An inconvenient truth behind high accessibility to medical services

One of the missions of National Health Insurance (NHI) is to help the sick and the uninsured by providing access to medical services at an affordable cost in Taiwan. Nearly 98% of Taiwanese citizens are enrolled in this government-run, single-payer social insurance program. People can seek ambulatory care at around 9500 NHI-contracted physician clinics or at some 500 hospital-based outpatient departments without referral. Accumulating evidence has shown that people in Taiwan have had more equal access to health care, greater financial risk protection, and increased equity in health care financing since the implementation of the NHI.\(^1,2\) A recent study revealed that the life expectancy of the poorer and previously uninsured group had improved more substantially than that of more affluent and insured individuals 10 years after the introduction of the NHI.\(^3\) The NHI program consistently receives a 70% public satisfaction rating and is recommended as a successful model for countries pursuing universal health care.\(^4,5\)

In this issue of the *Journal of the Chinese Medical Association*, Shao et al\(^6\) report that 92.6% of the randomly sampled NHI beneficiaries had utilized the medical service at least once in 2005. Around 82.3% of the population had visited physician clinics, 48.6% had visited a hospital outpatient department at least once in their lives, and 8% had had at least one experience of hospitalization over their lifetime. Shao et al conclude that people in Taiwan utilize NHI services frequently and tend to seek medical help at hospitals. The investigators also note their concern about the issue of overutilization that is associated with the high availability of and accessibility to medical services. Such concerns have been raised before, but policymakers have not yet come up with a solution.\(^7\)–\(^9\) Nevertheless, if the public, health care authorities and health care providers are unwilling to address the drawbacks caused by unregulated accessibility to medical services, the marvelous achievements of the NHI will be less likely to be sustained.

First, the NHI budget is inadequate and capped, whereas the demand for high-quality care is rapidly increasing and unregulated. Since the implementation of a global budgeting payment scheme in 2000, the financial risks have been shifted from the government to all NHI-contracted hospitals and clinics. The annual national cost of health care services was around 5–6% of the gross domestic product, significantly lower than the expected 7–8% measured against international standards. Moreover, the annual increase in the NHI budget was around 3–4%, lagging behind the real expenses of the medical services given the aging population with multiple morbidities, high-tech procedures, and new pharmacies. The government is not telling the public the truth that the financial deficits have been absorbed by all health care providers by an average of a 10% discounting payment since 2000. Providers have needed to increase their service volumes to keep their market share and to increase their per-case expense claims in order to protect their reimbursement from possible discounting under the global budget cap.\(^10\) Eventually, only hospitals achieving economies of scales were able to survive, and nearly one-third of the district hospitals were closed or merged.\(^11\) People in remote areas experience more difficulty in accessing secondary care at district or regional hospitals, let alone high-quality tertiary care.

The public should note that a vicious cycle has been forming because it is asking for greater benefit coverage for new treatments and high-quality care. The health care authorities and the legislators agree with these requests but retreat from increasing budgets or raising premiums. The government does not effectively limit the overutilization behaviors, but plans to lift more financial bars than the *status quo*, such as increasing the percentage of insurance-reimbursed beds from 65% to 75% for public medical centers. All the cost-containment strategies are applied to the provider side, for example the diagnosis-related group payment schemes for hospitalization and the upcoming capitation trials in several areas.

Second, more resources used are in ambulatory than inpatient services, and there is no financial analysis in Shao’s study. According to the official statistics released by the Department of Health,\(^11\) 65.8% of the total of NTD 473 billion medical expenses was used in ambulatory services and only 34.2% in inpatient services in 2009 (Table 1). The *de facto* absence of a referral system let patients choose specialists in hospital outpatient departments, even for minor illnesses or chronic diseases in a stable state. Hospitals also have incentives to increase their outpatient volumes because the financial margins and returns are higher for outpatients than inpatients. The mean expense of hospital outpatient visits was three times higher than that of visits to physician clinics (Table 1). As a result, although only 28.6% of total visits were to hospital outpatient clinics, they cost 53.9% of all ambulatory expenses. In fact, many hospitals, including several medical centers that are supposed to care for the severely ill, were already raising more revenue from outpatient than inpatient services. If resources cannot be reallocated more to inpatients, the
capability and quality of inpatient services will continue to decrease.

Third, the high availability of and easy accessibility to medical services also influence the choices of medical trainees in Taiwan. Junior physicians would rather choose specialties whose practices are usually based on ambulatory services with a less serious patient case mix and lower lawsuit risks, rather than those involving more critically ill inpatients. Moreover, the NHI reimburses the same per visit physician fee to all (NTD 228), regardless of the variations in specialty, professional seniority, time consumption and performance of care. Therefore, those doctors who can attract and handle a high patient flow turn out to be the mainstream and are most welcome by managers.

The inappropriate physician payment incentives have indeed had an adverse effect on how medical trainees choose their specialties. The distorted payment incentives have already affected the match between the workforce of physicians and health care needs. In fact, there has been lack of pediatricians, obstetricians, surgeons, anesthesiologists, pathologists, and emergent and intensive care physicians, not only in rural areas, but also in metropolitan cities. When the public are pursuing easy access to luxury coverage but are reluctant to share the financial responsibility, the resource allocation has been quietly biased toward a direction far away from the mission of the NHI.

High public satisfaction rates for the NHI are in part due to the high availability of and easy accessibility to medical services in Taiwan. Never-theless, “there is no such thing as a free lunch,” and the system’s achievements today will likely be at the expense of tomorrow’s quality and provision of the most necessary critical care. For long-term sustainability of the NHI, the health care authorities, legislators, the public, and all providers have to face the inconvenient truth in a responsible way.

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References