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Designing publicly funded healthcare markets – Note by Chinese Taipei

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More documents related to this discussion can be found at

http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm

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Chinese Taipei

This report mainly introduces the publicly funded healthcare planned by Chinese Taipei, and shares law enforcement experiences with healthcare service competition.

1. Chinese Taipei's Healthcare Industry

1.1. Implementation of National Health Insurance

1. Chinese Taipei began implementing National Health Insurance (NHI) in March 1995 as a mandatory social insurance[1]. Citizens have enjoyed equal rights to healthcare since participating in NHI, and healthcare institutions contracted by the National Health Insurance Administration (NHIA) provide healthcare services when insured persons become sick or injured, or give birth, and then report their healthcare expenses to the NHIA. While citizens are not required to pay the healthcare expenses when they go to the doctor, they still need to bear "administrative registration fees" and "items not covered by the NHI", as well as the transportation fees for going to the healthcare institution or transferring to other healthcare institutions. Healthcare services provided by the NHI include outpatient services, inpatient services, Chinese medicine, dental services, and other services related to childbirth, rehabilitation, homecare, and chronic mental illness rehabilitation. The scope of treatment and care includes diagnosis, examination, testing, consultation, surgery, medication, special materials, treatment, nursing, and insurance wards.

1.2. 93% of Healthcare Institutions (Hospitals and Clinics) are Contracted by National Health Insurance

2. Healthcare expenses accounted for 3.6% of Chinese Taipei's GDP in 2016. In 2016, there were about 22,384 contracted healthcare institutions[2], of which 490 were hospitals, 83% of which were private hospitals and 17% were public hospitals. There were about 20,000 clinics, of which 98% were private clinics and 2% were public clinics. About 93% of healthcare institutions in Chinese Taipei have joined the NHI, and provide

[1] In principle, insurance premiums are shared by the insured person, insured unit, and the government, but the sharing ratio may vary for different subjects. For employees, the premium sharing ratio is such that the insured person (employee) bears 30%, the insured unit 60%, and the government 10%. For employers, the insured person (employer) bears the whole amount of the insurance premium.

[2] Categories of healthcare institutions in Chinese Taipei include: 1. Hospitals: Hospitals, chronic illness hospitals, psychiatric hospitals, Chinese medicine hospitals, dental hospitals, and hospitals for the compulsory treatment of sex offenders; 2. Clinics: Clinics, Chinese medicine clinics, dental clinics, medical rooms, and public health centers; 3. Other healthcare institutions: Blood donation institutions and pathology institutions. Healthcare institutions shall be registered with the local competent authority of health and have a business permit in accordance with the Medical Care Act and Establishment Standards for Medical Institutions before practicing healthcare.

accessible healthcare to citizens. Furthermore, about 99.7% of citizens are covered by the NHI, which is designed with a no gatekeeper system[3], allowing citizens to freely choose where they want to seek medical attention. Hence, the healthcare market of Chinese Taipei is characterized by fair competition.

2. Publicly Funded Healthcare Markets

2.1. Implementation of Multiple Payment Systems

3. The NHI payment system has adopted a third-party payment mechanism, and established a unified payment standard based on healthcare services covered by the NHI, so that the NHI payment system is reasonable and fair. Furthermore, the NHIA began implementing the global budget system[4] in July 2002, maximizing the use of healthcare resources with a limited budget. Various payment strategies were developed under the global budget system, such as case payment, pay for performance, integrated care, and Chinese Taipei Diagnosis Related Groups (Tw-DRGs), which control healthcare expenses within a reasonable range while ensuring the quality of healthcare services.

4. Chinese Taipei established a quality assurance program to ensure the quality of healthcare services provided by each department under the global budget system. The evaluation results for healthcare institutions are used in global budget negotiations for the following year, and administrative review procedures, the self-discipline of service providers, peer reviews, and the establishment of clinical practice guidelines ensure the quality of healthcare provided to citizens.

5. Furthermore, Chinese Taipei continues to introduce new healthcare services in coordination with healthcare technology developments and actual clinical needs. The payment standards for relatively imbalanced items, such as critical care services, are appropriately adjusted after budget allocation. After the global budgets are discussed by healthcare institutions, then the healthcare services covered by the NHI and payment standards are revised together with representatives of agencies, experts, scholars, insured persons, employers, and providers of healthcare services covered by the NHI, in order to provide insured persons with the most suitable healthcare services.

2.2. Avoiding Wastage of Healthcare Resources

6. The healthcare expense review system is a necessary mechanism of the NHI to avoid wasting healthcare resources and ensure healthcare service quality. The review of healthcare service cases focuses on the items, quantity, and quality of healthcare services. Computer and data analysis technologies are used extensively to rapidly review the data submitted by healthcare institutions. The computer screens abnormal cases for review and management to increase review efficiency. Due to the large number of cases under the NHI, medical records are randomly retrieved and reviewed by medical and

[3] The gatekeeper system is a referral system where basic level physicians are responsible for examining and referring patients to a suitable healthcare institution.

[4] Procedures for implementing the global budget system begin before the start of each year. Healthcare institutions and payers negotiate the global budget for healthcare expenses in the following year based on the content of healthcare services.

pharmaceutical experts. A digital review is currently being promoted to strengthen the smart review system, helping medical and pharmaceutical experts carry out more accurate reviews and avoid wasting healthcare resources, thereby protecting the safety of insured persons and ensuring the quality of healthcare services.

7. Chinese Taipei continues to integrate care services, including the Family Doctors Integrated Care Initiative and the Patient-Centered Integrated Care Program, in the hope of improving cooperation between departments in a healthcare institution or between healthcare institutions, so that they may utilize their expertise and reduce the repetitive use of medications, diagnosis, and treatment. Starting in 2017, resource integration efforts have been expanded to encompass nationwide healthcare resource sharing, thereby encouraging healthcare institutions to upload patients' treatment, prescription and examination (testing) data to the NHI healthcare information cloud system, so that it may be accessed by other healthcare institutions when other doctors treat the same patient. This will reduce unnecessary and repetitive treatment, medication and examinations (tests).

8. Chinese Taipei has established a healthcare classification system to promote the balanced development of healthcare resources, and uses six strategies: (1) Enhancing basic healthcare service capabilities, (2) Guiding citizens' referral habits and adjusting the portion paid by patients, (3) Raising the critical care payment standard of hospitals, and guiding hospitals to reduce services for minor symptoms, (4) Strengthening cooperation between hospitals and clinics to provide continuous care services, (5) Enhancing citizens' self-care knowledge and capabilities, and (6) Strengthening healthcare institution management. The strategies drive the reasonable distribution of healthcare institutions and personnel to facilitate the division of labor and cooperation.

2.3. Hospital Evaluation System

9. Based on the core values of "patient safety" and "healthcare quality" expected of hospitals, the Ministry of Health and Welfare (MOHW) began conducting hospital evaluations, teaching hospital evaluations, and psychiatric care institution evaluations in accordance with the Medical Care Act in 1988. Visits are made to qualified hospitals for follow-up and guidance to continue monitoring the healthcare service quality of hospitals. Hospital evaluations include administration and healthcare; teaching hospital evaluations include teaching resources and management, teacher training, interdisciplinary teaching and academic exchanges, research and teaching results, and the training results of clerks, doctors, and other students and medical personnel. Hospital evaluation results are divided into "qualified" and "excellent", and there are three levels for necessary and key items, such as manpower allocation, environmental safety, equipment repair, and crisis management, specifically "excellent", "compliant" and "non-compliant or requires improvement". The above-mentioned evaluation results are announced on the MOHW's website for the consideration of citizens when choosing a healthcare institution.

10. Furthermore, the MOHW began implementing the hospital emergency medical classification system in 2009, requiring hospitals with first aid responsibility to provide appropriate emergency medical services based on their emergency medical classification, and they may not delay services without proper cause. Starting in 2018, the 199 hospitals nationwide with first aid responsibility were incorporated into 14 emergency referral networks based on areas where patients live, where they seek medical attention, and the hospital's emergency medical classification. Each network has a hospital with critical first aid responsibility as the base hospital, and integrates hospitals with moderate and

general first aid responsibility in the network to provide emergency room patients with upward, parallel, and downward referral services.

2.4. Healthcare Information Disclosure – Reducing Information Asymmetry between Doctors and Patients

11. Disclosure of information on healthcare quality: In addition to the hospital evaluations described above, Chinese Taipei also regularly discloses information on healthcare quality. Citizens can access related information on the NHIA's website before seeking medical attention. The disclosure of healthcare quality information encourages contracted healthcare service providers to improve the quality of healthcare services provided by individual healthcare institutions, and improves citizens' understanding of healthcare quality and use, which they consider when they are choosing a healthcare institution.

12. Establishment of the My Health Bank system: Citizens can use the system to rapidly access their most recent medical records, examination and test results, and preventive healthcare data for the self-management of their health. Doctors can also refer to the data when citizens are seeking medical attention, reducing the information asymmetry between doctors and patients, and increasing the safety and effectiveness of healthcare.

13. Accessing information on other healthcare institutions: Basic information on healthcare institutions in Chinese Taipei that are disclosed on the Internet for public access include the location of the healthcare institution, registration fee, services, departments, clinic hours, and violations. Furthermore, healthcare institutions that apply for healthcare expenses over a certain amount are required to disclose their financial statements for joint supervision by all sectors.

3. Competition in Healthcare Services is Mainly Non-price Competition

14. The establishment of healthcare institutions (hospitals and clinics) requires approval from the competent authority of health in accordance with the Medical Care Act. In 2016, there were about 22,384 contracted healthcare institutions, of which 97% were private healthcare institutions and 3% were public healthcare institutions. About 93% of healthcare institutions in Chinese Taipei joined the NHI. Hence, even though healthcare institutions are divided into public and private healthcare institutions based on their organization, payment by the NHIA to the healthcare institutions for citizens' medical expenses are based on a unified standard under the NHI system. Moreover, healthcare services covered by the NHI are the main source of income of healthcare institutions. Although healthcare institutions may set their own standards for the "administrative registration fee" and "healthcare services not covered by the NHI", such as vaccines[5], price differences of wards, medications and tests not covered by the NHI,

[5] For vaccinations required when citizens are traveling to high-risk countries or regions, due to special medical requirements, or as required by specific subjects, the government imports vaccines on a case-by-case basis, mainly to ensure that specific groups are able to gain the vaccines and immunity they need. Vaccines are usually in short supply in the international market, and it is difficult for Chinese Taipei to purchase vaccines, which are usually more

the municipality and county (city) competent authority announces the maximum healthcare fee (cap) that may be charged by healthcare institutions in accordance with Article 21 of the Medical Care Act. Hence, there are still considerable limitations imposed on their price competition. In other words, public and private healthcare institutions in Chinese Taipei can only engage in price competition in relation to the "administrative registration fee" and "healthcare services not covered by the NHI" due to the constraints of the National Health Insurance Act and Medical Care Act. Therefore, price is not the focus of competition between healthcare institutions, and both public and private healthcare institutions mainly engage in non-price (quality) competition. The quality competition strategies adopted by healthcare institutions include the acquisition of new equipment, attracting outstanding professionals, and improving the hospital's evaluation results.

15. In addition, the competent authority of competition law in Chinese Taipei has made dispositions related to the concerted actions of medical associations, such as jointly deciding to raise the registration fee and limiting basic level doctors to taking Sundays off every other week, but such cases are very rare.

4. Conclusion

16. With the implementation of mandatory national health insurance in Chinese Taipei, 99.7% of all citizens now participate in the NHI, which provides complete coverage, high accessibility to healthcare, and low premium rates. Multiple payment systems, a healthcare expense review system, and a national healthcare resource sharing and healthcare classification system are utilized to effectively control healthcare expenses, avoid wasting healthcare resources, and also maintain healthcare service quality. Overall, the NHI provides complete healthcare and has gained high satisfaction among citizens. As for competition in healthcare services, public and private healthcare institutions in Chinese Taipei can only engage in price competition in relation to the "administrative registration fee" and "healthcare services not covered by the NHI" due to the constraints of the National Health Insurance Act and Medical Care Act, and there are still considerable constraints on such fees. Therefore, there are very few cases of competition law violations in the healthcare service market, and the only cases are those where medical associations jointly decide to raise the registration fee and limit basic level doctors to taking Sundays off every other week. In practice, the healthcare service market of Chinese Taipei mainly engages in quality competition.

expensive, due to the small domestic market and not being an infected area. Better prices and a more stable supply of vaccines can be secured by having the government sign procurement contracts with vaccine manufacturers.