

INTERVIEW

Lessons From Taiwan's Universal National Health Insurance: A Conversation With Taiwan's Health Minister Ching-Chuan Yeh

Fourteen years of experience with national health insurance have produced important results that other countries might find of interest.

by **Tsung-Mei Cheng**

ABSTRACT: Taiwan established universal national health insurance in 1995, bringing overnight the then 41 percent uninsured under the umbrella of national health insurance (NHI). Financial worry due to illnesses is a thing of the past in Taiwan. As a result of successful cost containment, national health spending grew from the pre-NHI three-year average of 4.79 percent of gross domestic product (GDP) to only 6.1 percent today. Tsung-Mei Cheng explores with Taiwan's health minister Ching-Chuan Yeh, M.D., the ethical principles that underlie the NHI and how the NHI operates: financing, risk pooling, cost containment, provider payment, and the delivery system. Challenges for the future are discussed. [*Health Affairs* 28, no. 4 (2009): 1035–1044; 10.1377/hlthaff.28.4.1035]

Equity, Cost Containment, And Public Satisfaction

Tsung-Mei Cheng: Minister Yeh, you were appointed in 1995 as the founding CEO of the Bureau of National Health Insurance [BNHI], the government agency that runs the NHI [National Health Insurance]. Now, as minister of health, you supervise that agency. In the intervening fourteen years Taiwan's NHI has gained considerable international recognition. What do you see as its major achievements?

Ching-Chuan Yeh: First, we have the most egalitarian health system in the industrialized world. Access to basic health care is an inalienable right in our constitution. Residents living in remote mountainous areas and offshore islands, and the poor, get pretty much the same access and health care as the children of Presi-

dents Chen and Ma—everyone in Taiwan receives the same care in terms of access and service. Also, our cost is much lower compared to most OECD [Organization for Economic Cooperation and Development] countries.

Cheng: National health spending in Taiwan rose from 4.79 percent of GDP [gross domestic product] prior to the NHI's establishment (average for 1992–1994) to only 6.1 percent in 2007. The comparable increase in the U.S. was from 13.5 percent (average for 1992–1994) to 16.6 percent of GDP in 2007. How did Taiwan achieve such remarkable cost containment?

Minister Yeh: Basically, we should say it is thanks to the efficient services we have, including very low administrative cost, which was only 1.5 percent of total NHI spending in 2008. Having a single-payer system is the main rea-

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son for our efficient services and also the low prices for health care we can achieve.

Cheng: Taiwan's public has been very satisfied with the NHI—in the 70 percent range since inception and 79 percent as of July 2008. The NHI is said to have been the most successful public policy in Taiwan. What explains this high public satisfaction?

Minister Yeh: One reason for the high satisfaction is that NHI's premium and copayment rates are very low, yet everyone can have "all you can eat," so to speak. Easy accessibility is another reason. Anytime you wish to see a doctor, you can. For example, if you decide to see an ophthalmologist, within ten minutes you can find one to see, even in the evenings.

Competition Through Patient Satisfaction, Not Price

Cheng: NHI benefits are indeed broad: inpatient and outpatient care, drugs, dental care, vision care, traditional Chinese medicine, and kidney dialysis. You can afford all this with spending of only 6.1 percent of GDP, of which the NHI itself is roughly two-thirds, or 4 percent of GDP. You mentioned your system can achieve low prices. What mechanism is used?

Minister Yeh: We achieve low prices through a uniform national fee schedule the government sets. We can also modulate price increases, or even freeze prices. So doctors and hospitals must achieve very high productivity to survive. But critics say at such low fees we must beget problems with our service quality. Of course we wish to raise the premium rate from the current 4.55 to 5.3 percent of salary or wage so we can enhance quality—for example, increase the hospitals' nursing staffs. But political resistance to any premium rate increase is so great that if you could get such a bill passed, you could win all kinds of elections!

Cheng: Has complete freedom of choice of providers enjoyed by Taiwan's public also provided effective competition among providers?

Minister Yeh: Absolutely! Providers in Taiwan must be mindful of patients' demands to stay competitive, and they do compete for patients. In Taiwan, patients can carry the cash represented by their insurance cards to any provider of care, not just to a smaller network of providers, as under U.S. private insurance. It is quality competition, not price competition; but it certainly is competition.

Cheng: Taiwan does not have American-style private health insurance. Do you see it coming someday either as an escape valve for the rich in Taiwan (as is the case in Germany and the U.K.) or as a way to reduce the government's burden by shifting cost to the private sector through private health insurance, as in Australia?

Minister Yeh: As long as there is the NHI, there will be no private health insurance

that will provide benefits that are identical to those provided by the NHI. Taiwan has only private supplemental indemnity health insurance; it covers specific diseases such as cancer or disasters like injuries from traffic accidents. It is a cash benefit, and the money is used to help pay for copayments, hire special nurses, and buy nutritional foods—not for genuine inpatient medical services, which are covered by the NHI.

Health Spending And Technology Adoption

Cheng: Published government statistics show that the NHI's expenditures have outpaced its revenues by an average of 2 percent since 1998, except for the brief period 2002–2004. Then there was a balanced budget because in 2002 the government raised the premium rate by 7 percent, from 4.25 percent to 4.55 percent of wage and salary. How does the government handle this financial imbalance?

Minister Yeh: As you pointed out, the NHI raised the premium rate only once in its fourteen-year history: from 4.25 percent to 4.55 percent in 2002. This is not a good thing. In the interim, we started a tobacco tax that gives us

“As long as there is the NHI, there will be no private health insurance that will provide benefits that are identical to those provided by the NHI.”

an additional 4 percent of the total NHI revenue. We are thinking of further increasing the tobacco tax to yield yet another 2.5 percent of revenue for the NHI. In the end, 7.2–7.5 percent of the NHI's total annual revenue will have come from the tobacco tax. This is the easy part.

The bad part is that there has been a continuous shift toward increases in copayments, coinsurance, and extra charges. Extra charges have good and bad aspects: extra-charging the rich to cross-subsidize the poor is right—for example, charging more for private rooms. But increases in copayments by everyone are very bad, because they can be burdensome to poor people. Although we do make generous exemptions from copayments such as issuing waivers for cancer and serious illnesses,

general household out-of-pocket spending has been increasing. I have trouble accepting that. Someday we will need fundamental financing reform. In Taiwan, nonpayroll income, including capital gains, accounts for more than 30 percent of total national income, and yet this large income segment is not subject to the NHI premium assessment. The NHI's premium collection is based on payroll income alone. So we are thinking of adding nonpayroll income to the premium base for the NHI as an additional source of funding.

Cheng: Is it not quite unique in the world that a health system such as your NHI has had only one premium rate increase in its fourteen-year history? Why has Taiwan's public been so stubbornly unwilling to allow premium rate increases, which the NHI Law permits? Do they have a point by arguing that there is too much waste in the system and the government should first deal with that before asking the public to pay more?

Minister Yeh: Of course they have a point. But as with any proposed increases in fees for public utilities like bus and taxi fares, electricity, etc., the public always hides behind the argument “better service and eliminate waste be-

fore you ask us to pay more.”

We need better public communication to convince the public and tell them, “You can't say we will increase policemen's pay only when all crimes in the country have been eliminated—when there are no thieves, no violence.” We need to tell the public they have only two choices: namely, to pay a little more and get good service, or else be prepared that the quality and accessibility of services will deteriorate or be reduced.

“Our adoption of new technology, including drugs, is often delayed by two years and at times five years compared to the U.S.”

Cheng: Taiwan spends roughly 25 percent of the NHI budget on drugs. Given that your overall spending is low, are new drugs and devices introduced in a timely fashion? How do you reimburse the very expensive drugs? Multi-national pharmaceutical companies often allege that prices paid by the NHI are too low,

and they are unhappy about it.

Minister Yeh: The NHI introduces forty to fifty new drugs every year. So spending for new drugs per total NHI expenditure continues to rise. About one percentage point of the 3–5 percent annual growth in spending of the NHI is for new drugs.

Cheng: One hears often, nevertheless, that various new drugs are not covered by the NHI because they are expensive. Is this true?

Minister Yeh: There are some delays in coverage for new drugs. Our adoption of new technology, including drugs, is often delayed by two years and at times five years compared to the U.S., but not longer than that. In terms of target therapy drugs for cancer, the NHI covers thirteen of the total of seventeen drugs currently available in the world market.

Cheng: How about the wait for the adoption of high-price biologics?

Minister Yeh: The NHI does cover many of them, but we place certain restrictions on their use. The BNHI will pay subject to certain conditions. Admittedly, these conditions sometimes are too strict and physicians strongly oppose them. For example, there is now a debate over cholesterol-lowering drugs in the statin

family like Lipitor, which is very expensive. So the BNHI has set a limit on their use, such as that the patient's cholesterol must be above a certain level, or other ways to reduce the level, such as that lifestyle changes have failed.

Financing And Protection Of Disadvantaged

Cheng: Let us now turn to the financing of the NHI. Why did Taiwan adopt the premium model, rather than the general tax model used in, say, Canada's health system and the British National Health Service [NHS]?

Minister Yeh: Three reasons: first, previously existing social insurance schemes such as Labor Insurance, Government Employees Insurance, and Farmers Insurance were all premium based, so the public was familiar with that model. Second, the general tax model would not work in Taiwan, because the government's ability to levy taxes is poor—total tax revenue as a percent of GDP is currently 13 percent, down from a historical high of 18 percent. Finally, the Department of Health would have to compete for government budget allocation against other government departments such as defense, finance, education, and transportation; this may lead to unstable and insufficient funding for the NHI because the government's priorities may shift.

Cheng: What happens to those individuals or households who cannot afford the NHI premium?

Minister Yeh: The government pays 100 percent of the premium for low-income households—currently 1 percent of the population—and extends interest-free loans to the near-poor—2 percent of the population. I had proposed, in 2008, raising the tobacco tax from the current NT\$10 per pack to NT\$20 per pack and using part of the additional revenue as a subsidy for the near-poor.¹

Cheng: You mentioned that raising the tobacco tax is relatively easy in Taiwan.

Minister Yeh: Yes, because the antismoking campaign has been very successful in Taiwan, and the tobacco tax is regarded as a sin tax, so there is not much opposition.

Cheng: And did your proposal to increase the

tobacco tax pass the legislature?

Minister Yeh: Yes. It did pass, on January 23 of 2009. The new tax will be enacted June 1 of 2009. This will give the NHI an additional 4 percent of its total annual revenue, or NT\$16 billion (US\$485.9 million). I intend to use the new money for a variety of purposes. Namely, roughly a little less than half (NT\$7.2 billion, or US\$218.2 million) will go to NHI general revenue; NT\$2.16 billion (US\$65.5 million) for cancer research, prevention, and screening; NT\$1.44 billion (US\$43.6 million) for subsidies to the near-poor to ensure their coverage; and the rest to health care quality improvement, including health care in remote and mountainous areas and off-shore islands, care for rare diseases, suicide prevention, and narcotics addiction.

Cheng: I understand that, remarkably, over 98 percent of Taiwanese pay their premiums on time. How do you get such good compliance from the public?

Minister Yeh: The NHI's total premium revenue comes from three sources: government (25 percent), which will not default on premiums; employers (37 percent); and the public (38 percent). The BNHI is good at collecting premiums from the public—better than Taiwan's National Taxation Bureau. When people don't pay premiums on time, the BNHI telephones or sends notices to them immediately. Our citizens are very law-abiding, so compliance is very high. The "bad debt rate" is just around 1.5 percent. In the end, more than 98.5 percent of the premium is collected.

Provider Payment: FFS, Global Budgets, P4P, And Disease Management

Cheng: There is a consensus among health policy experts around the world that FFS [fee-for-service] is about the worst way to pay doctors, and yet it is also the most widespread method actually used around the world. Does Taiwan have plans to reform its FFS-based payment system?

Minister Yeh: We currently have FFS under a system of global budgets. Ideally, under global

budgets, FFS should be done away with. This is the goal. But it is very difficult to implement such changes. In reality, under our global budget system, fifty-three surgical procedures are under case payment (like your DRGs [diagnosis-related groups])—for example, the case-based global fee for total hip replacement is NT\$124,754 (US\$3,789).

Cheng: By “case payment” do you mean “bundled payment”—that is, a global fee for a fixed procedure? In the U.S. there is much talk of bundling the services going into the treatment of standard cases—for example, CABG [coronary artery bypass grafting]—and paying one global fee for the entire bundle of inpatient and ambulatory services, giving providers an incentive to practice cost-effective medicine across the

entire spectrum of delivery settings. But for that to happen, we must have patient-centered, clinically integrated care, which is still the exception in the U.S. Are you aspiring to that kind of system reform in Taiwan as well?

Minister Yeh: Our “case payment” is for inpatient services only and bundles fees for hospital and hospital-based physician services. It does not include fees for ambulatory services. We have developed our own version of DRGs but have not implemented them except for the fifty-three mentioned earlier.

Cheng: You mentioned that Taiwan has used sectoral global budgets to control health spending successfully. Health policy experts generally believe that such an approach can be useful in the short run, to break an upward trend in health spending, but that over the longer run this is a heavy-handed approach that inhibits a flexible adaptation of health care delivery to changes in technology—for example, shifts from inpatient to outpatient care made possible by new technology. Does Taiwan contemplate staying with the global budget approach forever?

Minister Yeh: We are aware that some scholars continue to challenge the global budget approach. The global budget approach is not as

bad as people imagine. We have five sectoral global budgets under one big overall global budget for the whole system: hospital, primary care, dental, traditional Chinese medicine, and kidney dialysis. Our hospital global budget includes hospital outpatient ambulatory care, and that part is almost 50 percent of the total cost of any hospital. So far this system has worked, even if not perfectly. Shifting patients from inpatient to outpatient care is effortless because both are under the same hospital global budget.

Cheng: Are there disease management programs [DMPs] in Taiwan? What payment schemes do you use for DMPs—pay-for-performance [P4P], or risk-adjusted capitation as in Germany and the Netherlands?

Minister Yeh: We have five P4P programs using the disease management approach—diabetes, breast cancer, asthma, tuberculosis, and hypertension; other programs are based on fee-for-service or case payment. Diabetes management and tuberculosis control are relatively successful because there are good indicators to measure outcomes by, for example, HbA1c for diabetes. Breast cancer P4P is considered so-so up to this point. There is no evidence as yet that P4P for asthma has made a big impact. Overall, however, the budget impact of these initiatives is still small. We need to take a much more aggressive approach to disease management. For that we need to overhaul our payment system, which is still largely based on fee-for-service payment to providers.

Health Information Technology: Toward A High-Performing System

Cheng: Everywhere around the world, electronic health information technology (IT) is now viewed as a necessary though not sufficient component of high-performing health systems. Denmark’s health IT is ranked number one among OECD countries, yet according to a Danish scholar, Taiwan’s health IT surpasses Denmark’s. What do you see as the most successful aspects of Taiwan’s health IT?

“All the data in our health IT system can be linked, so that we can know anything we choose to know about patients.”

Minister Yeh: There are two aspects to the NHI's health IT: one is the IC Card (Smart Card), a credit card-size card, which every insured has for accessing care, and the other is the wider IT system of which the IC Card is an important component. As all providers in Taiwan submit claims electronically based on the electronic patient records they keep, we can do very detailed profiling of both patients and providers. All the data in our health IT system can be linked, so that we can know anything we choose to know about patients, their utilization of health care, providers, and so on, quickly—usually within a day of service. We have complete profiles on utilization by patients' income level, geographic location, visit number, hospitalization number, etc. Thus, we are able to monitor our health system almost in real time.

Cheng: With so rich a database, do you do a lot of operations research, also called "health services research"?

Minister Yeh: This is where we fall short of our potential. We have so much valuable data, but there are not enough people asking the right questions as a basis for decision making.

Cheng: Does this have to do with your extremely low administrative budget: 1.5 percent in 2007?

Minister Yeh: Yes, this has to do with the budget. We have made our data, scrambled to protect patient privacy, available to academic researchers. Unfortunately, we do not have enough R&D [research and development] funding to incent researchers to ask the right questions; you need to have people doing strategic thinking. It is like in a war; winning or losing does not depend so much on the number of troops. Good commanders with good systems of information and operations staff are what are needed. We could do better here.

Cheng: Do you have an electronic medical record [EMR] or a personal electronic health record [PEHR]?

Minister Yeh: Not yet. At present, most hospitals have EMRs within their own walls, but interhospital communication still awaits standardization of nomenclature. But once we decide to develop a cross-system EMR, we can

accomplish it very quickly, because as a single insurer, we can have one single standard. We can go to a complete e-record in five years.

We are in the process of building the Picture Archiving and Communication System [PACS]—imaging switching center. I am aiming for its completion by the end of 2010. I expect to have all imaging done in the NHI electronically transferable within the entire Taiwan health system.

Cheng: What about a PEHR that links patients electronically to the health system? Does not the current NHI IC Card already feature important components of a PEHR, such as record of illnesses, diagnosis, prescriptions, allergies, etc.?

Minister Yeh: Yes, but I want our people to build quickly a more refined PEHR, one superior to the NHI IC Card we now use. I know it will be difficult because a more refined PEHR will first require us to upgrade our current IC Card to the second-generation IC Card. The present IC Card only has 36k of memory, which is not enough.

Preventive Care And Quality Of Care

Cheng: Many physician-leaders in Taiwan have voiced their concern about inadequate efforts at prevention, citing the time pressure on doctors. I have read that where the government did invest in prevention, as in cervical cancer prevention by Pap smear screening, patient outcomes have vastly improved. Is that a general finding?

Minister Yeh: Yes, it is. It is also true that at present, prevention is not as well done as it should be. We do a pretty good job with antismoking campaigns, but that is a different kind of prevention than the kind doctors typically think of. The current screening rate for breast cancer, ranging between 5 and 10 percent, is too low. Screening rates for oral cancer—another major cancer in Taiwan because of betel nut chewing—and colon cancer are also quite inadequate. We have to invest more in these activities.

Cheng: Do you believe that inadequate screening is in fact at least partly responsible for the

significant gap in five-year survival after diagnosis for colon, lung, and breast cancer in Taiwan compared to high-spending countries like the U.S., Germany, and Switzerland? For example, breast cancer five-year survival in Taiwan is 67.7 percent, compared to 87.6 percent in the U.S. and 73.3 percent in a fellow single-payer country, the U.K., which spends more on health care. I would imagine that as minister of health, you have these outcomes data in your sight. Are there any concrete plans to match the higher survival rates elsewhere?

Minister Yeh: Of course! To address this problem, I have designated a special sum from the tobacco tax revenue solely for screening of three major cancers in Taiwan: colon, oral, and breast. It would be great if within ten years the breast cancer mortality could be cut in half, just like we did with cervical cancer. The cervical cancer mortality in Taiwan was cut in half in the ten years from 1995 to 2005, even though its screening rate is not that high: 33 percent a year, with a three-year cumulative screening rate of only 60 percent. I am also optimistic about reductions in oral cancer mortality, because screening for it is easy. So our biggest problem is that we did not spend enough money on preventive screening.

Cheng: I have been told that once a cancer diagnosis is established in a patient in Taiwan, treatment (such as surgery) is done well and outcomes are excellent. Do you agree?

Minister Yeh: You put your finger on an important aspect of cancer care in Taiwan. Stage-specific five-year cancer survival rates in Taiwan are similar to those in high-spending countries. Although they are lower than in the U.S., they are better than in the U.K. What this shows is that our staging is too late, not that our treatment is inferior. The problem is, once again, that we do not have comprehensive and early cancer screening programs. This is due to inadequate funding for screening in the past few years.

When you look at survival after organ transplantation, we sometimes do better than the U.S. For example, because we do more liver transplantation here, we have much better outcomes than does the U.S. Kidney trans-

plantation results are also comparable to the U.S. But since we rarely do lung or heart-lung transplants, our outcomes are much worse.

Integrated Care And Care Coordination

Cheng: In all of the countries I have recently visited, there has been for several decades now a yearning among policy analysts for “integrated care.” Unfortunately, the providers of health care responded to that yearning merely by building vertically integrated health systems that include primary care outpatient practices, hospitals, pharmacies, home care agencies, nursing homes, and hospices. But these facilities were only legally and economically integrated. They never integrated patient care clinically in a patient-centered way. These systems are really just a bunch of silos owned by one system, with each silo doing its own thing and even billing separately. Let me first ask whether Taiwan also has had this faux systems integration.

Minister Yeh: We encourage vertical system integration, and it is happening. Big teaching hospitals have been integrating downward with small and medium-size community hospitals. What is behind the vertical integration? Hospital systems here are very competitive. Large hospitals and medical centers, in order to carve out their territory and guarantee their sources of patients who would be referred to them—that is, have a steady supply of patients—must reach out to remote, rural community hospitals to affiliate with them or even buy them. They invest in those hospitals so they can guarantee that all patients in the community will go to them.

Cheng: Do patients get better-quality care at the integrated hospital systems?

Minister Yeh: Yes, the quality of care is better at the integrated hospital systems.

Cheng: Is that because the vertically integrated systems actually try to give patient-centered, clinically integrated care, or is there some other reason?

Minister Yeh: Vertically integrated systems improve care continuity and thus produce better patient outcomes. In addition, they give

physicians in community hospitals opportunities for further training at larger hospitals or medical centers, making them better-trained physicians, whatever their specialties.

Cheng: In its book *Crossing the Quality Chasm*, the U.S. Institute of Medicine laments that American health care is highly fragmented, has poorly designed work-flow processes, and lacks even a rudimentary health IT infrastructure. Is Taiwan's health care as fragmented as is ours in the U.S.?

Minister Yeh: I am afraid so. It is human nature that we do not like to be cooperative. Taiwan is no exception.

Cost-Effectiveness Analysis In Coverage Decisions

Cheng: In the U.K., the National Institute for Health and Clinical Excellence [NICE]

performs technology assessment for the NHS based on cost- and clinical effectiveness of treatments. The NHS in turn makes its coverage decisions based on NICE recommendations. How does Taiwan make its coverage decisions?

Minister Yeh: Technology assessment in Taiwan is a touchy issue politically. Patients just don't care about cost-effectiveness, and politicians side with them. The argument is that everyone has but one life, and so what if saving my life costs more than saving other people's lives. This is typically how the average person thinks. What surprises me about the U.K. is that it could refuse to pay for kidney dialysis for the elderly. This would not be possible in Taiwan. Politicians here always ask the NHI to provide more and pay less. Do we pay for noneffective care? The most we can do is to ask that patients pay higher copayments, because the political price for rejecting coverage would be very high.

Cheng: So, in essence, the NHI's coverage decisions are greatly influenced by political interference?

Minister Yeh: Yes, greatly. NHI benefits are already very broad—we call it the “inclusive of

mountains and oceans” program. But now we must stop at providing shark fins and lobsters! Unfortunately, the problem is that it is not easy to say no in our political system.

Workforce: Is Length Of Physician Visit A Measure Of Quality?

Cheng: Does Taiwan have enough doctors and nurses? Taiwan's physician- and nurse-to-population ratios—1.7 and 4.5 per thousand people in 2005, respectively—are low compared to

higher ratios in OECD countries, especially for nurses. You train 1,300 doctors a year—the same number as twenty years ago, when the population was much smaller. How does this affect access to and quality of care in Taiwan?

Minister Yeh: In 1990 our population was twenty million. Now we are at twenty-

three million. But Taiwan's population will not exceed twenty-four million at maximum and also will begin to decline very rapidly after reaching twenty-four million because of our extremely low birth rate. So our problem now is not population size, but rather population aging. We have found that every year total NHI spending will increase by 1–1.5 percent as a result of population aging. It follows that we will need a growing health workforce. I do not think we have shortages of hospital beds. But we have too few nurses—4.5 nurses per 1,000 population, compared to 9.6 per 1,000 in wealthy OECD countries. Regarding doctors, there is no shortage, although at 1.7 doctors per 1,000 people, our physician-to-population ratio is lower than the 2.64 per 1,000 in wealthy OECD countries.

Cheng: Like Japan and South Korea, Taiwan is famous for its short physician visits and high utilization, averaging 12.4 visits per person per year (not including visits to dentists and traditional Chinese medicine). Is this a cultural phenomenon, or are there some other reasons? The World Health Organization [WHO] regards length of visit as a quality measure, based on evidence that longer visits result in better qual-

“Technology assessment in Taiwan is a touchy issue politically. Patients just don't care about cost-effectiveness.”

ity of care. Is this because doctors are under too much time pressure to see more patients?

Minister Yeh: There is no mistake that the high number of visits in Taiwan is a cultural phenomenon, as it is in Japan and Korea, where the number of visits is also high. Another reason is that any encounter with a doctor is counted as a visit. A visit to a provider just to look at a lab report counts as a visit.

Now I would like to ask, “What’s wrong with that?” In other words, seeing a doctor or going to a hospital is convenient for me; if I wish to see a doctor, I can see a doctor at any time, although the visit is short. I agree with what you said—that length of visit is regarded by the WHO as a measure for quality of care—but show me the evidence

that quality is not good here. I also agree that there is a trade-off between accessibility and quality. In Taiwan, though, because patients have frequent contact with their doctors, doctors are familiar with their patients’ conditions and therefore do not need as much time for each visit as they would when they see new patients.

There is also the issue about the cost of longer visits. If you insist that every patient should be seen for fifteen or thirty minutes, it would cost a lot more—a doctor consultation is expensive. If you compare the total cost and total social cost-benefit ratios of fifteen- or thirty-minute visits with three-minute visits, you will find that a lot of people cannot afford visits and would be worse off as a whole with longer, more expensive visits. Would a system where visits are so expensive that many people cannot afford to see doctors or get treatment, as they are in the U.S., be a good system? I would argue that despite our “three-minute visits” and alleged inferior quality, if the patient has something serious, the doctor would still take the time to examine and treat the patient. Why don’t we look at the overall final outcome—how is the patient in the end? The WHO regards length of visit as a quality indicator, but over the long haul, is that efficient

from the point of view of societal welfare? Is that cost-effective? Suppose we changed our system and required each physician to spend fifteen minutes per visit; what would be the consequences of such a requirement?

Lessons For Other Countries

Cheng: What lessons for developing countries trying to establish universal health insurance do you think Taiwan’s experience offers?

Minister Yeh: First, you need a cadre of competent technocrats who can devise sound policy and then implement it. Second, you need a political system reasonably free from corruption. Third, you need a physical infrastructure capable of delivering on health policy. Fourth, you need a head of state with

“Because we are a single payer, we can save a tremendous amount of administrative cost.”

dedication to the idea and willing to lead.

Most importantly, you need a good health IT system at the very beginning, to have the data capacity as a basis for policy making. Our every decision is based on quantitative evidence generated by our IT system. Taiwan invested heavily up front on health IT, and we have reaped the benefits of our powerful IT system ever since. The savings our IT system has generated have paid for the setup cost of that system many times over.

Cheng: What about solid economic development as a platform for the establishment of universal national health insurance—is that not equally important?

Minister Yeh: You are right. A country must establish national health insurance during good economic times. It should be noted that there are associated cost increases in the several years prior to the establishment of national health insurance. Fortunately, Taiwan had good economic growth for many years prior to the NHI’s implementation; so we were able to absorb the cost increases associated with its establishment.

Cheng: The election of President Barack Obama and a Democratic Congress in 2008 has given the U.S. another opportunity at major health reform—it is well known that the U.S.

has the highest health spending in the world (16.6 percent of GDP in 2007), and yet it leaves 15 percent (forty-six million) of its population uninsured. What, if any, of Taiwan's experiences with health reform may be relevant and useful for the U.S.?

Minister Yeh: My comments are that universal coverage improves equity, and contracting with all providers can improve access. Because we are a single payer, we can save a tremendous amount of administrative cost. As we discussed earlier, we also have a powerful IT system to help run the NHI efficiently. In the U.S. you have so many diverse providers, you could never hope in any way to integrate them into a coherent health system without an interoperable IT system. Precisely because we have a single-payer system, all

of our hospitals must follow the rule set by the single payer—there is only one set of rules. In the U.S. you have so many private health insurers, each with their own rules and nomenclature, that you spend a lot of money just on administration. Your records and images cannot easily be electronically transferred, and the whole system is fragmented and inefficient as a result. To us, government administration of the NHI is most important.

Perspective On The U.S. System

Cheng: If you were to give a lecture on the U.S. health system to college students in Taiwan, what major strengths and weaknesses of that system would you tell them about?

Minister Yeh: I thought about this question long and hard and concluded that where your system is better than ours is in the adoption of high technology, which is faster than it is in Taiwan. For example, the introduction of new drugs occurs on average two years earlier than Taiwan. For some technology, the U.S. leads us by five years. You are also way ahead in R&D. The U.S. spends a lot on R&D, and on medical education. Taiwan has eleven medical schools, but the best of them are only as good as the average American medical school. American

medical education is the best in the world. We simply have not spent nearly as much in training our doctors.

Thoughts On The Single-Payer Approach

Cheng: Finally, what do you think are the strength and weaknesses of the single-payer approach, now that Taiwan has lived with it?

Minister Yeh: A single-payer system has a single risk pool, since everyone is mandated to enroll. This enables cross-subsidization among diverse groups with not only different socioeconomic status but also different health status. In addition, the single payer wields monopsonistic power in procuring services and products—hence low prices for health care.

Taiwan's example also shows that while there is no choice of insurers, people enjoy complete free choice of providers. The latter compels the providers to be competitive and efficient. Furthermore, the administration of the single-payer system is simple, as there is one set of rules for everyone, whether it is regarding clinical protocols, quality indicators, fee schedule, etc.

However, there are some drawbacks to the single-payer system. Our system does not give us much room for flexibility and innovations in financing. For example, because of the ever-present political interference, it is difficult for us to raise the premium rate, permitted under the NHI Law, to maintain a balanced budget for the NHI.

Cheng: Thank you so much for sharing your insights with us on Taiwan's remarkable health system.

Minister Yeh: You are most welcome. It has been my pleasure.

NOTE

1. NT\$, short for the new Taiwan dollar (yuan), is Taiwan's currency. At the time of this writing, the spot exchange value of a U.S. dollar was about 32.93 new Taiwan dollars, or yuan.

“American medical education is the best in the world. We simply have not spent nearly as much in training our doctors.”