7. Social Factors –
A Paradise Lost in the Health Care Policy Process in Taiwan

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I. Introduction

The national health insurance (NHI hereafter) program of Taiwan, implemented in 1994, was a major step toward the establishment for Taiwan’s welfare state, and a major component that would comply to the fulfillment of the Copenhagen Commitments.

The NHI program caused a social movement to arise. The establishment of the program was arguably the most notable piece of legislation for decades, indeed, since the then-ruling Nationalist Party (Kuomintang or KMT) moved to Taiwan in 1949. Labor made its opposition to the NHI program heard by throwing eggs (and sometimes stones) at many of government officials and offices. Representatives of the industrial and commercial associations also took to the streets to voice their support for the new plan. Yet most surprisingly to many Taiwanese, the nation’s doctors, the “cream” of Taiwan’s society, marched with banners reading “Oppose to the communist medicine”. What made many people sorry was not only that doctors walked out on the streets, but also their wives and who rarely troubled themselves with

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And many in the academic community opposed to this legislation, too. One notable academician, now deputy minister of the Department of Health (DOH), even put forward a petition for people to sign, opposing the health plan.

The reasons for all this opposition were wide-ranging: labor called for lower premium rates and demanded employers pay more of the premium; the employer saw this legislation as nothing more than another “exploitation” of their pockets; the medical profession, whose leadership was historically close to the highest level of government felt their autonomy was under threat. And how about the academic community? Economists who subscribed to laissez faire ideology viewed the NHI as just another intrusion in people’s life. Sociologists, believing in “equality first”, wanted a system that relied not on premiums, but general taxes. Those who worked in the field of public health viewed the bill as a “disease insurance”, not really a “health insurance”, and claimed it would not aid public health.

By the time this bill was to enter the Legislative Yuan (Taiwan’s congress), the then-ruling KMT had faced strong challenges from the opposition party (the Democratic Progressive Party, DPP). The KMT went all out and twisted many arms to push the bill through the Legislative Yuan. The law went into effect on 1 March, 1995.

The NHI Act, nonetheless, has a number of merits in it. In contrast to previous legislation on providing health care insurance (such as the Labors’ Insurance, which I shall discuss later), the NHI introduced the concept of efficiency in health care utilization and delivery (Chen, 1995). Moderate co-payments were imposed to suppress excess demand, or so-called “moral hazard” on the part of the public; a referral system was attempted with a mechanism of differential coinsurance when a patient by-passes the service of a general practitioner and goes straight to the higher level of service; alternative payment systems were stipulated, and payment by case, payment by cash became legal, and now major reform is taking place in these areas as a way of cost containment in the NHI’s expenditure. And as a last resort, the DOH was authorized to put a budget on NHI’s expenditure, in the case that the expenditure gets out of hand (DOH, 1994).

Since those innovations were primarily economic, the NHI might be...
seen as “a success of economics” (Chen, 1996). Yet, I shall argue in this article, the NHI also represents a failure of political science and sociology, which were altogether absent in this legislation. This paper argues that many of the difficulties the NHI now faces are rooted in the absence of sociological perspective in the legislation and implementation thereof. And to make real reform possible, a sociological perspective must be taken into account to broaden the space of options.

II. Main Features of the Social Security System under the Authoritarian Regime

The KMT regime started a social security system soon after it took control of Taiwan. As many other nations had done, Taiwan’s social security system began with the chunk of the population that was the backbone of the national economy, and who would help in stabilizing the political situation. Therefore, labor (dependents not included) and public servants were among those who were covered first by the Labors’ and the Public Servants’ Insurance programs respectively. Farmers, employees of the private schools, and all levels of the lawmakers were later cover by various programs. By the time the NHI was implemented in 1995, those programs covered 51 percent of the population.

Under a then-authoritarian regime, those programs were public-run, and without a real exception, the programs operated in a deficit. Some of the programs were deep in debt. The red ink can be traced back to the modus operandi of the political economy at the time: as an authoritarian regime, the ruling KMT governed this land via a so-called Party-State system, which had tight grips not only on the state apparatus, but controlled a large part of the economy via a huge conglomerate of state enterprises (Tien, 1989). The regime also controlled virtually all aspects of society. And, the social security system was rendered part of the governing organ (Foo, 1995).

Under such circumstances, the KMT had many incentives at hand to make sure everyone towed the line. Many arms of the state, the Department of General Garrisons that enforced Martial Law was notable among them, looked over people’s shoulder. Public demonstrations were next to non-existence at the time. However, the KMT’s rule would not
last long if these strong arms were the single governing tool; it also utilized “carrots” as sweets to pacified the otherwise disgruntled people via a number of Keynesian economic policies and with profitable state-owned enterprise. The KMT promised to subsidize those social security programs, and therefore, any schemes for financial accountability were never taken seriously, and deficits were taken as a cost of maintaining rule. And the KMT administration never really made good on its promises on subsidization throughout its half-century tenure.

As I argued earlier, a number of financial safeguards were put in place for the new NHI program, and a financial accountability scheme was clearly laid out in the law. These merits, however, could only exist on paper as the system inherited prime characteristics from the old programs.

Despite that the NHI Act has innovated mechanisms that are supposed to enhance efficiency; it still possesses some serious drawbacks. Anachronism may be the word that would summarize many of the problems. The NHI was essentially modeled after the old programs in terms of the way it views the interfacing relationships between state and society. There is virtually no consideration of mechanisms that would facilitate conflicts of interests as if the state could do whatever it wished; no considerations on mechanisms that would bring the social forces into play, as if the society was still completely subordinate to the state. As a result, those economic innovations cannot really be carried out; alternative options for solving the problems are circumscribed, as the social forces find no access to this system.

1. Social development in Taiwan

The notion of society, or more precisely, of civic society, was a under-developed one in Taiwan. Historically, in Chinese society, family was virtually the sole prototype institution, and all the others were just replicates of it (Pye, 1992). Taiwan, having been exposed to some “exotic” experiences, might have some different cultural perspectives. Yet, the notion of society did not meet better soil to develop in Taiwan, either.

As the KMT government moved to Taiwan, the situation surrounding this newly defeated regime was grave: the native Taiwanese viewed them as a “foreign” regime, and the Communists on the other side of the
Taiwan Strait would do anything to get rid of it. In order to take hold on this island the government had to secure political legitimacy as well as economic soundness. Therefore, the KMT government, on the one hand, had to cater to a worldwide economic order by rendering Taiwan part of the world production system. On the other hand, it had to make the state apparatus the sole power center. Both did damages to the notion of civic society. The production in this island had to be organized into an export-oriented structure in which most of the production was to meet the demand of the world market. International conglomerates, with their high-tech know-how, ruled the nation’s production, and local business, or any products or production mode that sat well with the community’s culture and life were edged to the margin, or had to go extinct all together. The KMT’s organs were everywhere ion the society.

Things began to change during the 1970s when Taiwan was voted out of the United Nations, and the opposition was to rise in a big way. In order to secure legitimacy, the KMT government had to suppress the use of the strong arm tactics. Worse yet, incentives were reduced in number and in size as the Party State met tougher challenges both from inside and outside. And the KMT’s grip on society had to loosen, and the notion of civic society finally got the chance to see the light of day.

As pointed out earlier, public demonstrations were next to zero during that authoritarian age. Yet, demonstrations quickly became a way of life for many people in Taiwan. Anything could become the issue of the day, and tens of thousands of people could gather on the street, just for a single cause.

The age of a pluralistic society, eager to gain autonomy, had come.

Yet, the NHI Act failed to recognize all this, and the Act became a symbol of anachronism. The NHI was to be a public-run program, failing to recognize that the government had lost legitimacy as well as the resources to run such a huge, highly controversial program; the notion of co-determination, like that seen in the West European countries, was never considered. And as a result, it was difficult to get together the groups whose interests were on the line and come to a consensual agreement. Medical professionals, which did not really stand on their own feet during the authoritarian age, could not stand up and be counted as far as the health policies were concerned. The labor unions, for the same reason, were not true representation of labor, and could not play any active role in terms of the construction of the new health insurance
As democratization deepened in Taiwan, so did the capitalistic ideology. Just as political authority ruled before, now markets rule over all daily affairs. Society, though, did not have an equal opportunity to develop. At least, the society is not really ready to play a major role in taking on the formation of a health care system that better meets the needs of society.

2. How the NHI Has Fair

Since its implementation in 1995, the NHI has proudly accomplished many goals: nearly 100 percent of the population is now covered, and not every country can do that over such a short period of time; about 90 percent of the medical facilities are contracted, and accessibility is assured for most parts of the island; crushing financial stress was relieved for those whose family members came down with catastrophic diseases; administrative cost remains low, accounting for less than 2.5 percent of the benefit payments (DOH, 1998a). Despite these accomplishments, the NHI met a number of grave challenges: deficits are looming large and the program might become insolvent anytime; the abuse is believed to be on the order of more than 20 percent of the benefit outlay; the reimbursement incentives are so distorted that the structure of specialized health services is grossly out of balance. According to one survey, only six out of 1200 medical students who graduate annually would choose surgical specialties. As a joke goes, “In a few years, you might have to go to Japan for surgery. Or go to the Philippines for a cheaper one.”

Of course, the NHI Bureau has tried a number of measures: the co-insurance rates were raised as a way of suppressing “moral hazards”, the maximum income taxable for the premium has been raised; more and more procedures will be put under case payments (a version of DRGs); a global budget has been put on the dental services since July 1998, and a similar budget limit will be put on the sector of Chinese medicine, and finally the rest of the medical sector will be put under some sort of the lid.

The Department of Health is even considering a reform based on capitation. (DOH, 1998b) Should this notion materialize, the reform will look like another version of managed competition that has been tried in
other countries, notably in the Netherlands (Schut, 1995). Under these strategies, health alliances (the Taiwanese version of social HMOs) will be created, and the current Bureau will be downsized and made into one of the alliances.

These measures would be helpful. Yet, without certain social capital, the effects will be, at best, limited, and some of the measures might not even be workable. This in turn leads to the main theme of this article.

III. The Missed Social Perspective in the Making of Taiwan’s Health Policies

In this section, I shall illustrate my arguments by highlighting the following:

1. The medical profession did not live up to par, and therefore did not really measure up as the most important player for the making of health policies.

2. Community, along with the underdevelopment of civic society, has been in obscure existence, and therefore even the DOH considers a paradigm based on the concept of community care network (CCN) (Bogue and Hall, 1997) -- the community is not in a position to perform its role.

3. The hospitals have viewed themselves as economic units, with patient-days and number of visits as their “production”. They do not view themselves as social units, which is expected to generate social goods.

4. There is a dichotomy between the public sector and the voluntary sector; no mechanisms for cooperation are built in the system.

The Medical Profession

As pointed out earlier, physicians in Taiwan are the cream of the crop and have enjoyed a social status not comparable with other professions. Yet, the medical profession, or at least its leadership, has been conservative and failed to keep up with the social developments that have occurred around them.
Just like their colleagues around the world, medical professionals in Taiwan opposed the whole idea of national health insurance, for fear of losing their professional autonomy. The difference, though, is that the medical profession was unable to promote an alternative as a countervailing mechanism against the NHI. Rather, carrying the controversy onto the streets was about all they could do. By taking to the streets, the image of this profession was badly damaged and its prestige was hurt. With a damaged image, the profession had an even harder time negotiating with the NHI Bureau.

Moran and Wood (1993) argued that, an ideal physician must be a healer, a scientist, a professional, an entrepreneur, and a politician. Thanks to a medical education that paid no attention to social science and liberal arts, a doctor in Taiwan can be a good healer or an excellent scientist, but can rarely become anything other than that. In contrast, American doctors are able to develop a certain kind of medical ideology and with which they have successfully won over the government on the issue of health care. They are better politicians in the sense that they were able to communicate with the public and convince them of an ideology.

As the DOH considered a capitalization system based on something like HMOs, doctors fell into a great panic for they were not used to an environment in which risk-bearing was a fact of life. Certainly, entrepreneurship is in short supply.

And as a profession, there must be some intrinsic value that they must put before economic gains. One unintended consequence of the NHI, as pointed out earlier, is the imbalance of the specialties due to distorting incentives. Yet, there are still a small number of the medical students who, in the face of hard reality, chose a “disadvantaged” specialty for their career. It is legitimate to ask for a better reimbursement scheme, yet the medical profession itself should encourage their younger members to cherish the very core values of this calling.

The Hospitals

The hospitals in Taiwan, though officially non-profit organizations, have viewed themselves more as economic units than a social ones. The hospitals subscribed to a sort of expansionism and this has been more visible after the implementation of the NHI. Due to the distorting structure of incentives, outpatient services are more “profitable”, and the
hospitals rushed to set up a second out-patient centers, or even open a night shift of out-patient services. Mergers are everywhere. Taking advantage of the fee-for-service system of the NHI, many hospitals, and clinics, provide services that are not really medically necessary.

As argued by Shortell and others (1996), the hospital should be part of the community, working toward social good. The walls surrounding the hospital must be torn down, and the hospital must reach out into the community (Shortell, et al., 1995). Fee-for-service should not be the model, rather, the financial distribution should be based on the size of population in an area, adjusting for the differentials in risk factors. For this ideal to come true, the hospital must be a social, instead of an economic, unit.

**The Community**

The community as a concept has finally gained the attention in proportion to its importance in Taiwan. Community-oriented activities are now politically correct, and resources are made available in a scale that could not have been imagined previously. Yet, the efforts for constructing the community have not trickled down to health care. Community care is now still in the primitive stages; elements are not yet put together for community care networks.

In the wake of several decades of inflation in healthcare expenditures, health workers called for a change in the focus: high-tech, disease-oriented medicine must change to a public health–centered, population-oriented one. This is especially true if one considers the massive need for the long-term care in the near future. And the community is the center stage for this change.

**The Dichotomy between Public Programs and Volunteer Organizations**

The growth of the volunteer organizations in Taiwan has been impressive over the past several years. One is only awestruck by the energy, enthusiasm, and resourcefulness of these volunteer organizations, especially the Buddhist Tzu Chi Charity, during the reconstruction for the 1999 earthquake in Taiwan.

This abundance of volunteer organizations, however, has yet to find a
constructive way of working together with the public sector to produce social good. There is sometimes tension between these two sectors. Trust must develop between them.

IV. Concluding Remarks

Despite impressive progress over recent years, the notion of society, or civic society to be more specific, is still underdeveloped in Taiwan. This, in turn has, set limitations on the scope of healthcare reform: a medical profession that did not live up to standards is unable to play an affirmative role in the making of healthcare policies; hospitals viewing themselves as economic units will not produce social good; a community that lacks in some essential elements cannot serve as a vehicle for a community care network; mechanisms need to be developed to bring volunteer organizations to work together with the public sector.

This article does not portray a pessimistic picture. As pointed out earlier, the NHI has accomplished many of the goals envisaged by its creators, and these accomplishments are in line with what the Copenhagen Commitments called for, namely creating an environment for social development; eradicating financial barriers for the indigent, and promoting social integration. This paper pointed to a number of directions in which we can work to bring back the social perspective into the making of healthcare policies, and by so doing, broaden the scope for healthcare reform.

References


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