

The Health Insurance Coverage for Chinese Medicine Services in Taiwan

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Abstract: The voluminous amount of research on and widespread access to Traditional Chinese medicine (TCM) is indicative of the growing acceptance of traditional medicine (TM) and complementary and alternative medicine (CAM) in many countries. However, Taiwan is one of the few countries in which insurance companies cover the expenses incurred for traditional medicine services. Meanwhile, relative literature documenting the establishment of the Chinese medicine service is also rarely seen. The aim of this article is to present a historical outline of the major events that led to coverage for Chinese medicine services by the Bureau of National Health Insurance in Taiwan. This study may provide other countries with a more complete understanding of how to found an appropriate medical insurance system that will cover indigenous medicine services.

Keywords: Health Insurance Coverage For Chinese Medicine Services, The Labor Insurance, The Government Employees' School Staffs' Insurance, The Farmer's Health Insurance, The National Health Insurance

1. Introduction

The term “traditional medicine (TM)” refers to various systems of indigenous medicine, such as Chinese medicine, Arabic Unani medicine, and Indian Ayurveda. The World Health Organization (WHO) defines TM as follows:

“Traditional medicine includes diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.¹”

Besides, Complementary and alternative medicine (CAM) has a close but slightly different definition, and is described by the WHO as follows:

“The terms complementary and alternative (and sometimes also “non-conventional” or “parallel”) are used to refer to a broad set of health care practices that are not part of a country's own tradition, or not integrated into its dominant health care system.²”

Although the definitions of both terms differ, they are often used together as TM/CAM.

Of the many types of TM/CAM, traditional Chinese medicine (TCM), based on the unique philosophical foundation, complete theoretical system and great therapeutic facilities, has gained in popularity as an alternative to Western medicine over the past few decades. There has been a tremendous wave of interest in how this traditional medicine with five-thousand-year history works. Therefore, the number of publications on Chinese medicine and on related issues has increased markedly, particularly in Australia, Britain, Germany, and the United States.

Most people may think clinical therapy is a key to solving a disease, but it is not able to work alone without a complete health care system. Health care system with characteristics including policies, resources, organization, and financial arrangements also determines the accessibility, availability, acceptability, and convenience of the modern care services.³ Health insurance, which represents an integral part of the health care system, influences patients' access to medical resources. In the history of humankind, health insurance with other arrangements was originally structured to social insurance system. Traced back to 1601, the Poor Law was first established in England. But the first statute law, the Law of Disease Insurance, was not established in Germany until 1883.⁴

In Taiwan, Chinese medicine was not incorporated into the national health care system until very recently. Mainly through the efforts of Chinese medicine physicians and officials, it thus has been set up step by step. The Labor Insurance system, the first of its kind on this island, was established in 1950; it only began to reimburse patients for Chinese medicine services in 1975. The second health insurance system, the Government Employees' and School Staffs' Insurance system, was established in 1958, but only began covering health care delivered by Chinese medicine physicians in 1988. The third health insurance system in Taiwan was the Farmer's Health Insurance system; it started to reimburse patients for Chinese medicine services in 1989, four years after it had been established. The Taiwan National Health Insurance system was launched in 1995, and covered both Western and Chinese medicine services from the very beginning.

Taiwan's health insurance system can serve as a model for the authorities of countries that intend to incorporate coverage of TM/CAM services into their national health insurance systems. The National Health Insurance (NHI) system in Taiwan was designed by experts and scholars from many disciplines. The NHI in Taiwan is the only national health insurance system to cover Chinese medicine services; in fact, even the health care system in some countries where TCM is practiced popularly does not reimburse patients for services rendered by practitioners of Chinese medicine. Therefore, Taiwan has made efforts in obeying the WHO's assertion that TM/CAM should be incorporated into modern health care.

Substantial studies of health insurance coverage for Chinese medicine services have provided extensive discussions on how it is formed; however, these studies have only included some of the health insurance systems. Moreover, there is a surprising lack of literature supporting a causal relationship and correlation between various health insurance systems. In light of these concerns, the purpose of this article is to examine how the health insurance coverage for Chinese medicine services in Taiwan progressed to a mature stage equal to western medicine with a historical perspective. Two issues that need to be resolved in this regard are (a) how Chinese medicine physicians and officials have uplifted the health insurance coverage for Chinese medicine services into a complete system in process of time, and (b) what the upcoming obstacle the National Health Insurance will face.

2. Labor Insurance, Government Employees' and School Staff Insurance, and Farmers' Health Insurance

2.1. Campaign History

There had been three main health insurance systems launched before National Health Insurance system started.

All of these systems were fraught with hardship on the way to cover Chinese medicine services. The two main reasons are that doctors practicing Western medicine and authorities concerned had no desire to incorporate it, and that Chinese medicine physicians were divided into various interest groups. Both internal revolt and foreign invasion had made it be an unsolved question for years.

Labor Insurance program was established in Taiwan in 1950, and The Labor Insurance Act was promulgated in 1958. The coverage of Chinese medicine was incorporated into the Labor Insurance system in 1975; however, it was set up as a trial only covering fractures and dislocations treated by Chinese Traumatology and Chinese medicine services were still considered inferior to Western medicine services. The breaking point of a series of campaigns against inferiority started in December of 1987. At that time, Zhang Qi-Xiang, the chairman of the Committee on Chinese Medicine and Pharmacy, proposed to set up a trial that every county could establish a Chinese medicine hospital; nevertheless, all clinics that had not been given permission to join the Labor Insurance program argued that their rights should be equal to Chinese medicine hospitals.

In October of 1988, Dr. Wu Shui-Sheng was invited to be the leader in the movement to allow all Chinese medicine clinics to join the Labor Insurance program with the same status as hospitals. Subsequently, Zhao Shou-Bo, the minister of the Council of Labor Affairs, responded to their request and decreed that all Chinese medicine clinics could join the program in groups based on a determinative schedules management. At that time, in spite of the access of Chinese medicine clinics and hospitals to joining the Labor Insurance program, most Chinese medicine physicians were not satisfied with government's response, which implied the discrimination between Western and Chinese medicine services was unchanged because of the access of both Western medicine and dentistry had been ensured. Besides, on account of the inferiority of status and salary, most students who graduated from the Department of Chinese medicine (they had to learn both Chinese and Western medicine, and were qualified to take both licenses if they passed) would rather choose to be Western medicine doctors than Chinese medicine physicians.

Several months later, in April of 1989, over one thousand Chinese medicine doctors protested against this unequal treatment with the slogan "a fair treatment for both Chinese medicine and western medicine, a whole openness of the Labor Insurance for both Chinese medical hospitals and clinics." They also submitted a petition asking for the legislators' help. In response to this remonstrance, legislators Zhao Shao-kang, Lin Gen-Shen, and some other legislators promised to establish a special commission. Subsequently, over one thousand demonstrators marched in procession to the Department of Health and the Council of Labor Affairs to ask for more aid. Unfortunately, the Shi Chun-Ren, the Minister of Department of Health, refused to meet them; however, Jiang Wei-Lin and Li Ti-Yuan, the Vice Minister of Department of Health, expressed that they would follow the

lead of the Council of Labor Affairs. The members joining this parade were dismayed at the government's lack of response. Having no alternative, they turned and marched to the Council of Labor Affairs. They asked for an interview with vice minister Xu Xue-Tao and section chief Liu Jian-Xiang. They had no consensus after two-hour discussion. The representatives of the Council of Labor Affairs insisted that they would make a decision in March of the next year. Dr. Wu Shui-Sheng proclaimed that no consensus, no peace. Finally, at eight o'clock in the evening, a consensus that both the Council of Labor Affairs and Chinese medicine doctors would strive to aid health insurance coverage for Chinese medicine services was reached. They also agreed to announce the details by November 15th. The procession then dismissed.⁵

In January of 1991, the Bureau of Labor Insurance officially started to support the Farmers' Health Insurance program. However, in August of the next year, the newly elected Chairperson of the Taiwan TCM Association, Wu Shui-Sheng, found that the Department of Health and the Council of Labor Affairs were only willing to give clinics with a five-year or longer history access to the Labor Insurance program. Although it sounded like the Council of Labor Affairs gave the circles of Chinese medicine a good will, no significant progress had been made. The floor of a five-year or longer history access was only beneficial for some clinics. The status of Chinese medicine was still far from that of Western medicine and dentistry.

In December of 1992, in order not to let all the effort die without any illness, a protest was held again outside the offices of the Council of Labor Affairs. However, there were fewer participants (around 800) at this protest than that occurred in April of 1989 because some clinics which did qualify to apply for the Labor Insurance program were afraid their right of access would be cancelled if they supported this campaign. Different interest groups focus on their own interest brought about more black sheep. Some demonstrator started to give up. Nevertheless, in order to insist on the initial belief, Dr. Wu and some physicians wrote a letter with their blood asking President Li Deng-Hui for help. The next day, a consensus was finally reached after a negotiation with Cai Xian-liu, vice minister of the Council of Labor Affairs. They agreed to increase the number of Chinese medicine clinics to 700, which could apply to participate in the Labor Insurance program, and promised to draw up the qualification of joining the Labor Insurance program with new standard. This campaign then finished temporarily.

In 1993, Dr. Wu Shui-Sheng and chairpersons of the Taipei and Kaohsiung TCM associations paid a courtesy call to the Ministry of Personnel, the Central Trust of China, and the Council of Labor Affairs, in order to encourage absolute open access to the Labor Insurance and the Government Employees' and School Staff Insurance (GESSI) programs. Because of the positive responses from these units, in December of the same year, the Bureau of Labor Insurance issued document 82 Lao Yi Tze No.24954, which proclaimed that the Labor Insurance program was open to all hospitals

and clinics.

GESSI was actually launched by the Ministry of Personnel in 1958, but Chinese medicine services was incorporated into GESSI in 1988. In 1994, two legislators, Huang Zhao-Shun and Yu Ling-Ya accompanied a few doctors of Chinese medicine to the Central Trust of China to ask for open access to the GESSI program. Because government's policy of health insurance was not clear, they decided to hold a campaign in the Legislative Yuan. Finally, the legislator Chen Qing-Bao, the convener of the Procedure Committee, promised to sponsor a bill that would provide open access to GESSI. In December of the same year, the Ministry of Personnel was permitted to make a decision that access to GESSI was open to clinics and hospitals. In 1995, the government of the Republic of China launched the National Health Insurance program, which was in charge of the mechanism of medical care in Taiwan, originally belonging to the former insurance systems separately.

2.2. Labor Insurance

In March of 1950, the first compulsory social insurance program, entitled the Labor Insurance program, was established in Taiwan; however, the government of the Republic of China promulgated the Labor Insurance Act in 1958, and did not put it into effect until 1960. From 1968 to 2008, the Act was amended 9 times to expand coverage and provide more protection for employers and employees. After the National Health Insurance program was launched in March 1995, the Bureau of Nation Health Insurance took over the management of medical care after ordinary accidents under the fifth amendment of the Act. 6

As a first social insurance in Taiwan, government thought highly of the finance resource of it. According to Article 66 of the Labor Insurance program, last amended on May 14, 2008, the Labor Insurance fund shall be derived from the following sources: (1) lump-sum money contributed by the government when the Fund is established; (2) the current-year premiums and interest income, in addition to the balance after due payment of insurance benefits; (3) penalties on overdue premiums; (4.) income from investment of the Fund. These articles ensured the stability of the labor insurance program. Meanwhile, if we see the fund as a money inflow, and then the coverage is equal to a money outflow. Therefore, Article 2 also illustrates the clarity of the coverage, stating that the coverage consists of two types, ordinary insurance and occupational accident insurance: (1.) ordinary insurance, which provides seven kinds of benefits, including maternity benefits, injury or sickness benefits, medical-care benefits, permanent disability benefits, unemployment benefits, old-age benefits and survivor benefits; and (2) occupational accident insurance, which provides four kinds of benefits, including injury and sickness benefits, medical-care benefits, permanent disability benefits and survivor benefits.⁷ In a word, both inflow and outflow maintained a dynamic equilibrium.

The Labor Insurance coverage for Chinese medicine services did not start as Western medicine. In 1975, the

Ministry of the Interior first decreed that Chinese medicine services could be covered by the Labor Insurance system. In the beginning, it was set up as a trial only covering fractures and dislocations treated by Chinese Traumatology due to the pricing. In one year, evaluation of this program was qualified so the government continued to support this trial to cover the needs of the insured. In 1981, the coverage was broadened to include contusions.⁸

Although the Labor Insurance program was the first system which provided the health insurance coverage for Chinese Medicine Services, there were some disadvantages of this program, including limited clinics and hospitals, and limited coverage of medical services rendered. In order to solve these obstacles, some organizations started to expand the program. In 1983, Taipei City Hospital–He Pin Branch and China Medical University Hospital opened services for outpatients, while services for inpatients were yet to discuss because the amount of money to charge was not determined. Coverage at that time included internal medicine, gynecology, and acupuncture. Kaohsiung Municipal Chinese Medical Hospital also joined the Labor Insurance program in the same year. By 1989, more than 90 Chinese medicine hospitals and clinics had joined the Labor Insurance system. Nevertheless, in December of 1993, the Labor Insurance program started to be open to all hospitals and clinics after document 82 Lao Yi Tze No.24954 was issued by the Bureau of Labor Insurance issued.

2.3. Government Employees' and School Staff Insurance

In 1958, the Ministry of Personnel launched the Government Employees' and School Staff Insurance (GESSI). The initial goal was to enrich the livelihood and welfare of government employees and school staff. The Central Trust of China was the insurer before being merged with the Bank of Taiwan on July 1, 2007. The Bank of Taiwan then took over the role as insurer from the former institution.

The GESSI system included the following insurance programs: Government Employees' Insurance (GEI), Insurance for Teaching and Administrative Staffs of Private Schools (ITASPS), Retired Government Employees' Insurance (RGEI) Health Insurance for Government Employees' Dependents (HIGED), Health Insurance for Dependents of Teaching and Administrative Staffs of Private School (HIDTASPS), and Health Insurance for Retired Employees and Their Dependents of Government Organizations and Private Schools (HIRETDGOPS). However, in 1995, the mechanism of medical care operated by GESSI was transferred to the Bureau of National Health Insurance.

Coverage of Chinese medicine services by GESSI began in 1988, exactly 30 years later after it had been founded. From March in that year on, the Central Trust of China authorized four hospitals to set up Chinese medicine programs under the GESSI system, including Taipei City Hospital–He Pin Branch, China Medical University Hospital, Kaohsiung Municipal Chinese Medical Hospital, and Taiwan Hua-Lien Hospital.

In the beginning, patients who elected to receive Chinese medicine treatment in these hospitals had to get the referrals directly issued from GESSI-affiliated outpatient centers. After receiving the referrals, outpatients could get treatment at the assigned hospitals, although the hospitals were often not located in the cities in which the patients lived. At the end of the first year, the Ministry of Personnel decided to extend the Chinese medicine program of GESSI for two more years. In 1989, the referral mechanism was cancelled, and outpatients were allowed to receive medical services in any contracted medical care institutions. Four years later, the GESSI policy on Chinese medicine was broadly expanded to include treatments for various kinds of chronic diseases, including the application of chronic illness prescription refill slips of acupuncture and traumatology. Finally, in December of 1994, the Ministry of Personnel decided to include all clinics and hospitals in the GESSI system.

2.4. Farmers' Health Insurance

The Farmers' Health Insurance system was established based on the Omnibus bill of the Farmers' Health Insurance Act in 1985 by the Executive Yuan. The system was set up in certain areas of the country to improve the health and welfare of farmers. Because basic livelihood and medical care were ensured, farmers living in areas outside the reach of the program looked forward to an expansion of the system. In 1987, the program was expanded and, in 1989, the Farmers' Health Insurance Act was officially adopted.

According to Article 12 of the Farmer's Association Law, every member in all farmers' association must be insured, with various associations they belong to as their insured units. For other farmers that are not part of any farmers' associations, as well as are older than 15 years of age can participate in the program, if they are qualified according to the Examination Guidelines on the Application of Farmer's Health Insurance Recognition Standards and Qualifications.⁹

Chinese medicine services began to be covered by the Farmers' Health Insurance system in 1989. Two years later, operation of this system officially began to offer Chinese medical services. There had not been absolute open access for the Farmers' Health Insurance system before the NHI. After the launch of the National Health Insurance and prior the revision of Farmers' Health Insurance Act, the Farmers' Health Insurance program began only to cover maternity benefits, disability benefits and burial subsidies, and the Bureau of the NHI took over the mechanism of medical care originally operated by the Farmers' insurance system.¹⁰

3. National Health Insurance

National Health Insurance started in 1995, covering both Chinese medicine and Western medicine service, which resulted from the effort of Chinese medicine physicians and other experts. Moreover, having examples of how to build integrative insurance programs from the disadvantages of the Labor Insurance, GESSI, and the Farmers' Insurance, the NHI has developed into a full-blown medical system.

However, the NHI is yet to cover the inpatient of Chinese medicine services. The financial status of the whole system has also been in the red for years. If authorities concerned can solve these two problems, the NHI system would be invulnerable.

3.1. Legitimate Origin of the NHI

Article 157 of the Constitution of the Republic of China states that the government should put the policy of health care system (in which medical institutions are owned and operated by private corporations, but main part of the medical expenditure are paid by government) and public medicine system (in which all medical institutions are established and supervised by government) into practice in order to improve the health of the nation's people. However, the public medicine system was never implemented. The main reason for this is that financial payment should have been completely supported by the Federal budget (if it had been implemented), resulting in putting a very massive burden on the finance of the government.

Therefore, the three insurance systems, namely Labor Insurance, GESSI, and the Farmers' Insurance programs, were used instead of the public medicine system. Although the three former insurance systems were beneficial for those who were employed, individuals greater than 65 years and those under the age of 15 were ignored. On the basis of social security, Pen You-Zhi, a member of the National Assembly, proposed an amendment to the Constitution calling for the implementation of the National Health Insurance system in 1992. He also spent lots of time discussing how to set up modern medical institutions for Chinese medicine services with other experts, seeing the institutions of the refunds and payment of the NHI. Finally, in the same year, the second amendment to the Constitution was ratified. The amendment established the NHI as an obligation of the government.¹¹

The National Health Insurance Act was promulgated on August 9, 1994 by the President's Order of Hua Chung (1) Yi Tze No. 4505.¹² The NHI program started on March 1, 1995 and was operated by the Bureau of the National Health Insurance. The program provides for equal coverage of Western medicine and Chinese medicine. The NHI is a compulsory, single payer system, and is budgeted as a state-run corporation. The insured are classified, according to Article 8 of the National Health Insurance Act, into the following six categories: (1) Civil servants or full-time, regularly paid personnel in governmental agencies and public or private schools; (2) Members of an occupational union who have no particular employers, or who are self-employed; (3) Farmers or fishermen; (4) Military servicemen whose compulsory service terms are more than two months, and men who are currently in military-substitute service; (5) Members of a household of low-income families as defined by the Social Support Law; (6) Veterans, household representatives of survivors of veterans, and representatives or heads of household other than the insured or their dependents prescribed in subparagraphs 1 to 5 and the preceding item of this subparagraph.¹³

3.2. The Condition of Outpatient Services

Participation in the NHI program is mandatory for all ROC citizens and those from Hong Kong, Macao, or foreign nationals with a Taiwan Residence Certificate, Taiwan Resident Entry and Exit Permit, Alien Residence Certificate, Alien Permanent Residence Certificate or other documentation permitting long-term residence in Taiwan for more than four months.¹⁴ The number of people who enroll in this system changes each year, so does that of the NHI-insured medical service organizations. As of November 2007, over 22 million people were enrolled in the NHI system. The number of Chinese medicine hospitals decreased from 44 in 2001 to 22 in 2008, while the number of Chinese medicine clinics increased from 2225 in 2001 to 2798 in April of 2008.¹⁵ According to statistics and surveys in 2000, there was a seven-fold increase in the number of outpatients and a 15-fold increase in outpatient expenditures from the year 1995 to the year 2000.

Coverage of Western medicine services by the NHI system consists of both inpatients and outpatients services. However, coverage of Chinese medicine services by the NHI system only offer outpatients services, including diagnosis, prescription, medications, and acupuncture, traumatology. Also, some medical service organizations still offer inpatients services for Chinese medicine, such as Chinese Medical University Hospital, but patients have to make full payment on their own.

3.3. The Global Budget System

Most scholars are attentive to the financial status of the National Health Insurance program. To adjust the financial status, we can emphasize on two sides, the global budget system and the deductible systems. Compared with Western medicine, the deductible is cheaper for most outpatients, resulting in a slighter shock on the program. Based on this, the global budget is discussed in the following paragraph.

The global budget system means that prior to the beginning of the fiscal year, the Bureau and other contracted medical care institutions negotiate specific coverage for services, such as outpatient services in the departments of Chinese medicine, Western medicine, and dentistry, in order to determine the upper limit of the annual global budget, ensuring that expenditures will not soar to an undue extent without respect to the amount of medical usage.¹⁶

The main organization to facilitate the global budget system is the National Health Insurance Health Care Cost Arbitration Committee, set up by the Department of Health on November 8, 1996, on the basis of Article 48 of the National Health Insurance Act regulating that "for the negotiation and allocation of medical care payments, the National Health Insurance Health Care Cost Arbitration Committee shall be established." The Committee consists of 27 members: one-third each from healthcare providers, the insured, employers and one expert, and the competent authority. Chairperson of the Committee, appointed by the Department of Health, serves a term of two years and may be

re-appointed. The rest members are appointed by the Department of Health after consultation with organizations concerned. The Committee has a staff of 12 in two sections for the analysis of medical care expenditure, research and evaluation, and for organizing committee meetings.

The major functions of the Committee are: 1) within the total amount of payment approved by the Executive Yuan, to negotiate, three months before the beginning of the fiscal year, the annual global budget and its allocation; 2) to negotiate the proportion of allocation of the annual global budget for ambulatory and inpatient care in each region; 3) to negotiate the proportion of allocation of ambulatory service budget for physicians, Chinese medicine doctors and dentists, fees for dispensing service and pharmaceuticals; 4) to negotiate, when drug costs of ambulatory service exceed the pre-set amount of the global budget for drug costs, the proportion of the amount exceeded to be deducted from the amount allocated for ambulatory service budget.¹⁷

In 1999, with the charisma of Dr. Lin Jaung-Geng as the chairperson of the Taiwan TCM association and Shi Chun-Quan as the Chief Secretary, the panel of the global budget system on Chinese medicine was established. The panel was led by Yang Han-Quan and Lin Jaung-Geng and consisted of many representatives from the Department of Health, the Bureau of National Health Insurance, the Committee on Chinese Medicine and Pharmacy, and the Taiwan TCM association. The result of several committee meetings was a written agreement signed by both the Department of Health and the Taiwan TCM association to launch a pilot project that would include the incorporation of Chinese medicine into the global budget system beginning in July of 2000.¹⁸

The budget has been adjusted since it was launched. The budget increased by 5.83 percent, or about 15 billion NT dollars between the base year (from July of 1998 to June of 1999) and the year that the global system on Chinese medicine started (from July of 2000 to June of 2001). In the following years, the growth rate continued to rise. The rate was 2.0 percent in 2002, 2.07 percent in 2003, and 2.41 percent in 2004. In monetary terms, the average increase per year was about 16.5 billion NT dollars.¹⁹ In addition, the annual expenditure of Chinese medicine services given from the NHI system to all the NHI-insured medical service organizations had been around 4 to 5 percent, which had been lower than Western medicine and dentistry. It then decreased after the deductible was raised. However, the financial status has also improved since the global budget system was launched.

4. Health Insurance Coverage for Chinese Medicine Services in the World

Various countries have established their own health insurance systems. Their attitude toward Chinese medicine services imperceptibly determines how they incorporated it into their health insurance coverage. Noteworthy, in 1972,

while traveling with President Nixon in China, a New York Time journalist James Reston had an emergency appendectomy with acupuncture used as anesthetic, resulting in a huge crowd on earth in a fever of acupuncture therapy. So far, still a large people regard acupuncture as a synonym as Chinese medicine. Therefore, most governments or insurance companies outside East Asia only incorporate acupuncture into health care insurance system.

In Europe, Germany is probably the country which uses the biggest resources on research of Chinese medicine, including herbs and acupuncture. Its government has made a proposal that acupuncture for chronic pain in lumber part and knee would be covered, motivating more patients to use acupuncture therapy. In Belgium, some insurers started to provide health insurance coverage for acupuncture in 2001. In France, both the government and Western medicine doctors think Chinese medicine is getting more and more important in clinical therapy. Therefore, nowadays patients who receive acupuncture therapy can apply for health insurance coverage.

In Britain, medicines control agency (MCA) recently has begun sifting any Chinese herbal products circulated in the market to manage its quality, supervising the qualification of Chinese medicine physicians, and trying to bring Chinese medicine into health care systems.²⁰ Nevertheless, herbal products are currently seen as diet supplements, which means insurers do not have to incorporate them into the coverage.

In America, acupuncture has been incorporated into national health care insurance system in Cuba. Acupuncture is also quite popular in Canada, but patients have to pay by themselves.

United States is a country which is in favor of acupuncture and Chinese medicine development. The National Certification commission for Acupuncture and Oriental Medicine (NCCAOM) is one of the most influential organizations, which assess and promote recognized standards of competence in acupuncture and Chinese medicine. NCCAOM Certification is currently one the most important national standards for the practice of acupuncture as defined by the profession.²¹ There are a lot of famous graduate school of Chinese medicine, such as Pacific College of Oriental Medicine and Seattle Institute of Oriental Medicine, which cultivate many acupuncture specialists every year. Although receiving acupuncture is quite common in the U.S., there are quite few insurance programs, such as HMO or Blue Cross offering coverage. In Health Maintenance Organization (HMO), patients only accept medical treatments offered by doctors and other professionals in this program. Every person deciding to join HMO must choose a primary care physician, who will play a role as a gatekeeper to arrange medical access;²² however, patients who need acupuncture therapy do not have to ask for MD referrals first.

Chinese medicine is the most popular in Asia Pacific area. Some may call it Oriental medicine due to slight difference in China, Japan, and Korea. Chinese medicine develops quite well in Australia. RMIT University is one of the best

universities for Chinese medicine and acupuncture. The legal status of Chinese medicine is also the same as Western medicine, resulting in that Chinese medicine physicians is also called “doctor”. Therefore, the incorporation of Chinese medicine into health insurance system is more mature than other countries.

In Korea, similar to Japan, they have revised the original paradigm of Chinese medicine in accordance of local climate, environment, and culture since thousands years ago. Korean government nowadays spends a lot of money on education and research of Chinese medicine. Therefore, Chinese medicine, or commonly called traditional Korean medicine is a popular alternative for Korean. In order to meet this demand, the government has already incorporated traditional Korean medicine into health care insurance system.

In China, the basic medical insurance is a system covering Chinese medicine services similar to NHI of Taiwan; however, only people who are public servants can join this system without paying any money. Even if they join this system, receiving medical treatment costs them from 800 RMB to thousands RMB, which is a huge burden for most Chinese.

In Japan, Ministry of Health, Labor, and Welfare regulated that two hundred herbal medicine product and acupuncture would be listed in Health care coverage.²³ But Chinese medicine physicians do not have legal status.

5. Conclusion

The process of Taiwan’s public healthcare develops as scientists conduct experiments. We have to learn by experience. From 1865 to 1895, several missionaries came to Taiwan with sincerity, and dedicated themselves to helping modern medicine take root. They established some private hospitals, such as Mackay Hospital in Taipei, during this period, initiating the first step of healthcare on the island. The measures taken to combat the widespread epidemics that occurred during the Japanese occupation period from 1895 to 1945 laid the foundation for the future of Taiwan’s public health.²⁴ From on 1945 on, the government of the Republic of China started a serial construction of healthcare both on hardware and insurance systems. Three major insurance systems, the Labor Insurance, GESSI, and the Farmers’ Insurance were launched in 1950, 1958, and 1985, respectively. In 1995, the NHI program began with both Chinese and modern medicine coverage.

From a historical perspective, the development of health insurance coverage for Chinese medicine services in Taiwan is quite unique. Therefore, five of these characters are worth summarizing: (1) Apparently, the majority of people in Taiwan seek treatment in hospitals or clinics of Western medicine, but Chinese medicine services still exist with a superior health insurance coverage. (2) The success of health insurance coverage for Chinese medicine services was dependent on the effort of scholars and professionals. (3) Health insurance coverage for Chinese medicine services is quite mature compared with other areas in the world. (4) The

WHO suggests that medical insurance programs incorporate both traditional and Western medicine; members of the United Nations also state that insurance systems should equally cover Western and Chinese medicine services. (5) Most developed countries, such as the United States and Germany, spend substantial amounts of money on research in traditional medicine. Taiwan, with the efforts of the academic circle, has published many papers and books to aid in the integration of both medical paradigms. (6) The development of the Chinese medical insurance is a process, which needs some precedents, such as GESSI and the Labor Insurance systems, to pave the way for the NHI system.

Given the historical nature of this study, any implications based on the six characters mentioned in the preceding paragraph should be treated with caution. The data we collected lend support to a positive view on the development of health insurance coverage for traditional medicine. Countries that would like to advance medical policies could integrate the characteristics into domestic medical programs. It is possible that some significant improvements in insurance programs would be obtained when they adjust those characteristics based on their political and economic conditions.

The forming of health insurance for Chinese medicine services may account in part for the benefit of improving nationals’ health in different ways, but it is not entirely complete. The surrounding literature on medical insurance in accord with each other shows the financial status would be a potential risk for further extent. On the one hand, government is unlikely to pursue the goal of economic efficiency as a part of social insurance systems. On the other hand, medical resources have been abused substantially, causing that the cost of medical insurance surpassed the budget boundary. These two factors worsen the finances of the NHI system. The key to these problems adopted by most developed countries is setting up the transferal system, raising the taxation, increasing the percentage of medical treatment fee that patients pay, and enhancing the management efficiency of medical institutions.²⁵ According to surveys conducted by the WHO, the cost of treatment associated with traditional medicine is much lower than the cost of treatment associated with modern medicine. Chinese medicine, as well as other types of traditional medicine, is cheaper for most patients. Although it seems the impact is most on Western medicine, we have to notice that the coverage, expense, and the access rate of traditional medicine are soaring. Similarly, because the cost has been higher than the revenue since 1998, implying the government would adjust some policies to meet the deficit, there are going to be some influences on both Chinese medicine and Western medicine services.

Even though this body of article has the undeniable merit of offering valuable insights into the establishments of health insurance coverage for TM/CAM, it is not without shortcomings. The generalization of the success in Taiwan to other communities with different backgrounds may be limited. This is because the methodological problems of a single-case and historical perspective lack the comparisons.

Thus, the issue of how to apply the model is likely to puzzle medical policy-makers for some time to come; however, it is not within the scope of this paper to provide further discussion.

More probes to explore the panorama of the health insurance coverage for TM/CAM in various countries are obviously required, but this is an exciting first step. Future research should investigate how different health insurance systems interact with each other, as well as the strategic directions for implementing health insurance coverage for traditional medicine in the world. We are hopeful that prospective studies will stimulate original ideas by offering more detailed results and divergent views.

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- [7] See the Labor Insurance Act. <http://www.bli.gov.tw/en/sub.asp?a=0010243>
- [8] Chen Tai-Xi, *Zhongyiyao naru quanminjiankang baoxian zhi kexing fangan yanjiu* (Available proposals that Chinese medical insurance incorporated into the NHI). This is a project directed by Chen Tai-Xi, authorized by the Council for Economic Planning and Development (CEPD), and executed by the China Medical University.
- [9] See the website of the website of the Bureau of Labor Insurance, Council of Labor affairs, Executive Yuan <http://www.bli.gov.tw/en/sub.asp?a=0007466>
- [10] The data are from the website of the Bureau of Labor Insurance, Council of Labor affairs, Executive Yuan, <http://www.bli.gov.tw/en/sub.asp?a=0000054>
- [11] Refer to the second and the seventh amendment of the Republic of China in 1992 and 2005, respectively.
- [12] The latest amendment is the Sixth Amendment and Promulgation of Articles 64 and 82 by the President's Order of Hua Chung (1) Yi Tze No. 09400072571 on May 18, 2005. http://www.nhi.gov.tw/english/webdata.asp?menu=11&menu_id=295&webdata_id=1865
- [13] See Article 8 of the National Health Insurance Act, available on the NHI website http://www.nhi.gov.tw/english/webdata.asp?menu=11&menu_id=295&webdata_id=1865
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- [19] Lin Jaung-Geng, *Taiwan zhongyi fazhang si* (The history of Chinese medicine in Taiwan) (Taipei: Taiwan TCM association, 2004), Shi Chun-Quan, *Taiwan zhongyi yiliao baoxian* (Chinese medical insurance in Taiwan), 328.
- [20] See the website of the National Certification commission for Acupuncture and Oriental Medicine (NCCAOM) <http://www.nccaom.org/about/about.html>.
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- [23] See the website of the Ministry of Health, Labor, and Welfare <http://www.mhlw.go.jp/index.html>.
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