

Transforming System to Better Health Care Quality in Taiwan

Mei-Shu Lai, MD,Ph.D.

Professor, College of Public Health, National Taiwan University

Taiwan has approximately 23 million people with a standard of living comparable to that of many western countries. As the world's 19th –largest economy, it has a GDP of US\$ 344 billion and an average per capital income of US\$ 14,600. Life expectancies for women and men are 78.3 and 72.6 year respectively and the infant mortality rate is 5.9 per 1000 live births. Leading causes of death in Taiwan are malignant neoplasm, cerebrovascular diseases, accidents, heart disease, diabetes mellitus, chronic liver disease and cirrhosis. Although currently about 10 % of the Taiwan's population is over 65 years of age, Taiwan shares an aging-population trend common to many western countries. Health care spending per person is US\$ 755---almost 6.2% of the GDP. The democracy situation lead the people to the position of equal access of health care and equal quality of care.

Taiwan's health care system is a dispersing model. People tend to visit physicians frequently, on average, they visit physicians 14.7 times annually including dental and traditional medicine visit. Taiwan has 1.4 physicians per 1,000 populations. Two thirds of the physicians are employed by hospitals (on salary or salary plus bonus), and the remaining are private practitioners with their own small clinics. The hospitals run large outpatient departments. In March 1995, Taiwan established a National Health Insurance program. NHI is administered by Bureau of National Health Insurance (BNHI) under the control of Department of Health (DOH). By the end of 2004, it covered approximately 99%. All hospitals and approximately 90% of the clinics in Taiwan contracted with the NHI. Since 1995, the NHI program has undertaken the following steps to reform its payment system: introduced a DRG payment system for 50 procedures; introduced a separate global budget system for dental services, Chinese medicine, Primary Care group and hospital services; piloted a quality-based payment program whereby NHI pays for treatment of certain diseases (breast cancer, asthma, diabetes, tuberculosis and cervical cancer screening).

The problem aroused are: 1. The very successes of the past few decades in infectious disease control and reduced fertility are generating a demographic transition from traditional societies to society with rapidly increasing number of middle aged and elderly people with chronic disease dominating pattern. 2. The implementation of NHI of the past 10 years to achieve a state with equal accessibility to health care system, but facing the new challenge in quality of care and efficiency of the payment. 3. The democratic development leads the public to

involve in social insurance actively especially in the field of patient-centered care, health care quality and information transparency.

Taiwan DOH starts to deal with quality as a system property. As affirmed in the *Quality Chasm* report (Institute of Medicine): “ the current are systems cannot do the job. Trying harder will not work. Changing systems of care will”. In our report will focus on four levels within the health care system to examine the activities at which quality improvement can take place.

1. Level I: Health authority Department of Health’ quality policy and strategies
 - i. Quality and patient safety committee was set for more than 7 years with quality white paper published
 - ii. Quality codes were put in the newly promulgated health related law: e.g. Cancer prevention law, Genetic health law, National Health Insurance Law etc.
 - iii. Reform the hospital accreditation program assigning new value.
 - iv. Research initiative of building the National health care quality information system and a service agent to perform effectively
 - v. Share care national network (DM) initiated from national level 10 years ago and implemented in local level in recent 5 years.
2. Level II: National Health Insurance payment reform and quality improvement strategies
 - i. Global budget implementation with predetermined quality measure
 - ii. Pilot quality-based payment program whereby NHI pays for treatment of certain diseases (breast cancer, asthma, diabetes, tuberculosis and cervical cancer screening).
 - iii. National Health Insurance Reform Task Force report – quality is the main focus for the reform
 - iv. Profile analysis base on EBM and transparency of the result.
3. Level III: Organization quality action
 - i. Many hospitals participate TQIP (Taiwan quality improvement project) program for the internal accountability
 - ii. All cancer center participate the “Cancer core measure project” for external accountability
 - iii. Quality committee is established in each hospital and the hospital leaders put more effort on this committee’s activities.
 - iv. Patient education and promotion centers are set and operated in hospitals
4. Level IV: Patient and community

- i. Discharge plan was initiated in national level 15 years ago but now become a benchmarking activity in hospital level.
- ii. Multidisciplinary team work to provide the DM patients and major cancer patients a integrated and coordinated care.
- iii. DM patients are encouraged to own their DM passports to empower the self care skill.

There are a blooming quality related activities going on in past 10 years in Taiwan. It is the time to build a National quality policy and 5-year objective by setting the framework and recommends the priority area collectively. The organization and Microsystems are under the pressure of efficiency and democratic demand from society to carry a better care model. The survey of the experience of patients is essential to achieve the patient-centeredness aim. To establish the quality information platform to measure impact and outcome of implement strategies is essential to sharing the data and for external accountability.