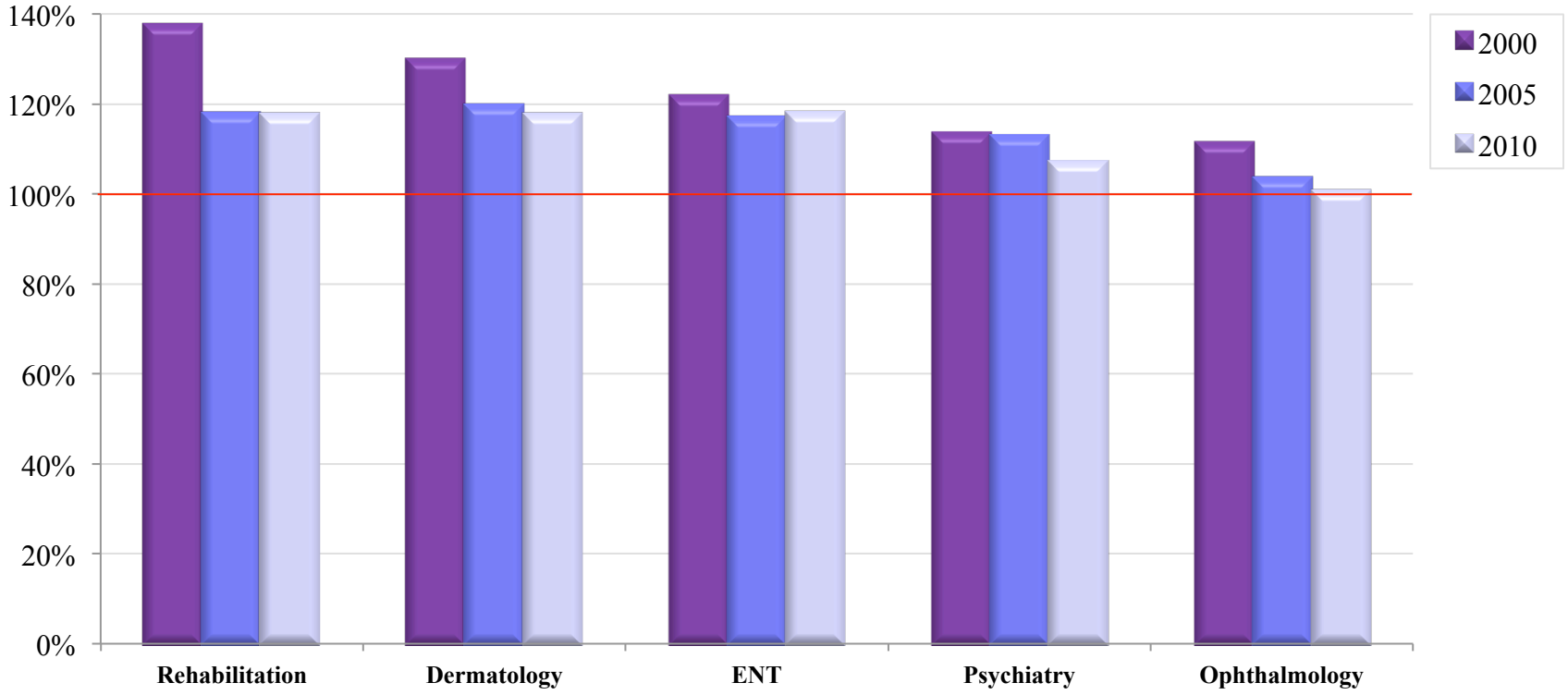
Ratio of physician: Active vs. Certified



Source: Website of Taiwan Medical Association, 2012

Preferred specialties

Ratio of physician: Active vs. Certified



Source: Website of Taiwan Medical Association, 2012

Distortion in specialty choices

- **Payment incentive**
  - 2011, NTD 1.4 b (USD 47 m)
    - 17% increase in physician fee, 228 -> 266 points/visit
  - 2012, NTD 2.14 b (USD 71.3 m)
  - GB annual increase cap, 5%

Will it work?

Who pays the doctors?

NHI or the provider institution?

Final words

- Reform efforts provide lessons for countries going through rapid economic and political transition
  - Economic resources
  - Political will
  - System response

Carpe diem

–If you build it, it will come

Comments & Discussions