

Cross-National Comparison of Taiwan, Japan, US, and UK's Health Insurance System

Yu-Ying Kuo

Associate Professor and Chair

Department of Public Policy and Management

Shih Hsin University, Taipei, Taiwan

yykuo@cc.shu.edu.tw

Abstract

Health care system has been closely related the life quality of human beings. In Taiwan, National Health Insurance (NHI) set off in 1995, which has been in name of social insurance but conduct in the way of social welfare. NHI is compulsory policy and every citizen is requited to join. NHI covers medical payment to the hospitals, and insurance revenue comes from employer, employees and government's payments.

In Japan, employees' health insurance began in 1922 and national insurance started in 1932. Citizens with specific jobs in private, public and non-profit sectors join the former, and the rest, including self-owners, farmers, fishers, or the ones in agricultural sectors have to join national insurance program. Japan's insurance payment includes medical and cash payment, which different from Taiwan system and benefit insurants while they are in medicine.

US and UK's health insurance systems are quite different. US health insurance has been market-oriented and commercial, except Medicare and Medicaid under the Social Security Act offering health care to the aging people and low-income family. Centers for Medicare and Medicaid Services (CMS), which is consist of the Center for Beneficiary Choices, the Center for Medicare Management and the Center for Medicaid and State Operation, is responsible for monitoring and delivering the service. Medical payments are general regulated by federal law, but every state government

has its own detailed implementation by state law.

By contrast, UK's National Health Service (NHS) has been totally government funded and all medical service has been provided by the public sector. The Secretary of State for Health (SoS) and the Department of Health are policy-planning centers, while NHS Executive (NHSE), Strategic Health Authority (StHA) and Primary Care Trust (PCT) are responsible for health policy implementation.

This paper cross-nationally compares health insurance experience of Taiwan, Japan, US and UK's health insurance system. Dwight Waldo pointed out: Reciprocal learning, mutual adjustment, institutional invention may be speeded, and a world unified but not unitary, harmonious but not homogenized, may develop. It is expected that reciprocal learning and mutual adjustment of difference countries' experience can achieve better health for well-beings.

Key Words: Social Health Insurance, National Health Insurance, Medicare, Medicaid, National Health Service

I. Introduction

Health care system has great influence on the life quality of human beings. In Taiwan, National Health Insurance (NHI) set off in 1995, which is compulsory policy and every citizen is required to join. In Japan, employees' health insurance began in 1922 and national insurance started in 1932. Citizens with specific jobs in private, public and non-profit sectors join the former, and the rest, including self-owners, farmers, fishers, or the ones in agricultural sectors have to join national insurance program. US and UK's health insurance systems are quite different. US health insurance has been market-oriented and commercial, except Medicare and Medicaid under the Social Security Act offering health care to the aging people and low-income family. Centers for Medicare and Medicaid Services (CMS), which is consist of the Center for Beneficiary Choices, the Center for Medicare Management and the Center for Medicaid and State Operation, is responsible for monitoring and delivering the service. Medical payments are general regulated by federal law, but every state government has its own detailed implementation by state law. For instance, Medicare payment covers Hospital Insurance (HI), Supplemental Medical Insurance (SMI), Medicare + Choice Managed Care (M+C) by federal law, but has different percentage of payment by state law. By contrast, UK's National Health Service (NHS) has been totally government funded and all medical service has been provided by the public sector. The Secretary of State for Health (SoS) and the Department of Health are policy-planning centers, while NHS Executive (NHSE), Strategic Health Authority (StHA) and Primary Care Trust (PCT) are responsible for health policy implementation.

This paper introduces Taiwan, Japan, US and UK's health insurance respectively and then cross-nationally compares the health insurance design, organization type,

payment, benefits and problems of each system.

II. Taiwan Experience

In February, 1986, Premier Yu Kuo-Hua made an important announcement in the Legislative Yuan, who declared that the government will realize national health program by the year 2000. Following the announcement, the Executive Yuan instructed the Council for Economic announcement, the Executive Yuan instructed the Council for Economic Planning and Development in July 1988, to organize a task force to study the policy. As the ambitious policy was new to Taiwan, several domestic and foreign scholars were invited to conduct the study. By July 1994, the task force drafted “National Health Insurance Bill,” and was presented to the Legislative Yuan for debate, which approved the policy a year later. The president soon signed the bill to become law. In the past there were 13 different health insurance schemes, including government employee's insurance, labor's insurance, farmer's insurance and military personnel insurance, only 59% of the population enjoyed coverage, with about 8 million people left out of the system. Most of these were children under the age of 14 and seniors over the age of 65. To implement the ideal of a national health care system, the government launched the National Health Insurance program in March 1995 to look after the health of the entire population, creating the Bureau of National Health Insurance (BNHI) as the responsible agency for overall planning.

The ten years between 1986 and 1995 were the critical years that Taiwan transformed from an authoritarian regime to a democratic system. To cope with new challenges from an open society, the ruling clique learned to compromise with outside forces, including the long suppressed legislative system, native forces, business,

opinion group, and even technocrats, which promoted those groups to an unprecedented importance. NHI was regarded by many as Taiwan's most important policy on people's life in the past forty years. It relates to a wide range of social activities, and the amount of money involved has been astoundingly high.

With respect to the policy process, NHI policy planning belongs to the Department of Health; NHI policy implementation is the main duty of the Bureau of National Health Insurance; and NHI policy evaluation is usually conducted by both. The responsibilities of the Department of Health and the Bureau of National Health Insurance are stated below.

Department of Health and Operational Team

The Department of Health (DOH) of the Executive Yuan is the competent authority for the NHI. Under the DOH are the NHI Supervisory Committee, the NHI Disputes Mediation Committee and the NHI Expenditure negotiation Committee, the NHI Task Force as well as the BNHI. In addition, the head office of the BNHI is responsible for system planning, promotion, implementation, supervision, research and development, manpower development, information management and auditing. To effectively manage the work of the BNHI and improve operating efficiency, six branches were set up to directly handle underwriting operations, insurance premium collection, review and payment of medical claims and management of NHI-contracted medical care institutions. Later, 21 liaison offices were added. On the personnel side, as of the end of June, 2006 there were 2,505 permanent staff and 517 temporary employees in the BNHI (head office, branch offices and outpatient center) for a total

of 3,022 persons¹. The entire staff devotes their efforts to providing the population with the best health care possible. To provide the public with convenient and comprehensive medical care, NHI services include western medicine, Chinese medicine, dental care and hospital care as well as preventive health and child delivery services to meet the public's diverse medical needs.

Bureau of National Health Insurance (BNHI)

With the implementation of the NHI in 1995, the public has obtained comprehensive medical care such as health prevention, clinical care, hospitalization, resident care and social rehabilitation. Starting from the Year 2000, the BNHI was committed towards establishing a proactive management-style for the National Health Insurance Program, upgrading healthcare services and public satisfaction levels, as well as providing excellent healthcare services. BNHI also implemented "directional management," firmly established annual objectives and integrated this with various annual plans, strengthening operating substance, effectively utilize resources, and continuing to seek quality improvements in both internal and external services.

The BNHI expressed its visions and missions as follows:

Visions of BNHI

- (1) Purchasing Health, not Healthcare for the Public;
- (2) Universal coverage;
- (3) Excellent quality of care;
- (4) Care to disadvantaged groups;
- (5) Financial stability.

Missions of BNHI

¹ NHI information and related figures are from <http://www.nhi.gov.tw/>

- (1) Health insurance for the public;
- (2) Upgrading quality of healthcare services;
- (3) Establishing partnerships among the medical, pharmaceutical and healthcare Community;
- (4) Using knowledge to create values,
- (5) Creating a virtual competitor and upgrading service efficiency.

In Taiwan NHI is a compulsory social insurance program with the entire population enrolled in the program. Therefore, a fair share of risk-pooling and extensive collection of financial resources for NHI can be expected. In return, all of the insured are provided with the right to equal opportunity of access to healthcare services. All citizens who have established a registered domicile for at least 4 months in the Taiwan area should be enrolled in NHI. After paying premiums and obtaining NHI cards, the beneficiaries of NHI are entitled to receive comprehensive medical services. Services are available at contracted healthcare institutions such as hospitals, clinics, contracted pharmacies, and appointed medical laboratories, in the case of illness, injury, or childbearing. In addition, to provide continued long-term nursing and medical care, the BNHI has also included home care and hospice care within the scope of National Health Insurance. In addition to providing health care services to insured, the BNHI also provides a portion of its expenditures to health prevention services for children, adults 40 years of age and above, pregnant women and for other women's diseases. The reasoning behind this is the fact that BNHI believes prevention is better than just treatment. These expenditures would help these groups discover their diseases early and seek treatment sooner to better maintain their health. In 2006, with the medical establishment and the public working hand in hand, the system is solidly entering its 12 year of operation. For the future, the BNHI will, to the best of its ability, continue looking for opportunities for reform and pledge itself to the

continuing development of a bright future for the entire population.

Complete Medical Care

The NHI provides the public with comprehensive medical care. Clinic and hospital payments include physician's diagnosis, examination, laboratory testing, surgical operations, prescriptions, medicines, materials, treatments, nursing care, rehabilitation and hospital stays. In terms of facilities, as of June 30, 2006 there were 18,045 NHI-contracted medical care institutions or 91.23% of all medical care institutions in Taiwan. In addition there were 4,068 NHI-contracted pharmacies-486 contracted home care institutions, 128 contracted community psychiatric rehabilitation service institutions, 22 midwifery institutions, 210 contracted medical laboratories, 25 physical therapy institutions and 6 nuclear medicine institutions. By simply enrolling in the NHI system and paying the premiums, the insured receives a NHI IC card. Afterwards, with this card, the insured can go to an NHI- contracted hospital, clinic, pharmacy or medical laboratory to be treated and receive comprehensive and appropriate medical care for illness, injury or receive medical services for childbirth. The NHI system is a mandatory social insurance program whose main purpose is to ensure that everyone is insured and is entitled to the rights of equal access to medical care services. All citizens holding ROC nationality or those registered in the Taiwan Area for more than four months (newborns in the Taiwan Area need only have a household registration of birth) are required to be enrolled in the NHI. Foreigners (including those from Hong Kong, Macao and mainland China) meeting the regulations of the NHI Act and holding alien residence certificates as announced by the competent authority, with the exception of employees of definite employers who must be enrolled in the NHI program from the first day of

employment, and the rest must be enrolled four months after their alien residence certificates are obtained in order to guarantee their right to have medical treatment.

Co-Payments and Global Budget

The majority of the NHI budget goes to medical expenses. The main source of income for the program is the premium revenues collected from the insured, insuring agencies and government subsidies at 38%, 37% and 25% respectively. Since the inception of the NHI to June 30, 2005, there have been a number of adjustments in the co-payment systems for outpatient and emergency care services. To encourage the public to visit community clinics for mild conditions and to refer to a tertiary hospital only if advanced examinations and treatment are needed. In order to promote the effective utilization of health insurance resources, on July 15, 2005, a referral system was initiated and revisions to the hospital outpatient co-payment system were made at the same time. In the early days, the NHI paid medical fees to healthcare providers on a “fee-for-service” basis. Currently the “case-payment” method has been gradually introduced and the global budget payment scheme has been promoted at the same time to improve the service quality of primary care. The global budget payment scheme was promoted phase by phase from dental services to Chinese medicine then western medicine primary care, and eventually to hospitals. The system was universally implemented in all medical care institutions by July 2002. To ensure the best possible outcomes for the global budget payment scheme, the BNHI has been working in collaboration with medical organizations to carry out quality assurance programs to supervise medical care providers enrolled in the system to provide the highest quality health services. In addition, based on the concept of purchasing not only medical care but also health, since 2001 the NHI has promoted the Medical

Benefit Payment Improvement Project to induce medical institutions to create for the public a comprehensive healthcare environment. Currently this project includes five diseases, namely, breast cancer, tuberculosis, diabetes, asthma and hypertension.

With the global budget payment scheme completely in place, the model for negotiating medical fee budgets for each fiscal year has stabilized. The current process is as follows:

1. Research: The medical community and the BNHI present health care and budget proposals for the fiscal year based on the DOH policy objectives.
2. Evaluation: (1) The NHI Medical Expenditure Negotiation: Committee convenes the quality and performance appraisal meeting, requesting experts and academics to review and evaluate each budget area. (2) If a score of excellence or higher is received upon review, a reward will be given during budget negotiations to provide incentives to health care providers to continually improve the quality of their care. Quality assurance funds are distributed based on scores of individual providers.
3. Negotiations: Following DOH deliberations on fiscal year medical fee growth rates, budget negotiations are conducted within the parameters established. The results of these negotiations for the years 2003~2007 are as follows: (1) Total individual medical fee growth rates for providers of dental care, Chinese medicine care, western medicine primary care and hospital care are determined, including budget for each plan, objective and monitoring methods.(2) The overall global budget of the year is announced following DOH approval.
4. Implementation and monitoring: (1) Once the global budget is determined, providers of each service draft a concrete implementation plan and monitoring program for the negotiated items and send them to the NHI Medical Expenditure

Negotiation Committee for reference. In addition, providers complete related legal procedures. (2) The NHI Medical Expenditure Negotiation: Committee follows up the status of implementation and monitoring, and when necessary, performs reviews and revisions. Results are used as reference for the next fiscal year's budget negotiations.

To ensure the sustainable operation of the NHI, the global budget payment scheme is under review and a series of reasonable payment standards are being formulated. Aimed at providing the same compensation for the same disease, payment standards have been gradually adjusted moving toward a unified, standardized system, along with Diagnosis Related Groups (DRG) methods. In addition, the concept of “health investment” has been introduced to strengthen links with the public health system. The related global budget payment scheme has been carried in three ways. First, implementation of the NHI financial responsibility system maintains a balance of income and expenditure. Second, as a macro adjustment mechanism, the global budget payment scheme must utilize micro-level measures on payment standards, such as case-payment and quality-based payment plans, in order to achieve the goal of changing diagnostic and treatment behaviors and ensure the reduction of waste. Third, professional medical groups must practice self-disciplinary measures to bring about systematization of reviews and auditing and through feedback from case analyses and peer pressure to keep fees under reasonable control and upgrade quality.

After implementing the global budget payment scheme, the level of health care quality can be met with the expectation of the general public. Through long-term oversight of professional medical care quality, the BNHI can carry out problem analysis and draft relevant strategies to achieve the goal of assurances on healthcare quality. The BNHI also issues quarterly reports on its long-term oversight of general

healthcare quality. It also informs each branch office and each government unit receiving authorized global budget funding of the report, focusing on improvements in drafting counter-measures for anomalies. In the future the Bureau will further develop “disease specific” healthcare quality indicators and make the results public. By making this public, the Bureau will encourage all institutions to engage in healthy competition and improve quality.

III. Japan Experience

In Japan, with some collaboration from the International Labor Organization, Japan enacted the first Health Insurance Law in 1922. Since it applied to all employees of industry, with five or more workers, plus their dependents, it may be called Employees Health Insurance (EHI). National insurance started in 1932. Citizens with specific jobs in private, public and non-profit sectors join the former, and the rest, including self-owners, farmers, fishers, or the ones in agricultural sectors have to join national insurance program. Ministry of Health and Welfare (MOHW) in Japan was established in 1938. The ministry was reorganized in the postwar period of occupation. Many of its functions concern welfare, pensions, and social activities, and in the health field its scope is extensive. Much of the work of MOHW is carried out through peripheral government agencies, which it supervises. Japan is divided into 46 prefectural governments and 26 larger municipal governments. Many of the preventive health services are provided through a nationwide network of health centers, staffed by physicians, pharmacists, public health nurses, midwives, health educators, sanitary inspectors, and others. The first health center law was enacted in 1937, and the costs of construction and operation of health centers are shared between the central and local governments. Since these facilities provide a full range of

preventive services without charge, private physicians -- paid under various health insurance programs, usually with substantial copayments required -- are seldom called on for preventive work.

The national resources for treatment of the sick in Japan belong mainly to a private market of medical care. There are thousands of physicians, dentists, and allied health personnel, hundreds of hospitals, clinics, pharmacies, and other facilities that provide services, even though nearly everyone is insured under various statutory programs. For ambulatory care, private arrangements are predominant. For a large portion of hospital care, however, physicians serve as institutional employees, the same as technicians, nurses, and others. In either case, the health insurance organization pays for the service on an itemized fee basis. Pharmaceutical procedures are also part of the private market. They are often dispensed by a private physician, but may be sold and purchased in a pharmacy. The drugs are manufactured by large pharmaceutical companies in Japan or imported from companies abroad. If laboratory tests or x-rays are required by an ambulatory patient, they also must be obtained from a private facility for a charge.

The administration of EHI could be handled in either two ways. If the plant had 300 or more employees and more than half of them agreed, the employer could establish a health insurance society; about 1800 such company-based societies were established. People in firms with few than 5 employees could enroll in a health insurance voluntarily. For employees in enterprises between 5 and 300 workers, the EHI was administered directly by the government through a unit of the MOHW. In addition, the MOHW later administered a causal worker's health insurance program and a program for seamen, based on legislation enacted subsequently.

The several types of health insurance in Japan, of course, provide extensive purchasing power for physician's care, drugs, hospitalization, and other health

services. Virtually all of these are paid for fee-for-service patterns, even for the services of full-time hospital-based specialists, who receive salaries. As a result, the delivery of medical care in Japan is subject to a great deal of abuse from overservicing.

In a rapidly developing industrialized economy, Japan has produced a large stock of health manpower, facilities, pharmaceuticals, and advanced technology. To promote environmental and personal prevention, it has developed a large national network of well-staffed health centers. To ensure that medical and hospital services are economically accessible, it has gradually built up a many-faceted program of social insurance. Yet to control utilization and limit expenditure, numerous copayments are required. Despite all the collectivized financing, the delivery of medical services is largely by private providers—physicians, dentists, pharmacies, hospitals. In the interests of efficiency, hospitals are staffed by full-time salaried personnel, including physicians. Yet the payment for both ambulatory and hospital care is entirely on a fee-for-service basis. Government regulation is quite limited, and public medical services are confined to prevention. The Japan Medical Association is politically very influential at the national level, as well as in the prefectures, cities, and towns. The total socioeconomic setting of the country, the people's personal life-styles and culture, as well as the health system, the population of Japan has achieved a remarkably good record of health and long life (Roemer, 1991).

IV. US Experience

The national health system of the United States embodies several major features. First, as an affluent industrialized country, the U.S. has abundant resources, and it spends a great deal of money in its health system. Second, as a federated nation, it

governs its system in a highly decentralized manner through numerous states, counties, and communities. Third, as a nation with free market economy, it incorporates very permissive *laissez-fair* concepts throughout its health system (Roemer, 1991).

Department of Health and Human Service

The Department of Health and Human Service (DHHS) is responsible for the nation's massive programs of social security and public assistance, as well as for most aspects of health. Within this department is a vast organizational structure to handle the program of the U.S. federal government in health resource development, health services, health research, health care financing epidemiological surveillance, health planning and regulation, and other governmental function within the national health system. In DHHS, many responsibilities are fulfilled by allocating money and delegating authority to numerous other public and private entities throughout the nation. The U.S. constitution grants the states a great deal of authority and responsibility in all social affairs, including health. Relatively few health functions are carried out directly at the national level; these include such tasks as the health examination of immigrants, regulation of drugs that move in interstate commerce, special epidemiological investigations, compilation of national health statistics, or medical services to American Indians. Health functions carried out by the states, for which the federal DHHS gives financial grants, include communicable disease control, environmental sanitation, preventive maternal and child health services, health manpower training, health facility construction, medical care of the poor, health service research , and several other fields.

In very broad terms, more than 60 percent of all U.S. health expenditures come from private sources, and less than 40 percent come from all public or public sector

sources, which epitomizes the entrepreneurial characters of the U.S. health system and help explain many aspects of its delivery patterns. The U.S. is the only affluent industrialized country in which less than half of health expenditures come from government sources and more than half from private sources.

General U.S. government revenues, as a source of health expenditures, include taxation levied at several political levels. The breakdown in 1980 was roughly 56 percent from federal government sources and 44 percent from state and local government sources. The major health function, on which both federal and state revenues are spent, is for medical care of the poor, principally through Medicaid. Federal taxation revenues are derived mainly from individual and corporate income taxes. State revenues come mainly from income and sales taxes. Local government revenues are derived mainly from taxes on property. The long-term trends have been toward an increase in the federal share of government health expenditures, although in the 1980s this trend was changed.

Medicare and Medicaid

The U.S. comprehensive health planning law of 1967 was passed as a sequel to the first national social insurance for medical care of the aged (Medicare) and the large public medical care program for the poor (Medicaid). Medicaid, which is administered by the federal government, with the assistance of about 150 private fiscal intermediaries, has two aspects. One is the mandatory hospital insurance for the elderly beneficiaries of the social security program. The other is the nonmandatory but government insurance for doctor's care and certain other medical service for the same population of elderly persons. The latter make direct payments to hospitals, doctors, and others on behalf of the government. Much smaller in their total

expenditures are the 50 state program of worker's compensation for occupational injuries or illnesses; each of these state programs is different, but a common feature is the payment of insurance premiums only by employers. The relevant expenditures are those made for medical purposes, and not for wage replacements during disability. Significantly, the need for general health planning was not appreciated until a substantial amount of health money was to pass through government channels. With such public visibility of health expenditures, one can appreciate that there would be political concern that the funds be wisely spent, greater than such concern for purely private expenditures.

The highly permissive and entrepreneurial character of the U.S. health system suggests the type of problems increasingly encountered. First, health care costs have been rising excessively. The free market in medical care has been so uncontrolled, even for services paid for by government programs, which have spiraled to levels much higher than the general consumer price index. The Medicare program for care of the aged permits the doctor to charge the patient any fee he wishes. Hospital charges have been mounting to especially towering heights, as hospital technology has increased, hospital personnel per patient have multiplied, and salaries have risen. With the escalation of costs, access of the lower-income groups to needed care have become more difficult. Government programs to finance care for the poor, like Medicaid, have been cut back at both federal and state levels. Even in the social insurance Medicare program, copayments required from the patient have increased, so that the heavy burden of illness in the aged is getting attention only with increasing difficulty. The whole political environment of the Regan administration in the 1980s has led to reduction in public expenditures for all human services, and much greater reliance on private sector financing. Besides, promoting competition among providers, the preferred provider organization (PPO), has been spawned, as a mechanism by

which groups of doctors and hospitals agree to serve certain public or private beneficiaries at competitively lower prices. For some years the prepaid health maintenance organization (HMO) has shown the economies achieved by modification of physician incentives, especially in hospital use, and a number of variations on the HMO theme are being explored. Although competition is politically favored in preference to regulation, a very great innovation in public medical care policy has been essentially regulatory. For example, prospective payment to hospitals for the diagnosis-related group (DRG) of each patient under Medicare, rather than for retrospective charges for each unit of service was adopted (Roemer, 1991).

Citizens Opinions toward Health Care System

Geyman (2003) pointed out that the U.S. health care system has three major problems: decreasing access to care, increasing costs of care, and nonsustainable, overly complex, inefficient system with poor performance. A survey, "Public Views on U.S. Health Care System Organization: A Call for New Directions," of more than 1,000 adults was conducted by Harris Interactive in May 2008 and released by The Commonwealth Fund, showing that Americans are dissatisfied with the U.S. health care system and 82 percent think it should be fundamentally changed or completely rebuilt. The Commonwealth Fund Commission on A High Performance Health System also released a report, "Organizing The U.S. Health Care Delivery System for High Performance," outlining what an ideally organized U.S. health care system would look like, and detailing strategies that could create that organized, efficient health care system while simultaneously improving care and cutting costs (PA TIMES, Sep. 2008).

The vast majority of those surveyed felt it was important that the elected

president proposes reform plans that would improve health care quality, ensure that all Americans can afford insurance, and decrease the number of uninsured. 47 percent of patients experienced poorly coordinated medical care in the past two years — meaning that they were not informed about medical test results or had to call repeatedly to get them, important medical information was not shared between doctors and nurses, or communication between primary care doctors and specialists was poor. Adults across all income groups reported experiencing inefficient care. And, eight in ten adults across income groups supported efforts to improve the health system’s performance with respect to access, quality and cost. In terms of access to health care, nearly 73 percent respondents had a difficult time getting timely doctors’ appointments, phone advice, or after-hours care without having to go to the emergency room. Although the uninsured were the most likely to report problems getting timely care without going to the emergency room, 26 percent of adults with health insurance also said it was difficult to get same- or next- day appointments when they were sick. And 39 percent of insured adult said it was hard to get through to their doctors on the phone when they needed them.

Respondents pointed out the needs for a more cohesive care system. Nine of 10 surveyed believe that it is very important or important to have one place or doctor responsible for their primary care and for coordinating all of their care. Similarly, there was substantial public support for wider adoption of health information technology, like computerized medical records and sharing information electronically with other doctors as a means of improving patient care. Nine of 10 adults wanted easy access to their own medical records, and thought it was important that all their doctors have such access as well.

The Commission report then outlines strategies that could help lead to a better health care system with higher quality and better efficiency:

- (1) *Payment Reform*: Report authors recommend moving away from traditional fee-for-service payment to a system in which providers and hospitals are paid for quality, patient-centered, coordinated health care.
- (2) *Patient Incentives*: Patients should be given incentives to go to the health care professionals and institutions that provide the most efficient, highest quality health care. However, in order for this to work, health care providers and health care systems would need to be evaluated to determine if they are providing high quality, efficient health care and information on performance would need to be publicly available.
- (3) *Regulatory Changes*: Regulations should remove barriers that prevent physicians from sharing information that is essential to coordinate care and ensure safe and effective transition for patients.
- (4) *Accreditation*: Providers and health systems should be accredited based on six attributes of an ideal health care system:
 - Patient information is available to all providers and patients at the point of care;
 - Patient care is coordinated among multiple providers and transitions from one provider to another or from a hospital stay are actively managed;
 - All health care providers involved in a patient's care have accountability to each other, review each other's work and collaborate to deliver good care;
 - Patients can get the care and information they need when and how they need it, including after hours, and providers are culturally competent and responsive to patients' need;
 - There is clear accountability for patient care;
 - The health care system is continuously working to improve quality, value, and patients' experiences.

- (5) *Provider Training*: Physicians and health care professionals should be trained to work in the type of team-based environment required for an organized health care system.
- (6) *Government Infrastructure Support*: As appropriate, the government should support the infrastructure necessary for a well-organized health care system. For example, aiding with the adoption of health information technology or performance improvement activities.
- (7) *Health Information Technology*: Providers should be required to implement and use electronic health record within five years.

V. UK Experience

The intention of the National Health Service (NHS) legislation of 1946 was to convert health service from a predominantly market commodity, purchased by individual and families, to a basic social entitlement of everyone, financed principally from public sources. Although the amount of this public support may fall short of total needs, the intention has been substantially achieved.

National Health Service and Department of Health and Social Security

The exact proportions of NHS funds derived from different sources were not identical over the years. At the time of the NHS reorganization in 1974, the funds for running the NHS (capital and operating expenditures) were derived from central government, local authorities, social insurance (workers and employers), patient payments and other sources. Clearly the overwhelming bulk of support has come from the general exchequer or treasury of the nation. In fact, this source is even greater

since a major part of the funds attributed to local authorities actually comes from national grants to those bodies. Patient payments included charges for prescribed drugs, prosthetic dental services, private beds in NHS hospitals, special spectacles, and other miscellaneous purposes. In the late 1970s, the Department of Health and Social Security (DHSS) appointed a working group on Inequalities in Health, chaired by Sir Douglas Black; the report, issued in 1980, became known as Black Report. The working group set out to examine whether the NHS had reduced the inequalities in health that had long prevailed among different social classes in Great Britain. Over the first 30 years of NHS, 1948 to 1978, the mortality rates of all five social classes had declined. The rates of decline of the upper classes, however, were substantially greater than those of the low classes. As a result, the degree of inequality between classes was actually greater than at the outset. Did this mean that the NHS had done little good? This question provoked a great deal of discussion among the health professions, the government, and the general population of Great Britain (Roemer, 1991).

Indeed health status is determined by far more than medical and related services. As Black Report states, the “material conditions of life” probably play the greatest part, and of course these differ enormously among the five social classes. Differences prevail in working conditions, housing, nutrition, frequency of unemployment, level of education, family stress and other features of the physical and social environment. The improvement in health services brought by the NHS was not matched by similar improvements in the material conditions of life for the several social classes. Organized health services can benefit health, but favorable living and working conditions can benefit health even more (Roemer, 1991).

Recent Paths of NHS

Previously , under the command and control model, the Health Authorities (HAs) were responsible for financing and managing services. After 1990 the HAs were allocated money to purchase or commission health care for their residents from the NHS Trusts, which provide hospital and community health services. The mechanism connecting purchaser and provider was the “contract.” Alongside the population-based approach to purchasing by HAs, the NHS reforms introduced a patient-based model in the form of general practitioner fundholding: a practice holding a budget with which it purchases a limited range of services for its patients (Powell, 1999).

Publication of The Health of the Nation White Paper in 1992 -- following a Green Paper of the same title a year before -- is said to have marked a significant shift in public policy, if only at the symbolic level. It is seen as a new health care paradigm, a program of social engineering rolling back the frontiers of Thatcherism not of the state. The document stressed a commitment to health rather than simply to health care, and paid dues to social and public health -- or collective as opposed to individual -- issues in improving health. This general commitment was translated into 25 specific targets. However, critics pointed out that the targets appeared to be largely extrapolations of existing trends, designed to make sure that the Government would be able to congratulate itself on making good progress toward them. Government action on structural issues such as unemployment, housing, and pollution was conspicuous by its absence. In short, there appeared to be little strategy and few mechanisms to achieve the targets (Powell, 1999).

The 1997 White Paper, The New NHS, aimed to create a “modern” health service. It claimed to break down walls between health and social care, abolish the internal market, and phase out GP fundholding. It offered no new money, with

improvements funded largely by cutting £1 billion in red tape over five years. It retained the separation between planning and providing services, but replaced competition with cooperation and partnership. The basic budgetholders in the NHS will be some 500 Primary Care Groups, covering populations of approximately 100,000 people. These are groups of GPs and community nurses who, for the first time, will have capped expenditure levels for all items, including drugs.

The 1998 Green Paper, *Our Healthier Nation*, claimed that the new public health policy would remedy the deficiencies of the Conservative Health of the Nation policy, as the latter ignored health inequalities, focused on individual behavior rather than the structural causes of ill-health, and paid no more than lip service to collaboration across government (Powell, 1999).

As shown in Table 1, there are many differences between health policies of New and Old Labor, and some differences between New Labor and the Conservatives. However, Labor's health policy seems to build on the Conservative legacy, and is characterized by evolution rather than being a paradigm shift. Rather than being a new and distinctive approach rejecting both the old left and the new right, it sees to be a pragmatic pick and mix, attempting to combine the best from the market approach of the Conservatives and the hierarchical approach of Old labor.

Table 1. Labor's Third Way in Health

The third way in health			
	Old Left	Third Way	New Right
Spending	High	Pragmatic	Low
Competition	Hierarchy	Partnership	Market
Accountability	Paternalism/national	Both	Consumerism/local
Public health	Social engineering	Neither	Individual responsibility

Source: Powell, 1999, page 366.

VI. Discussion and Conclusion

Table 2 summarizes above and compares Taiwan, Japan, US and UK's health insurance system, in terms of operation, sources, payment and the degree of government involvement. The health insurance systems of Taiwan and Japan are quite similar with the model called social health insurance. Although the design of payment is somewhat different, the source of the health insurance is quite similar. US and UK's experiences are quite different. US health system is quite entrepreneurial with low degree of government involvement, while UK is totally government-operated.

Table 2. Comparison on Health Insurance System of Taiwan, Japan, US, and UK

	Taiwan	Japan	US	UK
Operation	Social Health Insurance	Social Health Insurance	Private Health Insurance	National Health Service
Source	Employer's insurance premium, Employee's premium and government support.	Employer's insurance premium, Employee's premium and government support.	Individual, employee, group, or family purchase private company insurance	85% from government tax; 12% national health premium; 3% from copayments.
Payment	National Health Insurance pays most of the medical and pharmaceutical charges. Copayments are asked, depending on the type of	People above 70 years old and below 6 years old only pay 20% of charge. The general public pays 30%. The other is paid by governments.	Patients have to pay deductible and copayments	National Health Service pays most of the medical and pharmaceutical charge, though part of pharmaceutical charge is paid by patients.

	hospitals in use.			
Degree of government involvement	Middle	Middle	Low	High

The degree of government involvement reflects on the health expenditure as well. Table 3 further compares the percentage of health expenditure from government or the private sector. It shows in Taiwan 66 percent of health expenditure is supported by the government, 81.48 percent in Japan, 44.43 percent in the US, and 83.36 percent in the UK. Not surprisingly the UK has the highest percentage from the government, but Japan's percentage is quite high possibly because high premium is collected and government is responsible for most of the payment.

Table 3. Comparison on Health Expenditure from Government or Private (%)

	Taiwan	Japan	US	UK
Government	8.7	15.9	31.45	-
Social Insurance	57.3	65.58	12.98	-
Total	66.0	81.48	44.43	83.36
Private Insurance	0	0.32	36.64	-
Payment by Patient	30	17.27	14.07	-
Other	4	0.93	4.86	-
Total	34.0	18.52	55.57	16.64

OECD Health Data 2005, World Health Organization (2005), The World Bank (2005), and Health, Welfare and Food Bureau (2004). Taiwan data are in 2001, the others are in 2002.

Table 4 compares structure, process and outcome of health system, US health expenditure occupied 13.9 percent of GDP and health expenditures pre capita was

about 4,287 US dollars, which were the highest. Japan and UK's coverage of insurance is 100 percent. In Taiwan and Japan, each person each year had 12.9 times of medical treatment, and average days of staying in hospital are 9.2 in Taiwan, 15 in Japan, 7.2 in the US and 7.1 of NHS. In terms of the outcome of health system, Japan has the highest average expectancy of life, US and NHS are quite close, while Taiwan's tends to be lower.

Table 4. Comparison on Structure, Process and Outcome of Health Care System

	Item	Taiwan	Japan	US	UK	NHS*	
Structure	Total health expenditure/ GDP (%)**	5.7	7.6	13.9	7.6	7.6(0.1)	
	Health expenditures per capita (US \$)**	1,275	1,984	4,287	1,569	-	
	Coverage (%)	97.5	100	23***	100	100(0.1)	
	Government Health Payment/Health Insurance Payment (%)	64	-	-	-	82(6)	
	Emergency bed/thousand Bed/thousand		4.7		3.8	-	3.9(0.7)
			5.28	13.5	4.4	-	
	Physician/thousand	1.29	1.7	2.3	-	2.6(0.8)	
Process	In use/person/year	12.9	12.9	5.3	-	5.2(2.8)	
	Times of hospital treatment/hundred	12.3	13.0	12.5	-	15.4(3.3)	
	Average days of hospital treatment	9.2	15	7.2	-	7.1(1)	
Outcome	Public satisfaction (%)	61	-	-	-	57(29)	
	Mortality rate/thousand of infants	6.43	4.5	-	-	6.6(1.3)	

	Average expectancy of life					
	Male	71.89	76.6	73	-	73.2(1.3)
	Female	77.76	83.0	79		79.9(1)

Note:

Data of total health expenditures as percentage of GDP are in 2001(National Health Insurance, <http://www.nhi.gov.tw/>). The other data for Taiwan are in 1995, for the US are in 1990, for Japan are in 1992, for NHS are in 1996 from Javier Elola (1996) Health Care System Reforms in Western European Countries: The Relevance of Health Care Organization. International Journal of Health Services, Volume 26, Number 2, Page 239-25.

* NHS includes Denmark, Finland, Norway. Sweeden, Ireland, UK, Greek, Italy, Spain; Standard deviation is in (); data are in 1992 form OECD.

**OECD Health Data in 2003 and 2002.

*** Coverage in the US only included Medicare (13%) and Medicaid (10%), private insurance of 63% was not included.

This paper does not conclude with which country's health insurance system is good or bad, but with an overview of different health insurance systems. By knowing different countries' experience, reciprocal learning and mutual adjustment can be stimulated, though institution design of a country's health insurance system still has its own contextuality.

References

- Geyman, J. P. (2003). Myths as barriers to health care reform in the United States. International Journal of Health Services, 33, 315-329.
- Gottschalk, M. (2000). The shadow welfare state: labor, business, and the politics of health care in the Unites States. Ithaca: Cornell University Press.
- Haley, B. A., & Deevey, B. (1997). American health care in transition: a guide to the literature. Westport, Connecticut: Greenwood Press.
- Klein, R. (2003). Comparative health care policy: lessons for (and from America).

American Journal of Public Health, 93, 61-63.

Monheit, A. C., Wilson, R., & Arnett III, R. H. (1999). Informing American health care policy: the dynamics of medical expenditure and insurance surveys, 1977-1996. San Francisco: Jossey-Bass Publishers.

Newhouse, J. P. (1996). Free for all? Lessons from the RAND health insurance experiment. Cambridge, Massachusetts, London, England: Harvard University Press.

Powell, M. (1999). New labour and the third way in the British National Health Service. International Journal of Health Services, 29, 353-370.

Roemer, M. I. (1991). National Health Systems of the World: Volume 1, The Countries. Oxford University Press, Inc..

Ron, A., & Scheil-Adlung, X. (2001). Recent health policy innovations in social security. New Brunswick, New Jersey: Transaction Publishers.

Westerfield, D. L. (1993). National health care: law, policy, strategy. London: Praeger Publishers.

Websites

<http://blog.udn.com/alexandroslee/1634954>

http://health.dayoo.com/node_2670/2005-07/14/112132674681466.shtml

<http://iwebs.url.com.tw/main/html/amoeba/29.shtml>

<http://world.people.com.cn/BIG5/14549/6907377.html>

<http://world.people.com.cn/BIG5/14549/6907427.html>

<http://www.csia.cn/darticle.asp?id=SS,20040916,00020450&columnid=30001213>

<http://www.legco.gov.hk/yr05-06/chinese/sec/library/0506in08c.pdf>

<http://www.legco.gov.hk/yr97-98/chinese/sec/library/c08plc.pdf>

<http://www.legco.gov.hk/yr97-98/chinese/sec/library/c09plc.pdf>

<http://www.legco.gov.hk/yr97-98/chinese/sec/library/c10plc.pdf>

<http://www.legco.gov.hk/yr98-99/chinese/sec/library/989crp12.pdf>

<http://www.med8th.com/humed/3/040315mgdylxthzc.htm>

<http://www.nhi.gov.tw/>

<http://www.nyu.edu/projects/rodwin/Japan.html>

<http://www.self-learning-college.org/forum/viewtopic.php?t=11>

<http://www.sss.net.cn/ReadNews.asp?NewsID=2446&BigClassID=10&SmallClassID=27&belong=sky>

http://www.usc.cuhk.edu.hk/wk_wzdetails.asp?id=4391

http://www.who.int/health_financing/issues/socialprotection/en/medical_savings_accounents_dp_02_3.pdf

<http://www.wretch.cc/blog/cypunicorn/18009750>