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**HEALTH, POLICY AND MEDICALISATION:
A CASE STUDY OF TAIWAN'S HEALTH CARE REFORMS**

by

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**A thesis submitted in fulfillment of the requirements for the degree of
Doctor of Philosophy**

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Abstract

This thesis charts the rising importance of the state in extending the influence of modern medicine, contextualised within the history and political-economic dynamics of the health care reforms in Taiwan, a leading Newly Industrialised Country (NIC) which has a distinguished record of health improvement. It highlights the processes by which health care reforms represented a shift towards medicalisation, particularly as consolidated by the creation of a universal National Health Insurance (NHI) system in 1995. The thesis seeks to analyse these processes by bridging the gap between medical sociology and health policy evaluation. It deploys a range of methods: historical analysis of secondary sources and multiple methods of data collection. These include qualitative in-depth interviews with key actors, a questionnaire survey and relevant policy documents.

This thesis employs an overarching framework for analysis, which embraces both the 'political economy' and the 'cultural critique' approaches to health, in ways which seek to integrate discussion of policy issues and developments at the macro, meso, and micro-levels. It starts by locating the NHI reform against longer-term historical processes of modernisation, often as a result of outside influences, and the associated transformation of medical paradigms that occurred in different periods. It charts how particular structural factors have impinged on medicine to enable it to become a dominant collegiate profession, with special reference to the role of the state in promoting the legitimisation of particular modes of medical intervention. The thesis highlights the fact that the NHI has extended the influence of doctors, but paradoxically also provides the basis by which medical autonomy has been undermined. On the other hand, it charts the social impacts of modern medical care, and argues that the NHI has played an important role in stimulating the process of medicalisation and consequently fostered a culture of dependency and passivity contained in medical technology and in the healing relationship.

This thesis is a reminder that the contemporary Taiwanese health care state is arriving at a moment of crisis, and that deep reflection on the strengths and weaknesses of the NHI reform is necessary in order to deal with problems associated with growing medicalisation, public demands for greater social equity, and new threats to health, the latest being SARS.

Abbreviations

ARNHI	Alliance to Rescue the National Health Insurance
BLI	Bureau of Labour Insurance
BNHI	Bureau of National Health Insurance
CLA	Committee of Labour Affairs
CTs	Computed tomography scanners
DoH	Department of Health
ESWL	Electrohydraulic shock wave lithotripsy
FI	Farmers' Insurance
GATT	General Agreement on Tariffs and Trade
GEI	Government Employees' Insurance
HMO	Health Maintenance Organisation
IT	Information technology
JCRR	Sino-American Joint Commission on Rural Reconstruction
LI	Labour Insurance
MPAT	Foundation of Medical Professional Alliance at Taiwan
MRI	Magnetic resonance imaging
NCMC	Negotiation Committee for Medical Costs (of the NHI)
NHE	National health expenditure
NHI	National Health Insurance
NHS	National Health Services
NICs	Newly Industrialised Countries
NTUCM	National Taiwan University College of Medicine
NTUH	National Taiwan University Hospital
OECD	Organisation for Economic Co-operation and Development
PPRA	Promoting Patient Rights Association
PRC	People's Republic of China
ROC	Republic of China
SARS	Severe Acute Respiratory Syndrome
SI	Servicemen Insurance

SMEs	Small and medium sized enterprises
TFRD	Taiwan Foundation for Rare Disorders
THRF	Taiwan Health Reform Foundation
TMA	Taipei Medical Association
WHA	World Health Assembly
WHO	World Health Organisation
WTO	World Trade Organisation

CHAPTER ONE

INTRODUCTION

1.1 Research Context: Concerns, Fundamentals and Approaches

This thesis is an empirical case study of the health care reforms in Taiwan, a non-Western but modernising society, focusing centrally on the role of the state in shaping the development of medicine and its delivery to the population. The development of health and health services are addressed in a historical policy context, with the aim of providing a framework for analysing the various influences that have configured it. This development of the health care delivery system is seen as parallel to the construction of a process of 'medicalisation', in terms of the growing dominance of the Western biomedical model, and an associated system of medical professional power and curative health care. This process of medicalisation is addressed within the context of Taiwan's universal National Health Insurance (NHI) system, which was introduced as a major social policy reform in 1995.

In this study, medicalisation is considered as a historically and socially constructed phenomenon, rather than merely the expected and hence 'natural' outcome of modern society. This is embedded in the trajectory of the 'health care state', politics and processes which are a significant feature of the development of the welfare state (Moran, 1999: 4). In terms of this, we start with an assumption that the evolution of health care, and its spread to ever more sections of the population, has underlined the rising importance of the state in extending the influence of modern medicine. Thus deepening medicalisation is a consequence of medicalised policies. This research study seeks to investigate the processes by which health care reforms represented a shift towards medicalisation, also facilitating the growth of medical autonomy.

An overarching framework for the analysis of health is adopted, including both the 'political economy' and the 'cultural critique' approaches to health. On the one hand, considerable attention is paid to the history and political-economic dynamics of the Taiwanese health care state, as a means of gaining insights into the underlying logics of the health care system. In this regard, the development of the health care system is seen as 'in tune' with the broader processes of modernisation, on the grounds that the expansion of health care is a key part of modernising values. Also, medical care reforms often play an important role in the course of economic modernisation in being viewed as promoting human capital through improved health. Important to this story is therefore an investigation of Taiwan's industrialisation process, with one by-product being the role of state ideology in facilitating the establishment of the medical-industrial complex, which locates medical care and associated activities such as the pharmaceutical and technology industries as part of the capitalist infrastructure.

In analysing the trajectory of the Taiwanese health care state, particular attention is paid to the transformation of medical paradigms over time, with a view to revealing the structural factors that impinge on medicine in becoming a profession. In other words, we will focus on the role of the state in promoting the legitimation of particular modes of medical intervention, associated with changes in the construction of medical knowledge. As far as Taiwan's medical history is concerned, the influences of outsiders are shown to be important, linked to Taiwan's colonised history and the re-building process that occurred in the post-World War II era, in contributing to shifts in Taiwan's medical paradigms. We will examine the influential agents and their impact on Taiwan's health care system, particularly the increasing marginalisation of the traditional Chinese medical system, in an attempt to understand the wider utility of modern medicine in serving the needs of those elite groups who dominated the state.

Alongside discussion of the changes in the nature of medicine, we will chart the changing nature of the Taiwanese state, particularly the significance of state autonomy in managing health care reforms to accord with the principles of state ideology. We will first trace the trajectory of the authoritarian state, with a view to clarifying the link between the authoritarian tradition and the creation as well as reform of the NHI scheme. This came to be associated with a new system of governance and consumption of medical services, as part of a gradual shift to a more liberal society under the growing trend towards democratisation.

On the other hand, drawing attention to the social impact of modern medical care on social relations, this thesis adopts the 'cultural critique' approach to health care, in terms of a concern about how medicine shapes a culture of dependency and passivity contained in medical technology and in the healing relationship (Ehrenreich, 1978). Put another way, to what extent has modern medicine created a dominant culture, which affects both people's and professionals' health behaviours? This study takes into account the social-cultural settings in which the health-related phenomena are known and experienced. Here culture is considered as a potential determinant of health policy which affects decision making and behaviour strategies in relation to health and illness. Thus the ideological predispositions that underpin the health system are considered important, and analysed in order to show the interactions between conceptions of ill health and medical practices.

Medicalisation is a well-known theme in medical sociology. The phenomenon of increasing medicalisation in modern societies has been strongly criticised by social scientists in the past three decades (Conrad, 1996: 138; Morgan *et al*, 1993: 22-8). However, the concepts of medicalisation have, by and large, been applied to Western societies. This current study seeks to start rectifying this bias by presenting the

processes of medicalisation and their impact on the current reforms of Taiwan's NHI, a leading Newly Industrialised Country (NIC). In terms of medicalisation, we will seek to explain the expansion of modern medical care in contemporary Taiwan. We will ask to what extent the NHI has extended the influence of biomedicine and medical power, and therefore caused increasing medical intervention in social life and social relations? The dynamics affecting the medicalisation process within the NHI are explored, although the issue is complicated by the fact that it is inextricable from relationships between the state, the medical profession, and the public (including non-governmental organisations). The three together are seen as constituting a 'medical triangle'. The medical triangle is used in this thesis as an analytic tool for developing the discussion of the complex relationships among various social agents. This is embedded in a wider context of medicalisation that is involved with three levels: the *international* level, for example the doctor-patient relationship; the *institutional* level, for example the organisation of medicine; and the *policy* level, in terms of the political economy of health policy.

The relevant themes involved in this process are many, including sovereignty, citizenship, power, governance, autonomy, dominance, equity and inequality. The relationships within the triangle are intertwined, and some relationships can even re-order other relationships. My main intention, borrowing Ginzberg's (1990: ix) words, is to provide 'a broader and clearer understanding of the multiple forces that are jostling each other and the probabilities that attach to one or another's gaining dominance', in order to present an original perspective on Taiwanese health and health services. To this end, we centre on the role of the NHI in both stimulating and constraining the process of medicalisation and medical power through regulating the health care system, including the governance of medical service and the governance of consumption. In so doing, this

study attempts to provide a novel and expanded perspective on the on-going debates about NHI reform. Hitherto this has been mainly concerned with either cost containment or reorganisation, based on the fact that the NHI has often been in a financial crisis and the Bureau of National Health Insurance (BNHI) has been criticised as bureaucratic and ineffective.

Related to medicalisation is a concern with the situation of medical dominance in Taiwan, referring to the dual role of the NHI in legitimising medical intervention and eroding professional autonomy. In other words, we will look at the changing relationship between the medical profession and the state, embedded in the regulatory system of the contemporary health care state, in order to understand better the consequences of professional expansionism. As well as the development of medical power, shifts towards greater patient autonomy are also charted by a focus on the growing emphasis of consumerism in the NHI. We will therefore examine the extent to which consumerism has stimulated challenges to current biomedical dominance and medical power.

The thesis gives special attention to the fact that Taiwan's significant economic achievement, the so-called 'economic miracle' brought about by its spectacular global economic development, was associated with a 'health miracle', i.e. dramatic improvements in people's health status, which was created alongside it. Thus the thesis takes into account the international context of globalisation, and its influences on population health and state health care in particular. Linked to this, in response to the convergence and divergence debates, it charts the structured diversity of national policy outcomes process in the field of health and welfare policy (Ginsburg, 1992).

In short, this thesis presents the grounds for evaluating the Taiwanese health care state from a new viewpoint in terms of a concern with the construction of

medicalisation, combining cultural and political economic analysis. Unlike previous research into Taiwan's NHI as well as other health care systems in various countries, it attempts to bridge the gap between medical sociology and health policy evaluation. I will now clarify how the body of this thesis will seek to realise these objectives.

1.2 The Structure of the Thesis

This thesis is divided into nine chapters, and falls into three parts. Part One consists of the first three chapters, which together establish the conceptual structure and the analytical approach for the overall thesis. In this chapter, I introduce the main concerns of this research, together with a discussion of the theoretical approaches involved in investigating the issues under discussion. In sum, this thesis sets out to explore the interface between the public (or patients), the medical profession and the state, as well as the effects of government policy on health, in order to ascertain the influence of the state in expanding or restricting the development of medicalisation. In pursuit of this, a broad framework for analysis is adopted, embracing both political economy and the cultural critique approaches to health policy.

Chapter two elaborates the theoretical framework. It begins with a critical review of sociological literature on medicine and society, including a number of important subjects: critiques of modern medicine, construction of medical knowledge, professionalisation and medical dominance, medicalisation, and culture and medicine. In so doing, it seeks to provide the theoretical fundamentals of this study and clarification of key terms. The second part of this chapter presents the study's investigative framework – that seeks to encompass the macro, the meso and the micro levels, which is borrowed from Mohan's analytical approach to British health care reforms (Mohan, 1996). The remainder of the study seeks to maintain this focus on

three levels throughout.

In the third chapter, we demonstrate the methodology employed in this research. Drawing attention to the need to align the research concerns and the theoretical perspectives to research practices, this chapter outlines the empirical strategy used for data collection, and the principles guiding the investigation. It explains why the study adopted a qualitative research approach, and a case study was used as the main strategy for elaborating the contextual understanding of the issues and processes. The methods of data collection used included in-depth interviews, a questionnaire survey, and documentary analysis. Linking to the medical triangle as an analytic fundamental for developing arguments in this thesis, this chapter further explains why specific stakeholders, as the key actors, were chosen for interviews.

The second part of the thesis is the empirical study itself. This explores the Taiwanese context concerning the evolution of the health care system, in order to make more sense of the processes and consequences of medicalisation. This part is sub-divided into five chapters as follows.

Chapters four and five present a comprehensive historical account of the political-economic dynamics of the health care state in Taiwan, in an attempt to gain insights into the formation of Taiwan's health care reforms at both the macro- and meso-levels. In Chapter four, we review the development of the health care state up to 1945, charting the context in which modern Western medicine emerged and developed in Taiwan. Situated within the process of modernisation, this chapter elaborates the shifting of medical paradigms from the traditional model, in the first instance to a model of missionary medicine, then to a model of colonial medicine in the mode of a German-Japanese paradigm. It therefore charts how influential outsiders played an important role in enabling this transformation. In addition, we explore the wider

utility of medical advances in the context of Taiwan's being colonised by Western imperialist powers and then Japan. We will also examine how far medicine helped to improve health, and how far medicine functioned as a tool of the imperialistic states.

Because Taiwan's post-war development was characterised by its rapid industrialisation, as a process of economic modernisation, in the fifth chapter we focus on the determinants of state health measures, to analyse how the medical-industrial complex was established to match specific economic and political needs of the state. We explore the role of the authoritarian state in shaping the trajectory of Taiwan's health care system. We analyse at this point the changing nature of the state, in terms of the tension between economic development and political domination on the government's priorities. To this end we examine how far the authoritarian governance of the Guomintang state had contributed to the formation of a selective health care system before the mid-1990's, and its gradual decay to the emergence of a state-centred universal system, i.e. the NHI, in 1995. Outside the structural factors, as the external factors, this chapter further examines the internal factors, addressing the question of how far the systematic crises within the existing health care system brought about the launch of the NHI. Moreover, in parallel with the previous chapter, a focus is put upon the shifting of the medical paradigm into an American model, linked aid dependency. We therefore examine how a wider process of transmitting American values and medical practice to Taiwan was thereby facilitated.

Chapters six and seven will involve an empirical investigation of the processes and consequences of medicalisation in the context of the NHI system. It examines this through at both meso and micro levels, focusing on the extent to which the NHI has extended or constrained the influence of medicine. The background details about the operation of the NHI system is presented in Chapter six, where the acceptability of

social insurance over taxation as the fundamental of the Taiwanese health care system is also documented. In this chapter, we will focus on the contradictory notions of 'power' and 'regulation', to assess how far the contemporary NHI regulatory system has caused changes in the relationship between the state and the medical profession, referring to the increase or decrease in medical autonomy. Related to this are the medical profession's reactions against NHI regulation. We will explore the various strategies adopted by the professionals, and assess the extent of 'over-medicalisation' within the Taiwanese system. As a key aspect of medicalisation, we also look at the influence of policies on people's health help-seeking behaviour, and the NHI's impact on patient autonomy.

Chapter seven addresses issues around the role of patients as consumers in health care, examining to what extent consumerism has stimulated challenges to current medical dominance. It looks at consumerism in the NHI as an aspect of changing relationships between the civil society and the state. A broad field of consumerism is identified, involving relations between the formal consumer movement, the litigation system, the medical profession and the NHI administration. In relation to this, the chapter elaborates three areas of discussion. Firstly, it analyses the recent development of medical malpractice settlement procedure, and explains whether consumerism has impacted significantly on the medical profession. Secondly, it charts the emergence of patients' self-help movements in recent years as a result of dissatisfaction with the unequal distribution of health care. Thirdly, it reviews the NHI reforms in relation to the growing emphasis on consumerism within the BNHI, in an attempt to make clear the realities behind government political rhetoric.

Chapter eight extends the analysis of the development of the Taiwanese health care state to the international domain, i.e. the macro-level, and analyses the

implications of globalisation. That is, how extensive are the social influences of globalisation on Taiwan's health? We explore the correlation of economic development and health improvement, and examine how a 'health miracle' was created alongside the 'economic miracle' in Taiwan, at a considerable social cost in terms of health inequality. On the other hand, in tune with the critique of convergence theory, we seek to explain divergent trends in health. The impacts of the Asian Financial Crisis of 1997 are explored as an example, examining how significant domestic structural factors have been in giving rise to NHI reform. Finally, we will evaluate Taiwan's struggle to be involved in the international health and economic community, as an example of globalising processes, through organisations such as the World Trade Organisation (WTO) and the World Health Organisation (WHO).

Part Three consists of Chapter nine, which seeks to draw conclusions from this study of the Taiwanese health care state and medicalisation. It provides an overview of the main debates and findings presented in the previous chapters and attempts to answer the questions raised in Chapter 1 from the overall perspective of this research study. Finally, we end by suggesting implications for further research.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1 Introduction

This chapter explains the underlying logic of the investigative framework of this thesis, with a view to introducing the major theoretical concepts that underpin the analysis of the chapters in Part Two. It looks at a number of theoretical perspectives on the socio-cultural dimensions of health and health care with a view to developing a critical analysis of medicalisation, and uses them to develop a framework that may enable a textured analysis of the evolution of the health care reform in Taiwan.

The main body of this chapter includes two parts. The first part is a critical review of sociological literature on medicine and society, aiming to provide the theoretical fundamentals of this study and clarification of key terms. Particular attention is paid to the perspectives brought to bear on culture and medicine, with a view to elaborating the ‘cultural critique’ approach to the analysis of this thesis. The second part of this chapter presents the study’s investigative framework – which takes account of the macro, the meso and the micro levels, and is borrowed from Mohan (1996); it aims to identify the social forces that shape the current approach to health in Taiwan. The remainder of the thesis seeks to maintain this focus on three levels throughout.

2.2 Medicine and Society: The Theoretical Underpinnings of this Thesis

This section is an overview of the major theoretical perspectives informing this research study, with the aim of extending sociological discussion of medicine to a broader context in terms of the socio-cultural dimension. It seeks to bring together

different theoretical disciplines about health studies, thereby contributing towards filling the gap between sociological criticisms of medicalisation and health policy evaluation, as noted in Chapter 1. The sociological literature I am going to review falls into four groupings: critiques of modern medicine, construction of medical knowledge, professionalisation and medical dominance, and the medicalisation thesis. In addition, the cultural studies approach to health will be taken into account by considering the relationship between medicine and society, i.e. the extent to which medicine is viewed as a cultural system. We shall now move on to the details of these themes.

2.21 Critiques of modern medicine

As this thesis is concerned with the development of a Western biomedical model in Taiwan, we think it is essential to portray the situation of this model in modern society and in sociological criticism. It is said that modern biomedicine has become the dominant paradigm of Western medicine since the end of the eighteenth century (Nettleton, 1995: 2-3). Nowadays the biomedical model still forms the dominant approach to health in the way it 'underpins the organisation and delivery of health care in the modern world' (Taylor, 1997: 50). However, in the face of the triumphant claim of modern biomedicine as representing a significant contribution to improved health, critiques of the biomedical model have been developed over the past few decades, and the questioning of the biomedical approach has also become more radical (Jones and Moon, 1987: 21-30; Nettleton, *ibid.*, pp.5-8). Different critiques have different views on the merits of medicine, and likewise they raise various solutions to the biomedical model, which now appears problematic. In general, the critiques of modern medicine may be classified into three groups: the rational critique, the social critique, and the

holistic critique. I will now briefly review each of these.

- *The rational critique*

Simply stated, the rational critique represents an approach to medicine that upholds the positivistic paradigm from within the existing system of scientific rationality. This critique tends to be sceptical towards the effectiveness of modern biomedicine in that medicine is not considered to live up to scientific ideas unless benefit is proved, thereby contributing to the establishment of an evidence-based approach towards health-related interventions (Oliver & McDaid, 2002). Referring to the influence of Cochrane (1972), who initially argued for the importance of well-controlled quantitative evidence in government health care decision-making and accordingly urged the removal of inefficient practices from the British National Health Service based on the result of such evaluation, this approach pursues improved efficiency of medical care. Increasing emphasis has been laid upon the financial side of the health care system, and the corollary of this is that there is a requirement for the transference of financial resources from inefficient medical items to efficient ones (Jones & Moon, *ibid.*, pp.22-3). Based on a distrust of government decision-makers' being neutral in choosing the commissioned party to conduct relevant evaluations, some critics (Ham *et al*, 1995) suggest the necessity for setting up independent charitable funding of research to oversee the operation of evaluations.

In the international domain, the global trend of health care reforms has focused on governments' worsening finance with strategies highly dependent on the rational model. According to Ham (1997: 27), the agenda of international health care reforms in the past three decades has been as follows: to achieve cost containment at the macro level

in the period from the late 1970s to the early 1980s; to increase efficiency and enhance responsiveness at the micro level in the late 1980s; to tackle the cost-effectiveness of healthcare and of the difficult choices involved in setting priorities in the mid-1990s. In tune with the rational critique, he argues for (1990, 1997, 1999) an efficiency-based approach to health care reform. The policy instruments that he suggests are, for example, to introduce market-like mechanisms, to strengthen managerial strategies and to make use of budgetary incentives.

- *The social critique*

In essence, the social critique offers a sociological perspective on the construction of health and illness, in reaction to the dominant paradigm of the biomedical model, which defines human health as ‘the absence of biological abnormality’ (Taylor, 1997: 50). This critique attacks the linear causal explanation of disease whereby each disease has a cause and can be treated within a biological process. Instead, it extends the analysis of disease to a broader context: that is, it is suggested that the body needs to be located within its socio-environmental context, while biomedicine, by contrast, underestimates the influences of people’s material circumstances on ill health (Nettleton, 1995: 5-6). In this respect, illness and treatment are socially constructed rather than ‘scientific’, as biomedicine claims.

As far as the metaphor of the ‘physician as body-mechanic’ from the biomedical model is concerned, critical sociologists argue that physicians play a role in exercising a form of social control through their treatment (Taylor, *ibid.*, p.61), thereby contributing to the performance of the surveillance of the body and of populations by the medical profession through the employment of medical knowledge (Foucault, 1976; Turner,

1995). Related to this is the critique of medicalisation relating to the extensive power of medicine over many areas of life, as we will explore in more detail later.

The contribution of scientific medicine has been considered limited by social critics, referring to its excessive claims of achievement. It is argued that there exist other factors that play more crucial roles than medical intervention in the improvement of health. For example, Dubos (1960), through his research into the decline of the death-rate in the previous hundred years, contends that health improvements owed little to the development of laboratory medicine but were more closely linked to sanitary improvements. Echoing Dubos' claim, McKeown (1979) argues that medical intervention was of little importance in contributing to the decline in deaths from infectious disease during the period of the early nineteenth century to the mid-1930s. Rather, the improvements in living conditions and environmental situations are considered as the decisive causes of the reduced mortality.

The biomedical model is also denounced by social critics on the grounds that it fails to elucidate how social inequality can affect health (Nettleton, 1995: 5-6). Drawing attention to the linkage between health and socio-economic circumstances, the social critique suggests that health inequality is related to social structures and varies according to social variables such as social class, gender or race (*ibid.*, p.161). On the other hand, attention is paid to social causes of health and ill-health, in terms of the material conditions of life, such as housing conditions, poverty, unemployment and public scheme allowances, referring to the influence of the Black Report published in 1980 in a British context (Hardey, 1998: 88-9; Ham, 1999: 81). In a similar regard, Wilkinson (1999a, 1999b) reminds us of the importance of the extent of income inequality in affecting the variations in health between different economic groups, and

Furthermore suggests a psychosocial approach to health, in terms of the raising of the quality of social life as the most crucial determinant of health.

The holistic critique

Although the biomedical model as orthodox medicine has dominated all medical approaches to health over the last 150 years (Stacey, 1988), in the past two decades an increase in the use of non-orthodox therapies has been identified in post-industrial societies (Hardey, *ibid.*, p.13). Non-orthodox medicine may reflect an opposition to the orthodox approach to health, in two regards. Firstly, non-orthodox approaches imply the idea of holism in terms of paying attention to both the mind and the body, in comparison with the biomedical dualism of mind and body. It is thought that the mind can affect the body in positive ways. Moreover, holistic medicine suggests a whole-person approach to health: that is, to situate the whole person in the context of his/her social environment for a satisfactory understanding of illness (Hardey, *ibid.*; Saks, 1998; Turner, 1995: 9). In this respect, health and illness are considered as an interactive relationship between nature, health and the body.

The second point is related to a methodological dispute existing between orthodox and non-orthodox medicine. Orthodox medicine has its roots in rationalism (Hardey, *ibid.*, p.11) and relies on the commitment adopted from the discipline of science, particularly the idea of scientific evaluation as value-neutral (Hodgkin, 1996). It is argued that the orthodox medical profession tends to maximise validity and exclude bias in evaluating their medical interventions (Fox, 1993; Saks, *ibid.*, p.200). In contrast, scientific proof is not so relevant to non-orthodox therapy (Saks, *ibid.*, p.200), which, as alternative practice, sometimes has to work out things on its own side, parallel to what happens to traditional medicine. Instead of depending on scientific technology, the holistic movement is more likely to

involve a patient-centred approach to health, in that an expectation is put upon physicians to offer empathy and sensitivity to patients' problems, together with an emphasis on individual responsibility for health within a consumer-orientated society (Hardey, *ibid.*, p.14).

2.22 Construction of medical knowledge

Having briefly reviewed the three critiques, I will now apply them in more depth. In terms of this, a fundamental critique of modern medicine points to the construction of medical knowledge in relation to the role of the medical profession in performing social surveillance. It is argued that medical knowledge, which claims scientific objectivity and independence, lays the basis for the exercise of professional power (Turner, *ibid.*), which in turn contributes to the formation of professionalism and medical dominance. Therefore, before we move on to a discussion of professionalisation, in this section it is essential to deal with the issues surrounding the construction of medical knowledge.

From the factors which the critiques focus on to explain the forces shaping medical knowledge, the debates fall into two general groupings: the micro-focus group, typified by social constructionists, and the macro-focus group, referring to the political economy critics.

- *Social constructionism*

Simply stated, social constructionism is essentially an approach which questions the claim of medical knowledge to be universal, and is concerned to examine biomedical knowledge and bodily experiences through cultural and social analysis (Lupton, 1994: 11). Social constructionists argue that medicine is a form of social practice that reflects a particular way of viewing the world, rather than a neutral, ahistorical enterprise

(Hillier, 1991: 180; Nettleton, 1995: 18). In this respect, disease labels or medical categories are considered as socially constructed.

Based on an analysis of the development of medical conceptions, Foucault (1976) identifies the emergence of the clinic in 18th century France as a major change in the medical approach to disease. As far as the construction of medical knowledge is concerned, there are three points which can be extracted from Foucault's argument. Firstly, the establishment of the clinic is important in that it provides the base on which a new medical approach, including medical observation, bedside teaching and physical examination, was implemented and promoted. Therefore, within the clinical-anatomical approach the body becomes the object of medical activities. Secondly, clinical medicine adopts the localised pathological process in which the analysis of disease is localised within the internal structures of the body. Consequently, the body becomes the subject of a detailed analysis of clinical techniques on the grounds that it is viewed as an entity distinct from a person. Thirdly, the notion of disease is a product of the 'clinical gaze', through which particular ways of viewing the body are defined and performed by medical men. A disease entity is merely a social construct that is largely influenced by the exercise of medical discourses. In other words, the main body of medical knowledge is formed by clinical experience rather than scientific objectivity. On the other hand, the clinical gaze implies a political dimension to the debates surrounding the body. That is, the ways the body is viewed and described are based on an exercise of power, which serves to establish the 'political anatomy' of the body (Foucault, 1977).

Likewise, based on Foucault, Armstrong (1983) draws attention to the influence of changes in the medical approach to the view of the body and the construction of medical knowledge. He argues that a new medical gaze emerged as a result of the

development of more survey techniques of health/illness data and greater specialisation, in that a new political anatomy of the body is formed by the extension of disciplinary power from the confines of the body to the social sphere. In this respect, medicine is a manifestation of certain surveillance strategies (Armstrong, 1987), since medical men exercise their social power of control over the body of medical knowledge.

As Nettleton (*ibid.*, p.24) notes, the Foucauldian approach provides a new model of illness by suggesting that the analysis of disease needs to be located in a wider social context, in that the body, disease and medical discourse are inseparable.

- *The political economy critique*

Generally speaking, political economy criticisms of medicine centre on the role of political and economic factors in constructing particular patterns of illness and disease, as well as in shaping the forms of medical practice. Drawing attention to the needs of society, this approach considers the extent to which medicine serves particular interests at a societal level. The following parts will sketch the main theoretical perspectives under three sub-titles: functionalism, the Marxist critique, and the critical political economic perspective.

Functionalism

In terms of functionalism, it is argued that the explanation of social phenomena is based on the functions they perform, in that societal continuity whereby individuals are socialised strongly into conformity is considered very important (Bilton, 1981: 21-3). The maintenance of social order is of particular importance; therefore, the problem of social order is channelled through the process of socialisation into a consensus of norms and values.

Based on the functionalist perspective, sickness is considered a potential state of social deviance, and medicine as a necessary institution of social control in that the medical profession plays a major role in exercising the control. According to Parsons (1951, 1978), a leading functionalist scholar, sickness is defunctional, owing to its effect on the sick person being enabled to evade his/her social responsibilities. In this sense, sickness is viewed as one area where particular control is possible to be put upon individuals in order to maintain societal equilibrium. Accordingly, the notion of the 'sick role' is conceptualised under the social aspects of medicine as an institution of social control.

The Marxist critique

The Marxist critique places a great emphasis on the political-economic factors that contribute to upholding the modes of capitalist production. It is argued that medicine as an institution of social control serves the interests of the state and the ruling class, and the organisation and practice of medicine support the underling logic of the existing capitalist system. In this respect, state intervention in medicine is attacked for two reasons (Allsop, 1995: 148; O'Connor, 1973; Gough, 1979; Offe, 1984). First, on the political side, the state is concerned to legitimise its position by virtue of spending on health for the electorate. Second, on the economic side, the state serves the requirements of capitalism for profit typified by supporting the medical industry.

Well-known Marxist critiques of modern medicine are as follows. Navarro (1978) contends that medical legislation and policy formation are primarily determined by the nature of the class struggle. Through a case study of the evolution of the British health sector, he posits that the British health services represent a dominant ideology of the bourgeois class. Drawing attention to the structural constraints that underlie an

advanced capitalism, McKinlay (1984: 4) argues that the medical-industrial complex fosters and reinforces the broader interests of capitalism. Also, he suggests that key decision-making always follows the doctrine of profitability in accordance with the logic of capitalism. Accordingly, health improvements will be implemented by the state only when they facilitate an acceptable level of profit (McKinlay, 1977: 463). Doyal (1979) echoes the Marxist accusation regarding capitalism as the determinant of ill-health, and points out that the patterns of health and illness within the capitalist structure reflect the character of profit. Modern biomedicine represents its contradictory nature in the ways it offers help for the ill on the grounds that medical provision is accomplished in a fetishised form; that is, the medical approach concentrates on individual body pathology but meanwhile hides the role of society in determining health (Jones & Moon, 1987: 29).

The critical political economic perspective

In a sense both the functionalist and Marxist critiques do not necessarily always denounce the direct effects of medicine but may even view them as having some beneficial effects. Informed by Marxist critiques of the nature of the capitalist economic system, a critical political economy approach to medicine otherwise retains a broadly negative attitude towards modern medicine. Overall, modern medicine is charged with several shortcomings. Firstly, medicine is perceived as socially biased in its distribution; accordingly, health care under capitalism is ineffective, under-regulated and inequitable (Tudor-Hart, 1975; Freidson, 1970a; Lupton, 1994). Secondly, within an industrialised capitalist society, different segments of the medical care industry, including the health-care providers, pharmaceutical companies and the manufacturers of medical equipment, share a vested interest in terms of profit-making (Taylor, 1997:

56). Given this, a growing trend of deepening medicalisation seems to be unavoidable. Thirdly, it is claimed that modern medicine is harmful in the way it causes not only direct clinical harm but also other disabling effects, such as the erosion of individual capacity for self-care (Illich, 1976; Weitz, 1982). This point is similar to the cultural criticism perspectives on modern medical care, as we shall explain later.

2.23 Professionalisation and medical dominance

Medicine as a profession originated with the expansion of professional occupations in relation to the development of industrialisation. In general, this arose for two reasons. Firstly, the tremendous progress of industrialisation in the eighteenth century gave rise to the growth of industry and commerce. This development in turn resulted in the emergence of new forms of professional services as a response to meet the needs of consumers (Hannay, 1988: 192). The second reason relates to the striking achievement of science and technology in the nineteenth century. The medical profession was at an advantage because the appearance of scientific medicine contributed to shaping physicians in a new image, and accordingly patients became more dependent on the skills of physicians.

From the functionalist perspective, the common characteristics of a profession or the so-called 'traits' that characterise professions are as follows: specialised knowledge that informs professional practice, formal and prolonged training that is related to the entry to the profession, ethical orientation towards providing service to the public, and a monopoly of practice that is self-accounting and self-regulating (Johnson, 1977; Hannay, *ibid.*, p.191; Hardey, 1998: 68; Cocherham, 1995: 188). These professional traits seem to fit the medical profession very well, as Hardey (*ibid.*) points out. This leads us to examine the process in terms of professionalisation and its end-state,

professionalism (Johnson, 1972), by which the medical profession may claim to have such attributes.

- *The process of professionalisation*

According to Conrad & Schneider (1990: 141), 'the status of the medical profession is a product of medical politicking as well as therapeutic expertise'; professionalisation, therefore, can be considered in terms of a strategy of occupational control (Turner, 1995; Johnson, 1972). This perspective accounts for the role of the medical profession in winning a legitimation of professional privilege, whereby the state also has a strategic role in the procedure by supporting the formation of medicine as a profession on the one hand, and involving itself in the control and management of the profession on the other. It is in this sense that the following sections will address the process of professionalisation with regard to three elements: organised autonomy, legitimised monopoly, and the growth of medical expertise (Conrad & Schneider, *ibid.*, from which this section borrows heavily).

Organised autonomy

It has been argued that the medical profession is well organised on the grounds that state-sanctioned autonomy enables the medical profession to perform self-scrutiny of their knowledge and their work (Freidson, 1970a). Professional organisations play the role of gatekeepers by virtue of certain strategies, including controlling the criteria for membership, setting up practice rules and ethical codes and performing medical training. Accordingly, the medical profession upholds the image of medicine as a profession; meanwhile, it becomes increasingly powerful and authoritative.

Commentators have questioned the essence of professional autonomy. Friedson

(*ibid.*) suggests a potential for failure to self-regulate existing within the medical profession. That is, medical professionals tend to abuse their freedom to pursue economic interests on the one hand, and professional organisations generally lack efficient mechanisms to restrain individual members on the other. According to Hardey (*ibid.*, p.69), state-sanctioned autonomy is a paradox, since the medical profession is highly dependent on the state's authorisation of its social position; in effect, the state leaves only technical matters to the jurisdiction of the medical profession.

Legitimised monopoly

The second dimension of professionalisation refers to medical monopoly as a legitimate privilege approved by the state. This is concerned with the function of law in upholding the position of professionals, particularly 'orthodox' practitioners or the well-educated, whose monopoly of medical services is legitimised. Medical education, licensure and training construct the infrastructure that serves the purpose of a professional monopoly, whereby the medical profession plays a crucial role in securing the monopoly situation by controlling the implementation of medical education and training commissioned by the state.

There is a political dimension worth noting in relation to the realisation of medical monopoly. That is, the monopoly of medical practice is a result of competition between different professional groups, typified by 'qualified practitioners' vs. 'unqualified practitioners'. Admittedly, orthodox medicine is based on the paradigm of scientific medicine, upon which the state-granted qualifications for medical practice are based. Accordingly, practitioners are qualified in terms of being orthodox physicians. The fact that qualified practitioners constitute the majority of professional organisations has resulted in disadvantageous circumstances surrounding the position of unqualified

practitioners, such as non-orthodox physicians, who are in turn isolated from the competition of markets for expertise. Consequently, medical monopoly becomes a control over the medical division of labour by a particular group of physicians, who have vested interests, as Sharma (1992) indicates.

Growth of medical expertise

The third dimension of professionalisation is concerned with the influence of the advances of medical expertise. Despite the fact that many empirical studies have indicated that scientific medicine is limited in its contribution to health improvements (Dubos, 1960; McKeown, 1979), medicine still has much popular credit for improved health, due to circumstantial evidence, i.e. health improved at the same time as doctors rose to prominence. Of particular importance are the recent accomplishments of surgery and bacteriology, both of which have made great strides in upholding the popular credit of medicine (Conrad & Schneider, *ibid.*). Therefore, professionalisation can be facilitated by the paradigm of scientific medicine as the dominant value (Johnson, *ibid.*), in that medical professionals are enabled to establish their power over the diagnosis of ill health in the name of science. However, the development of increasing complexity in medical technology, for example in the use of computers, may cause de-skilling in the medical profession when conventional expertise is replaced by new technology (Turner, *ibid.*, p.139). In this sense, the growth of medical expertise can also lay the basis for deprofessionalisation, except that doctors still control the use of technological knowledge.

- *Professional dominance*

In a way professionalism is a result of the exercise of occupational strategies, and this

view leads us to pay attention to the dynamics of the power relationships that contribute to the formation of medical dominance. Overall, this power structure consists of two levels: micro-politics and macro-politics. At the micro-level, there is a 'competence gap' (Waitzkin, 1979) between professionals and lay men in the medical encounter. Professional dominance will be reinforced by unequal access to medical knowledge and resources between professionals and laymen. In terms of the macro-political level, Marxist critics argue that professional dominance contributes to the economic and political functioning of the capitalist system (Turner, *ibid.*, p.130). It is claimed that the medical profession duplicates, by and large, the values of the capitalist class by controlling the working class under the auspices of the state.

Based on Friedson's professional dominance perspective, but extending it to a broader politico-economic context, Willis (1993: 106) argues that the professional dominance of medicine is sustained at three levels. Firstly, autonomy refers to the level at which doctors are able to control their own work without direction and evaluation from other health occupations. Authority at the second level implies that doctors are in control of directing or supervising the work of others within the medical settings. The third level, medical sovereignty indicates the privileged position of doctors in the wider society, where they are regarded as institutionalised experts on all matters relating to health. This conceptual framework requires us to consider that the analysis of medical dominance reaches beyond the domain of medicine and needs to be connected with the medicalisation arguments. The formation of medical dominance involves not only the medical profession but also the other social agents who exercise their influence within and outside the domain of medicine. Given this, medical dominance implies medicine as a dominant profession and medicine as a dominant ideology/culture. This is an implicit assumption of this research, and it is in this regard that the thrust of the

argument is constructed.

- *Deprofessionalisation and proletarianisation*

In reflecting on the professional dominance theory, commentators have suggested other alternatives to the medical profession, typified by the arguments concerning deprofessionalisation and proletarianisation (Hafferty and McKinlay, 1993: 4; Wolinsky, 1993: 14; Hardey, *ibid.*, p.84; Turner, *ibid.*, pp.135-7). Firstly, the deprofessionalisation perspective argues that the medical profession has been losing its prestigious position in society, and accordingly the social distance and cultural gap between doctors and patients are both declining. According to Haug (1973), who first put forward the deprofessionalisation argument, the factors that are influential in deciding the development of deprofessionalisation are as follows: the increased use of automated retrieval systems, the increased access to medical knowledge for the public, the increasing specialisation within medicine, the growth of self-help patient movements, and the rising cost of health care. Later on she suggests that the development of corporatisation is a new factor that can transform the context of medical dominance (Haug, 1988; Wolinsky, *ibid.*, p.15). This argument is also related to the proletarianisation perspective that follows.

The proletarianisation perspective, as the second alternative to professional dominance, is concerned with the contradiction between professionalism and bureaucracy (Hall, 1968) observed in changing health care systems, particularly within developed countries. As McKinlay (1988), considered the most eloquent spokesperson for the proletarianisation argument (Wolinsky, *ibid.*), points out, the growing corporatisation and bureaucratisation of medicine have made a great impact on the medical profession in the ways doctors are losing control over their work. McKinlay

and Stoeckle (1988) identify seven traditional professional prerogatives which are lost through the process of proletarianisation: the criteria for entrance, the content of training, autonomy, the objects, tools, and means of labour, and the remuneration for labour. Through identifying a tendency for medical professionals increasingly to operate within bureaucratic settings, Turner (*ibid.*, p.135) claims that a decline in professional status will occur accompanied by the undermining of professionalism.

2.24 Medicalisation thesis

The expansion of medical intervention in modern societies has caused debates on 'medicalisation', i.e. a concern over the influences of the increasing medical social control. Criticisms started in the 1970s from some social scientists who first called attention to the widening realm of psychiatry (Conrad, 1996: 138). The writings of Freidson (1970a, 1970b) present an influential model of the professional dominance perspective, in which an initial concern about medicalisation is expressed. As he indicates, there has been widening medical jurisdiction: that is, the medical profession has been granted a monopoly power that can be extended over areas of life which were previously not the concern of medicine. Zola (1978), adopting Parsons' theoretical concept regarding the view of medicine as an institution of the social system, claims that medicine operates as a major institution of social control. Drawing attention to the political consequences of medicalisation, he suggests that political expediency is a crucial factor contributing to the 'medicalizing of society' as a result of the development of medicine's potential (Zola, *ibid.* p.95; Enrehreich, 1978: 31). Zola's argument has since been referred to as the 'medicalisation thesis' (Allsop, 1995: 143). In addition, Illich (1975, 1976) charts the conception of 'medicalisation of

life' under his criticism of the sickening impact by which institutional medicine has become a threat to health.

Although a great deal has been written on the issues surrounding medicalisation, the definition of medicalisation has not so far been enunciated. As Conrad (*ibid.*, p.139) points out, 'the key to medicalisation is the definitional issue'. In general, medicalisation criticisms might fall into two rough groupings: medicalisation of life and medicalisation of social relations.

- *Medicalisation of life*

In terms of the criticism of the medicalisation of life, critics focus on the extensive power of medicine over the area of life (Illich, 1975; Zola, 1983; Hillier, 1991; Morgan *et al*, 1993; Freund and McGuire, 1995; Nettleton, 1995; Conrad, *ibid.*). Accordingly, medicalisation is regarded as a process of legitimating medical intervention in areas which were previously not defined and treated as medical problems. Medicalisation in this respect implies a possible outcome whereby more and more human matters will become subject to the jurisdiction of medicine. It is argued that medicalisation occurs in both fields of deviant behaviour and 'natural life processes' (Conrad, *ibid.*, p.141). Significant examples of the former are alcoholism, children's hyperactivity and obesity; of the latter: pregnancy and child-delivery, the menopause and ageing.

In a way, 'medicalisation of life' refers to a profound dependency on consumption created in the citizenry by the capitalist mode of production and consumption, in that lay people are denied the opportunity to realise their 'natural' creative capacities and then turn to their realisation in the sphere of consumption (Navarro, 1975; Taylor, *ibid.*, p.56).

- *Medicalisation of social relations*

The critique of the medicalisation of social relations centres on the interactional level of medicine. This is concerned with medical professionals' expanding role in social control, which in turn shapes and promotes the development of medicalisation. As Cornwell (1984: 117) indicates, 'medicalisation implies *relationship*, and it implies *interaction between two worlds*... One is the world of lay people and of commonsense health beliefs; the other is the world of medicine and of applied science.' She argues that the lay world is dominated by the medical world *per se*. Based on Cornwell's framework, we may suggest that initial medicalisation is strongly linked with medical professionals in the way they exercise their medical control over patients. This arises for two reasons. It is argued, first, that the medical profession controls the power of constructing the concepts of health and illness, as the professional dominance theory claims (Freidson, 1970b). Accordingly, medical professionals hold a commanding position in defining the conditions for medical intervention. Secondly, modern scientific technology contributes to further extending the criteria of professional dominance in the way the medical profession may claim their competence by appealing to scientific effectiveness (Morgan *et al*, *ibid.*, p.23).

An important aspect of the medicalisation of social relations relates to the function of medicine as moral regulation (Turner, 1995: 13). As Turner has suggested, this perspective is concerned with medicine's 'governmentality' in terms of the general regulation of human bodies in Foucault's terms. Related to this is the cultural critique of modern medicine. Critics focus on medicine's damaging effect: that is, modern medicine produces social dependency and reduces individual autonomy (Illich, 1976; Enrehrich, 1978). More discussion of cultural criticisms will be pursued in the section that follows.

In a sense medicalisation has emerged as an object of critiques concerning the domination of modern biomedicine. Basically, the process of medicalisation is embedded in the biomedical paradigm, in that a biological explanation is offered and particular forms of practice are transmitted. The medicalisation thesis suggests that medical professionals tend to offer technical solutions in terms of biological treatment to non-medical problems (Nettleton, 1995: 28). Related to this is the argument that rationalisation is a form of legislation in modern societies, (Habermas, 1971). Medicalisation in this sense can be viewed as a specific form which rationalisation takes in the area of health and illness, as Cornwell (*ibid.*, p.119) claims. Based on Habermas' theoretical perspective, she (*ibid.*, pp.119-120) contends that the process of medicalisation takes place at two levels: medicalisation 'from above' and medicalisation 'from below'. The former occurs at the level of culture as a whole referring to the domination of the ideology of scientific medicine within Western societies. The latter occurs at the level of sub-cultures in relation to the changes in social life and social relations caused by the practices of scientific medicine. She concludes (*ibid.*, p.120) that 'the dominant tendency in our culture is towards modern scientific and technical forms of legitimation'.

2.25 Culture and medicine

Simply stated, the cultural studies approach to health reminds us of the importance of the interplay of cultural factors as the basic values which impinge on medicine and underlie the health system (Levine, 1993: 198). This is a common concern of medical anthropology, in which a holistic approach to studies of medicine is recommended. It is argued that a health care system has two inter-related aspects: a social aspect and a cultural aspect (Landy, 1977; Helman, 1986: 42). The social aspect indicates

'organisation into certain specified roles and the rules governing the relationships between these roles in specialized settings' (Helman, *ibid.*). This view accords with the approach of conventional sociology to medicine as a social system. In terms of the cultural aspect, it is argued that health-related concepts, theories, normative practices and shared modes of perception need to be brought together for the analysis of medicine as culture. Medicine is viewed as a cultural system. According to Kleinman (1980: 24), this is 'a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions'. It is in this sense that Kleinman (*ibid.*) identifies the health care system as the totality of the interrelationships of the health-related components of society, including patterns of belief about the causes of illness, norms governing choice and evaluation of treatment, socially-legitimated statuses, roles, power relationships, interaction settings, and institutions. Overall, he claims that the analysis of medicine needs to be embedded in the configurations of cultural meanings and social relationships.

On the other hand, the cultural studies approach to health may provide a broader context for the investigation of the modern medical establishment based on a cross-cultural orientation. It is argued, first, that cultural variations decide the conceptions, experiences and expressions of health and illness (MacLachlan, 1997). Secondly, this approach values the notion of multiculturalism, whereby critics challenge the claims of medicine to be scientific, as the medical profession would like the general public to believe (Payer, 1988; MacLachlan, *ibid.*). It is suggested that medicine is not quite an international science because cultural factors intervene at every step of the delivery of medical care (Payer, *ibid.*, pp.24-6). Accordingly, cultural biases are unavoidable in the practice of medicine by physicians.

In tune with the cultural studies approach to health, the cultural critique maintains

a severely negative attitude toward modern medicine, focusing on the damaging effects of medicine. For example, Illich (1975) argues that medicine has damaging effect on three levels . Firstly, at a clinical level, iatrogenesis can happen because of improper medical interventions. Social iatrogenesis at the second level refers to the expanding nature of medicine accompanying the industrialisation of society in maintaining a sick society. This is typified by the increasingly unrealistic health demands induced by the medical-industrial complex. The third level is structural iatrogenesis, concerning the impact of medicalisation on the individual's autonomy. That is, people's capacity for self-care has been undermined during the process of medicalisation, in that ill health as a personal challenge is transformed into a technical problem. Ehrenreich (1978: 1) points out that the price of scientific medical care is in terms of physical harm, social dependency, and political impotence. He claims that medicine is a capitalist mode of healing, and he denounces modern medicine as a mode of extending bourgeois cultural and political hegemony (*ibid.*, pp.16-22). Like Illich, he agrees that the medical system has generated people's biological dependency on the grounds that the healing relation is a direct relationship of domination (*ibid.*).

In sum, the cultural studies approach to health/medicine offers an insight into medicine in that it is concerned to investigate the social-cultural settings in which the health-related phenomena are known and experienced rather than solely to understand the biological dimensions (Lupton, 1994: 161). This approach inspires us to consider culture as a potential determinant of health in that culture acts as a normative component to affect decision making and behaviour strategies in relation to health and illness. Drawing attention to the social impact of modern medical care on social relations, the cultural critique as a critical approach to health care leads us to take a further step to examine the nature of modern medicine. That is, it is important to

consider how medicine shapes a culture of dependency and passivity contained in medical technology and in the healing relationship, and how this process is carried out to match the principles of state ideology in pursuit of capitalist development.

Thus far I have presented a large amount of sociological literature about health and medicine, the aim being to provide the theoretical fundamentals that inform the investigation of this study directed towards developing a critical analysis of medicalisation and the health care state in the context of Taiwan. In other words, the theories and conceptions reviewed will be adopted to fit into this study's explanatory framework, and elaborated in the section that follows, revealing a holistic approach that comprises different theoretical criticisms exploring the circumstances and consequences of medicine becoming a dominant profession and ideology in Taiwan. On the one hand, this thesis draws attention to the macro perspectives on medicine, investigating the structural constraints that underlie the construction of the Taiwanese health care state. In the analysis of the wider significance of political and economic systems in upholding the development of Taiwan's capitalist system, the role of the state in moulding the development of modern medicine is identified, embedded in the trajectory of modernisation. On the other hand, the cultural studies approach to health, representing the micro perspectives, is adopted in this thesis, concerning the analysis of the social values that impinge on individual social agents' health-related behaviours in facilitating the formation of a medicalised society. In so doing, this study seeks to gain insights into the social construction of medical knowledge and its relevance to the phenomenon of medical dependency, investigated in the real context of the contemporary NHI system. Following this I will explain how the investigation in this study will seek to configure relevant conceptions and issues in pursuit of a holistic approach to the analysis of the Taiwanese health care system.

2.3 The Analytic Framework of the Thesis: Towards a Holistic Approach

This section is an attempt to bring together the different theoretical perspectives surrounding health and illness noted previously, towards comprehending the socio-cultural dimension of the contemporary Taiwanese health care reforms. In tune with sociological tradition concerning the relationship between agency and structure (Turner, 1995: 3), the analysis of this thesis is organised to explore the relationship between health-related action and the structural determination of social relations by considering the constraining elements of the health care system. Particular attention is paid to the interplay of cultural factors that may affect health-related conceptions and behaviours. Crucial cultural factors include: normative practices and shared modes of perception towards health and illness, images and perspectives of the healer, the basic values that influence diagnoses and treatments, the ideological predisposition that underlies the health system, and the roles and trust assigned to government bureaucracies (Levine, *ibid.*, p.198; MacLachlan, *ibid.*, p.21; Helman, *ibid.*, p.42; Payer, *ibid.*).

In this section, I will outline the analytic framework (see Figure 2-1) upon which the rest of the thesis will be based. The frame is three-fold, including the macro, the meso and the micro levels, borrowed from John Mohan's (1996) analytic structure based on a literature review of the origins of the British NHS reforms implemented in the early 1990s. According to Mohan, the accounts at the macro-level are related to those 'which emphasise convergence between health care systems or which stress the impacts on the British health sector of external forces beyond its control' (p.676). The accounts at the meso-level focus on 'the ways in which global economic trends are mediated by national state policies' by considering 'the ideological and political

strategies' pursued by the government (pp.676-7). Finally, the main area of interest at the micro-level is involved with 'the internal characteristics of the problems facing health care systems and the impacts of changing consumer demands and preferences' (p.677). Drawing attention to the socio-cultural dimension of health care, the analysis of this thesis further otherwise points to a very different way in which critical elements affecting the medicalisation process are identified and associated with a concern with the social impacts of health-care services in the context of Taiwan. Particular attention is paid to the introduction of a conceptual tool of the 'medical triangle' (see Figure 2-2), which consists of three pairs of relationships: the state-profession relation, the profession-public relation and the state-public relation, serving to enable a deeper understanding of the operation of crucial social forces that shape the current approach to health.

This explanatory structure will be applied in Part Two of the thesis, where many relevant empirical examples will be presented. It should be noted, however, that the way this investigative framework is presented involves a risk of over-simplification. These three levels cannot be rigidly separated; they are often interrelated. In fact, the interactive effects between levels are very important, for they make it possible to treat the health care state as an organic whole. I will now briefly preview the main issues of this thesis, connected to the theories reviewed above, using the three level category, but it may not be possible in some discussions to avoid an overlap between the levels.

Figure 2-1 Analytic Domains of This Thesis

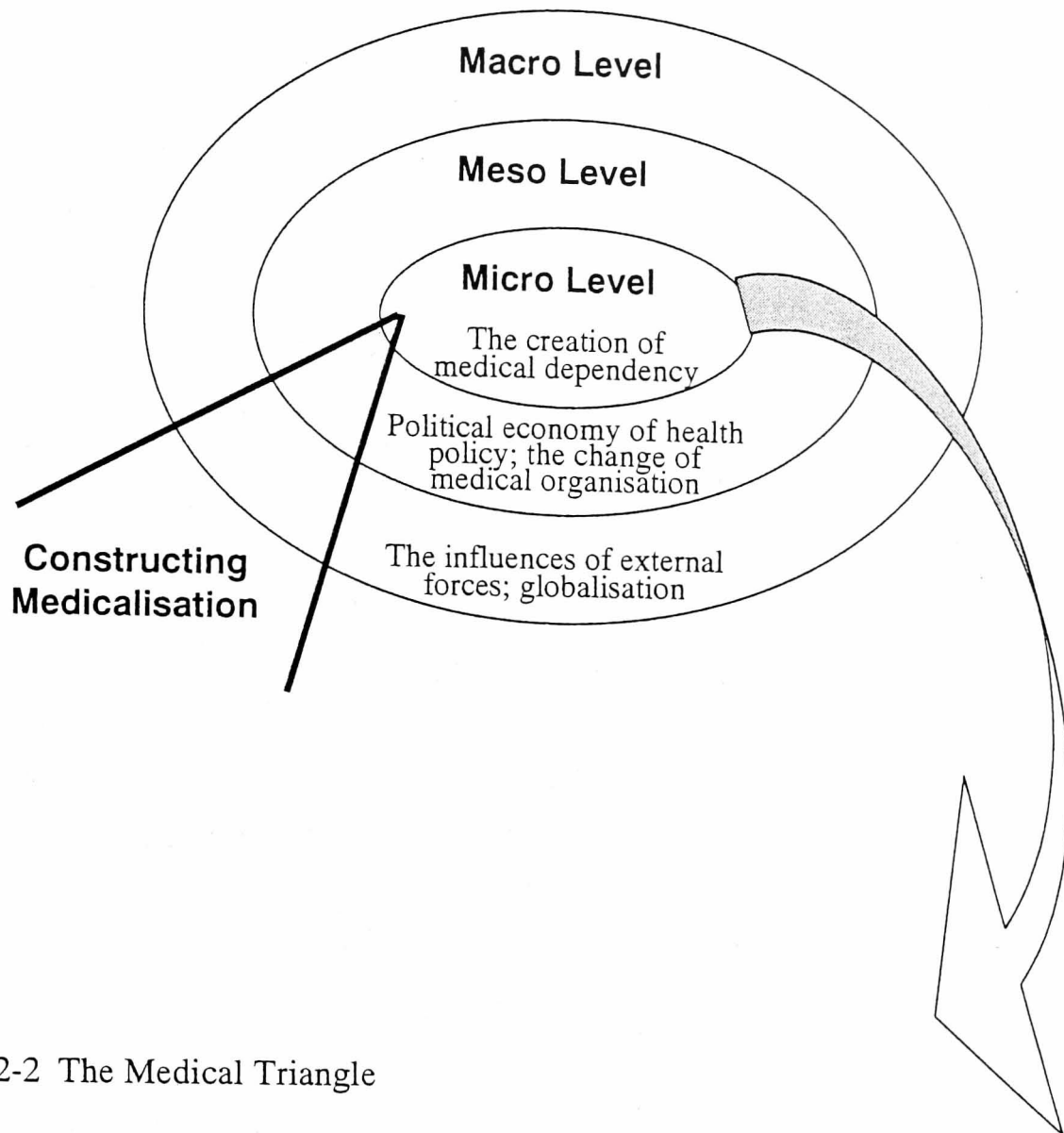
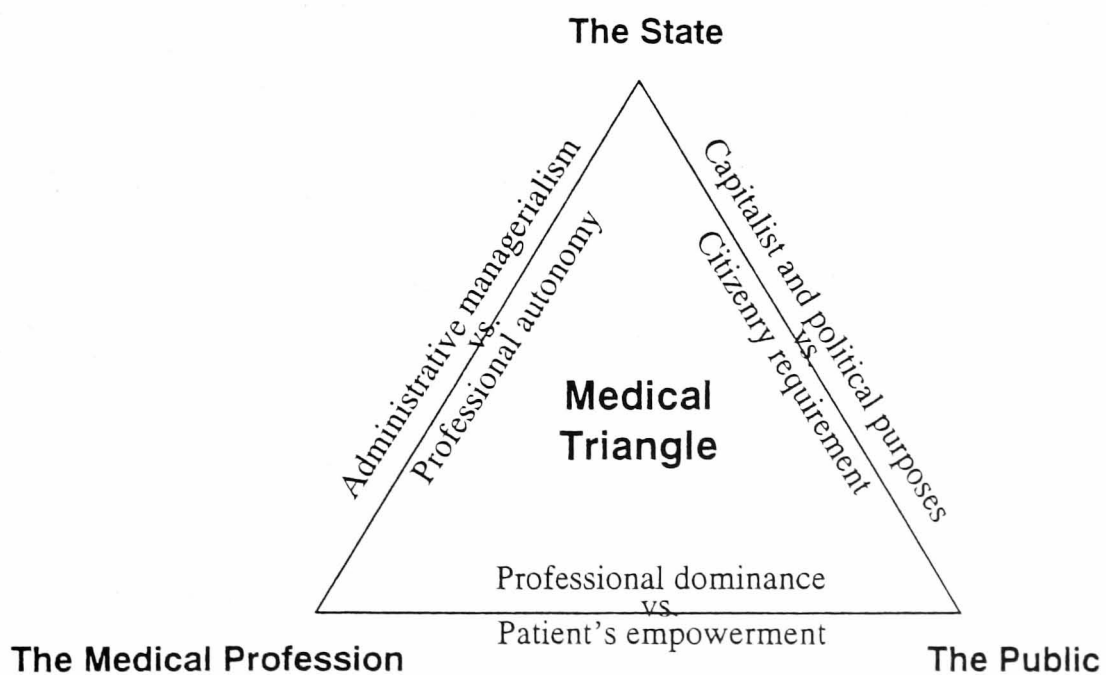


Figure 2-2 The Medical Triangle



2.31 Macro-level perspectives

At the macro-level, this thesis is concerned with the extent to which Taiwan's health care reforms have been driven by external forces, with special reference to the establishment and shifting of medical paradigms. In terms of this, it traces the origin and development of the Western biomedical model in Taiwan, embedded in the process of modernisation, and examines the role of influential outside agents as facilitators in enabling a process of transmitting Western ideology and medical practices to indigenous Taiwanese society. The investigation also covers the post-World War II development of Taiwanese medicine, with regard to the influences of the Cold War order on the state health measures. In these processes, there is an attempt to highlight the importance of political and economic factors in constructing medical knowledge and in shaping the forms of medical practice, as indicated by the political economy critique.

On the other hand, drawing attention to the convergent perspectives on the development of the welfare state with regard to 'the logic of industrialism' (Kerr *et al*, 1962), this thesis seeks to explore the extent to which the domestic political-economic system has been influenced by globalised forces in that it argues that there are social consequences of globalisation relating to health in the case of Taiwan. In this regard, it examines the correlation between economic growth and health improvement, as far as both the beneficial and damaging effects on health brought about by Taiwan's global economic development are concerned. Inspired by the social critique, particular attention is paid to social causes of health and ill-health, with the intention of exploring the social construction of health inequalities.

Another important dimension of globalisation in health is related to the international diffusion of health policy innovation, typified by the shift of policy

concerns from those concerned with access to medical care to those issues surrounding governmental rationing in recent years. This thesis will examine the actual practices of the globalisation of health policy reforms in the context of the NHI reform. On the other hand, and more importantly, this study seeks to explore the underlying logic of the international political and economic dynamics, with the aim of elucidating the practicalities of globalisation in the case of Taiwan's struggle to be involved in the international health community.

2.32 Meso-level perspectives

At this level, the analysis seeks to depict the political-economic structure in which a tendency towards deeper medical dependency is shaped and developed. In one way this is a response to McKinlay's (1977) claim that the micro approach of 'doctor bashing' needs to shift to a macro approach in terms of an analysis of the political and economic framework which impinges on physicians in upholding the development of medicalisation. Thus, a 'structured divergence' approach (Ginsburg, 1992) to the analysis of the construction of medicalisation is developed in this thesis, involving two dimensions of issues: health policy formation and the change of medical organisation.

The first dimension is concerned with the political economy of Taiwan's health policy. We aim to explore the exercise of state autonomy in the formation of the health care system. On the one hand, this thesis draws attention to the economic dynamics of the Taiwanese health care state, in relation to the role of state health care in serving the economic purpose of capitalism for profit embedded in the process of Taiwan's modernisation, i.e. a concern with the establishment of the medical-industrial complex as part of the capitalist infrastructure. On the other hand, this thesis is devoted to an understanding of the political implications of Taiwan's state health-care provision, in

relation to the pursuit of political legitimacy as one of the most important goals that the state seeks to attain. In this regard, we will investigate the extent to which medicine acts as an institution of social control to accomplish political purposes by an autonomous state.

As far as the development of medicine is concerned, the role of state policy in facilitating the process of professionalisation is important, typified by its contribution to setting up the infrastructure of professionalism, such as education, licensure and training. Accordingly, there is a close link between state authorisation and the formation of medical monopoly. In Taiwan, this process is involved with competition for the monopoly of medical services between orthodox medicine, i.e. the Western biomedical model, and non-orthodox medicine, i.e. traditional Chinese medicine. Given this, this thesis will explore the dynamics of medical monopoly in the context of Taiwan's contemporary medical system, in order to examine how far traditional systems survive independently or in some degree of relation to modern medicine. On the other hand, as professional expansionism is progressing quickly in contemporary Taiwan, the Taiwanese state is also granted a stronger legitimate position to circumscribe professional power through the operation of regulating the practice of medicine and the growing use of managerial strategies. This thesis will develop these issues in relation to the dual role of the state in enhancing and restricting medical power by considering the change of medical autonomy caused by state health policy, particularly the NHI reform.

The change of medical organisation, as the second dimension to the meso-level perspectives on the construction of medicalisation, is concerned with the organisational constraints that impinge on doctors and underlie their behaviour strategies in accordance with the principles of medical managerialism. This thesis will consider this

development in two regards: the proletarianisation of medicine as the internal factor, and health care reforms as the external factor. Referring to the former, it will examine the recent development of corporatisation and bureaucratisation of medicine in Taiwan with respect to their impacts on the autonomy of individual professions. Important to this issue is the mechanism for creating a common interest between doctors and their institutions, whereby the philosophy of over-medicalisation is encouraged to develop, due to the pursuit of financial return from the insurance system. It is in this regard that the second issue, i.e. health care reforms, is linked to the transition of medical organisations. That is, the state-managed health care system, namely the NHI, has impacted on the medical marketplace to such a degree that the development of the medical care delivery system, including medical organisations and medical professionals, has been significantly affected by the insurance payment system. Related to this, this thesis will discuss the social consequences of the liberalisation of professionalism, referring to the abuse of medical professional power and its impacts on the doctor-patient relationship. These are, in fact, accounts belonging to the micro-level, to which attention is now turned.

2.33 Micro-level perspectives

As this thesis treats medicalisation as a historically and socially constructed phenomenon rather than just an expected outcome of modern society, the analysis at the micro level seeks to comprehend the ways in which medicalisation concepts are shaped and medicalised health-related behaviours are performed internally within the health care system. We will consider the processes and consequences of medicalisation in relation to the creation of medical dependency operating at two levels: medicalisation from above and medicalisation from below, as Cornwell (1984: 119) suggests. In terms

of medicalisation from above, this thesis charts medicine as culture by investigating the extent to which the medical model, particularly that of modern biomedicine, has formed a dominant approach to health in Taiwan. The extent to which traditionalism plays a part in affecting the construction of medical knowledge and practices will also be examined.

Referring to medicalisation from below, the thesis centres on the social impacts of modern medicine on social life and social relations. On the one hand, it will investigate the situation of medical dependency in contemporary Taiwanese society, with a view to understanding the roles of doctors and patients separately in contributing to the formation of a medicalised pattern for solutions. In line with the cultural critique, it will look at the damaging effects of the exercise of medical professional power, in terms of how far professional dominance has eroded the individual's autonomy and caused patient dependency in a Taiwanese context. On the other hand, it argues for the necessity of individual empowerment as a superior approach to health, relating to the holistic critique (Hardey, 1998). Following this there will be a discussion of whether patient's empowerment in terms of consumerism could help to fix the patient's social independence. The significance of consumerism in health care will be identified in the context of the NHI reform, where the rhetoric of consumerist terminology has been increasingly used by both the state and the civil society, as an influence of the rational critique approach to health policy reform. In addition, the analysis of consumerism will be linked to the debate about deprofessionalisation by examining the extent to which the medical profession is losing its prestigious position because of the impact of consumer movements.

One more important dimension at the micro-level is related to the changing relationship between the state and the public with respect to the extent of the fulfilment

of citizenship. This study seeks to identify the extent to which the recent health care reforms in Taiwan represent shifts between the insurance model, the citizenship model and the consumerist model. Related to this discussion is the changing nature of the state, as far as the roles and trust assigned to government bureaucracies by the public linked to the tradition of authoritarian governance are concerned, with a view to examining the formation of the image of the state role as being more reliable in comparison with private enterprises in the provision of social services. In so doing, this thesis attempts to pinpoint the gap between the intention of the state and the anticipation of the public in relation to the contemporary NHI reform.

2.4 Conclusion

This chapter has presented the theoretical framework of this thesis, including the theoretical fundamentals that underpin the analyses of this thesis and the investigative framework that guides this research study to proceed. In one way, this thesis is an attempt to set up a broad approach to the analysis of health and health policy by bringing together different sociological perspectives on medicine and medicalisation in the case study of Taiwan's health care reforms. In this regard, this chapter has argued for the necessity of a comprehensive analytic frame comprising the rational critique, the sociological critique and the holistic critique, and meanwhile has highlighted the significance of the cultural critique approach to health. It is on the basis of this theoretical predisposition that a three-fold explanatory framework that seeks to encompass the macro, the meso and the micro levels has been further developed, with the aim of comprehending the socio-cultural dimensions of the contemporary Taiwanese health care state. As far as the arrangement of chapters is concerned, this thesis has managed to allocate relatively parallel attention to each level. The main body

of this empirical study consists of five chapters: Chapters 4 and 5 focus on both the macro-level and meso-level perspectives; Chapters 6 and 7 look at accounts at both meso and micro levels; and Chapter 8 analyses issues at both macro and meso levels.

The next chapter, as the last chapter in Part One, will deal with the methodological issues of this research. It will play a crucial role in linking this theoretical chapter with all of the empirical chapters in Part Two.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter addresses the methodology employed in this research, in that it outlines the principles behind the research towards advancing beyond existing knowledge (Hall & Hall, 1996: 29; Bulmer, 1984: 4; Kaufmann, 1978: 240). It attempts to bring the research concerns, together with the theoretical insights developed in the previous two chapters, down to research practices. It presents the empirical strategy used for data collection, and meanwhile explains the principles guiding the investigation of this research.

As noted previously, this thesis focuses on the contemporary health care reforms in Taiwan, concerned with the role of the state in shaping the development of medicine and the delivery of health-care services. Because in a sense health care reforms may signify a shift towards medicalisation, this research seeks to evaluate Taiwan's health policy through investigating the social construction of medicalisation within its context. In this regard, the discussion of this chapter will focus centrally on the methodological background of the case study of the NHI, which offers a real context in which an empirical investigation of the process of medicalisation can be performed. One assumption to be explored is that the NHI has created a new bureaucratic structure, which leads to the increase and decrease of medical power at the same time, and contributes to the creation of a dominant culture affecting people's health behaviours. In so doing, this thesis aims to produce a theory, namely a systematic way to explain social phenomena based on organised knowledge

(Sarantakos, 1993: 10), which makes possible a satisfactory explanation of the construction of medicalisation within the context of the NHI. The main body of this chapter includes two parts: research approach and research procedures. We shall now enter into these two parts.

3.2 Research Approach

This research seeks to investigate how the NHI represents a shift towards medicalisation, and meanwhile the change of medical autonomy is relevant. In this respect, it is essential to provide a holistic and dynamic picture of how medicalisation is constructed, as well as to comprehend the reasons for and consequences of medicalisation. A primarily qualitative approach is considered proper, for it enables us to work out a 'contextual understanding' of the issues concerned (Bryman & Burgess, 1999). As we shall see later, the approach adopted is concerned to uncover the perceptions of the relevant social agents and the social circumstances in which particular social actions are shaped and constructed (Jones, 1994: 60-1).

In terms of qualitative approach, the main strategy adopted in this research is a case study, which investigates the contemporary NHI system situated in its socio-cultural context. It is generally accepted that a case study allows an empirical investigation to retain its holistic and meaningful characteristics within its real-life context (Yin, 1994: 3; Robson, 1997: 52). According to Yin (*ibid.*, pp.3-4), the case study as a research strategy can be used for three purposes: exploratory, descriptive, or explanatory. In line with Yin, the case study employed in this research serves all these three aims. That is, this study is concerned to explore health-related concepts with respect to medicalisation, and to describe the processes and consequences of

medicalisation with regard to the influence of policy intervention, in that it attempts to explain how medicalisation, as a contemporary phenomenon, is socially constructed within the real-life context of the NHI.

In sum, the research strategy has two focuses: on the one hand, it deals with the evaluation of Taiwan's health care reforms, and it looks at the social construction of medicalisation, on the other. In so doing, this research aims to draw on medicalisation criticisms grounded in empirical data, attempting to develop a new paradigm to evaluate Taiwan's health care reforms.

3.3 Research Procedures

Based on the case study approach, multiple sources of evidence were considered essential in this research for they offer different dimensions of the object under study. More importantly, different sources of evidence will be woven into a narrative account in a way in which they can support each other (Gillham, 2000a: 20; Yin, *ibid.*). The methods of data collection used in this research included in-depth interviews, a questionnaire survey, and documents. Considering that interviewing could contribute to forming an illustrative dimension of the study owing to its being involved the views of real people (Gillham, 2000b: 10), interviews were adopted as the main tactic in this research. The survey, as the secondary method, had a role of helping me, as a researcher having no medical background, to get to know the medical profession in its setting. In other words, it served to assist me in entering into the circumstances in which medical professionals were situated to produce their specific philosophies and approaches. In addition to these two methods, documentary data collection was undertaken in parallel with considering the case under study in its

context. Details regarding the designs and performances of these three methods will be illustrated later on.

Based on the fact that the NHI was a newly established system, and that there was relatively sparse data available for research on medicalisation, the case study as a research strategy was designed to comprise two-phased fieldwork, including exploratory research and a main field study. The fieldwork in the first phase was set up with broad aims, in terms of getting to know about the impact of the NHI in its social context. The follow-up fieldwork in the second phase was an actual investigation in order to collect a range of different kinds of evidence regarding medicalisation in the NHI setting (Gillham, *ibid.*, pp.15-6). The sections that follow will provide details about the research design and procedures, categorised by the methods used for data collection.

3.31 Interviews

- *The first phase of interviews*

An exploratory piece of research was conducted from October 1998 to January 1999, attempting to explore the impacts of the NHI, as a relatively new, large-scale and universal health care scheme, on Taiwanese society. The interview questions were concerned with the socio-economic evaluation of the NHI based on four indicators: access, equity, efficiency and quality. In addition, in the light of the 1997 Asian Financial Crisis on Taiwan's health and health policy, the questionnaire also focused on how the interviewees and/or their groups viewed the Crisis as influential in changing the NHI policy. Although all the interviews were based on the same questionnaire that included the points mentioned above, the focus of each interview differed by taking account of the individual interviewee's background.

The interviews aimed to obtain a holistic understanding, in terms of different perspectives, of the impact of the NHI. As I have expressed in the previous two chapters, a model of 'medical triangle' (the state, the medical profession and the public) is adopted in this thesis to explain the social actions between different agents in relation to the subject under study. In terms of the medical triangle, I set the scene by bringing in several specific stakeholders, who played the roles of the key actors in the way they represented the different views on the NHI reforms. I identified the stakeholders from five groups: government agencies, the parliament, medical service institutions, social pressure groups, and scholars. Overall, fifteen semi-structured interviews (Table 3-1) were undertaken, including two pilot interviews and thirteen formal interviews. In each group, three interviews were conducted. Based on the concern for the nature of this research as policy analysis, all interviewees were chosen as being opinion-leaders in their groups. I will look at their views and investigate their behaviours in Part Two of this thesis.

In a sense an opinion-leader was considered as a key actor who may express the opinion of his/her group regarding specific policy issues. Although I cannot be sure that the opinion leaders necessarily well represented the views of the NHI reforms, they certainly showed us something about different aspects on the issues concerned, which we shall refer to briefly below. Besides, I consider it essential to give detailed background information on all interviewees related to the reasons for choosing them for interview, on which this chapter will now focus.

Table 3-1 The List of Interviewees
(From October 1998 to January 1999)

No.	Name	Post / Position	Group	Interview Date
1-01	Mr. X1	First Secretary of the Minister of the DoH	Government agency (central government)	07/11/98
1-02	Mr. X2	Spokesperson and unofficial leader of the Alliance to Rescue the National Health Insurance	Social pressure group	16/11/98
1-03	Mr. X3	Associate Professor	Scholar (in social welfare regarding finance)	11/12/98
1-04	Mr. X4	Former Manager-General in the BNHI / Chair of the Bureau of Health, Taipei	Government agency (administrative sector)	19/12/98
1-05	Mr. X5	Associate Professor	Scholar (in social welfare regarding economics)	21/12/98
1-06	Mr. X6	Clinician / President of the ROC Primary Care Association	Medical Service Organisation (local clinic)	24/12/98
1-07	Mr. X7	Representative of Consumers in the NHI Supervisory Board, DoH	Social Pressure Group (consumers/labourers)	28/12/98
1-08	Mr. X8	Manager of the Medical Management Centre, Chang-Geng Hospital	Medical Service Organisation (large-sized hospital)	05/01/99
1-09	Mr. X9	Legislator	Parliament (the ruling party)	06/01/99
1-10	Mr. X10	Legislator	Parliament (the main opposition party)	12/01/99
1-11	Mr. X11	Representative of Employers in the NHI Supervisory Board, DoH	Social Pressure Group (employers)	12/01/99
1-12	Ms. X12	Special Assistant for Legislator Hao Rong-Bin	Parliament (the second opposition party)	13/01/99
1-13	Mr. X13	Former Manager in Taipei Branch of the BNHI / the Executive Secretary of the BNHI	Government agency (administrative sector)	15/01/99
1-14	Mr. X14	Chair of Li-Xin Hospital	Medical Service Organisation (district hospital)	18/01/99
1-15	Mr. X15	Secretary-General of the Taiwan Labour Front	Social Pressure Group (labourers)	21/01/99

Interviewing context in the first phase of fieldwork

A. Government agencies

Three people were interviewed in this group; representing the different perspectives of government agencies: the central government in charge of health policy, policy planners in the administrative sector, and direct implementation agents at the local level. First of all, I conducted a pilot interview with Mr. X₁ (Interview No.1-01), who had a medical background and also specialised in medical affairs management as an academic at Yang-Ming University. He had been the former Manager of the Department of Planning and Evaluation in the Bureau of National Health Insurance (BNHI), and was the First Secretary of the Health Minister at the time of the interview. Apart from providing the perspective of policy-making in the central government, X₁ played a role of gatekeeper in helping me to gain access to the Department of Health (DoH) as well as to several medical institutions.

Mr. X₄ (Interview No.1-04), as the second interviewee in this group, had been the Director in the run-up to the NHI system, and then became the Manager-General of the BNHI after the NHI was put into practice. X₄ contributed to this research because he knew about the policy process very well, since he attended the planning and organisation of the NHI and was in charge of policy decisions in the BNHI. His opinion characterised the thoughts of the planners in the BNHI, which operationalised policies as well as dealt with the problems of the NHI. Particular attention was paid to the tension between the BNHI, as the NHI executive department, and the DoH, as the authoritative department in charge of policy-making.

At the local level, Mr. X₁₃ (Interview No.1-13) was chosen for interview because he had a managerial background, being in charge of the Taipei Branch of the BNHI.

He had worked in the Bureau of Governmental Employee Insurance for many years before he came to the BNHI. When I interviewed him, X₁₃ was the Executive Secretary of the BNHI. This background made him an appropriate figure to represent the point of view of direct implementers.

B. The parliament

The interviews in this group aimed to gain an insight into the ideologies of political parties in influencing NHI policy, through the investigation of their policy priorities regarding the NHI reforms. I gained access to all three main political parties, namely the Koumintang as the ruling party, the Democratic Progressive Party as the main opposition party, and the New Party as the second opposition party. Legislators who had a reputation for concern over the NHI were considered appropriate interviewees. Given this, I interviewed Mr. X₉ (Interview No.1-09) and Mr. X₁₀ (Interview No.1-10), belonging to the Koumintang and the Democratic Progressive Party respectively. As to the New Party, Ms. X₁₂ (Interview No.1-12), who was a special assistant to Legislator Hao Rong-Bin, was interviewed because Hao was too busy to find time for my interview. Based on the fact that a general election had just been held in December 1998, a particular issue was included in these interviews; that is, to what extent and in which ways had the interviewee's party considered NHI reforms important in terms of being able to affect the electorate?

C. Medical-service institutions

The foundations of the NHI delivery system were laid on a patient-referral procedure, a classified patient-delivering route by level of institution: from local clinic through district hospital then regional hospital to medical centre. However, this new policy

suffered a serious defeat just a few days after the implementation. In this context, interviews in this group focused on the perspectives of medical service institutions on the NHI regulation. Related to this were two important issues: the competition for outpatients between different levels of institutions and the change of medical organisation. The interviews in this group covered opinion-leaders in various-sized medical service institutions. Mr. X₆ (Interview No.1-06), a clinic-based doctor and the President of the ROC¹ Primary Care Association, characterised the main thoughts of grassroots level clinicians in that he was involved heavily in a campaign against the NHI privatisation reform. At the middle level, Li-Xin Hospital, a district hospital with massive publicity based on its outstanding operational strategies. I interviewed the Chair of this hospital, Mr. X₁₄ (Interview No.1-14), who was also an inspector of the National Medical Association as well as a commissioner of the NHI Health Care Expenditure Arbitration Committee in the DoH. As regards large-sized hospitals, I chose Chang-Geng Memorial Hospital, a top teaching hospital well known for its managerialism. The interviewee was Mr. X₈ (Interview No.1-08), the Manager of the Medical Management Centre of the hospital, occupying several crucial positions such as a National Policy Advisor to the President, and a Councillor in the Private Hospital Association.

D. Social pressure groups

By interviewing in this group I aimed to comprehend the views and ideologies of insurance contribution payers, including employers and consumers, on the NHI scheme. Given this, interviews were conducted within both employers' and labourers'

¹ ROC is the abbreviation of the Republic of China, which is the formal name the Taiwanese government prefers to use, even if it is not accepted by international society. There are some national social organisations putting 'ROC' in their names, based on both the law and the government preference.

organisations. Within employers' groups, Mr. X₁₁ (Interview No.1-11) was interviewed. Lo had an actuary background and was the Executive Vice-President of the China Life Insurance Company. In many ways his opinion characterised the employers' point of view since he was an Employers' Representative in the NHI Supervisory Board, as well as a representative of the Improvement of Industrial and Business Association. Within labourers' groups, interviews were performed in both formal and informal organisations to gain a balanced view. In addition, based on the fact that all NHI subordinate commissions included only formal, i.e. government-sanctioned, organisations, it was essential to bring the voice of informal organisations into this research. Referring to formal organisations, Mr. X₇ (Interview No.1-07) was chosen because he was a Consumers' Representative on the NHI Supervisory Board. This place of commissioner was based on his position as a Standing Director in the National General Trade Union, the largest labourers' organisation. To supplement this, I also obtained access to the Taiwan Labour Front, a more informal but very active labourers' organisation, and interviewed its Secretary-General, Mr. X₁₅ (Interview No.1-15).

E. Scholars

The purpose of interviews in this group was to obtain an academic perspective on the evaluation of the NHI. One pilot interview and two formal interviews were conducted. Mr. X₂ (Interview No.1-02), a professor of social welfare, played a role of gatekeeper in the way he helped me to obtain access to the Alliance to Rescue the National Health Insurance (ARNHI), in which he was the spokesperson and an influential opinion-leader. The ARNHI consisted of various social pressure groups and individuals, including consumers' organisations, labourers' organisations, feminists'

groups, children's welfare groups, disabled groups, academics, legislator's assistants, and primary care clinicians. Its mission was to oppose NHI reforms towards privatisation.

The other scholars I interviewed were Mr. X₃ (Interview No.1-03) and Mr. X₅ (Interview No.1-05), specialists in finance and economics respectively. Both scholars had accomplished a number of studies on and produced considerable publications about the NHI in recent years.

- *The second phase of interviews*

The second phase of fieldwork, as the main field study, was an attempt to comprehend the context of medicalisation within the NHI system, including the interactional level, the institutional level, and the policy level, explained in Chapters One and Two. It was an actual investigation in order to collect various evidence regarding the main issues under study. The empirical evidence was concerned with contributing to the analysis of 'medicalisation' and the dominance or proletarianisation of physicians as a major concern of this research.

Furthermore, this field study sought to clarify the multiple forces that were jostling each other to gain dominance² under the NHI regulation system. Being interested in the dynamics of the power relationships that contributed to form medical dominance, I tried to cast light upon the procedures of the legitimation of medicine as a dominant profession. An emphasis was placed on the development of medical social control. In this respect, the cultural factors were considered important for they were viewed as potential determinants of health: that is, the ways in which social values acted to affect the behaviours of individual social agents. In terms of a cultural

² These phrases are borrowed from Ginzberg (1990: ix)

critique approach, this study concerned over how medicine contributed to shape a culture of dependency and passivity contained in the NHI services.

This fieldwork was conducted from July to August 2000. In common with the first phase of fieldwork, interviewing was adopted as the main method of data collection. Drawing attention to the changing relationships within the medical triangle, eighteen semi-structured interviews were performed with the stakeholders within five groups, including government officers, physicians and hospital managers (including Western-style and traditional Chinese medicine), consumer groups (including patient and non-patient groups), experts, and scholars (Table 3-2). Also, like the first phase of interviews, most of the interviewees were opinion-leaders in their groups. The section that follows will give detailed background information about all interviewees.

Before proceeding further, there are two things worth noting. First, some of the interviewees could be assigned to two groups owing to their backgrounds crossing different groups. Second, like the interviews in the first fieldwork, the interview questions differed between different interviews, on the grounds that interviewees' backgrounds were taken into account and therefore contributed to producing different focuses.

Table 3-2 The List of Interviewees

(From July to August 2000)

No.	Name	Post / Position	Group	Interview date
2-01	Ms. Y1	Assistant professor/ Committee Member in the Medical Review Board of the DoH/ Advisor of the Promoting Patient Rights Association	Expert (On medical law and medical malpractice)	18/07/00
2-02	Mr. Y2	Associate professor /	Academic	21/07/00

		the former Prime Secretary of the Minister of the DoH	(In medical affairs management)/ Government	
2-03	Mr. Y3	Clinician/ President of the Taipei Medical Association	Physician (Western primary care)	28/07/00
2-04	Ms. Y4	Director of the Taiwan Foundation for Rare Disorders	Consumer group (Patient group)	31/0700
2-05	Ms. Y5	the former Manager of the Department of Medical Affairs, BNHI/ Executive Secretary of the NHI Supervisory Board	Government	31/07/00
2-06	Mr. Y6	Physician in charge of family medicine, Xin-Zhu Hospital / Part-time physician, Taiwan University Hospital	Physician (Western-style hospital)	01/08/00
2-07	Mr. Y7	President of the National Union Association of Chinese Medical Doctor / Chinese medicine physician	Physician (Traditional Chinese medicine)	02/08/00
2-08	Ms. Y8	Secretary General of the Consumers' Foundation / Lawyer	Consumer group (Non-patient group) / Expert (in medical malpractice)	02/08/00
2-09	Mr. Y9	Director-General of the Bureau of Medical Affairs, DoH	Government	03/08/00
2-10	Mr. Y10	Deputy of the Chang-Geng Chinese Medicine Hospital / Chinese medicine physician	Physician / Hospital manager (Traditional Chinese medicine)	04/08/00
2-11	Mr. Y11	Chairman of the Committee on Chinese Medicine and Pharmacy, DoH	Government	08/08/00
2-12	Mr. Y12	Director of the Division of Chinese Medicine Administration, DoH	Government	08/08/00
2-13	Mr. Y13	Senior Specialist in the Chinese Pharmacy Empirical Promotion Team, DoH / President of the Society for Modern Acupuncture Research	Government	08/08/00
2-14	Mr. Y14	Section Chief in the Bureau of Medical Affairs, DoH	Expert (on medical issues regarding aboriginal tribes) / Government	09/08/00
2-15	Mr. Y15	Clinician / The former Mayor of Peng-Hu County	Expert (on medical issues in remote islands)/ Physician (Western primary care)	09/08/00
2-16	Mr. Y16	Deputy of the Kang-Ning Hospital	Hospital manager (Western-style hospital)	10/08/00
2-17	Mr. Y17	Associate professor	Scholar (In public health)	11/08/00
2-18	Ms. Y18	Committee member in the Consumers' Foundation / Director of the Nutrition Office, Veterans' General Hospital	Consumers' group (non-patient)	14/08/00

Interviewing context in the second phase of fieldwork

A. Government officers

The intention of interviews in this group was to gain an insight into the ideological predisposition and political strategies of the ruling party, concerning the state's role in regulating the health care systems. Overall, five interviews were conducted in this group; they covered three government departments. Mr. Y₉ (Interview No.2-09), the Director-General of the Bureau of Medical Affairs in the DoH, represented the supreme authority at the national level in charge of policymaking and budget allocation. In comparison, Ms. Y₅ (Interview No.2-05), the former Manager of the Department of Medical Affairs in the BNHI, was interviewed on the grounds that she could reveal the viewpoint of the BNHI implementers. In so doing, an intention was to examine whether there was a gap between policy-making and policy implementation. In addition, this study paid attention to the situation of traditional Chinese medicine under the direction of the DoH, which ideology was thought to be conducive to the development of modern biomedicine by and large. In this respect, I interviewed Mr. Y₁₁ (Interview No.2-11), the Chairman of the Committee on Chinese Medicine and Pharmacy in the DoH, to gain an insight into the circumstances the traditional system faced. Within this interview, Mr. Y₁₁ introduced me to his two chief subordinates, i.e., Mr. Y₁₂ (Interview No.2-12), the Director of the Division of Chinese Medicine Administration, and Mr. Y₁₃ (Interview No.2-13), a Senior Specialist in the Chinese Pharmacy Empirical Promotion Team, for two follow-up interviews regarding detailed policy issues.

B. The medical profession

The interviews in this group sought to represent different stakeholders in the changing medical organisation. To gain a holistic understanding of the different views of medical personnel, interviews took account of the opinions of both physicians and hospital managers. In addition, based on my concern to look at different medical and health practice models, interviews were conducted within both Western-style and Chinese medicine health-service institutions.

Within the Western-style medical bloc, three people were interviewed. Mr. Y₃ (Interview No.2-03), a clinic-based doctor and the President of the Taipei Medical Association, depicted the circumstances of primary care clinics situated under the NHI regulation and hospitals' competition. Mr. Y₆ (Interview No.2-06), a physician in charge of family medicine in the Xin-Zhu Hospital and a part-time physician in the Taiwan University Hospital, characterised employed physicians facing the change of their clinical power under the bureaucratisation development of medicine. In comparison with the viewpoints of physicians, Mr. Y₁₆ (Interview No.2-16), the Deputy of the Kang-Ning Hospital, was interviewed. He revealed the essential aspect of those middle-sized hospitals that emphasised the value of managerialism under the competition of both large-sized hospitals and primary care clinics.

In addition, two interviews were conducted within the Chinese medicine bloc. The first was Mr. Y₇ (Interview No.2-07), a Chinese medicine physician and the President of the National Union Association of Chinese Medical Doctors. He characterised the grass-roots Chinese medicine clinics. For comparison, I obtained

access to Chang-Geng Chinese Medicine Hospital and interviewed its Deputy, Mr. Y₁₀ (Interview No.2-10), who was also a practising Chinese medicine physician.

Related to all interviews in both blocs was an investigation of the de-skilling of medicine. In other words, this was about how the growth of medical expertise might extend medical power but decrease professional autonomy at the same time. Based on the data collected, I will explore these issues in the latter chapters situated in a Taiwanese context related to the challenge to medical dominance.

C. Consumer groups

This research paid attention to recent consumer movements with respect to patient's empowerment. The aspects of both groups representing patients as well as non-patients were taken into account. Referring to the former, I selected the Taiwan Foundation for Rare Disorders, on the grounds that this Foundation was generally considered as successful in comparison with the majority of patient groups. Ms. Y₄ (Interview No.2-04), the Director of the Foundation, was interviewed, because she was a key worker and also the mother of a child with some rare disorder. As to non-patient groups, I obtained access to the Consumers' Foundation, a non-profit making private organisation with better resources and a powerful voice. Two persons in authority were interviewed. The interview with Ms. Y₈ (Interview No.2-08), the Secretary-General and a lawyer, focused on the dimension of medical malpractice. The other interview was performed with Ms. Y₁₈ (Interview No.2-18); it sought to comprehend the general concerns of the Foundation about the issue of consumerism in the NHI.

D. Experts

In terms of experts in particular area, the interviewees chosen were experts in two specific areas: medical malpractice, and the NHI provision of health care for aboriginal tribes and in remote islands. Regarding medical malpractice, Ms. Y₁ (Interview No.2-01), an assistant professor in medical law, was considered an appropriate figure. Based on the fact that she had been involved as both an official malpractice review authority and patient self-help organisations, she was able to offer a comprehensive understanding of the whole system. Ms. Y₁ also played a role as gatekeeper and she introduced me to the Taiwan Foundation for Rare Disorders. In addition, Ms. Y₈, mentioned previously, could be considered in this group in the way she revealed the situation of medical disputes from the viewpoint of a consumer group. As regards the second issue, concerning the NHI provision for aboriginal tribes and residents in remote islands, two experts were interviewed. The first was Mr. Y₁₄ (Interview No.2-14), the Chief of the Section of Mountains and Remote Island Areas in the Bureau of Medical Affairs of the DoH, having an aboriginal origin and a medical background. Initially I tried to interview Y₁₄'s brother, Z, who was an active worker in the aboriginal inhabitants movement. However, Z thought that Y₁₄ knew health issues much better than himself. So, Y₁₄ was recommended for my interview. The second interview was conducted with Mr. Y₁₅ (Interview No.2-15), a grass-roots clinician and the former Mayor of the Penghu County, a remote island from Taiwan. In the whole interview arrangement, Y₁₅ could offer the dimension of the health issues concerning residents living on a remote island from a doctor's viewpoint.

E. Scholars

Two interviews were performed in this group, with regards to the aspects of medicine management and public health respectively. Mr. Y₂ (Interview No.2-02), an associate professor in medical affairs management having a background as a high-ranking health officer, represented the first group. He had been interviewed in the first phase of fieldwork that focused on different issues; at that time he was the Prime Secretary to the Minister of DoH. On the other hand, the interview on public health was concerned with the roles of medicine and health policy in dealing with people's health needs. In this respect, I interviewed Mr. Y₁₇ (Interview No.2-17), an associate professor in public health.

- *Dealing with the interview data*

All interviews were recorded on audio tapes, and then transcribed into printed materials in Chinese³. Some of the transcription manuscripts were translated into English as quotations from interviews in a few chapters of this thesis.

3.32 Questionnaire survey

- *The background*

In the first phase of fieldwork, a small-scale questionnaire survey of the grassroots level clinicians in Taipei who closed down their clinics in 1998 was carried out. This survey was initiated in the interview with Mr. X₆, a Standing Director of the Taipei Medical Association (TMA). He communicated his fear that the primary care

³ The interview with Mr. Y₃ was an exception. The recording failed because some technical problem occurred. As a result, it became impossible to conduct transcription. Instead, the interview notes were used for analysis in this research.

provided through grassroots level clinics was declining in importance by relying on the NHI payment system. Furthermore, he requested me to conduct a questionnaire survey entitled 'A survey of the reasons for closure of local clinics and the resultant job transference for clinical-based doctors in Taipei, 1998' and to produce an analytic report for his association. I accepted this invitation to perform the survey, on the grounds that I had observed a contradictory view between the medical profession and the BNHI about the situation of the development of primary care. That is, on the one hand, grassroots level clinicians claimed that their services were declining in importance because of the new NHI systems. On the other hand, NHI officers revealed that primary care clinicians benefited greatly from the NHI, according to a few preliminary interviews.

In general, this survey was concerned with the situation of primary care under the contemporary development of modern medicine in becoming an institutionalised expertise. It sought to gain a better understanding of the perspectives of grassroots level clinicians under the impact of the new medical markets constructed within the NHI regulation. In detail, this survey had two concrete goals. First, it attempted to find out the main reasons for closure of the clinics in Taipei, the capital city of Taiwan, during the year of 1998. Second, it sought to trail the subsequent whereabouts of those clinicians. The year 1998 was chosen because it was near to the time of the survey, in that the technical problems, regarding finding the clinicians, were fewer in comparison with doing a survey on those who closed their clinics much earlier.

The findings of this survey will be used to reveal certain crucial issues that this research would follow up and deal with. It should be noted that through direct

contacts with doctors this initial survey opened a route into the investigation of medical professionals' philosophy.

- *The procedure of the survey*

A questionnaire was adopted for this survey. Overall, there were seventeen questions in the questionnaire comprising three issues: basic information about the closed clinic and its clinician(s), the reasons for closure, and the whereabouts of the clinician after the closure. The survey was carried out mainly based on telephone interviews and supplemented with self-administrated postal questionnaires⁴. Three telephone interviews, as the pilot survey, were undertaken by myself in the very beginning. The main survey was performed by several interviewers under the administration of the TMA, by whom the survey was commissioned.

The sample of survey was drawn from the membership files of the TMA; according to this, 109 clinics were closed during 1998. The respondents were either clinicians or their family members who could answer the questions. In the end, I received 75 effective questionnaire replies for analysis. The response rate was 68.8%.

After the survey, all questionnaires were coded, and the data was entered into SPSS for Windows 6.1 in carrying out quantitative analysis. The data analysis served to produce descriptive statistics, including 'frequency' for all questions and 'mean' for certain questions.

⁴ All respondents were contacted by telephone in the beginning. When the interviewers found that the respondents were unable to be contacted by telephone (this arose for two typical reasons: the recorded telephone number was not used any more, or the clinicians had moved abroad), the self-administrated postal questionnaire was sent to the recorded address instead.

It should be admitted that the size of the sample was small. Therefore, I cannot be sure that the results of the survey well represented the views of different kinds of clinics.

3.33 Use of documents

Documentary data collection was undertaken all the time throughout the research. The range of archives was various, including government publications, reports and minutes, legislative documents and minutes, academic articles and theses, newspapers, and electrical publications on web sites. The use of documents helped establish the context of this case study. Besides, content analysis was performed in relation to particular issues, in that the use of documents was viewed as important evidence to support arguments.

3.4 Conclusion

This chapter is an illustration of the empirical strategies adopted in this research for collecting and interpreting data. I have explained that this research is dual-focus in that the evaluation of the NHI reforms, as the focus of the empirical investigation of this thesis, was carried out in parallel with the discussion of the construction of medicalisation. Put another way, the former is examined by virtue of the investigation of the latter, indicated as the research strategy.

As empirical research, the case study was used as the main strategy embedded in the research process, and served to work out a contextual understanding of the issues concerned. In addition, a qualitative research approach was adopted, on the grounds that the social actions involved were complicated since the social relations contained

in the NHI reforms were many and intertwined. It was, therefore, considered essential to conduct multiple methods of data collection, including in-depth interviews, a questionnaire survey, and documents. The data collected will be used in a comprehensive discussion of the subject under study, as we shall see later.

I have so far presented the conceptual framework and the research process, elaborated in the first three chapters of this thesis. From now on I will enter into an examination of the empirical evidence.

CHAPTER FOUR

CONTEXTUALISING THE HEALTH CARE STATE:

HEALTH CARE REFORMS BEFORE 1945

4.1 Introduction

This chapter is a historical review of the development of the Taiwanese health care state up to 1945, the year when the World War II finished and which also marked the end of Taiwan's colonial era, covering the context in which modern Western medicine emerged and developed in Taiwan. It centres on the evolution of health care systems in which the dominance of modern medicine was gradually formed. Particular attention is paid to the shifting of medical paradigms with a concern over the role of the state in promoting the legitimation of different models of medical intervention. Given this, Taiwan's medical history is identified as a shift of medical paradigms, from the traditional model first to a model of missionary medicine, then to a model of colonial medicine in the mode of a German-Japanese paradigm.

Referring to the analytic framework of this thesis (see Chapter 2), this chapter focuses on both the macro-level and meso-level perspectives, with a view to exploring the political-economic dynamics that affected the development of medicine. In terms of a political economy approach, we are concerned with the structural factors that impinge on medicine in becoming a profession, in particular with the identification of the character of government ideological predispositions and with the political strategies involved in health care reforms. In addition, this chapter pays attention to the process of Taiwan's modernisation and addresses its implication for health and health care reforms, for health growth is a key part of modernising values, and

medical care reforms often play an important role in the course of economic modernisation. At the risk of over-simplification, I want firstly to indicate one thing: the development of modern medicine in Taiwan up to World War II revealed a process under considerable outside influence. I will elaborate this story and its impact on Taiwan in this chapter.

This chapter begins, in Section 2, with a brief review of the situation of Taiwan's health before the modern age, followed by an illustration of how modern medicine emerged in late 19th century Taiwan. It then moves on to elaborate the transformation of medical paradigms in terms of missionary medicine and colonial medicine, situated within the process of modernisation as elaborated in Sections 3 and 4. I conclude by pinpointing the implications of these changes with regard to growing medical interventions.

4.2 The Prelude: the Picture of Health and Medical Advances in the Early Eras

This section traces the history of Taiwan's health and medicine in the pre-modern age, focusing on the role of medicine in functioning to promote health improvement. In the attempt to cast light on the factors that enabled medical reforms, particular attention is paid to the social agents who facilitated the course of medicalisation in terms of health care reforms. As we shall see, the course of Taiwan's medicalisation indicates the importance of outsiders in the way they involved themselves in the pursuit of economic or political benefits. I shall now move on to elaborate who they were and their influences on Taiwan's health.

4.21 Western imperialists and the entry of Western medicine into Taiwan

The first contact of Taiwan and the West occurred in 1544 when some Portuguese, as one of the sea powers at that time, sailed past the neighbourhood of Taiwan during their exploration journey of the East. From a distant view, they marvelled at the beauty of the landscape and exclaimed 'Ilha Formosa!', which meant 'beautiful island' in Portuguese, by which the image of Taiwan was primarily passed on to the West. Accordingly, Taiwan became a new objective for the Western traders to explore. As a result of this process, the Dutch occupied the south of Taiwan from 1624 to 1662; Spain conquered the north of Taiwan in 1626 and then was expelled by the Dutch in 1642 (Zhuang, 1998: 17; Li X-F, 1989: 15-6). For Taiwan, in the sense of medical history, these two imperial countries opened up a new site of contact with Western medicine, although actual influence on the indigenous society did not occur until the entry of other imperial medicines in the 19th century, as will be illustrated later.

At a time of expanding mercantilist imperialism, the nature of the 17th century imperial medicine in Taiwan might be identified as serving a simple purpose: that is, to offer protection to the settlers from the attack of indigenous diseases in the under-developed hygienic conditions of the colony. It is said that the Dutch conquerors had doctors from their home country, and they also established hospitals in Taiwan (Zhuang, *ibid.*, p.18;). All of these were arranged by the Dutch East India Company, which received special permission from the Dutch government to take charge of all colonial administration in Taiwan and the other Asian colonies. The Dutch doctors and hospitals in Taiwan served only the Dutch, with the exception of providing missionary medicine at the request of the Dutch churches (Li, *ibid.*, p.59; Zhang L-Y, 1998: 166). Accordingly, Taiwanese people were brought into contact with Western

medicine at the first time. This contact did not make a considerable impact on Taiwan's medical systems, for the Dutch missionary doctors treated only the aboriginal inhabitants on the grounds of a given policy concerning preaching to Taiwanese aboriginal tribes. Added to this is that the contact did not last for long, owing to the fact that Dutch missionaries were unwilling to stay in Taiwan for long because there was a high risk of dying from malaria as an endemic disease (Li, *ibid.*, p.59). Consequently, 17th century Dutch medicine did not really take root in Taiwan.

As to the 17th century Spanish conquerors, historical records about their medical activities in Taiwan are lacking. We cannot therefore assume anything specific. But one thing which can be certain is that the role of medicine did not reach far beyond securing the Europeans' health, like 19th century Western imperial medicine. The Netherlands and Spain, as the older mercantilist imperial powers, put great emphasis on short-term commercial interests instead of a long-term colonial development programme (Zhuang, *ibid.*, p.18). Although the provision of missionary medicine did offer an opportunity to establish contact with some of the indigenous population, the influence of medicine was limited and piecemeal, and no longer existed after the withdraw of the imperial powers from Taiwan. From a historical standpoint, this result was very different from the consequences of the Western medicine that arrived in the later colonial era, when medical intervention revealed more about the nature of imperialism, as we shall see later.

4.22 Chinese governments and Taiwan's medical advances

The end of Taiwan's first contact with the West occurred when Zheng Cheng-Gong, a General of the Ming Dynasty, expelled the Dutch occupiers from Taiwan in 1661.

This event had important political implications for the development of Taiwan. For one thing, it opened up a formal relationship between Taiwan and the Chinese governments, who had never revealed a real concern about developing Taiwan before. When the sovereignty of China changed from the Ming to the Qing dynasty, General Zheng had no alternative but to retreat to Taiwan. However, this retreat gave rise to an attempt to modernise Taiwan, on the grounds that General Zheng viewed Taiwan as a base for counterattack. He made great efforts to build up this under-developed island. During the reign of Zheng and his two successors, a range of development constructions were carried out; these advances initiated the modernisation process of Taiwan.

After Zheng's governance, Qing dynasty incorporated Taiwan into its territory in 1684. However, the Chinese Empire was not interested in developing Taiwan until two hundred or so years later, as a result of the campaigns against Western imperial nations, when the Qing bureaucracy learned of the imperialists' intention of seizing Taiwan. Moreover, the 1884 China-France war, in which France attacked Taiwan over a dispute about the sovereignty of Vietnam, made the Qing realise the importance of Taiwan's geostrategic position. Therefore, in a very short time, Taiwan became a province of China, and the Chinese government determined to develop Taiwan under the rule of the first Prime Minister (*Xunfu*), Liu Ming-Chuan. Liu embarked on an extensive programme of modernisation, such as building railways, opening up commercial and trading places, developing post services, establishing schools, producing military equipment, and promoting agriculture. However, he did not contribute much to improving public health (Zhuang, *ibid.*, p.30). At a time of admiration and discovery of Western science and technology, Taiwan was viewed as a

laboratory by the Chinese government for performing a Westernisation experiment (Zhuang, *ibid.*, p.31). The main medical advance, as part of this Westernisation movement, included establishing Western-style public hospitals, in which the government hired Western doctors to serve both servicemen and the civilian populace. A basic foundation was therefore laid for the modernisation of Taiwan's medical system. However, Liu's successor did not continue to operate these modern hospitals, because of financial pressure. Accordingly, the primitive development of modern Western medicine in Taiwan quickly disappeared (Li X-F, *ibid.*; Zhuang, *ibid.*; Zhang L-Y, *ibid.*).

4.23 The situation of Taiwan's health and health care in the pre-modern era

Taiwan lacks records about the situation of its population health and medical care for the period before it was developed (Li X-F, *ibid.*, p.18; DoH, 1995: 24). As discussed previously, the entry of European imperial powers and the take-over of Chinese governments in the 17th century initiated the opening up of this under-developed land. Records of the hygiene and health situation of Taiwan's newly developing period show that Taiwan was hitherto an area suffused with 'poisonous vapour' coming from its hot and damp weather (typical features of a tropic and marine climate), together with a lack of physicians and medicine; consequently, plagues were pervasive, and people easily died of infectious diseases (Li, *ibid.*; Zhuang, *ibid.*, DoH, *ibid.*) Except for the aboriginal inhabitants, who had adjusted well to Taiwan's environment, all outsiders, such as the immigrants from China, the Western settlers and missionaries, and the Chinese army and officers, suffered from the bad conditions of hygiene and medical care.

In general, the epidemics prevalent within Taiwan in the 17th century, when the European conquerors first arrived, fell roughly into two types of disease: endemic diseases and infectious diseases. The former were such as trachoma, conjunctivitis, beriberi, and struma; the latter included malaria and dysentery, as Li Xin-Fen indicates (*ibid.*, pp.23-7). Although the specific environmental conditions of Taiwan contributed considerably to the occurrence of these diseases, the poorly developed public health system and lack of medical care resources were the main reasons leading to a prevalence of various epidemics, combined with high rates of fatality. Besides, a popular habit of smoking opium, started from the Dutch-colonial period, was a serious problem that affected people's health very much (DoH, *ibid.*, p.27).

Simply put, the situation of Taiwan's health in the pre-modern era was generally poor. This brings us to raise the following question: how about the situation of medicine and health care? In seeking to answer this question, first of all we need to note that the 17th century Dutch medicine and the late 19th century Westernised medical advances did not help to solve the health problems very much, for they served few native inhabitants on the one hand and existed for only a short period on the other. Attempting to provide a clear picture of the situation of health care in that period, here we borrow Kleinman's (1980) framework of medical pluralism, in terms of a generalised medical setting comprising the popular sector, the folk sector and the professional sector. In the 17th century, traditional Chinese medicine was the dominant system of healing in the professional sector. However, it did not cover many people, on the grounds that the number of Chinese medicine physicians in Taiwan did not rapidly increase after mass immigrants came from Mainland China (Li, *ibid.*, p.29). This had given rise to a booming folk sector of health care, including bone-setters,

herbalists, temple prescriptions, midwifery, and witchcraft (Li, *ibid.*, pp.28-9). Separate from the practices provided by the professional and folk sectors, ‘secret prescriptions’ (*mifang*), involving knowledge which was passed through family and social networks but not shared with outsiders (Kleinman, *ibid.*, pp.63, 65), and ‘informal prescriptions’ (*pianfang*), involving knowledge which differed from that of the professionals and was passed through social networks, also played an important role in looking after people’s health throughout a popular sector (Li, *ibid.*, p.30).

On the other side, it is essential to look at the state’s ideology and its responses to the situation of Taiwan’s poor health. As already noted, Chinese governments did not pay much attention to improving Taiwan’s health and medical systems until the 1880’s Westernisation Movement. From what we have presented in the earlier parts of this section, it seems that political ideology always dominated the decision-making of health measures within the Chinese governments. Specifically, General Zheng Cheng-Gong and his successors of the Ming dynasty regarded Taiwan as the base for a counterattack against the Qing government. They did not have a long-term plan for Taiwan’s development; so, not surprisingly, no medical measures were included in their administrations. As to the Qing dynasty, its bureaucracy was not concerned about Taiwan until it realized the importance of Taiwan’s geostrategic location in the wars in the 1880s. Regarding medical care, public poorhouses were the only institutions operated by the Qing government, where the poor and the sick were received and cured (Zhuang, *ibid.*, pp.25-7; DoH, *ibid.*, p.29). In the late stage of the Qing reign, Liu Ming-Chuan, the first Governor-General, built a few Western-type public hospitals and pharmacies under the existing policy concerning a Westernisation Movement. But this effort was not continued afterwards when the new governors

experienced financial problems. These events may have important implications for examining the nature of state health care, which was by all means politically directed in the case of pre-modern Taiwan. Also, it seems that only when the state had extra resources, did it seek to provide medical care for the selective population groups of the indigenous society. In other words, state health care was a demonstration of its benevolent and paternalistic intentions (Arnold, 1988: 16). This brings us to a further investigation of the nature and consequences of medicine and health care in the modernisation era of Taiwan.

4.3 The Initiation of Modern Western Medicine: Missionary Medicine

4.31 Imperialism and the Christian evangelisation in Taiwan

Following the discovery of new world sailing routes in the 16th century, the Western sea powers started to extend their territories by establishing overseas colonies, and Taiwan became one of the targets they fought over. As a result of the defeat of the Qing in the Anglo-French Allied War of 1858, Taiwan was opened for trade through the opening of two treaty ports, Anping (in the South) and Huwei (in the North), followed by the opening of Dagou (in the South) and Jilong (in the North) in 1863. The opening of these four main ports of Taiwan indicated a new era of Taiwan's contact with the West, the second after the expulsion of the Dutch in the 17th century.

Apart from free trade, the freedom of preaching was also determined between China and the European imperial states, based on the request of the churches of the latter. This new development revealed the situation in which Christian evangelisation in Taiwan had not been allowed since the expulsion of the Dutch in 1662. Britain was the first imperial empire that attacked Taiwan in the 19th century. Therefore, it was

dominant in all foreign trading with China by forcing the Chinese governments to open treaty ports. This was followed by the arrival of the English Presbyterian Church missionaries, who came to Taiwan as the earliest among all Western churches, and soon dominated the evangelisation work. In truth, the Presbyterian Church monopolised all preaching work in Taiwan until the middle of the Japanese colonial period, i.e. the early 20th century, and is still the largest church in Taiwan nowadays. This church created a unique opportunity for establishing contact with the indigenous population for the Western imperialists and the later Japanese colonisers through the application of mission medicine, which made a tremendous impact on the traditional medical systems and caused a shifting of medical paradigms, a process on which this chapter will focus later.

Before proceeding further, in line with the political economic approach to health it is essential to look at the relationship between Church and State concerning the nature of missionary medicine in Taiwan. In general, the entry of Christianity into Taiwan occurred at two periods of time¹; both entries were highly supported by the state and private enterprises. Christianity was first introduced to Taiwan in the 17th century when the Dutch occupied Taiwan. At that time evangelisation was included in the colonial administrations managed by the Dutch East India Company under the approval of the Dutch government (Li, *ibid.*, pp.43-50; Xu, 1965: 1-5). All mission staff were employed by the Company and carried out the mission of 'civilising'

¹ Before the Dutch, Spain had introduced Roman Catholicism to Taiwan during its reign from 1626 to 1642. However, the Spanish Church was expelled by the Dutch in 1642; consequently, Roman Catholicism disappeared from Taiwan. The second entry of Roman Catholicism into Taiwan happened in 1858, when the Qing dynasty was forced to allow the preaching activities of Western churches as part of the Tianjin Treaty of 1858. Likewise, Roman Catholicism did not win in the preaching campaign this time. Because it was of little significance to the formation of Taiwan's missionary medicine, particularly in the early era of modernization, I am not extending my discussion to the role of Roman Catholicism.

Taiwanese people. It is in this regard that medicine came to be seen by the state as having a wider utility in the service of empire (Arnold, *ibid.*, p.16). Analysts (Xu, *ibid.*, p.4; MacLeod, 1932: 25-9) indicate that the Dutch intended to establish an administrative organisation of State/Church as one linked body, copied from their homeland. As Li (*ibid.*, p.45) puts it, '*just like State and Church worked together to govern the Dutch in their motherland, the Dutch ruled their colonies by the East India Company accompanied by the Christian missionaries.*' Under this political-religious structure, the earliest missionary medicine is revealed as a compound of political, commercial, and religious interests pursued by the ambitious imperialists.

The second occasion of Christian evangelisation in Taiwan points to the arrival of the Presbyterian Church in the mid-1860s as a revival of Christianity. In common with the Dutch Protestant Church, this expansion was under the protection of the imperialist state together with the sponsorship of profit-making enterprises (Lai Y-Z, 1965: 8-9; Huang W-H, 2001: 51). From the viewpoint of the Taiwanese Presbyterian Church (Lai, *ibid.*, p.9), they had to 'hitch a ride' from the outcomes gained from the aggression of their imperial state, for Christian preaching had been prohibited in China before. Besides, the public lacked the understanding of Christianity, which had been a lost religion in Taiwan for 200 years. Given this, the influx of Presbyterian missionaries was generally considered to be related to the Western imperial powers and their unequal treaties. Accordingly, an attitude of hostility towards Western missionaries took root. As Huang (*ibid.*, p.51) indicates, China was forced to accept modern Western medicine throughout the spread of missionary medicine, which coexisted with and was enhanced by politics, commercial businesses, and religions.

4.32 Christian missionaries and the founding of modern Western medicine

From the 1860s onwards, the missionaries of the English Presbyterian Church came continuously to Taiwan to preach the Gospels, after they had expanded, by and large, their influence in the South of China. From the very beginning, the medical mission was viewed by the Church in Taiwan as a very important part of its evangelising activities (Lai, *ibid.*, p.24), but there was an important paradox in the ways to use it. On the one hand, the performance of the medical mission had a firm foundation in the Bible, referring to Jesus Christ's many examples of healing sick people. This explains the occurrence and continuous existence of Christian hospitals in many places of the world. The other side of the paradox, which seems more important, points to missionary healing as a bridge to establish contact with the indigenous people and to further develop a religious influence over them. It is said that this part of missionary medicine in Taiwan was successful in terms of building up a good relationship between the missionaries and the general public, on the grounds that the Taiwanese people used to feel antipathy towards Christianity and Christian missionaries (Lai, *ibid.*, p.24; Chen Y-X, 1997: 56). According to *A Centennial History of the Presbyterian Church of Formosa*, published by the Presbyterian Church of Taiwan in 1965, the majority of the patients of their clinics came from the poor classes, such as farmers, in a variety of places in Taiwan. Most patients came to the Church and the mission clinics as a last resort, after they had tried all other ways of healing or when they could not any longer afford the medical expenses (p.25).

It is a general belief that the late 19th century Presbyterian missionaries introduced and laid the foundation of modern medicine, in terms of Western medicine, in Taiwan (Zhuang, *ibid.*, p.36; Zhang L-Y, 1998: 166; DoH, 1995: 30;

Zheng Y-E, 2001: 5-6; Li X-F, 1998; Chi, 1994). In terms of the Christian missionaries, three Presbyterian missionaries played the most significant roles in developing Taiwan's modern medicine system through the establishment of Western-style hospitals (Zhang, *ibid.*, p.167; Chen Y-X, *ibid.*, p.55-61). James L. Maxwell, the first Taiwan parish Minister appointed by the Presbyterian Church of England arrived in Tainan (located in South Taiwan) in 1865, and built Taiwan's first Western-style hospital, Xin-Lou Hospital, in 1867. The second missionary was George L. Mackay, appointed by the Presbyterian Church in Canada, arrived in Danshui (located in North Taiwan) in 1872, and built the Kay Hospital in 1880. David Landsborough, as the third missionary, like Maxwell, was appointed by the Presbyterian Church of England to preach to Taiwanese people in 1895. He also built a famous Christian hospital, the Zhanghua Christian Hospital (located in Middle of Taiwan), in 1906. These three hospitals were all Western-style hospitals, in which free healing was provided, followed by the training of Taiwanese apprentices in modern Western medicine and the translation of modern medical textbooks (Chi, *ibid.*, p.310; Zhuang, *ibid.*, pp.33-54, Chen, *ibid.*) Thus, a biomedicine-based model of healing and training was developed and spread; meanwhile, the traditional healing systems experienced their first challenges, which we shall elaborate later. Accordingly, a new medical paradigm in terms of missionary medicine was gradually set up. It is in this sense that Du Cong-Ming (1959: 486-501), well-known as Taiwan's first doctor of medicine, called the period of 1865-1895², i.e. from the year when the first formal parish minister arrived

² Du in his 1959 book, *Brief Histories of the Chinese Medicine and Western Medicin*, identifies Taiwan's medical history as five periods: the era of primitive medicine (before 1544), the era of miasma medicine (1544-1865), the era of missionary medicine (1865-1895), the era of Japanese-governed medicine (1895-1945), and the era of Republic of China medicine (1945 onwards). This chapter is a brief review of the transition of health care and medical paradigms covering the first four eras, and the next chapter will explain the development of medical paradigms in the fifth era.

in Taiwan to the year when Japan began its colonial rule in Taiwan, 'the era of missionary medicine', hitherto often quoted in literature. Basically this chapter agrees with such a view, regarding these specific 30 years as the era of missionary medicine indicating a new medical paradigm. It should be noted, however, that after 1895 missionary medicine still existed in Taiwan, and still played an important role in providing health care and spreading the knowledge of modern Western medicine to the Taiwanese people.

In terms of missionary medicine as a new medical paradigm, there are two things worth noting. First, the theoretical foundation of modern biomedicine greatly differed from that of the traditional healing systems. A biomedical model of healing is concerned with material substance and the division of component parts, and accordingly, its diagnosis emphasizes the removal of pathogens afflicting a specific organ (Kleinman, 1980: 91; Ohnuki-Tierney, 1984: 92-9). By comparison, the traditional Chinese medicine concentrates on the functional attributes of an organic whole: that is, a concern with the imbalances of the bodily system, the so-called *yin/yang* (Kleinman, *ibid.*; Chen S-K, 1992: 109-115). Its diagnosis, therefore, involves an examination of the disharmony in the systematic correspondences of the Five Elements – metal, wood, water, fire, and earth – and of the imbalance in circulation of *chi* (vital essence or energy) (Kleinman, *ibid.*). In terms of the modes of treatment, the biomedical model is based on science, referred to as physiological science and anatomical knowledge, particularly in the time when missionary medicine was developed in Taiwan. In contrast, traditional Chinese therapies are concerned with a combined use of herbal medicine and diet regulation, based on diagnoses resulting from operating four types of diagnostic methods: observation, listening,

questioning, and touching. These differences had formed a basis on which missionary medicine stood at an advantage in making progress in treating those problems that Chinese medicine was weak to deal with. An apparent example was surgical treatments, which contributed very much to building up a high appreciation among many Taiwanese patients towards missionary medicine. According to the above-mentioned *A Centennial History of the Presbyterian Church of Formosa* (Lai Y-Z, 1965: 25), the majority of the therapies provided by the Church in the missionary era belonged to surgery, among which the treatment of eye diseases occupied the dominant place. As is well-known, MacKay was very popular with the general public for his distinguished skills in extracting teeth. In addition, Landsborough was a famous surgeon (Chen Y-X, 1997: 56-61; Zhuang, *ibid.*, p.33-55; Zheng Y-E, 2001). Missionary medicine also involved healing infectious diseases, such as the treatment of tuberculosis in the Xing-Lou Hospital and the treatment of malaria by MacKay (*ibid.*). In sum, this period of missionary medicine was successful in terms of impressive medical efficacy.

The second point is about ideological changes caused by the missionary medicine concerning the conceptions of ill health and the performance of medical practices. Simply speaking, this is an influence of Christian teaching on healing. As we have noted, for a long time traditional Chinese medicine and folk therapies had been the main types of healing in Taiwan. It is pointed out that Chinese medicine was the dominant system of healing in Taiwan before the arrival of Western Christian missionaries (Chi, 1994: 310). In a way Chinese health beliefs contributed to the popularity of folk healing, because of the existence of a general belief that illness resulted from defending ghosts/gods, in relation to ancestor/god worship as the core of

Chinese religion. It followed, then, that the removal of ill health was attributed to the seeking of divine advice and folk prescriptions (Li X-F, *ibid.*). Likewise, Chinese medical theory was, by and large, affected by traditional values as well. The notion of *yin/yang*, as an example, referred to living in harmony with the cosmos or nature, in which the idea of ghost/god worship had a place of relevance to health and ill health (Lai, *ibid.*, pp.25-6). It is in this regard that the missionary medicine cast new light on the causes of disease, in the way that it brought biomedical analysis of disease in place of the notion of sin. Moreover, it spread the idea of 'spiritual healing' in terms of the contact with evangelism during the therapeutic course (Lai, *ibid.*, p.26), which was the purpose of mission medicine. Similar experiences could be found in other places of the world. For example, Vaughan (1991), through his study of the medical missions in East and Central Africa, posits that the development of missionary medicine in Africa is a secularisation process of medical discourse, and the practices performed by the medical missionaries involved not only 'science' but also belief and ideology (p.72).

Before we turn to the next section regarding another medical paradigm, there is one more point worth noting: that is, to a substantial extent Christian missionaries contributed to the rise of Western medical education in Taiwan as part of the formation of a modern model of a medical system. This advance was achieved through the training course of physician apprentices and medical assistants given by the missionaries in missionary hospitals as well as in theological seminaries (Lai, *ibid.*, p.83). Considering the Scots' unique contribution to the advancement of medical science and practice in the 18th and 19th centuries (Hamilton, 1981), our curiosity is extended to the origin of this missionary medicine education in terms of two questions.

First, why were the Scottish Presbyterian missionaries interested in medical teaching? Second, in which ways was the missionary approach to medical education influenced by the Scottish Enlightenment?

Essentially, teaching is viewed in the Bible as one of the three major tasks (the other two are preaching and curing) that Jesus performed during the period of his missionary services on earth; accordingly, education is generally included in the Church's evangelisation (Huang Z-S, 2001: 15; Lai Z-Z, 2000: 1). This context may explain why those Presbyterian missionaries embraced medical teaching in their preaching work in Taiwan, apart from providing medical treatment as the main part of their medical mission.

On the other hand, what might be relevant was that 19th Scottish medicine traced back its extraordinary advances in education as part of the achievements of the Scottish Enlightenment. In the first place, there is a necessity to review the backgrounds of the 19th century missionaries in Taiwan. Among the three founder missionaries of the earliest three Christian hospitals in Taiwan, two persons were from Scotland. They were Maxwell and Landsborough, who both had a medical background: Maxwell was a graduate of Edinburgh University, and Landsborough graduated from Glasgow University (Chen Y-X, *ibid.*, p.57 & p.61). MacKay, from Canada, did not have a degree in medicine, but received medical training in Toronto and New York (Lin Y-N, 1959). He had Scottish origins from his father, George MacKay, who initially was a Highlander, and studied in Edinburgh Divinity College before he preached in Taiwan (Lai Y-X, 1995: 37-8). In addition to these three distinguished missionaries, many other missionaries also came from Scotland and were educated in Scottish higher education institutions, centred round Glasgow

University, Edinburgh University, and the Free Church Divinity College (Lai Y-X, *ibid.*, pp.35-6). Edinburgh and Glasgow were the cradles of the Scottish Enlightenment, which involved a rise of Scottish intellectual life occurring in the 18th and early 19th centuries (Chitnis, 1976: 4-5; Hamilton, *ibid.*, pp.107-113). It was claimed that innovations were to be of practical use, as part of the Enlightenment spirit. In this context, Edinburgh and Glasgow became the dominant medical schools in 19th century Britain, for both promoted a practical approach to medical education to replace the previous approach, which focused on theoretical training given in old medical schools such as Oxford and Cambridge (Hamilton, *ibid.*, pp.109-113). It was in this regard that medicine obtained an important position in the priorities of the Scottish Enlightenment (*ibid.*, p.111). A broadly based university education system for physicians and surgeons was, then, established and flourishing, and Scottish medical schools produced a great many graduates in the 18th century and later. These developments meant that Scottish training in medicine and surgery was qualified to lead the world (*ibid.*, p.126).

In sum, it is not clear if the 19th and early 20th centuries missionaries in Taiwan, as medical education pioneers, continued a Scottish tradition of medical training. However, the influence of the successful Scottish medicine, clinically-based medical teaching and advanced surgical skills in particular, could easily be observed from the accomplishments of mission medicine in Taiwan. Added to this were the missionaries' relevant Scottish backgrounds. Therefore, it would be only half-right to consider the origin of Taiwan's modern Western medicine as being a result of the 19th missionary medicine brought by Presbyterian ministers, as most commentators have indicated. The other aspect to this question, which is more important but has been always

ignored, is that the heritage of Scottish medicine played an invisible role in shaping the primitive form of Taiwan's modern medicine.

4.4 Moulding A System of Modern Western Medicine: Colonial Medicine

In 1895 Taiwan was ceded to Japan as a result of China being defeated by Japan in the 1894-95 Sino-Japanese War. This made Japan one of the new imperial powers in the context of the late 19th century burst of imperial activity by the industrial West. Hereafter a new medical paradigm in terms of a model of colonial medicine was gradually formed, in that medicine became a demonstration of the superior political, technical and military power of the settlers, and hence a celebration of imperialism itself (Arnold, *ibid.*, p.17). Different from the 17th century European conquerors, medicine achieved its great influence in imperial ideology and practice under the Japanese colonial governance. A new approach to health policy, i.e. strong state interventionism in public health, was gradually established, based on a German-Japanese model of medical care. This section is an investigation of the whole course of the formation of this new medical paradigm, concerning the nature and the consequences of medicine as part of the imperial infrastructure.

Before proceeding further, there is one thing worth noting. That is, missionary medicine still existed in Taiwan and continued to play an important role in the health of Taiwanese people during the Japanese colonial reign from 1895 to 1945, which is defined as a period of colonial medicine in this chapter. In addition to providing medical care for the public, the three missionary hospitals, as the largest private medical institutions in Taiwan, cooperated with the Japanese government in treating leprosy as well as helping opium-smokers to abstain from their addiction (Zhang L-Y,

1998, pp.168-9). The colonial government maintained a good relationship with the Presbyterian Church until the occurrence of the 'Mukden Incident' on September 18, 1931, which led to the Japanese occupation of Manchuria (located in the north-east of China) and a later invasion of the rest of China. After this event, the colonial rulers changed their attitudes towards Christian churches and missionaries. Under the existing policy of Japanising Christianity, they oppressed all Western Christian activities, including the provision of medical care by the Church. The situation of the Church became even worse after the occurrence of the Pacific Ocean War of 1937, which launched the Second World War, because Japan, as part of the Axis, was hostile towards Britain. Consequently, all Western missionaries were expelled from Taiwan, and all Taiwanese churches were merged into the Japanese Christian Church (Li X-F, 1989: 55). The operation of the three missionary hospitals was affected as a corollary. After the Second World War finished in 1945, Western missionaries were allowed to come again, and the provision of missionary medicine were gradually renewed and developed (Zheng Y-E, *ibid.*, p.10). Nowadays missionary hospitals, both Protestant and Catholic, still have a crucial role in providing medical care in Taiwan. According to Chen Yong-Xing (1997: 63), in 1995 there were 40 missionary medical care institutions in Taiwan.

The three Christian hospitals had great difficulties in operation during and after the period of the Second World War, according to Zheng (*ibid.*, p.10). Specifically, the Xin-Lou Hospital in the south was merged into the Zhanghua Christian Hospital in the centre, and was operated by the South Assembly Office of the Presbyterian Church during the Second World War. It was closed after the end of the War and was re-opened with the name of the Xin-Lou Therapeutic Clinic in 1950 under the support

of the Tainan Christian Medical Group. Finally a rebuilt Xin-Lou Hospital was opened in 1985. The Mackay Hospital in the north was under military requisition for Japanese governors in 1943, and experienced a difficult time after the War. It even needed the help from the Reformed Church of America in the initial period, and was operated well under native Taiwanese physicians in the later era. The Zhanghua Christian Hospital was bombed during the War, but was rebuilt afterwards. It was further expanded under the notable operation of David Landsborough IV, the son of David Landsborough (as the founder of the hospital), after 1952. To date, these three Christian hospitals still exist, with great publicity and excellent assessments by the health authority.

4.41 Health and colonialism

Before Taiwan was ceded to Japan, according to the Bakan Treaty of 1895, Japan had attacked and occupied the Penghu Islands, located between Taiwan and China and subordinate to Taiwan. In that battle, Japan took only four days to take Penghu, but its troops suffered seriously from cholera during the attack (Zhuang, 1998: 64-5). In parallel with the conquest of Penghu, the Japanese armed force were severely attacked by plagues and Taiwan's endemic diseases, cholera and dysentery in particular, when they conquered northern Taiwan in the summer of 1895 (Hong Y-X, 1995: 1-8). The following conquest of the rest of Taiwan still met the same problem, in that many Japanese soldiers became victims of Taiwanese endemic diseases. It was reported that in only the first seven or so months after the arrival of Japanese conquering army, among them 26,094 combatants were hospitalised owing to illness, and 4,642 died from disease (*ibid.*, p.6; Fan Y-Q, 1993: 13). The total of the sick and dead reached

over half of the military (Fan, *ibid.*, p.13)! Certain infectious diseases contributed particularly to this phenomenon. It was said that among the sick 62% of them contracted infectious diseases, of which malaria was the main disease; among the dead 80% of them contracted infectious diseases, of which cholera contributed the most (Fan, *ibid.*).

Through the painful experiences of conquering Taiwan, the Japanese realised the considerable differences of climate and disease type between their homeland and the colony. Also, they discovered the fact that the hygienic conditions of Taiwan were very bad and difficult to live in (Hong, *ibid.*). In view of the needs of looking after the health of soldiers and colonial administrative personnel, from the very beginning the colonial governors stressed the importance of hygienic improvement in determining the success of Japan's settlement in Taiwan (Fan, *ibid.*, p.14; Hong, *ibid.*; Zhuang, *ibid.*) Added to this was a concern over the health of the latecomers from Japan as part of a further settlement plan (Hong, *ibid.*). Based on the fact that Taiwan was the first colony of Japan in the context of a growing imperialist state after the Meiji Restoration of 1868, a successful solution to Taiwan's health problems was highly desirable. As a result, a number of medical institutions were gradually established to cure infectious diseases and to prevent the spread of epidemics. During this process, a powerful state intervening in people's health as well as social life was gradually formed, and we will explore this in more detail later.

Referring the necessity for the imperialist state of looking after the health of the military, Doyal (1979), in her analysis of British imperialism in East Africa, argues that effective medical provision in African colonies was essential. The reason was that the British imperialists had to '*maintain a healthy military capacity in the event of*

inter-imperialist conflict', in which the British colonial health policies in East Africa served to '*ensure the security and profitability of the newly annexed African territories*' (p.240). In other words, general health improvement was not the main goal the colonial health policies pursued. Rather, state health measures served to cultivate a healthier military force for the imperialist states as well as to develop a controlling system within the indigenous societies. Obviously, the role of modern medicine was extended from securing the health of the imperial settlers to facilitating a wider process of transmitting imperial ideology and practice to the indigenous society. In this sense, medicine became a tool of empire in the way it enabled the realisation of an encompassing imperialism (Arnold, 1988; Liu S-Y, 1999: 138).

In terms of a model of colonial medicine under the Japanese governance, one feature is particularly worth noting. Biomedical domination was a norm woven throughout colonial regulations in all aspects of the colonial activities. By biomedical domination is meant the way of governing colonial Taiwan based on biological principles implemented by Gotou Sinnbei's government after his being appointed as the Colonial Civil Administrator in the Taiwan Governor-General Office in 1898. As Gotou indicated in his congratulatory address in the first Taiwan Medical Association Assembly,

'...As everyone has known, I had determined to lay the foundation of the operation of this new land [Taiwan] on biology just when I took my new post here. Since the foundation was placed upon biology, medicine would be the most appropriate approach to this plan....'

(Quoted from Hong *trans.*, 1995: 79)

Gotou was generally considered as a notable colonial engineer, who '*transformed the territory from an embarrassment to a colonial showcase through the massive restructuring of the political, social, and economic order*' (Peattie, 1984: 19). He had a

medical background. Before he was involved in colonial affairs (the Colonial Health Advisor in the period of 1896-1898 and then the Colonial Civil Administrator in the period of 1898-1906), Gotou had studied at the German National Health Institute for two years (Fan, 1993: 25). Analysts (Liu, *ibid.*; Fan, 1993 & 2001; Huang W-H, 2001; Martin, 1995) claim that his biological approach to colonial governance was a product of the great influence of Bismarckian political philosophy, relying on Social Darwinist ideas concerning the important role of a centralised and authoritarian state in racial struggles. In the context in which Japan was ambitious to undertake a vast territorial expansion modelled on Western settlement experiences, Gotou's proposals for a scientific approach to colonial governance and development were welcomed by the Japanese authorities (Fan, *ibid.*, pp.23-30; Peattie, *ibid.*, p.19). On the one hand, modern science was viewed as a very important means to modernise Japan so as to become a world power. On the other hand, there existed an urgent need to protect the Japanese immigrants in Taiwan who would come after the military settlement. At a time of expansive nationalism, when Japan as a new imperial power was devoted to competing with its Western counterparts, the Meiji rulers and their successors upheld Social Darwinism as the principle of Japan's development (Fan, 2001: 5-6). By Social Darwinism was meant a world view implying certain key catchphrases such as 'struggle for existence', 'survival of the fittest', 'natural selection', in the light of the evolution theory established by Darwin in his influential 1859 publication, *On the Origin of Species* (Hawkins, 1997: 3-4). From the standpoint of Gotou, the government was responsible for assisting the Japanese people to become a healthy race in order to reach the goal of 'survival of the fittest' in the context of imperial competition.

In terms of biologicalism or biological principles, what contributed the centrality of the ideas was a gradual evolutionary way of transforming the colonial society from a pre-modern to a modern state through the application of practical managerial skills. Related to this was the fact that the Japanese colonial policy in Taiwan laid its foundation on a real understanding of the indigenous society; that is, the colonial rulers paid great attention and respect to the existing traditions of the indigenous society, through the use of modern scientific skills (Fan, *ibid.*, pp.27-30). In an attempt to collect information about the indigenous traditions, social surveys as a new method, depending on the application of modern scientific techniques, were employed as an efficient means by which the colonial officers learnt about the indigenous population. The first census of Taiwan was taken in 1905; it contributed to establishing a colonial population data base for making health policy, as well as creating a standard for the Japanese residents in Taiwan who were becoming acclimatised to the Taiwanese environment (Fan, *ibid.*, p.21).

On the other side, biologicalism pointed to a modern technological approach to the colonial health activities and policies, typified by the performance of public health, which took priority over all other health promotion issues. In terms of the growth of public health in Taiwan, commentators (Li T-Y, 1953: 4; DoH, 1995: 33; Jiang, 1997: 19-21; Fan, 1993) rate very highly the results of communicable disease control under the colonial government. The colonial health administrative system was based on a thorough network of colonial police, which was linked to a Chinese system of self-policing households, the so-called *bao-ja* system³ (Fan, *ibid.*, p.203; Chen, C-C, 1984: 216). The colonial police apparatus was also assigned to carrying out public

³ According to Chen (1984: 216), 'Historically, a number of households, usually ten, were grouped into a *chia* [*jia*], and a number of *chia* [*jia*], usually ten, were grouped into a *pao* [*bao*], but their number varied according to the locality.'

health programmes, including combating epidemics and preventing the spread of contagious diseases in different areas (Chen, *ibid.*). The medical police produced a marked effect on communicable disease control; in the meantime, this system played an important role in social control. Related to this was a colonial medical system, in terms of a synthesis of Governor-General Office hospitals, public medicine, and medical schools, which together contributed to the enforcement of public health programmes through a greater involvement in epidemic judgement and treatment under the control of the colonial officers (Fan, *ibid.*).

The growth of public health under the Japanese governance marked a turning point in the development of public health in Taiwan. Specifically, plague, the so-called Black Death, as the most severe epidemic disease among all notifiable diseases during the colonial period, was eradicated in 1918 through quarantine restrictions and sanitary improvement. Smallpox was well controlled after the occurrence of the pandemic in 1920 through the application of cowpox vaccination. Except for a few cases, cholera disappeared after 1920, as a result of quarantine restrictions, public health education, cholera vaccination, and the enforcement of fly control. Malaria had been the leading cause of death in the early colonial period. However, through the use of quinine, the enforcement of the Malaria Prevention and Control Regulations of 1913, and the improvement of hygienic conditions, malaria mortality saw a sharp drop from 30 persons per ten thousand population to 7 persons per ten thousand population on the eve of the Pacific War (Jiang, *ibid.*, pp.19-21; DoH, 1995: 33; Fan, *ibid.*).

In general, the success of communicable disease control under the colonial government resulted in the efficient progress of public health in Taiwan as well as in

the development of preventive medicine. On the other hand, this progress would have important implications for Taiwan's modernisation.

4.42 A German-influenced medical paradigm

It is noteworthy that the system of colonial medicine in Taiwan was greatly affected by the German medical model, involving the formation of a centralised health administrative system. In terms of this, logically we need to trace this influence to the insights German medicine had given to Japanese health care reforms; then we may link the German-influenced Japanese medicine to the development of the colonial medicine in Taiwan.

It is argued that Japan experienced a transition in the conception of health from individual health to public hygiene under the influence of German medicine in the 1870s; accordingly, the foundation of state intervention in health care was firstly laid (Liu S-Y, 1999: 100-101). A further transition towards a German medical paradigm happened when a new medical system was promulgated and realised by the Meiji Government after 1870. Significant changes included medical education reforms, the introduction of a military medicine model, which emphasised a top-down approach to health policy, and the promotion of germ theory and laboratory medicine in medical research. As a result, a new Japanese medical model was formed, based on a German medical paradigm but revealing a more centralised and authoritarian approach to health care (*ibid.*, pp.102-3).

It is in this context, in which the Japanese medical care reforms were modelled on German medicine, that we suggest the importance of a German medical paradigm in affecting the formation of the medical system in Taiwan, as a type of colonial

medicine and as a transformation from a traditional system to a Western-type modern system. In this sense, this section goes on to show some evidence relevant to support this argument.

In the first place, we need to indicate one fact. That is, many important colonial leaders had studied medicine in Germany, and then broadcast the ideologies of German medicine within Taiwan. A significant example was Gotou Sinnbei, as explained already. Another colonial officer vital to the formation of the colonial medical model in Taiwan was Takagi Arie, who was in charge of the Taipei Hospital and the Taiwan Governor-General Office Medical School, and who was the first Chairman of the Taiwan Governor-General Office Research Institute, also setting up the Taiwan Medical Association. Arie promoted the development of bacteriology in Taiwan during his period as health administrator (Liu, *ibid.*, p.117). Likewise, Horiuti Jirou, who was Takagi's successor as the President of the Taiwan Governor-General Office Medical School, and who contributed greatly to the development of Taiwan's hygienic and medical systems during his 50 years of endeavours in Taiwan, made great efforts to develop germ theory research in Taiwan (Zhuang, 1998; Hong, 1995). These two examples may reveal the great importance of bacteriology in the development of the colonial medicine in Taiwan, as we take into consideration the backgrounds of Tagaki and Horiuti: they had studied bacteriology in Germany at a time when bacteriology and laboratory medicine dominated German medicine in the 19th century. In addition to these influential colonial officers, the Taiwan Governor-General Office Medical School sent one or two Japanese academics to Germany to study every year, in tune with the *de facto* policy of imitating German medicine (Hong, *ibid.*, p.92). As a result, German medicine was increasingly

introduced to Taiwan, and accordingly a German medical paradigm was reproduced in the colonial system to a considerable extent.

In addition, the development of malaria research in Taiwan during the colonial period is an appropriate example to explain the way in which the colonial medicine in Taiwan was affected by a German medical paradigm. As noted previously, to some extent malaria threatened the Japanese take-over during their attack on Taiwan, as well as later in the early colonial era. This forced the Japanese colonists to put great efforts into malaria research during the early stages of colonial governance. On the other hand, under the influence of German medicine there was a growing interest in bacteriological research in Japan. Accordingly, the colonial leaders and scholars were encouraged to pay much attention to malaria research in Taiwan, on the grounds that 'plasmodium' had been confirmed as the pathogen of malaria by a French military doctor, so that a bacteriological approach to malaria analysis was established (Fan, 1996: 144-5). In Taiwan, malaria research was concentrated in some specific research institutions funded by the Governor-General Office. This research field reached maturation in the 1930s. It is argued that the success of malaria research can be greatly attributed to the establishment of the system of specialist research institutions for malaria, which duplicated the German pattern of scientific research at a time when German science dominated other Western countries (Fan, *ibid.*, pp.142-3). We may suggest that the institutionalisation of medical research reveals another dimension to the instrumentality of modern medicine, in that the production of new medical knowledge serves the needs of the imperialistic state, particularly through the employment of state regulation and centralised control.

4.43 Tropical medicine and colonial economy

We now move on to the economic dimension of colonialism, with regard to the role of medicine and health care in contributing to upholding the modes of the imperial capitalist economy. In terms of this, particular attention is paid to the emergence and development of tropical medicine, as a new and distinct medical discipline that typified the instrumentality of colonial medicine in its relationship with the imperialistic state.

First of all, it is essential to clarify the economic role that Taiwan played in the context of the Japanese imperial economy. At a time of becoming increasingly industrialised in early Meiji era, Japan was faced with balance-of-payments difficulties caused by rapid agricultural export growth. In reaction, it determined to capture an economic surplus through controlling the economic sectors and trades in its colonies (Ho, 1984: 347-8). Given this, the economic role of Taiwan was determined as a source of agricultural products to support the industrial development in Japan, and also as a source of industrial products for preparations for war after the mid-1930s (Liu K-Z, 1975: 58). It was in this context that health care provision and public health improvement became part of the economic infrastructure, insofar as they contributed to improving human capital as an important factor in economic development.

As the pursuit of economic interests was central to colonial development, powerful government efforts relating to the strengthening of the social-economic infrastructure became essential, in that health and education were normally considered very relevant to the raising of labour productivity. A good example is Liu's (*ibid.*, pp.58-72) case study of the relationship between economic development and population growth during the colonial period. He indicates that the goal of the

colonial public health measures was to pursue reductions in Taiwanese mortality, which in turn contributed to raising the population's natural rate of increase. This then helped to satisfy the need for a greater labour force in agricultural development; and finally a greater agricultural surplus would be attained. From the standpoint of the Japanese governors, the population policy in Taiwan served the purpose of pursuing maximum profit, which implied that population growth was based on the lowest cost together with a value increment (*ibid.*, p.63). It is in this regard that specific public health measures and elementary schooling were carried out, for both policies cost little but contributed significantly to the improvement of human capital⁴. In a similar regard, Ho (*ibid.*), based on an analysis of the Japanese colonies, including Taiwan, highlights the importance of investing in public-health measured in terms of raising labour productivity, and confirms the linkage between formal education expenditure and the improvement of human capital (pp.352-4). However, he doubts that the elementary education expenditures by the Japanese Government, largely in the 1930s, could have produced any significant outcome in human capital by the end of the colonial period, for education has a long gestation period. Instead, he urges us to consider the effect of the colonial education on the post-colonial development (*ibid.*, p.354). This point will be pursued in the next chapter.

⁴ According to Liu (1975), the communicable diseases control by the colonial government until 1920, when most of the diseases were well under control, cost only US\$0.30 dollars every year per person. Afterwards the hygienic and health expenditure, mainly for buying medical equipment and training health workers, was generally less than US\$1 dollar every year per person. However, the mortality dropped significantly from 33 per ten thousand in the period of 1906-1909 to 19 per ten thousand in the period of 1940-1943. At the same time, the birth rate saw a gradual increase in terms of from 40 persons per ten thousand in 1906-1909 to 45 persons per ten thousand in 1940-1943. This gave a striking growth in the natural increase rate: that is, from 7 persons per ten thousand in 1906-1909 to 25 persons in 1940-1943 (pp. 66-7).

As to the colonial elementary schooling, the governmental expenditure was only between US\$0.026 and US\$0.043 dollars every year per person. However, the Government reaped a good reward as NT\$1 dollar of expenditure on the countryside education equalled NT\$14 dollars of long-term social revenue in the agricultural production later on (pp.69-70).

In addition, one line of argument has centred on the evaluation of the Japanese colonial medical measures. It is argued that the main purpose of Gotou Sinnbei's opening of a new medical school was to prepare a healthy environment for Japanese capitalists to invest in, instead of concerning the health and well-being of the Taiwanese (Huang W-H, *ibid.*, p.95; Dai G-H, 1985: 12). Related to this is a concern over the development of Taiwan's tropical medicine, dominated by the same Government. In the first place, the emergence of tropical medicine in Taiwan was to serve the purpose of reducing the cost to Japanese colonisers in sickness and death from Taiwan's epidemic diseases. In truth, the development of tropical medicine took priority over all other colonial affairs after the early colonial period (Huang, *ibid.*, p.109). The role of tropical medicine in serving colonial purpose was reinforced from 1914 onwards, in that Japan was very interested in expanding its economic territory to the South Seas, the German-governed Micronesian Islands in particular, under the concept of 'southern advance'. Based on the concern over strategic necessity, in that the Micronesia islands stood athwart lines of communication west across the Pacific to Asia, together with economic advantage, namely the Japanese commerce in the western Pacific, Japan took possession of Micronesia in 1914, and continued to expand its territories in South Pacific afterwards (Peattie, 1984b: 172-185). During the whole course of Japan's colonial expansion in the South Seas, Taiwan naturally became the base from which the colonisers set out on their settlement voyages. Regarding this are three explanations, as follows.

The first reason is geographical: that is, Taiwan was a 'relay station' of the southern advance route, for it is located between Japan and the South Pacific. The second is political realities. Taiwan was the first colony of Japan, therefore it was

viewed by the Japanese colonists as a place to practise colonial governing skills (Huang, *ibid.*, p.100), with the aim of developing a bigger Asian empire. Given this, tropical medicine research played an important role in securing the colonial foundation from the outset, as well as in producing the medical knowledge for the use of the southern advance. Following an expanded war zone in the South Pacific in the 1930s, the Taiwan Governor-General Office further promoted tropical medicine research in Taiwan, on the grounds of providing medical knowledge about acclimatization for the Japanese immigrants in the new colonies (Fan, 2000: 57-8). In addition to the production of medical knowledge, the tropical medicine in Taiwan acted as a supplier of medical specialists in the way a number of medical scholars and students in Taiwan were assigned to the war areas and charged with the mission of malaria prevention and treatment (Fan, 1996: 153).

The last explanation is economic, concerning the development of Japanese industry in its colonies. A significant example was the sugar industry. Based on a successful experience in sugar cultivation and refining in Taiwan, several Japanese companies developed the sugar industry in two South Pacific islands, on the grounds that these islands had Taiwan-like natural conditions for growing sugarcanes (Peattie, *ibid.*, p.191). The colonial Government offered substantive support to the Japanese entrepreneurs. For example, in 1916 Horiuti Jirou, as the President of the Taiwan Governor-General Medical School, was appointed by the colonial Government to supervise the health affairs of the Kuhara Industry Limited Liability Company in Tawao (located on the eastern coast of North Borneo), together with a technician of the Monopoly Bureau of the Governor-General Office to supervise the construction affairs.

In sum, the development of tropical medicine in colonial Taiwan is best understood in terms of the context of colonial encounter. It is not so much a factor of medical advance as such, but rather a consequence of imperial expansion. Again, it highlights the role of modern medicine as a tool of empire in facilitating colonisation.

4.44 The downfall of traditional medicine

From the viewpoint of health care reform, there is one more thing about the development of colonial medicine in Taiwan worth noting. That is, during the colonial period the Western modern biomedicine became a dominant system of healing: in the meantime the traditional Chinese medicine gradually lost its orthodox position in the professional sector of medicine. In tune with the main concern of this thesis regarding the influences of policy intervention, what we intend to investigate in this section is the role of the colonial state in affecting the transformation of medical systems in Taiwan, in relation to the influences of the government's ideological predispositions and political strategies.

First of all, it is essential to place the development of Taiwan's colonial medicine in the context of the transformation of medical paradigms in Japan, because the shifting of medical systems in Taiwan was, by and large, a product of the ideological change which occurred in Japanese medicine guided by the Meiji state following the Restoration of 1868. As the Meiji leaders felt a great necessity to modernise Japan so as to become a world power, they set out to embark on a programme of radical reform modelled on the West, in which the reforms of the existing medical system were included. Based on the realisation that modernisation required Westernisation, the Meiji government imitated the model of German medicine at the expense of the

traditional Japanese medicine, *kanpo* (Leichter, 1979: 237-41; Garland, 1995: 259-60; Ohnuki-Tierney, 1984: 91). *Kanpo* was a medical system that was strongly based upon traditional Chinese medicine, introduced to Japan from China in about the 6th century (Garland, *ibid*; Ohnuki-Tierney, *ibid.*; Saito, 2000: 517). It was the dominant system of healing in Japan before the Meiji Restoration. The Restoration leaders, however, ‘saw *kanpo* as a vestige of the nation’s feudal past and tried to eradicate it as part of their drive toward modernisation’ (Garland, *ibid.*, p.260). Therefore, a delicately devised course of ‘Westernising’ Japanese medical systems was set out. Significant reforms were as such, for example: the establishment of the Medical Section in 1872, which was elevated to a Medical Bureau in 1874, under the Ministry of Education in charge of the administration of medical education based on the German model; the promulgation of the nation’s first Medical Law in 1874, which prescribed public health organisation and administration, medical education, dispensing of medicines, and licensing of hospitals and medical personnel; the proclamation of the condition for practicing *kanpo* in 1868, that the physician must first pass an examination in seven subjects of Western medicine; and the realisation of the Medical Practitioners Law in 1906, which prescribed great details of regulation about medical practices (Leichter, *ibid.*, pp.239-241; Ohnuki-Tierney, *ibid.*, p91). As a result, a modern medical system based on the Western biomedical model was formed; meanwhile the approach of state intervention to health care was established.

In parallel with the medical policy developments in Japan, from the outset of governing Taiwan the colonial leaders considered the system of traditional Chinese medicine as a backward part of the feudal society and intended to replace it with the modern Western medical system. Moreover, they looked down upon Chinese

medicine practitioners, on the grounds that the Japanese greatly esteemed a scientific approach to medicine under the influence of German model. As Yamakuti Hidetaka, the first President of the Taiwan General-Governor Office Medical School, posits it:

'These so-called 'doctors' in this island (Taiwan) – how on earth are they like physicians? Can they be entrusted with people's precious lives? Details are not needed, for everyone knows the answers very well! In truth, they know nothing about physiology and pathology. The worst are those who are illiterate- they stuff their patients with grass roots or tree barks which are seized on carelessly after only hearing the patient's words. Although they look somehow like the kanpo physicians in the inland [Japan], they are not the equals of the latter. In fact, they are clumsy and inferior. They might barely be compared with the inland quacks as medication sellers. As is well understood, to a considerable extent this medication-selling behaviour has done harm to our society. Careful contrast of these two (groups) shows up the extent to which these Taiwanese "doctors" have done harm.'

(Cited by Zhuang Y-M, 1998: 172)

On the other hand, the colonial government had a great need for a number of medical personnel to conduct health-related affairs in Taiwan, and the model of modern Western medical system was considered proper and efficient. In this regard, a pragmatic approach to medical education was followed, and served to promote the development of clinical medicine (Liu S-Y, 1999: 120). In line with the Meiji concern about education as a key to facilitate modernisation, the colonial rulers spent generously on public educational facilities, including medical education (Tsurumi, 1984). A consequence of this was that the most talented Taiwanese youths were encouraged to study in a medical school so as to seek a career in modern medicine (Tsurumi, *ibid.*, p.281; Lai Z-Z, 2000). The colonial government first built a Medical Institute for Training Native Physicians in 1898, where medical hygiene, the operation of microscopes, and clinical medicine were taught. Secondly, the Government established the Taiwan

Governor-General Office Medical School in 1899, which initiated the formal Western medical education in Taiwan. It should be noted that this School also took responsibility for training Chinese medicine physicians from 1907 onwards (Chi *et al.*, 1996: 1330).

In a sense the colonial medical education functioned as a safety valve of the colonial governance (Tsurumi, *ibid.*, p.308). On the one hand, it played the role of delivering the political values of the conquerors to the elites of the indigenous society. On the other hand, it helped to set up two different types of medical education in Japan and Taiwan, in an attempt to support the ideology that Japanese medicine was superior to the colonial medicine in Taiwan (Liu, *ibid.*). This was in terms of the dichotomy between medical education and medical research in Taiwan. That is, medical education emphasised the approach of clinical medicine in terms of being of practical use, while the medical research, which was controlled by the Governor-General Office, focused on experimental medicine. As experimental medicine stood dominant in Japan within both the fields of medical research and medical education, the approach of clinical medicine in medical education in Taiwan caused the colonial medicine to occupy an inferior position to Japanese medicine.

In addition to the educational establishment, the colonial government suppressed the development of traditional Chinese medicine through the control of licensure. On the one hand, the Japanese governors declared that all medical practitioners needed to gain permission from the colonial authority, together with an announcement that the name of 'physician' belonged to Western medicine practitioners only, prescribed in the Taiwan Medical Practice Regulations of

1986. On the other hand, the colonial government was reluctant to make Chinese medicine practitioners qualified for practice. In truth, it held only one qualification examination for Chinese medicine practitioners in 1901. Even worse, the colonial rulers devalued the professional status of Chinese medicine practitioners through licensing them as 'Class C' professionals, who were to be replaced gradually by fully qualified 'Class A' physicians, who were graduates of the medical college (Chi, 1994: 310; 1996: 1330). As a result of these colonial policies, traditional Chinese medicine gradually lost its orthodox position in Taiwan's health care system, and finally became of little importance by the end of the period of colonial governance. In the meantime, Western modern medicine laid solid foundations in Taiwan and became the dominant system of health care. This is illustrated by a sharp fall in the number of Chinese medicine practitioners during the colonial period, compared with a striking increase in the number of Western medical physicians during the same period. According to Zhang Li-Yun (1998: 181), there were 1,223 Chinese medicine practitioners in 1901, and only 97 practitioners in 1942. For comparison, there were only 259 Western medicine physicians in 1897, and 2,241 physicians in 1942.

4.5 Conclusion

In this chapter, I have explored the major events that contributed to the changes of health care systems, and described the influential agents who enabled the shifting of medical paradigms, with a view to reveal the structural factors that were imposed on medicine in its becoming a profession. This is concerned with the nature of medicine and suggests the importance of governments' ideological

predispositions and political strategies in the process of developing the health care state up to 1945.

In sum, the 17th century Netherlands and Spain, as the older mercantilist imperial powers, focused on short-term commercial interests without much concern for a long-term colonial development programme. At that time medicine was not linked to a function of a tool of civilising the indigenous people, as it was under the later imperialists, but played a limited role in protecting the health of the European settlers. Later on Chinese governments took over Taiwan from the Dutch and started a 230 or so years reign, during which political considerations continually dominated the extent to which Taiwan could be developed. In detail, General Zheng Cheng-Gong of the Ming dynasty and his successors made many efforts to develop Taiwan, which was considered as the initiation of Taiwan's modernisation, on the grounds that Taiwan was viewed as a base of counterattack against the Qing dynasty. The succeeding Qing dynasty considered Taiwan of little value and therefore was not concerned to develop it for two hundred years. It was in the 1880s, when the Western imperial powers and Japan showed their great interest in Taiwan, Qing governors started to take an active view of Taiwan's development by virtue of modernisation. In a sense modernisation served not only to demonstrate the political and military potential of the Qing Government, but also to conduct a large-scale experiment of Westernisation on the grounds of the success of the West imperial nations, which had put great pressure on this old empire to seek for transition. As for the medical establishment as part of the programme, the main concern seemed not so much with health improvement as such, as the interest in trying to introduce Western

advances. The result, therefore, was not surprising: the experiment was quickly dropped when financial pressures occurred. Around the same time, Western Christian missionaries arrived in Taiwan in the 1860s as a result of the expansion of Western imperialism, and they contributed significantly to introducing modern Western medicine, i.e. biomedicine, to Taiwan. Accordingly, the first image of modern Western medicine for Taiwanese people was a compound of political, commercial and religious interests related to the ambitious imperialists of the West. In this context, the Christian missionaries seriously promoted missionary medicine, because it offered the unique opportunity to establish contact with the indigenous population. Then, in the colonial era during the Japanese occupation of Taiwan from 1895 to 1945, great attention was paid to medicine, for it served to protect the health of settlers and soldiers, as well as to develop a controlling system within the indigenous society. Also, medical advances were seen as having a wider utility in the process of civilising Taiwan; accordingly, medicine became a demonstration of the superior political, technical and military power of the rulers (Arnold, 1988).

Overall, the influences of outsiders were important in contributing to shifting Taiwan's medical paradigms. As I have pointed out in different sections of this chapter, Western missionaries and Japanese colonial governors played a key role in introducing and laying the foundation of modern Western medicine independently. Their influences were so strong that they actually created an era of missionary medicine and an era of colonial medicine in Taiwan's medical history. Referring to the model of missionary medicine, an important dimension was the influence of Christian teaching on healing, which brought biomedical analysis of

disease in place of the traditional notion of viewing offending gods/ghosts as the cause of sickness. Accordingly, this change gave rise to a secularisation process of medical practice; also, the impressive medical efficacy of modern medicine caused some of the general public to turn to Western medicine. In terms of missionary medicine, the heritage of Scottish medicine, connected with the 19th century Scottish Enlightenment, which included inspiring medical advances and medical education, may have played an invisible role in shaping the primitive form of Taiwan's modern medicine, in relation to the methods of medical training particularly. As to the model of colonial medicine, the most obvious feature was that medical intervention was strong and revealed very much about the nature of imperialism. This far-reaching medical interventionism (Arnold, *ibid.*, p.18) meant that the role of modern medicine was extended from securing the health of the imperial settlers to facilitating a wider process of transmitting imperial ideology and practice to the indigenous society.

As a result, before the end of the Second World War modern Western medicine had laid a firm foundation in Taiwan. It had become a dominant system of healing in place of traditional Chinese medicine. Medicine became more of a profession *per se*, but meanwhile it was put under more state scrutiny. Before we leave this chapter, it should be noted that the story of the medical paradigm transition in Taiwan is not finished yet. The post-war development was important in the sense of a new paradigm, when a US-influenced model of medicine was formed and then extended its great influence on governmental policy-making, as we shall see in the next chapter.

CHAPTER FIVE
DEVELOPING THE HEALTH CARE STATE
IN THE POST-WORLD WAR II ERA:
TOWARDS CREATING A NATIONAL SYSTEM

5.1 Introduction

This chapter presents the political and economic context in which the Taiwanese health care reforms were developed during the process of post-war development, in order to understand better the creation of an NHI scheme in 1995. The process of Taiwan's industrialisation is addressed on the basis that the establishment of the medical-industrial complex is concerned with its functional role of being adopted to match specific economic and political needs. Particular attention is paid to the transformation of the nature of the state, in relation to the formation of a potent state in managing health care reforms.

Like the previous chapter, this chapter focuses on both the macro-level and meso-level perspectives, namely the structural factors that impinge on state health activities and result in economic development being high on the governmental list of priorities. It begins, in Section 2, with a political-economic investigation of the state health efforts in the immediate years after World War II, with a concern for the breaking-down of the Japanese colonial heritage, i.e. the well-controlled public health. This is followed by a discussion of the rebuilding of the health care system modelled on that of the US, contextualised in the process of aid dependency. Particular attention is paid to the 1950s land reform, concerning its functional role in forming a solid basis for industrialisation. The chapter then moves on to examine the state's initiation of a

social-insurance approach to health care, situated within the process of industrialisation in terms of a sequence of economic development programmes up to the mid-1980s. At the same time, the geo-political dynamics of economic development are also highlighted, based on a concern over the extent to which state welfare strategy is linked to particular military purposes.

The rest of the chapter, i.e. Section 3, focuses on the political-economic circumstances in which the NHI emerged at the turn of the 1990s. Particular attention is paid to the systematic crises, including insufficient administrative capacity to manage the moment of crisis and serious funding pressures, which together furnished the launch of the NHI in 1995. This is an attempt to make clear the realities behind the political rhetoric. The chapter ends with a concluding remark on the nature of the Taiwanese health care state, through a brief review of the political-economic influences on the making of Taiwan's health care reforms.

5.2 The Political Economy of Health Care in the Post-1945 Development

In terms of the political economy of health care, this section is concerned firstly with the economic dimension of state health care, referring to the extent to which the medical-industrial complex was constructed to serve the economic purposes of capitalism for profit, and secondly the political dimension, regarding the instrumentality of health care in contributing to the achievement of political legitimacy; both aiming for a understanding of the trajectory of Taiwan's post-war development. In parallel with the previous chapter, a focus is put upon the shifting of the medical paradigm into an American model, on the basis that the US is viewed as an influential agent that enabled the process of Taiwan's capital accumulation in the

post-1945 era.

5.21 The colonial heritage and its decline

- *Health status and public health measures*

To begin with, it is essential to review the immediate post-war years of the health situation, concerning the state role in rebuilding the health of the post-war population, in comparison with what the Japanese colonisers had achieved in health promotion. It is said that at the time when the Chinese Nationalist government repossessed Taiwan, the hygienic situation was very bad, many medical facilities were severely damaged, and people were undernourished; consequently, communicable diseases were spread easily in Taiwan (DoH, 1995: 184 & 379-380; Zhuang Y-M, 1998: 363; Chen S-F, 2000). Accordingly, there was a pandemic of cholera and smallpox, together with the reappearance of plague in 1946-7. Considering that plague and cholera had disappeared in Taiwan since 1918 and 1920 respectively, and smallpox was well controlled after 1920, their re-occurrence directed the attention of the authorities to the cause of the plagues. A general condemnation was made of the loose operation of seaport quarantine, which had resulted in the passing on of several plagues from China to Taiwan through the Chinese conquerors and immigrants (DoH, *ibid.*, p.82; Chen, *ibid.*, Zhuang, *ibid.*, p.363). Related to this was dissatisfaction with the new government vis-à-vis the colonial Japanese government, which had put great efforts into public health and therefore improved very much the control of communicable diseases. It is in this regard that the Nationalist government was impelled to take account of communicable disease control as the priority in its list of health administration reforms, which originally had focused only on the take-over of the

medical institutions left by the colonial governors (Chen, *ibid.*, p.35; DoH, *ibid.*, p.81).

The spread of plagues in the immediate post-war years had given rise to social unrest, in that the occurrence of the 2-28 Incident in 1947 was particularly worth noting. This Incident is an important political event in which the Nationalist government eradicated its political dissidents, who covered the whole spectrum of the Taiwanese elite (Chen, *ibid.*, pp.55-65; Zhuang, *ibid.*, pp.363-4; Huang W-H, 2001: 145-6; Chen Y-X, 1997: 97-114). Accordingly, the Nationalist state apparatus was re-structured after the Incident, in that a new Department of Health, as a first-level unit directly under the Taiwan Provincial Government, was set up with a mission to avoid the increase of turbulence through manipulating public health measures (Huang, *ibid.*, p.146; DoH, *ibid.*, p.87). It was straightaway that the new agency carried out a large programme of public health measures, focusing on farm villages (DoH, *ibid.*). Finally, plague was wiped out in 1948; smallpox disappeared after 1955; no more cases of cholera were found after 1947. Besides, malaria was eradicated in 1965 as a result of continual efforts made by a special research institution set up in 1948 (DoH, *ibid.*, pp.184-8 & 379-81).

The change in the degree of state policy intervention in the population's health suggests the importance of the instrumental role of public health. That is, the operation of public health measures was central to stabilising public discontent; this then contributed to securing the political legitimacy of the Nationalist government, originally an outside political regime. For comparison, during the Japanese hegemony over Taiwan, the improvement of public health played the role of protecting the health of the colonisers at the time when the Japanese conquered Taiwan, and of civilising

the indigenous society afterwards. Obviously the functional role of public health measures was furthered in the hands of the Nationalists. That is, public health has more of the nature of social control in the way it serves the consolidation of the ruled and their acceptance of outside rulers.

Outside the sphere of public health, the Nationalist Government undertook few positive measures in developing health care systems, on the grounds that it was preoccupied by the civil war on the Mainland. After taking over the institutions of medical care and medical education from the Japanese, the government devoted itself only to preserving the status quo (Zhang L-Y, 1998: 309; DoH, *ibid.*). Accordingly, people's health care relied more upon a laissez-faire economy, which meant a lack of attention from the state. In terms of medical paradigms, the German-Japanese medical paradigm, which had gained a dominant role with the backing of the Japanese colonisers, still prevailed in the early post-war period. Its leading position was challenged by American medicine after the 1950s, as a consequence of the American aid to Taiwan, on which this chapter will focus later on.

- *The social-cultural dimension to the degeneration of public health*

Before proceeding further, an important issue needs to be clarified here: what were the causes of the degeneration of public health in post-war Taiwan? There can be little doubt that the war was the most crucial factor. Besides this, the loosening operation of seaport quarantine was also important, as already noted. These are macro viewpoints. More understanding may be gained by a closer examination of the micro-level dynamics. In terms of this, what we are concerned with is the social-cultural dimension to the change in people's health-related behaviours. According to Chen

(Chen S-F, *ibid.*, pp.66-75), at the time the Nationalists took over Taiwan, the Taiwanese tended to relapse into 'bad' health practices, for example, disposing of household waste freely, refusing to receive immunisation against particular infectious diseases, and seeking divine advice instead of going to see a doctor while ill. It is said that these kinds of practices existed prior to the Japanese 'civilisation', and their recurrence then contributed considerably to the reversion to the infectious disease pandemic in Taiwan. She highlights the importance of the process by which public consciousness of health is formed on the basis that an individual is likely to pursue good health of his/her own will. She argues that the remarkable progress of public health under the colonial governance was not a real change in people's health-related behaviours, but rather a result of the intimidating laws, which entailed severe punishments; and the corollary of her argument is that without enforced discipline the Taiwanese soon revived their old health practices.

Following Chen's research, two points are worth stressing. The first is concerned with the meaning of public health advances in the context of colonial dominion. In the case of Taiwan, despite the fact that the improvement of hygienic conditions and vaccination services contributed greatly to the progress of public health, Taiwan was not really transformed into a 'civilised' society in the sense of health: the colonial rulers shaped the indigenous society in the light of their own notions of progress without considering the reactions of the ruled. The second point involves citizenship as part of the notion of modernity. That is, progressive health practices are a revelation of modernity, and the satisfaction of individual health needs constitutes an important part of citizenship rights in a modernised society. Related to this is the notion that health must be progressed within the process of modernisation.

5.22 Aid dependency and the shifting of medical paradigm

In 1949 the Chinese Nationalist Government lost control over the Mainland, and the Goumindang, as the ruling party of the Government, sought exile in Taiwan as a result of suffering defeat by the Communist Party. Hereafter the Goumindang assumed the ruling power in Taiwan for five decades until it lost the Presidential Election of 2000. At the same time, the Communist Party ruled over China, now named the People's Republic of China (PRC).

Originally the US supported the Guomintang regime, based on a standpoint of anti-communism. In view of the result of the Chinese civil war, the US's China policy was later adjusted towards accepting the Communist regime, on the grounds that the US held an expectation about the PRC's role in securing Asia against the expansion of Soviet power. However, the PRC chose to stay in the Communist bloc. Its hostility towards the US became more obvious, revealed by the PRC's determination about joining the Korean War in 1950. This made the US turn its attention to the geostrategic location of Taiwan, concerning the Gomintang's role in cooperating with the US for the maintenance of peace and order in the West Pacific area (Wen X-Y, 1990: 86-91; Hsu, 2002: 176-7). In this context, a U.S. Aid Mission to Taiwan was determined, in pursuit of Taiwan's geopolitical stabilisation first and economic development as secondary (Wen, *ibid.*, pp.91-100; Zhao J-C, 1985). In short, it was the Cold War order that initiated American aid.

- *American aid*

The American Aid Mission to Taiwan was undertaken for 15 years, from 1950 to 1965. It played an ever-important role in Taiwan's post-war development, in the way that the US provided various support, including financial assistance, material relief

and technical support. American aid enabled the Guomintang rulers to sort out the country's deficit financing and inflationary spiral (Lin Z-X, 1970; Li & Chen, 1987: 21; Wen, *ibid.*, p.1). Of particular importance is that Taiwan's economy was therefore transformed from a type of colonial economy, which mainly served the interests of the Japanese colonisers, to a type of capitalist economy, referring to a new mechanism of industrial production by which Taiwan was fitted into the global division of the capitalist system (Huang W-H, 2001: 141-2; Wen, *ibid.*).

However, there is an important paradox concerning the contribution of American aid to Taiwan's economic development. Essentially, American aid served the purpose of protecting Taiwan from Communist China's attack so as to secure the US's defensive line in the West Pacific area. Except for real military assistance, typified by the fact that the Seventh Fleet was commanded to garrison the Taiwan Strait, the US offered economic assistance that aimed to enhance Taiwan's self-sufficiency in its economy, as both the US and the Guomintang authorities understood that economic stability was the key to persisting with the battle against the Chinese Communists (Wen, *ibid.*, p.93; Lin, *ibid.*, p.112). Accordingly, effective financial measures were adopted. It is said that the inflationary spiral was soon controlled under the import of American agricultural products and raw materials that could be used for producing living necessities, together with the US's supervision of Taiwanese currency supply through the application of a relative fund¹ (Lin, *ibid.*, pp. 112 & 132-3; Li & Chen, *ibid.*, pp.22-3).

¹ This relative fund was part of the New Taiwanese Dollar Fund of the U.S. Aid. According to the Sino-American Bilateral Agreement, the Taiwanese government was requested to provide a sum of Taiwanese currency equal to the US donation and save it in Taiwan's Central Bank each time when the US made a contribution to Taiwan. This was based on the consideration that the increase of the fund would give rise to a shrinking effect of currency supply. The use of the fund would be based on the agreement of both Taiwan and the US, in an attempt that the increase of currency supply would reach a state of well controlled. This fund played a positive role in stabilising the inflationary spiral in the early 1950s, as well as in levelling currency increases during the era of American aid (Lin Z-X, 1970: 122-3 & 132-3).

At a time when Taiwan had low domestic savings and a large state financial deficit combined with a lack of foreign exchange, American aid did contribute greatly to Taiwan's economic growth in offering considerable capital investment. According to Lin's research (*ibid.*, p.131) on the gross fixed capital formation within Taiwan's main industries, the American aid accounted for 24.4% of the total gross fixed capital formation in 1951-52, 35.4% in 1953-56 (which is the period when the First Economic Development Programme was conducted), 39.4% in the period of 1957-60 (the Second Phase of the Economic Development Programme), and 18.4% in the period of 1961-64 (the Third Phase of the Economic Development Programme). On average, the American aid accounted for 28% of the total gross fixed capital formation during the 15 years under aid (see table 5-1).

Table 5-1 American Aid as a Percentage of the Gross Fixed Capital Formation
within the Main Industries, 1951-64

Unit: NT\$ million dollars

Period	Item	Sub-total	Agriculture	Industry	Electricity	Transportation
1951-52	Gross fixed capital formation (a)	2,320	836	740	267	477
	American aid (b)	565	203	56	164	142
	b/a (%)	24.4	24.3	7.6	61.4	29.8
1953-56	Gross fixed capital formation (a)	9,674	3,302	3,344	1,703	1,325
	American aid (b)	3,422	884	1,028	1,010	500
	b/a (%)	35.4	26.8	30.7	59.3	37.7
1957-60	Gross fixed capital formation (a)	22,870	5,917	7,789	4,578	4,586
	American aid (b)	9,000	2,297	2,677	2,129	1,897
	b/a (%)	39.4	38.8	34.4	46.5	41.4
1961-64	Gross fixed capital formation (a)	36,887	9,236	13,516	5,841	8,294
	American aid (b)	6,804	1,968	953	3,351	532
	b/a (%)	18.4	21.3	7.1	57.4	6.4
1951-64	Gross fixed capital formation (a)	71,751	19,291	25,389	12,389	14,682
	American aid (b)	19,791	5,352	4,714	6,654	3,071
	b/a (%)	28.0	28.0	19.0	54.0	21.0

Source: Lin Z-X (1970), p.131.

On the other hand, Taiwan was obliged to cooperate with the US authorities in the use of American aid as specified by the Sino-American Bilateral Agreement. As a consequence, the US was able to intervene, by and large, in Taiwan's economic and financial policy-making, and accordingly a post-war American model gradually came to dominate the state apparatus (Lin, *ibid.*, p.130; Wen, *ibid.*). Specifically, three dimensions to this issue are worth stressing.

First, to outward appearances the emergence of the US economic assistance to the defeated countries during the immediate post-war years served the purpose of promoting the growth of the defeated, so as to form an anti-communist alliance. In practice, this action also involved seeking for outlets for the American surplus of agricultural commodities, in an attempt to promote the stability of the American agricultural economy (Lin Z-X, 1987: 39; Zhao, *ibid.*, p.33). In terms of this, the American Aid Mission to Taiwan during the 1950s did not avoid a capitalist profit-making purpose. Such an intention became more obvious in 1959-60, when the US turned the focus of its aid to Taiwan from supporting economic infrastructures and industrial establishments to the promotion of private investment and export expansion, based on the fact that flourishing American private enterprises were eager to seek overseas markets for investment (Wen, *ibid.*, pp.97, 272-3; Schreiber, 1968: 128).

The second dimension is related to the reform of the public administrative system. The American aid authority acted not only as a sponsor but also as a supervisor in rebuilding and modernising Taiwan's post-war system of public administration, which originally was a mixture of the colonial Japanese and the Mainland systems. The Americans intervened in a broad area of reforms, including: the improvement of fiscal administration in the central government, consisting of budgeting, treasury, and accounting and auditing; the training of public enterprise

accountants and the establishment of a supervisory board of public enterprise accounting; the amendment and editing of several administrative and tax laws plus regulations; and the classification of official posts in the government, in an attempt to assist private enterprises in making the same effort (Zhao, *ibid.*, pp.241-52).

The third dimension is concerned with the system of talent education, which came under an item called 'technical cooperation' under American aid. Specifically, this kind of aid included two types: sending Taiwanese technical personnel abroad for study, and inviting American experts and professionals to Taiwan to take charge of technical advisors (Wen, *ibid.*, p.113; Lin, *ibid.*, p.122; Zhao, *ibid.*, pp.26-7). Such support had to be for specified programmes that had been approved by the American aid authorities, who focused on the beneficial effect of the aid on Taiwan's economy (Zhao, *ibid.*). In total, during the American aid era, 2,706 technical personnel were sent abroad, mostly to the USA itself. It should be noted that this method of talent education worked in all spheres of economic-related activities (Table 5-2), in which health/public health was included.

Table 5-2 Technical Personnel Sent Aboard for Study and Training
under American Aid, 1951-65

Industry	Number	%
Agriculture	692	25.6
Industries	656	24.2
Transportation	141	5.2
Public Health	202	7.5
Education	477	17.6
Public Administration	262	9.7
Mass Communications	208	7.7
Military Affairs	48	1.8
Others	20	0.07
<i>Total</i>	<i>2,706</i>	<i>100.0</i>

Source: Wen X-Y (1990), p.114.

In the light of the information presented above we may now direct attention to a major issue: a type of aid dependency was gradually formed under the across-the-board American aid. The influences of American aid on Taiwan reached far beyond material assistance and involved the delivery of American concepts through the aid network, as Wen indicates (*ibid.*, p.270). It is in this context that the transference of a health care system, in terms of the post-war 'Americanisation' of Taiwanese medicine, occurred, on which this chapter will now focus.

- *The shifting of the medical paradigms*

The formation of aid dependency may give us some insight into the shifting of the medical paradigms in post-war Taiwan. On the one side, abundant American notions of health care were introduced to Taiwan as a corollary of the health-related technical cooperation under American aid, namely the influence of the two hundred or so health personnel who were sent to learn American health care systems (see Table 5-2). It is said that under American aid almost all health-related department director-generals and first-rank managers in the government and major medical colleges went at some time to the US for visiting and training (Huang W-H, 2001: 171). As a consequence, a new medical paradigm modelled on American health care systems was increasingly developed, at the cost of the existing German-Japanese medical model, which was viewed as part of the colonial heritage that represented 'backwardness'. Accordingly, the post-war Taiwanese society suddenly filled with American values, referring to the phenomenon of the so-called 'Americanisation'. This situation was continued in the post-American aid era, revealed by a growing trend towards studying in the US prevailing in both government and universities.

In terms of the post-war American medical paradigm, there are several features worth noting. In the first place, the tradition of ‘lecturing system’ (*jiangzuo*) in medical education, inherited from the Japanese, met with a fierce challenge. A ‘lecturing unit’ was a section of a medical institute within a medical college; it had its own budget and staff, separated from the other offices, under the direction of a ‘lecturing unit professor’. In a medical college affiliated teaching hospital, each medical speciality had only one ‘lecturing unit professor’, who dominated all affairs in college and hospital. Under the ‘lecturing system’, there was a large overlap of personnel between teaching hospital and medical college, and the former needed to follow the lead of the latter (Yeh S., 1982: 4-5 & 152; Fu, S-N, 1950: 266). A typical example was revealed by the change in the relationship of the National Taiwan University³ College of Medicine (NTUCM) and its affiliated hospital, the National Taiwan University Hospital (NTUH).

At a time of high admiration of American values and dependence on American funding, the tradition of ‘lecturing system’ in the NTUCM was strongly criticised by the university authorities, which had the backing of the Nationalist governors and American aid authority (Huang, *ibid.*, pp.137 &163). In the face of the strong resistance to reform towards an American paradigm from the college authorities, represented by Du Cong-Ming, the Dean of the NTUCM and also Chair of the NTUH, Fu Si-Nian, the President of the National Taiwan University, exclaimed in public that Taiwan’s health reform should initiate the American-style reforms, particularly the modern hospital system, which revealed better qualities such as ‘easy access’,

² This part borrows heavily from Huang (2001), pp.137-193.

³ The National Taiwan University was the successor to the Taiwan Imperial University in the Japanese-colonial era. It has been the very top university in Taiwan and represents a major trend in

'equality' and 'scientific management' (Fu, *ibid.*, p.267). Also, the approach to medical education in a teaching hospital was argued, on the basis that American medicine highlighted the role of clinical treatment, while the Japanese model focused on medical research. The dispute ended with the abolition of the 'lecturing system', replaced by an American style of medical education, centred on laboratory teaching. Added to this was the democratisation of decision-making procedure in a medical speciality. The number of professors within a medical speciality was increased, and accordingly, the decision-making in a speciality was based on the verdict of a committee instead of the dictatorship of a 'lecturing unit' professor (Huang, *ibid.*, p.172).

In addition to the changes in the medical education model, the existing doctor's training system also underwent a major transformation. Initially, a medical graduate firstly had to work as an unpaid teaching assistant for his/her 'lecturing unit professor' in conducting medical practice or research before he/she was considered qualified for self-practice or medical teaching (*ibid.*, p.161). The American style of training, however, denied this 'lecturing system', and enhanced clinical training by performing an internship system. That is, a medical college student had to complete his/her training by working as an intern in a teaching hospital in the last stage of his/her college course. The training procedure was even extended to the period after graduation, namely a residency programme (Ye, *ibid.*, p.155; Fu, *ibid.*, p.281) . The American system required that a medical graduate had to work as a resident (house doctor) and accept the supervision of senior physicians, such as the chief resident and attending physicians, before he/she was approved as qualified for practising medicine and teaching his/her fellow residents and medical students (Wei H-Y, 1962).

In a way the change in the doctor's training system indicated a new division of

labour within the medical profession. Equally important was the promotion of the nurse's role in a hospital. Originally, the notion of 'nurse' under the Japanese model was of a less professional individual, since such a person, normally a woman, acted as something between a patient-carer and a chore-doer. An American-style division of labour in medicine, by contrast, empowered a nurse to throw off the role of a doctor's assistant and to gain a professional position (Huang, *ibid.*, pp.173-4; NTUCM *et al*, 1985: 103-112). This development was typified by the case of the NTUH, where a Nursing Department was established as a follow-up to the founding of the NTUMC Affiliated Nursing School under the US funding and supervision (*ibid.*).

In sum, the shifting of medical paradigms in post-war Taiwan has a close link with a wide-ranging package of American aid, through which we suggest the important role of the state in shaping the approach to a medical model. The Taiwan case reveals one thing: it is through the reciprocal interaction between the US and Taiwanese states that a wider process of transmitting American values and medical practice to Taiwan was facilitated. In this sense, the shifting of medical paradigms is not so much a product of medical autonomy as such, but rather a consequence of state interference.

However, in terms of the transition in medical autonomy, in this period the Taiwanese medical profession also started to constitute itself as a social actor with a powerful potential in the political sphere, because the process of professionalisation (in this case, the establishment of the post-war American model) would enable doctors to gain more political resources, such as a more positive public image and the growth of medical expertise (Moran & Wood, 1993: 3). As professionalism is occupational control granted by the state, based on the existence of a regulatory contract between

the profession and the state (Freidson, 1970b; Moran & Wood, *ibid.*, p.26), the shift from a 'lecturing system' to an American system seemed to signify the strengthening of the individual autonomy of consulting clinicians, whereas the Japanese-German system was based more on a hierarchy of doctors.

Historically, the German system was characterised by a system of collective bargaining, involving the employment of powerful self-governing institutions (Altenstetter, 1999: 51; Moran, 1999: 110). On the one hand, insurance funds (sickness funds) were granted the authority to exercise day-to-day control over doctors' expenditure and patients' demands (Pflanz, 1971; Ginsburg, 1992: 93). However, on the other hand, the associations of insurance doctors were also able to negotiate fees and medical services with the funds based on their monopoly bargaining position, and consequently they could exercise overwhelming influence over the quality and distribution of health care services (Ginsburg, *ibid.*; Light, 1986: 7). It is in this context that the medical practice in Germany was and is still affected very much by the hierarchical system of medicine. Interestingly, in the medical encounter German doctors generally have an authoritarian attitude towards their diagnosis, and accordingly patients can do nothing except follow orders, as indicated by Payer (1988: 76). As Taiwanese medicine moved into the post-war era in the context of medical paradigm shifting, it appeared essential to pay attention to the potential for change in professional autonomy, as well as the influence on the doctor-patient relationship.

Simply speaking, American medicine puts more emphasis on the character of physicians as a consulting profession, serving the purpose of solving practical problems for laymen with the backing of modern technology. Therein lies a

mechanism whereby 'the survival of medical practice depends upon the choice of laymen to consult it', as discussed by Freidson (1970b: 21-2). In a way, the post-war 'Americanisation' of Taiwanese medicine facilitated a greater possibility of reinforcing the individual autonomy of Taiwanese physicians, for the development of professionalisation, connected with growing state intervention in medical education and training, gave rise to the growth of medical power. Equally important was the potential to form a model of the 'sick role', referring to the mutual obligations borne by doctors and patients for effective treatment so as to help patients to return to normal, as described by Parsons (1951). Based on the fact that American hospitals vis-à-vis German and Japanese hospitals appeared to have more of the nature of openness, equity and effectiveness, at the time when the shifting of medical paradigms occurred, the introduction of the American system may have contributed to the forming of a new pattern of Taiwanese doctor-patient relationship, in terms of greater mutual participation in the processes of medicalisation, on which the next two chapters will focus.

5.23 Land reform as a solid basis for industrialisation

During the immediate post-war years of economic unrest, the Guomintang state embarked on a programme of agricultural land reform, which was the earliest economic policy adopted by the Taiwan state and proved to be a successful strategy of reform (Lin Z-X, 1987: 41-5; Li & Chen, 1987: 211; Wei E., 1993: 50; Zhao J-C, 1985: 121-2; Amsten, 1992: 84-8). This state activity is considered equally important vis-à-vis American aid to the formation of a solid basis for Taiwan's post-war economy, for it demonstrates a model of industrialisation nourished by agricultural

surplus (Lin, *ibid.*, p.41).

The land reform consisted of three phases of programmes implemented from 1949 to 1953. First, the existing practice of farm rent, which showed that 50-70% of the total crop yield was often given to the land-owner, was put under state scrutiny, under which the ceiling of farm rental was fixed at 37.5% of the total main crop yield, the so-called '37.5% Rental Reduction Programme'. Added to this was an application of a rent period that should be not shorter than 6 years, to replace the prevailing practice that supported an uncertain rent period, which had helped owners to manage their farming lands advantageously at the expense of tenant farmers. Accordingly, the incomes of tenant farmers were greatly increased, together with higher incentives for production, which gave rise to a significant increase in total agricultural production (Li & Chen, *ibid.*, pp.221-2).

Secondly, public farming land taken over from the former Japanese occupiers was sold to farmers on easy terms, and tenant tillers were offered a preference to buy. Based on the fact that the instalments were generally cheaper than the rental under the 37.5% Rental Reduction Programme by 10-20%, farmer buyers, by and large, benefited from this policy.

The last stage of land reform is called the 'Land-to-the-Tiller Programme', referring to a statutory duty, specified by the related regulation, imposed upon landlords – that a landlord was obliged to sell up his/her holdings above a maximal size to the tenant farmers through a procedure of reselling, in which the government first requisitioned extra land from owners and then sold it to tenants on easy terms. Meanwhile, landowners were given land bonds in kind and stocks in public enterprise as a compensation. On the one hand, this policy had an effect on evening out the

distribution of land holdings (Lin, *ibid.*, p.44). However, on the other, it might have encouraged the development of private enterprises, in the way landlords transferred their capital investment in land to industry and business (Li & Chen, *ibid.*, p.227).

American aid also played an influential role in assisting with the implementation of Taiwan's land reform (Zhao, *ibid.*, pp.117-122). A Sino-American Joint Commission on Rural Reconstruction (JCRR) was established in 1948 to take charge of the provision of financial support as well as far-reaching technical assistance, including the drafting of relevant laws and programme proposals, supervising the programme under progress, and assessing the programme results (Zhao, *ibid.*, p.118). One particular point is related to the influence of the 'green revolution', in terms of the introduction of new technology under the direction of the JCRR. This reform contributed to extracting a surplus of labour force from agriculture, in support of the policy of industrialisation (Chen Y-X, 1992: 78; Amsden, *ibid.*).

Equally relevant is the carrying out of a programme of establishing health networks at local level to take charge of public health affairs, in that elementary health care by the state served to ease the social tension caused by the restructuring of agricultural communities (Huang W-H, 2001: 149). In fact, this was a follow-up to the Japanese-colonial programme of health promotion, which included establishing health clinics in main cities of Taiwan. The new agenda focused on rural areas. The government set up 15 health stations in 1945, and reached its policy goal, in terms of each township having one health station, in 1954 under the financial support from the JCRR (Xiong & Jiang, 1999: 628).

Overall, at a time when agricultural production accounted for twice industrial production, this thorough land reform acted as an effective instrument for achieving

particular political and economic aims. In terms of political aims, the Guomintang government, as an outside political regime, was keen to pursue political stability at the beginning of its reign in Taiwan. The land reform, on the one hand, played an important role in diminishing Taiwanese landlords' power in politics (Liu J-Q, 1995: 72-3; Huang, *ibid.*, pp.148-9), and in gaining political support from a large number of peasants on the other (Liu, *ibid.*; Chang J-S, *ibid.*, p.182). In addition, the increase of agricultural production helped to solve the problem of food supply for the Guomintang military forces and the Mainland immigrants (Isida, 1992: 38). As regards the economic perspectives, what we are concerned with is that this land reform contributed to forming a stable agricultural economy, which was essential to capital accumulation. Thus, agriculture in Taiwan acted as the back-up to industrialisation in the way its increasing output served to satisfy the needs of industrial production.

5.24 A brief history of Taiwan's industrialisation: up to the mid-1980s

Taiwan is a model of industrialisation that supports an argument popular in studies of development – that industrialisation is a prerequisite for economic development (Hewitt *et al.*, 1992: 1). In the face of the lack of the factors of production, namely capital, labour and land, the Guomintang rulers managed to make good use of economic development programmes to stimulate the progress of industrialisation (Ye & Ma, 1967: 753-6) (see Table 5-3). This section presents the context in which the industrial production was central to the achievement of Taiwan's rapid and lasting economic growth, and consequently gave rise to a world-renowned 'economic miracle'. The sections that follow will then focus on the formation of the

medical-industrial complex, addressing the functional roles of state health efforts in serving specific economic and political purposes.

Table 5-3 Taiwan's Major Economic Development Programmes
1953-1985

Economic Development Programmes	Period	Inflation (Average)	Planned Economic Growth Rate (Average)	Achieved Economic Growth Rate (Average)	Industrialisation Strategies
1 st Phase	1953-56	9.5%	-	8.1%	Import substitution (Pursuing economic self-efficiency)
2 nd Phase	1957-60	8.3%	7.5%	7.0%	Import substitution (pursuing economic self-efficiency)
3 rd Phase	1961-64	3.8%	8.0%	9.1%	Export-led growth
4 th Phase	1965-68	2.9%	7.0%	9.9%	Export-led growth
5 th Phase	1969-72	0.6%	7.1%	11.6%	Export-led growth
6 th Phase	1973-75	19.5%	9.7%	6.0%	Export-led growth
7 th Phase	1976-81	8.7%	8.0%	9.4%	Second-stage import substitution (developing heavy-chemical industries)
8 th Phase	1982-85	-0.9%	8.0%	6.9%	Industrial upgrading (from labour-intensive to technique-intensive)
Average	1953-85	6.6%	7.9%	8.5%	-

Sources: Council for Economic Planning and Development (1990), *Taiwan Statistical Data Book*, pp. 1-2; Li & Chen (1987), pp.179-209.

Notes: 1. Inflation rates were calculated from the data of the growth rate of the wholesale prices.

2. Planned economic growth rates were quoted from Li & Chen (1987), pp. 179-209, Table 3-1 ~ 3-8.

3. Achieved economic growth rates were calculated from the data of the growth rate of the gross national product.

4. The Sixth Phase of Economic Development Programme was implemented for three years only. Thus, the average inflation, planned economic growth rate and achieved economic growth rate were based on the data of 1973-75.

To begin with, it should be noted that the launch of the first programme in 1953 was more of a strategy to win the US financial support; thus its content focused on the ways by which American aid could be used effectively (DoE, 1971a: 2; Ye & Ma, *ibid.*, p.756; Li & Chen, *ibid.*, p.127). Likewise, the second programme revealed a similar feature (Executive Yuan, 1957: 2, 17, 140). In the American aid era (1950-1965), Taiwan conducted three 4-year economic development programmes, the so-called the First, Second and Third Phases of Economic Development, covering the periods of 1953-56, 1957-60 and 1961-64 respectively. The first two programmes aimed to pursue self-sufficiency in the economy. In terms of economic strategies, these two programmes served to transform the initial type of agriculture-based economy to a type of industry-based economy. This stage of industrialisation was based on an approach of import substitution of consumer goods, typified by the protection of infant industries, such as textiles, cement, chemical and fertilizer industries, towards an inward-oriented growth (Lin Z-X, 1987: 45-53; Amsden, *ibid.*, pp.88-9; Sasamoto, 1992: 23-5). Then, in view of the saturation of the home market and the limited size of the economy, the government introduced a package of reforms that promoted export-led growth from 1956 onwards, and accordingly a model of export-led production prevailed in Taiwan's economy in the 1960s and 70s (Sasamoto, *ibid.*, pp.23-5; Li G-D, 1993: 85-8; Amsten, *ibid.*; Lin, *ibid.*, p.56).

In the context of pursuing export-led growth, the Taiwan government carried out the Third, Fourth, Fifth, and Sixth Phases of Economic Development Programmes, covering the periods of 1961-64, 1965-68, 1969-72 and 1973-76 respectively (DoE, 1971b & 1971c; IECDC, 1969 & 1973). As a result, a type of open economy was formed, and Taiwan began to enter the world market (Lin, *ibid.*, pp.61-6; Li G-D, *ibid.*, pp.85-66).

The First Oil Crisis occurred in 1974, and accordingly Taiwan's economy was affected to some considerable degree. In reaction to this, the government gave up the completion of the sixth programme in 1975, and executed the Seventh Economic Development Programme instead, covering 1976-81. Meanwhile, a major public construction project with the name of 'Ten Constructions Programme', referring to the establishment of a number of basic infrastructure projects in areas such as energy and transport, was introduced in an attempt to fill the hole caused by decreasing private investment, so as to stimulate Taiwan's economy (Lin, *ibid.*, pp.162-3). This programme resulted in a critical change in Taiwan's industrial structure from light industries to heavy-chemical industries (Lin, *ibid.*, p.84; Sasamoto, *ibid.*, p.27). In a similar regard, a further project with the name of the 'Twelve Constructions Programmes' was launched in 1978. In terms of industrialisation strategy, the seventh programme covered an era of so-called 'second-stage import substitution', when the government focused on the pursuit of economic stability through the development of heavy-chemical industries, which contributed to producing basic raw materials and components for industrial production (Sasamoto, *ibid.*, p.27; EDC, 1976: 1; CEPD, 1981: 4).

A short-term economic development programme, i.e. the Eighth Phase of Economic Development Programme covering 1982 to 1985, was implemented after the Second Oil Crisis occurred in 1979. Also, a 'Fourteen Constructions Programme' was launched in 1984 towards extending the development of heavy-chemical industries as well as completing the establishment of the economic infrastructure, in which medical establishments were included (we will explore this in more detail later on).

Entering the 1980s, Taiwan's economy was characterised by an approach of

liberalisation, in terms of a greater dependence on the free market (Li G-D, 1993: 57). On the international trade side, the state launched a new programme towards trade liberalisation, typified by the relaxation of control over foreign exchange and the abandonment of tariff protection policy, due to the pressure for the revaluation of the New Taiwan Dollar (the Taiwanese currency) plus a strong requirement from the US (Lin, *ibid.*, pp.106-112; Li, *ibid.*, p.89). On the industrialisation strategy side, industrial upgrading became necessary in pursuit of continual economic growth. As a result, labour-intensive methods of production were gradually replaced by technology-intensive methods of production (Sasamoto, *ibid.*, p.28).

Overall, from an economic standpoint it is without doubt true that the development of Taiwan's post-war economy was a successful experience. As the Taiwan government regarded the achievement of economic stability as the golden rule of economic development (Amsden, *ibid.*, p.90; Li, *ibid.*, p.72; Li & Chen, 1987: 150-2), the economic performance showed that this policy target was fully met. In terms of this, there are two points worth stressing. Firstly, effective control of inflation has been observed throughout the era of implementing the eight economic development programmes. The inflationary spiral in the immediate post-war years soon became well controlled: there was a sharp fall from 42.9%⁴ in 1951-52 to 9.5% in 1953-56 (see Table 5-3). This was followed by a gradual decrease from 8.3% in 1957-60 to -0.9% in 1982-85, except during the periods of 1973-75 and 1976-81, in which inflation was 19.5% and 8.7% respectively, because of the occurrence of the two Energy Crises. Secondly, economic growth reached far beyond the state goal during most of the periods when the eight programmes were implemented (see Table 5-3). In particular, the growth rate reached a peak of 11.6% in 1969-72, and 9.4% in 1976-81 when Taiwan's economy was affected by the Second Oil Crisis. Overall, Taiwan's

⁴This figure was based on Taipei, the capital city, only (Lin, 1970: 134).

inflation averaged a rate of 6.6% during the 30 or so years when the eight major programmes were implemented; meanwhile its economic growth had increased at a rate of 8.5% per annum.

In addition, the transformation of Taiwan's productive structure into an industrial economy was of parallel importance to economic growth. As we can see from Table 5-4, the proportion of agriculture in Taiwan's net domestic product saw a steady decrease from 38.37% to 6.83% during the period of the eight economic development programmes, whereas the proportion of industry in Taiwan's net domestic product saw a gradual increase from 17.68% to 45.30% at the same time. It should be noted that 1963 was the turning point for industry, for it was in this year that the net domestic product of industry exceeded that of agriculture.

Table 5-4 Percentage Distribution of Net Domestic Product:
1953-85

Unit: %

Year	Total	Agriculture	Industry	Services
1953	100.00	38.37	17.68	43.95
1954	100.00	31.73	22.15	46.11
1955	100.00	32.91	21.10	45.99
1956	100.00	31.64	22.40	45.97
1957	100.00	31.78	23.89	44.33
1958	100.00	31.12	23.95	44.92
1959	100.00	30.51	25.71	43.78
1960	100.00	32.89	24.92	42.20
1961	100.00	31.57	25.03	43.40
1962	100.00	29.35	25.69	44.96
1963	100.00	26.82	28.13	45.05
1964	100.00	28.33	28.91	42.75
1965	100.00	27.43	28.61	43.96
1970	100.00	18.03	34.53	47.44
1975	100.00	14.91	39.13	45.95
1980	100.00	9.19	44.68	46.13
1985	100.00	6.83	45.30	47.88

Source: Directorate-General of Budget, Accounting and Statistics, Executive Yuan
(2002c), *Statistical Abstract of National Income in Taiwan Area, Republic of China*.

In summary, Taiwan's post-war development revealed a successful case of capitalist production based on a model of a mixed economy, including a market economy that implied efficient mechanisms on which the development of private enterprises depended, and a state-interventionist approach to the transformation of economic structures (Li, *ibid.*, pp.55-6). What is central to the operation of this model was the important role of the state in directing Taiwan's economic development towards the pursuit of economic growth. As far as health care reform is concerned, the economic dynamic has important implications for the formation of state health efforts, since the economic ideology may well have by and large shaped the trajectory of the Taiwan welfare state. We shall now turn to the economic dimension of state health activities in Taiwan.

5.25 The economic dimension of state health efforts

This section is concerned with the overall arrangement of health care projects in the development of Taiwan's industrialisation, with a view to examine the growing role of 'welfare' in economic and social planning. Referring to the eight economic development programmes, a social development project that contained health care did not appear until the third programme (see Table 5-5). At a time when the Guomintang rulers were worried about Taiwan's unstable economy and the geopolitical crisis, the first two programmes (1953-56 and 1957-60) served to win American aid. Accordingly, these two programmes were not so much economic development guidelines as such, but rather a mixture of individual projects concerning agriculture, industry and transportation, without a general framework for mapping out other non-productive departments (Li & Chen, *ibid.*, pp.120 & 177; Executive Yuan, 1957;

DoE, 1971a).

A Social Development Project came out in the third programme (1961-64), because the government was determined to further the degree of economic development (Li & Chen, *ibid.*, p.122). Referring to health care, a sub-project with the name of 'public health' was included under the Social Development Project. The major policies included the prevention of infectious diseases and goitre, the promotion of health education, of environmental hygiene and industrial health improvement, empowering health authorities, and strengthening food and medicines management (DoE, 1971b: 235-6). It was specified in this project that the promotion of public health should be adapted to suit economic development needs (*ibid.*, p.234).

In a similar regard, the fourth programme (1965-68) stipulated that the improvement of public health and protection, as part of the Social Welfare Plan that belonged to the social development project, should be adapted to match the situations of economic development, as the 'golden rule' (DoE, 1971c: 363). Regarding health care, this programme contained a Medical-Care Plan, which entailed a broad range of health activities, such as: extending medical services and standardising the establishment of hospitals and physician licensure, prevention of infectious diseases, family planning (in this case, birth control), environmental hygiene and industrial health improvement, strengthening food and medicine management, strengthening maternal and child health services, health education and training, and prevention of mental illness.

The fifth (1969-72) and sixth (1973-75) programmes did not include a social development project, as there was a debate within the government about whether an economic development programme should contain social development (Li & Chen,

ibid., pp.177-8; IECDC, 1969 & 1973). It should be noted, however, that the sixth programme still involved a reform of the Labour Insurance Scheme, concerning the provision of medical benefits, as well as the planning of a medical insurance scheme for government employee's dependants under the Project of Human Resource Development (IECDC, 1973: 272-3). (More details about the evolution of Taiwan's social insurance systems will be given later.)

In the 7th programme (1976-81), a Social Development Project was restored, and under this project two sub-projects regarding national health promotion and social welfare advancement contributed to furthering state health efforts (EDC, 1976: 44-5; Li & Chen, *ibid.*, p.178). The National Health Promotion Plan included extending medical services to isolated areas through itinerant medical service teams, enlarging public medical facilities, improving national nutrition, mental health promotion, and industrial safety improvement. As far as health care was concerned, the Social Welfare Advancement Plan involved strengthening the functions of the existing social insurance schemes that contained medical-care provision (referring to the Labour Insurance and Government Employees' Insurance), and introducing social services for the elderly and the poor. One thing is worth stressing – that the main aim of these welfare efforts was specified as the promotion of a balance between economic and social development, in that social welfare improvement was viewed as the purpose of pursuing economic growth (EDC, *ibid.*, p.44). Doubtless this meant a major change in the state's welfare activities.

Following the previous step, the eighth programme (1982-85) took a balanced view of economic development and social welfare (CEPD, 1981: 151), and went even further. That is, a project with the name of 'National Health and Social Welfare' was

introduced as an independent project, being equal to the other economic-related projects at the policy level (CEPD, *ibid.*, p.ii). Basically, this project was an extension of the previous ones. Specifically, the element of national health included: improving national nutrition (particularly of people in isolated areas and the poor), an extensive medical-service network, reforming medical affairs administration, establishing more public medical institutions, improving medicine and food management, and promoting industrial hygiene (*ibid.*, pp.153-4). The element of social welfare focused on enlarging the enrolment to the Labour Insurance Scheme and the Government Employees' Insurance Scheme, and extending the contents of social services (for example, free health checks for the elderly and health care for the disabled) (*ibid.*, pp.154-5).

Table 5-5 Taiwan State Health Activities in the Major Economic Development Programmes, 1953-1985

Economic Development Programme	Period	The Arrangement of Health-Related Project	Major Health-Related Activities
1 st Phase	1953-56	None	None
2 nd Phase	1957-60	None	None
3 rd Phase	1961-64	Social development project\ public health	Prevention of infectious diseases and goitre; promotion of health education; environmental hygiene and industrial health improvement; empowering health authorities; strengthening food and medicine management
4 th Phase	1965-68	Social development project\ social welfare plan\ public health and protection	Extensive medical services; standardising hospital establishments and physician's licensure; prevention of infectious diseases, family planning (birth control); environmental hygiene and industrial health improvement; strengthening food and medicine management; maternal and child health services; health education and training; prevention of mental illnesses
5 th Phase	1969-72	None	None
6 th Phase	1973-75	Human resource development project \ improve social insurance systems	Improving the Labour Insurance Programme (provision of medical-care); planning of a medical insurance scheme for government employee's dependants

7 th Phase	1976-81	Social development project \ national health promotion and social welfare advancement	National health - Establishing an itinerant medical service team; enlarging public medical facilities; improving national nutrition; mental health promotion; industrial safety improvement Social welfare - Strengthening the functions of the existing social insurance systems and social services
8 th Phase	1982-85	National health and social welfare project	National health - Improving national nutrition; an extensive medical-service network; reforming medical affairs administration; establishing more public medical institutions; improving medicines and food management; promoting industrial hygiene Social welfare – Enlarging the enrolment to the existing social insurance schemes; extending the contents of social services

Sources: Executive Yuan, 1957; DoE, 1971a & 1971b: 235-6 & 1971c: 363-70; IECD, 1969; IECD, 1973: 272-3; EDC, 1976: 44-5; CEPD, 1981: 153-5.

In the light of the above review of state health efforts in Taiwan's major economic development programmes, it is now possible to identify the underlying 'logic of industrialism' (Kerr *et al.*, 1962), which is important and implicit throughout the whole process of industrialisation. That is, state intervention in health care is closely linked to the degree of industrialisation, in that the main reason for a shift towards state health provision is, by and large, economic. The process of Taiwan's industrialisation reveals that health care, as part of social development, is subordinate to economic development, based on a philosophy that the state investment in health care may enhance the productivity of the workforce and create a beneficial industrial environment. In this sense, the Taiwanese case seems to support the convergence theory concerning the development of social security, typified by Harold Wilensky (1975), who argues that the growth of welfare state spending is a consequence of economic growth within societies, no matter in capitalist or communist countries. Moreover, Wilensky gives economic development a central place among various structural and cultural determinants of welfare efforts (*ibid.*, pp.27, 29), and he claims that political ideology is irrelevant to social security spending (*ibid.*, p.47).

Yet the Taiwan case does not support Wilensky so much when the change in the state arrangement of economic development and social welfare in the mid-1970s is taken into account. That is, the state economic ideology was adjusted towards an approach that was more a balance of both economic growth and welfare provision, in terms of a growing role of 'welfare' in economic and social planning. Related to this was the growing mobilisation of medical professions in matching the relevant political shifts. Why did this reform happen? To what extent was this adjustment based on the state's autonomy? The sections that follow will firstly explore the geo-political dynamics of economic development, and secondly investigate the Guomintang state's policy orientation in relation to specific health-care schemes. In so doing, we aim to gain an insight into the formation of the extensive Taiwanese health care state.

5.26 The geo-political dynamics of economic development

This section is concerned to explore the interactive development between geo-political dynamics and economic policies, situated within the post-war context of the changing cross-straits relationship. In so doing, it seeks to clarify the nature of the Guomintang state, so as to explain the extent to which state welfare efforts became a consequence of the interplay of political and economic factors. In this regard, we will look at the major economic development programmes again, with a view to examining the influences of the geo-political strategies on health policy.

It is from the beginning of the Guomintang's occupation of Taiwan in 1949 that a military aim of retaking the Mainland was set up, and played a subsequent role as a guideline for rebuilding Taiwan's post-war economy (Li & Chen, *ibid.*, p.11).

Referring to this, the preface of the First Phase of Economic Development Programme (1953-56) provides the background information to the use of the government's financial gains, including American aid and the proceeds from selling gold and recalled foreign exchange, as an excuse for asking continual American aid through the making of the ever-first economic development programme. As it said:

'...In these 45 months time [from January 1949 to September 1952], the financial resources that we received accounted for about US\$5.68 million dollars each month, i.e. approximately US\$68 million dollars each year. They were used to support the current 600 thousand national army, as well as to maintain [Taiwan's] combat capability at a high level....'

(DoE, 1971a: 2)

Obviously, the initial nature of the Guomintang state was military-oriented: the pursuit of external security actually takes priority over all other government policies, even in an 'economic' development programme. In fact, the results of the programme did not meet the mutual desires of the US and the Guomintang governments, in terms of reaching a balance between government revenue and expenditure (*ibid.*, pp.2-6). In view of this, the Guomintang government emphasised the existing policy of retaking the Mainland as an excuse for its failure of achieving the planned aims. As it said:

'The Taiwan Economic Development Four-Year Programme was implemented at the beginning of 1953 and has been fulfilled at the end of 1956. During this period not only an increase of agricultural and industrial production has been seen, but transport and commercial businesses have also progressed to some extent. ...However, the necessity for "opposing the Communists and counteracting Russia" has caused the government to prepare for repossessing the Mainland through national armament, and given rise to relatively high national defence expenditures. Consequently, the planned aims -- balance of state-budget, balance of payments, and balance of material supply and demand -- have yet to be completed and need more efforts to continue the work. ...'

(*ibid.*, p.65)

A similar military-oriented logic of economic development was seen in the following economic development programme. Then, in the Third Phase of Economic Development Programme (1961-64), the government highlighted the military aim as one important mission that economic development should undertake, and as an excuse for its failing to reach expected economic goals. As it said,

'Taiwan's economy undertakes two missions: one is that the national living standard should be gradually improved; the other is that the national defence capacity should be continually strengthened. Because the latter is of necessity, the occurrence of a budget deficit was unavoidable, and therefore affected economic stability.'

(DoE, 1971b: 8-9)

Added to the Guomintang's geopolitical strategy was the consolidation of the Cold War order under the direction of the US, which played a role of guaranteeing Taiwan's survival against Communist China (Hsu, 2002: 170). Despite the fact that the Guomintang was serious about preparing for retaking China, its economic and military strength was far from reaching this goal. In addition, the US did not support the Guomintang's retaking policy owing to its existing diplomatic strategy about maintaining a stable Taiwan, serving as an anti-Communist front base (Wen, 1990: 27, 158-9, 217). It was in this sense that an approach of 'limited battles' was established. Following the disillusionment over repossessing the Mainland was a diminishing militaristic approach to economic development. In fact, as far as the eight economic development programmes were concerned, political slogans like 'retake the Mainland' and 'oppose the Communist and counteract Russia' did not appear in the Fourth, Fifth, Sixth and Seventh Programmes, covering 1965-81.

The Guomintang's geopolitical strategies during 1970s and 80s turned to a

peaceful direction: that is, to construct Taiwan as ‘the Exemplary Province of the Three Principles of the People’⁵, in that the importance of state welfare efforts was acknowledged in the sense of a ‘system competition’ with its Communist rival on the mainland (Hsu, *ibid.*, pp.171-2). This can be well illustrated by the Eighth Phase of Economic Development Programme (1982-85), where the motive for and purpose of economic development were clearly specified:

‘...The current stage of a livelihood-based social-economic development should focus on the enhancement of the mechanism of a planned liberal economy and a greater cooperation between public and private enterprises, so as to enable prompt responses to the changing situations domestically and internationally. Both the quantity and quality of people’s material and mental lives should be improved towards the increase of the well-being of the people in this repossession base [Taiwan], which then will make a powerful call for greater support from the mainland compatriots. Precious experiences will be accumulated throughout the process of designing and executing this programme, and they will become the blueprint for developing a new China after repossessing the Mainland. ...’

(CEPD, 1981: 5)

Another significant example is the Fourteen Constructions Programme of 1986, where Taiwan’s affluence played an ideological role in spurring the ‘mainland compatriots’ into aspiring to the Three Principles of the People. It said:

‘The implementation of these construction projects will give rise to an extensive public investment. In the short-term, this will spur civic investment towards a speedy economic growth domestically. In the long-term, the accomplishment of various public infrastructures will enrich national power and promote the international position of our country politically and economically, together with an increase of social well-being. Since our country is becoming increasingly affluent and modern, there will be a growing living standard gap between the repossession base [Taiwan] and the Mainland. The mainland compatriots will

⁵ The ‘Three Principles of the People’ – nationalism, democracy and livelihood – were generated by Dr. Sun Yat-sen, the Founding Father of the Republic of China. In a way the Guomindang rulers managed to follow the ‘Three Principles of People’ as the guidelines for governmental administration.

then be spurred into aspiring to the Three Principles of the People. Accordingly, the objective of unifying China by the Three Principles of the People will be soon completed.'
(CEPD, 1986: 2)

In the light of the evidence presented above, we can see a close link between state militarism and economic development. On the one hand, Taiwan's economic growth served particular geo-political purposes, due to the problematic statehood of the Guomintang. In terms of this, the Guomintang regime sought for external support to uphold its ruling legitimacy, as Wang Zhen-Huan (1989) indicates, in that American influence played a very important role in shaping Taiwan's post-war development.

On the other hand, Taiwan's export-led industrialisation development gave rise to a great dependence on the world market. This had important implications for the enhancement of the Guomintang's legitimacy. First, an export-led model of economic growth required a close association with foreign investors. Thus, increasing reliance on foreign investment in the 1960s and 70s may have helped the Taiwan state to secure powerful political allies (Amsden, 1992: 100), which meant real support from the international community at a time when Taiwan was faced with diplomatic isolation after its seat in the United States was replaced by China. Related to this was the promotion of a strategy of 'substantial' diplomacy', raised by Jiang Jing-Guo, the Guomintang's Premier and the later President, in 1973, towards gaining external support for Taiwan's sovereignty through non-political contacts, such as economic activities.

Second, rapid economic growth also contributed to forming greater internal legitimacy within Taiwanese society (Fu L-Y, 1995a: 176), in that increasing

economic gains have, by and large, compensated for geopolitical difficulties. In addition, based on the fact that the Guomintang state relied on exporters to make contact with the world, the state interests (towards greater legitimacy) and enterprises' interests (towards greater profits) became more interlinked (Fu, *ibid.*, Wang, *ibid.*). This, in a sense, may have contributed to securing a legitimate position of the Guomintang regime.

5.27 The state's initiation of social insurance systems

In terms of state autonomy we are concerned with the state's capacity: that is, whether or not the state as an autonomous social actor is capable of shaping an institutional structure beneficial to the pursuit of its own goals (Skocpol, 1985). In the case of Taiwan's post-war development, the autonomous role of the Guomintang state was clear, not only in the development of capitalist economy but also in the moulding of the welfare state (Fu, *ibid.*, p.168; Wang Z-H, 1992 & 1996; Gold, 1985; Lin W-I, 1994). This was characterised by the style and method of authoritarian government, in terms of a top-down policy process in which the state, using means of coercion rather than social consensus, imposed itself from above on the society, with the aim of maintaining its ruling legitimacy (Wang, *ibid.*; Gold, *ibid.*).

In the formation of the Taiwanese health care state, the Guomintang's policy orientation was central to the making of a developmental agenda of social insurance schemes (see Table 5-6) up to the lifting of martial law in 1987. Concerning the emergence of state-managed health care, the initial health care system included three different public schemes: labour insurance, government employees' insurance and military servicemen's free health care. Specifically, a Labour Insurance (LI) Scheme

was introduced in 1950, and specified that the workers employed by government-owned enterprises (who occupied the better part of the whole insured) as well as those employed by private enterprises with more than 100 employees, might participate in this scheme on a voluntary basis⁶. This was followed by the enforcement of a Servicemen Insurance (SI) Scheme, covering military personnel, in the same year. The government promulgated the Labour Insurance Act in 1958 and put it into effect in 1960, so that the Labour Insurance was transformed into a statutory scheme. Meanwhile, the Government Employees' Insurance (GEI) Scheme was implemented in 1958.

In terms of insurance benefits, both the LI Scheme and the GEI Scheme provided benefits for maternity, illness, injury, disability, old age, death, and a burial subsidy in the case of any dependent of the insured dying; benefits were paid in either cash or medical-care. By comparison, the SI Scheme provided only death, disability, and discharge benefits. A medical-care benefit was not included in the scheme, but belonged to a separate health-care system, in which military personnel and their dependants were offered free medical-care by specific government-run medical institutions.

⁶ In truth, the insured subjects of the Labour Insurance Scheme were extended on a gradual basis. In detail, initially only the workers employed by government-owned enterprises were insured when the scheme was launched in March 1950. In a very short time, the workers employed by private enterprises with more than 100 employees were also insured in April. Successively, the Craft Workers' Insurance Program was carried out in 1951, followed by the Fishermen's Insurance in 1953. The government promulgated the Labour Insurance Act in 1958, and put it into effect in 1960. At this time, all the three separate programs were nullified (BLI, 1996: 1-2).

As to the number of employees specified, it was reduced to 20 in July 1950, and to 10 in June 1951. Nowadays, the workers employed by either public or private enterprises with more than 5 employees must participate in the Labour Insurance scheme on a statutory basis (the Legislative Yuan, 1981).

Table 5-6 Major Social Insurance Schemes in Taiwan, 1950-1990

Scheme	Implementation Year	Insurance Benefits
Labour Insurance	1950	Maternity, illness, injury, disability, old age, death, burial subsidy in the case of any dependent of the insured dying
Servicemen Insurance	1950	Death, disability, discharge*
Government Employees' Insurance	1958	Maternity, illness, injury, disability, old age, death, burial subsidy in the case of any dependent of the insured dying
Retired Government Employees' Insurance**	1965	Maternity, illness, injury, disability, death, burial subsidy in the case of any dependent of the insured dying
Insurance for Teaching and Administrative Staff of Private Schools	1980	Maternity, illness, injury, disability, old age, death, burial subsidy in the case of any dependent of the insured dying
Sickness Insurance for Dependents of Government Employees	1982	Illness, injury
Sickness Insurance for Retired Government Employees	1985	Illness, injury
Sickness Insurance for Spouses of Retired Government Employees	1985	Illness, injury
Farmers' Health Insurance	1985	Maternity, illness, injury, disability, death
Sickness Insurance for Retired Teaching and Administrative Staff of Private Schools	1985	Illness, injury
Sickness Insurance for Spouses of Retired Teaching and Administrative Staff of Private Schools	1985	Illness, injury
Health Insurance Scheme for Local Representatives, Village and Borough Wardens and Neighbourhood Heads	1989	Maternity, illness, injury, burial
Sickness Insurance for Dependents of Teaching and Administrative Staff of Private Schools	1990	Illness, injury

Source: Ke M-X, 1990: 351-96.

Notes:

* Among all these schemes listed above, the Servicemen Insurance Scheme is the only one that does not provide a medical-care benefit.

** The Retired Government Employees' Insurance Scheme stopped accepting any new enrollees in July 1985; meanwhile, the Sickness Insurance for Retired Government Employees was put into effect.

Overall, the initiation of the Taiwanese welfare state reveals one thing – that the Guomintang gave preference to three key groups, i.e. labourers, civil servants and military servicemen. Regarding this policy orientation, we may consider the political and economic dynamics to be influential factors which impinged on the authoritarian state. In part, the state welfare provision served the purpose of pursuing political stabilisation (Ku Y-W, 1995; Zhan H-S, 1995), at a time when the whole society lacked trust in the Guomintang government as an outside political regime. In this sense, the implementation of the social insurance schemes was politically wise, for it contributed to winning the hearts of the insured people.

The insured people fell roughly into two groups: government employees and non-government employees. Military personnel, civil servants and government-owned enterprises' workers together with some of their dependants constituted the first group; workers employed by medium or large private enterprises comprised the second. Related to this classification was an underlying logic of the Guomintang's welfare efforts, which was multi-faceted. First, the welfare provision for people in the first group revealed the state's role of being a paternalistic employer; while that for people in the second group showed the state's needs of capitalist production. Referring to the latter, the LI scheme served economic development in the way it could help workers to recover from injuries or ill-health so as to waste no time in contributing to economic production, as revealed by Ke Mu-Xing (*ibid.*, pp.353-4), the Director of

the Planning and Evaluation Office of the Labour Insurance Bureau.

Second, the provision of social insurance could be characterised as a way of benevolent control over the key groups, in that social control was exercised implicitly because the schemes served to reinforce societal norms about the work ethic. Fu (1993) argues that the reason for the GEI system being kept separate from the LI system is that the Kuomintang government viewed this system as part of the personnel administration that served to keep control of civil servants (pp.58-9). Besides, she contends that the LI system functioned as a means of social control, on the basis that the martial law (enforced on May 20, 1949) enabled the state's intervention in union administration, implying control over union members (*ibid.*, p.57). From the standpoint of the government, Ke (*ibid.*, p.353) also posits that the implementation of the LI Scheme in 1950 facilitated the prevention of industrial disputes together with an enhanced connection between the government, employers and labourers.

The continual development of the LI and the GEI after the 1960s still suggests the importance of state autonomy in moulding a particular social-insurance approach that was devoted to meeting the economic and political needs of the authoritarian state. On the economic side, the government highlighted its intention to improve these two systems towards an extensive coverage of insured subjects and an increase of insurance benefits, as part of its economic development agenda, typified by the Sixth, Seventh and Eighth Economic Development Programmes. On the political side, the occurrence of political crises drove the Guomintang to adopt social-insurance strategies to legitimise its ruling authority (Aspalter, 2001: 13-4; Ku, *ibid.*, pp.352-3; Lin K-M, 1998: 9). Specifically, the coverage of insured subjects under the LI was

extended in 1973, two years after Taiwan's expulsion from the United Nations, and in 1979, one year after Taiwan's losing diplomatic ties with the US.

A diverse range of illness insurance schemes, covering several new social groups, was implemented in the 1980s, when social movements and intensifying electoral competition entailed challenges to the rule of the Guomintang (to be pursued in more detail in the next section). The insured subjects included new social groups such as the dependents of government employees, private schools' staff, farmers, and official posts and people's representatives at local level (see Table 5-6). Based on the fact that most of the beneficiaries used to be the Guomintang's main supporters in the past, this reform revealed more a political strategy for electoral competition (Lin K-M, *ibid.*).

To sum up, the evolution of the Taiwanese health care system suggests the significance of state autonomy, linked to the existence of authoritarian governance, in initiating various health-care schemes at different historical moments, towards serving specific economic and political purposes. In terms of state health care, a social-insurance approach was adopted with an emphasis on occupational status, which, by and large, reflects a notion of 'industrial achievement-performance' (Titmuss, 1974) as an underlying logic of the Taiwanese welfare state. Related to this was an implicit faith in work ethic as the basis for welfare, in that welfare allocation depended on people's value in the labour market rather than people's needs (Fu, 1993; Ku, 1998).

Given the basis that the Taiwanese welfare system was selective—that only specific social groups were selected by the state to be insured—and residual—that the government provided only residual, rather than comprehensive, social protection to

the non-productive or disadvantaged people—, commentators claim that Taiwan was a belated or marginal welfare state (Lin W-I, 1991 & 1994; Lin K-M, 1998; Ku, *ibid.*; Fu, *ibid.*). In spite of being a laggard, Taiwan continually paid much attention to health care reforms. The state health efforts continued and reached a peak in 1995, when an first-ever universal health care scheme, the National Health Insurance (NHI), was carried out.

We have so far managed to present a whole picture of Taiwan's post-war development up to the mid-1980s, towards making sense of the state health efforts contextualised in the political-economic dynamics. The description and analysis of this narrative has been long. We will now move on to the very recent past, dating from the mid-1980s to the time before the implementation of the NHI (in 1995), concerning the political and economic dynamics that furnished such a radical change.

5.3 Creating A National Health Care System

It is without doubt that the mid-1980s was a turning-point in Taiwan's history, for a critical transition in the political-economic structure has come about since then. This change has important implications for the Taiwan state's health effort, as we shall explore in this section. In short, we will continue the unfinished narrative of Taiwan's health care reform from this decisive moment, and focus on the relevant external and internal factors that influenced the creation of an NHI in 1995.

5.31 The political-economic dynamics at the turn of the 1990s

On the economic side, the Taiwanese industrialisation strategy in the late-1980s was characterised by an industrial upgrading from a labour-intensive to a capital-intensive

and technology-intensive type of production. This change had a tremendous impact on small and medium sized enterprises (SMEs)⁷, particularly the so-called 'sunset industries', which were labour-intensive, such as shoes, clothes, umbrella, and rubber products industries. Added to this was the increase of costs caused by the raising of wages, rising prices for factory land, new legal requirements concerning protecting workers, elevated standards of environmental protection, and the revaluation of the New Taiwanese Dollar. Consequently, there was a trend that SMEs tended to close their plants in Taiwan, together with a transference of their capital to the neighbouring countries where labour was cheaper and the standard of environmental protection was lower, such as Southeast Asia and China (You, 1994).

At the same time, the investment environment in mainland China has significantly improved since Deng Xiao-Ping, the leader of the PRC, announced a reformist and open-door approach to the Chinese economy in 1978, followed by opening specialised economic areas for foreign investment (Wen S-R, 2001: 113). In an attempt to attract more Taiwanese investment, the PRC governments at both central and local levels have offered Taiwanese businessmen vis-à-vis other foreign investors preferential treatment, such as reduced income tax rates and generous heritage and asset transfer rights (Lee K., 1993: 185). This has proved to be very attractive to the Taiwanese enterprises. A significant increase of outward capital investment to China has been seen since the late 1980s, based on a new cross-Strait policy promulgated by the Taiwanese government in November 1987, that the Taiwanese are allowed to visit

⁷ SMEs here are defined as industries that hire less than 100 employees, according to Zhou & Lin (1999: 34-5), whose research shows that the SMEs have always accounted for over 98.9% of the total Taiwanese industries since the 1960's. The significance of SMEs to Taiwan's economic development can be revealed by certain statistics: their employees accounted for 64.28%, 52.52%, 57.89% and 63.82% of the entire number of all employees in 1961, 1971, 1986, and 1991 respectively; their shares of all value of exports were 68.1%, 66.4%, 56.9%, and 48.8% in 1981, 1986, 1991, and 1997 respectively (quoted from *ibid.*, pp.41-2).

their relatives in China, followed by a policy regarding the opening of outward investment to China (Wen, *ibid.*, Lee, *ibid.*). Also, the development of democracy since the lifting of martial law in July 1987 might have played a considerable role in empowering the Taiwanese businessmen to take steps towards higher investment in China. As a result, the state was no longer able to control outward capital investment to China, as Wong (2002: 29) indicates. Accordingly, the Guomintang state gradually lost its dominant role of controlling Taiwan's economic development.

On the political side, party competition came to be an emergent issue challenging the political domination of the Guomintang government. This happened after the Democratic Progressive Party, the first-ever opposition party, was founded in 1986, and won victories in local elections from 1989. Even worse, a New Party was formed within the Guomintang in 1993, as a result of an internal struggle between the Taiwanese-dominant faction and the mainlander-dominant faction (Hsu, 2002: 289), and became the third political party, later becoming influential in general elections.

In addition, the lifting of martial law in 1987 opened a door for Taiwan's civil society, typified by frequent outbreaks of political demonstrations and collective protests, covering a variety of social groups such as labourers, rural peasants, homesick mainlander veterans, residents living near industrially-polluted areas, and college students asking for more democratic universities (Lin W-I, 1991: 38; Hsu, *ibid.*, p.268). The emergence of such social-political movements further challenged the authority of the Guomintang state, whose authoritarian tradition of governance began to appear out-of-date and inflexible in the face of the growing trend towards democratisation.

In short, in the wake of the economic liberalisation and political democratisation

which occurred at the turn of the 1990s, the authoritarian state was no longer able to dominate economic development on the one hand, and was faced with external challenges from opposition parties as well as public demand for social reforms, on the other. Situated in such a moment of crisis, the Guomintang regime had to seek for possible solutions to secure its ruling legitimacy. It is in this regard that an expansionist approach to welfare provision was developed by the Guomintang government, so that a universal health care scheme, covering the whole electorate, arose out of public demands for better health care.

5.32 The organic crises that furnished the launching of the NHI

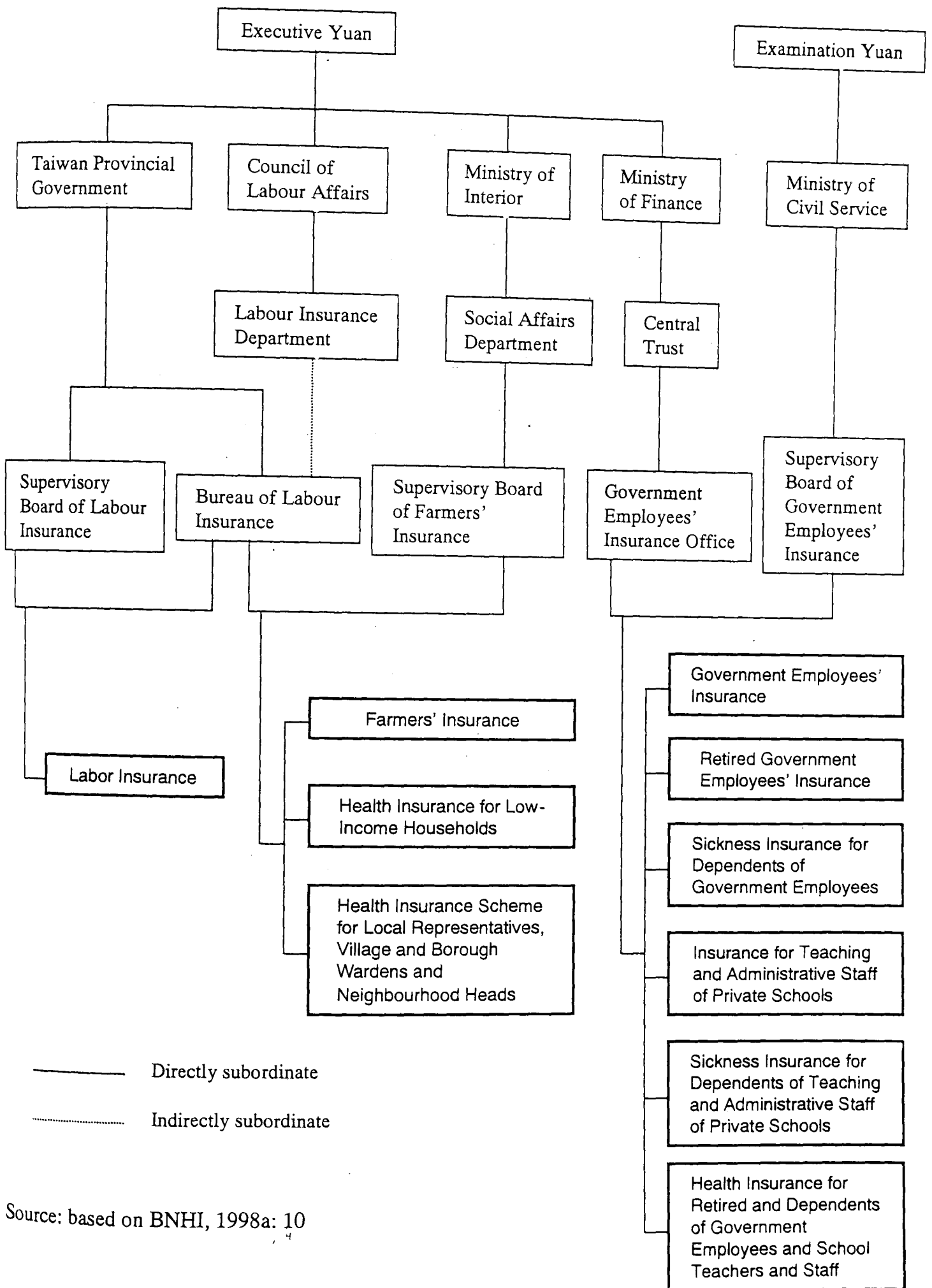
In terms of the organic crises, what we are concerned with is the administrative dynamics of the government, as the internal factors which contributed to changing the existing health-care scheme to towards a unified system, the NHI. In other words, the incompetence of the government bureaucracy at sorting out the internal crises had been the last straw that broke the camel's back, namely the old health-care system.

- *Divergence among schemes*

Prior to the implementation of the NHI, there were ten government-run health insurance schemes, roughly falling into three groupings: labour insurance, farmers' insurance, and government employees' insurance schemes. In terms of the organisational system, the government agencies involved with the insurance administration were many. In the LI system, the Council of Labour Affairs and the Taiwan Provincial Government were the competent authorities in charge of policy-making at the central-government and the provincial-government levels

respectively. In addition, under the Taiwan Provincial Government, a Bureau of Labour Insurance (BLI) was set up to discharge insurance matters, and a Supervisory Board of Labour Insurance was established to supervise the BLI as well as to settle relevant disputes. In the Farmers' Insurance (FI) system, the Ministry of Interior was the competent authority, and the insurance operation was discharged by the BLI. Besides, a Supervisory Board of Farmers' Health Insurance was established to supervise insurance operations as well as to settle relevant disputes. Referring to the GEI system (in which several sickness insurance schemes for private school staff were included), at the insurance-operation level a Government Employees' Insurance Office, affiliated to the Central Trust, and a Supervisory Board of Government Employees' Insurance were established to be in charge of insurance matters and supervising insurance operation separately. Meanwhile, the Ministry of Finance, affiliated to the Executive Yuan, and the Ministry of Civil Service, affiliated to the Examination Yuan, discharged the responsibilities of insurance policy-making at the policy-making level. The affiliations between these government agencies are shown as below (Figure 5-1).

Figure 5-1 Taiwan's Health Insurance System Prior to the NHI



Source: based on BNHI, 1998a: 10

The complexity of administration gave rise to several problems. First, administrative costs were high, owing to overlapping responsibilities and duplication of administration. Second, administrative communication was not very efficient due to 'selfish departmentalism', and consequently it was often difficult to reach agreement on health care reform, for example, on the proposals for co-payment at the point-of-services, patient-referrals, and extensive services to cover the dependants of the insured who were not insured (CEPD, 1990a: 100). This explains why the model of integrating existing health-care schemes through extending existing services to the non-insured was losing ground, while the model of establishing a new NHI was raised within the government.

Another important factor contributing to forming a new administrative system was that the shares of contribution diverged so greatly that it was by no means easy to find a solution to the argument over inequity, referring to an ideal that health policy should be equitable. Specifically, under the LI scheme an insured worker employed by a certain employer should pay 20 per cent of the compulsory contribution, and his/her employer should pay the remainder, i.e. 80 per cent (LI Act, Article 15, Paragraph I). In the case of a self-employed worker, the proportion of payment was 60 per cent paid by the individual and 40 per cent paid by the government (LI Act, Article 15, Paragraph II), on the grounds that this kind of worker did not have an employer to undertake an employer's liability. By comparison, under the GEI scheme, a government employee was requested to pay 35 per cent of the compulsory premium, and the government as an employer needed to pay the remainder, i.e. 65 per cent (the GEI Act, Article 9). As regards the FI, an insured farmer had to pay 30 per cent of the total contribution, and the government should pay 70 per cent (the Farmers' Health

Insurance Act, Article 12, Paragraph I). Table 5-7 shows the differential rates of contribution in the major health insurance schemes prior to the NHI.

Table 5-7 Sharing Percentages of the Insured Premium in the Health Insurance Schemes Prior to the NHI (1990)

Unit: %

	The Government	Employer	The Insured Person
Government Employee's Insurance System			
Civil servants	65		35
Dependents			
Spouse	50		50
Parents	50		50
Retired personnel	0		100
Retired civil servant	50		50
Retired civil servant's spouse	50		50
Teachers and administrators in private schools	32.5	32.5	35
Dependents			
Spouse	25	25	50
Retired teachers and administrators in private schools	25	25	50
Spouses	25	25	50
Labour Insurance System			
Workers without specific employers	40		60
Governmental workers with specific employers	80		20
Private workers with specific employers		80	20
Farmer's Insurance System			
Farmers	70		30
Low-income Household Health Insurance System	100		0
Servicemen Insurance System			
Career servicemen	100		0
Compulsory servicemen	100		0

Source: CEPD, 1990a: 54.

As can be imagined, the differentiation of contribution percentage policies between the health insurance schemes caused much dissatisfaction among the public.

For example, private employers complained about unfair employers' liability between themselves and the government; the insured also complained about differential treatment between different social groups. The settlement of this dispute, however, seemed to be beyond the administrative capacity because of two reasons. First, this divergent health care system was an outcome of the interplay of various political and economic factors in different historical contexts. Second, the administrative department lacked enough political support for reform due to the decline of the Guomindang's authoritarian governance.

In total, the health insurance schemes prior to the NHI provided insurance coverage for only 59 per cent of the population (Table 5-8), who were occupational groups and some of their dependants. The non-insured population were socially disadvantaged groups, such as the unemployed, children, the elderly, and housewives/househusbands. Based on the consideration of social justice together with a surplus from economic development, the government was urged to improve the situation by means of health policy intervention. As Xu Li-De, the former Deputy Premier, a very important figure in charge of the NHI planning, points out:

'Given that our country has had a continual and rapid economic development and a rise in the average national income, both the government and the public have realised the importance of protecting people's physical and mental health.'

(Xu L-D, 1995: 1)

'Statistical evidence shows that among the non-insured population the majority were children under 14 years old and the aged over 60. They actually were a group of people who needed health insurance the most. Some of them were sick and lacking in family's support; some became very poor because of being sick. In a society where social justice was pursued, this problem appeared to be an urgent matter, for this reason the Government positively promoted a National Health Insurance.'

(*ibid.*, p.7)

Table 5-8 Enrolment in the Insured Health Insurance Schemes Prior to the NHI
(February 1995)

Scheme	Number of enrollees	Percentage of the total population
Government Employees' Insurance	1,796,793	8.48%
Labour Insurance	8,415,244	39.70%
Farmers' Insurance	1,740,653	8.21%
Other Social Insurance Schemes	146,382	0.70%
Military Health Care System	480,000	2.26%
Uninsured population	8,617,133	40.65%
Total population	21,196,205	100.0%

Source: the BNHI, 1998a: 6.

- *Serious Financing Pressure*

Underlying the well-turned political rhetoric were serious financing problems facing the government. In terms of the three main health care schemes, on the eve of the implementation of the NHI, the GEI had a deficit of NT\$ 40.6 thousand million dollars (about US\$1.45 thousand million dollars); the FI had a deficit of 68.6 thousand million dollars (about US\$2.45 thousand million dollars); the LI did not have an overt debt but in truth had a 'potential' deficit of approximately 100 thousand million dollars (about US\$3.75 thousand million dollars), on the grounds of having insufficient reserve funds for old-age benefit (Xu, 1995: 8). The financial pressure was so great that it actually threatened the Guomindang with the loss of its ruling authority, at a time when party competition was increasingly heated. As Mr. X4, the First Manager-General of the BNHI who was deeply involved with the NHI planning, put it,

'In fact, initially the pressure [to introduce a NHI] was not from the ruling elite who were concerned with the pursuit of social justice.... In the 1990s, just the FI scheme, the state subsidy to its deficit had reached NT\$20 thousand hundred dollars each year, and it seemed impossible that the scheme could survive. So the government turned to think in this way: since it [the FI Scheme] would die sooner or later, why not launch a large-scale scheme and wait to see if it [the NHI] would survive?.... Besides, a serious problem had appeared in the LI scheme: that is, from utilisation standpoint the LI was out of control, because it was living off the reserve fund of the old-age benefit!'

(Interview Notes, No.1-04, 1998)

On the other hand, the worsening government finances since the late 1980s had caused the government to decide to get rid of financial responsibility for social insurance deficits (Lin K-M, 1998: 16). In this context, the administrators of the three major health care schemes learnt that it was hopeless to expect state subsidy, and consequently started to support a new NHI. As Mr. X4 pointed out:

'Based on the understanding that the government intended to implement an NHI, the FI and the LI immediately gave up all endeavours [concerning sorting out their deficits]. At that time, the government was really situated in no way to return!'

(*ibid.*)

We can now comment on the creation of the NHI. Although external factors, i.e. economic growth and political democracy, contributed considerably to shaping the desire for a NHI system, the organic crises which came from within the system were doubtless central to sinking the old system. Thus, the implementation of the NHI in 1995 was not so much a factor of an enlarged welfare state as such, but rather a consequence of declining state autonomy reaching a moment of crisis.

5.4 Conclusion

In this chapter, I have reviewed the long narrative of Taiwan's post-World War II development in relation to economic modernisation, aimed at contextualising the evolution of state health efforts that finally accelerated the creation of an NHI in 1995. In order to gain an insight into the complicated historical data, this chapter has presented three important dimensions to the construction of the health care state: industrialism, state autonomy and pressure from below. We shall first summarise our arguments with a view to reaching some conclusion about their relative importance. To this end, we will then pinpoint the significance of the Taiwanese case, with special reference to its theoretical implications.

First of all, by industrialism is meant the economic dimension to state health efforts. The process of Taiwan's industrialisation revealed that the state intervention in health care had a close link with the degree of industrialisation: that is, the state health efforts before the 1980s served as a 'human power investment' strategy, in that they facilitated a healthy work force so as to raise labour productivity through the provision of health insurance for the occupational population. A significant example was the implementation of the LI scheme, which showed the state's needs for capitalist production and reflected an underlying logic of the Taiwanese welfare state – that the notion of 'industrial achievement-performance' was at work as the basis for welfare, referring to an implicit faith in the work ethic. This moral norm continued to play an important role in the NHI scheme of 1995, typified by the NHI insurance beneficiaries being established on the basis of people's occupational affiliations, as we shall see in Chapters 6 and 8.

In terms of state autonomy, the autonomous role of the Guomindang state in

shaping the trajectory of Taiwan's post-war development was significant. Economically, the state appeared capable of directing the planning of capitalist development, which first pursued economic stabilisation and then economic growth, and presented a trajectory of growing export-led industrialisation. The initial nature of the Guomintang state was military-oriented, so the pursuit of external security dominated economic development. In the context of the Cold War order, the Guomintang regime obviously gained extra benefit from Taiwan's export-led development over against its economic counterparts in terms of external support for Taiwan's sovereignty, as Taiwan's economy became increasingly dependent on the world market. The state health-care provision had a wider utility in the sense of being an authoritarian political strategy. Initially, the public health measures in the immediate post-war years played a role in compensating for public discontent with worsening public health status, so as to legitimise the ruling authority of the Guomintang government as an outside political regime. Similarly, the implementation of the three major health care schemes (LI, GEI and servicemen health care) in the 1950s appeared to be a factor serving to raise the political legitimacy of the Taiwanese state, faced with a challenge to its problematic statehood from China.

As the Guomintang government became disillusioned by its failure to repossess the Mainland, a diminishing militaristic approach to economic development was adopted in the 1970s. As a consequence of this, there was a significant change in state welfare ideology, in terms of the growing role of welfare in economic and social planning. It was in this context that health care provision, as the main part of the social security system, developed more a method of benevolent control over the key

social groups, for it helped to enhance the internal legitimacy of the Guomintang regime. On the other hand, the welfare efforts of the Taiwanese state also played an ideological role in spurring the ‘mainland compatriots’ into aspiring to have a Taiwanese experience, in the sense of a ‘system competition’ with its Communist rival on the mainland.

However, the authoritarian state gradually lost its dominant role in controlling Taiwan’s economic development, as a result of economic liberalisation, which came to the fore in the 1980s and resulted in a growing trend towards outward investment throughout the 1990s, and political democratisation, which has come about since the lifting of martial law in 1987. Hereafter the social and political pressures from below played an influential role in stimulating new reforms of the health care system. In terms of this, I have argued that there are two dimensions of evidence for this change. Firstly, the increasingly heated party competition as well as greater public demand for social reforms compelled the Guomintang state to adopt an expansionist approach to welfare provision in order to secure its ruling legitimacy. Consequently, a diverse range of health insurance schemes, covering the Guomintang’s main supporters in the past, was implemented in the 1980s. Secondly, the organic crises which came from within the government contributed significantly to changing the existing health care system towards a unified system, the NHI, in 1995. In short, the crises involved two levels of issues: the divergence among different health care schemes, and the financing pressure facing the government. The former referred to the problem of social division, which also entailed unequal shares of insurance contribution, and the inefficiency of the administrative system. The latter arose out of the insufficient insurance rates in the main health care schemes, due to the state’s concern about the

electoral competition. The financing problems were so serious that they finally caused the government to decide to end financial responsibility for social insurance deficits. In the light of this information, we suggest that the implementation of the NHI was more a consequence of declining state autonomy reaching a moment of crisis.

In summary, Taiwan's post-war health care reforms revealed a great deal about the nature of health care being an instrument for achieving economic development and political domination, since the authoritarian governance of the Guomintang state was the key to the formation of a selective health care system before 1995, and the decline of the authoritarian governance also contributed to the launching of a state-centred universal system in 1995. By contrast, the civil society appeared to be of little relevance to the development of the health care state, because it was inactive under the authoritarian government before the mid-1980s, and became active but still unorganised later, so it was little involved in the making of health policy (Lin K-M, 1998: 34-9; Lin W-I, 1994: 277).

Referring to state influence on medicine, this chapter has argued that there was a shift of medical paradigms from a German-Japanese model to a post-war American model in Taiwan after the war. This transition had a close link with a wide-ranging package of American aid, which gave rise to a particular form of aid dependency. As in the previous chapter, we suggest the importance of the state's role in dominating the development of the medical system. In the period under discussion, it was the reciprocal interaction between the US and Taiwanese states in which a wider process of transmitting American values and medical practice to Taiwan was facilitated, and accordingly the whole medical system underwent a critical transformation. In addition, the later development of the health care system towards the increasing role of welfare provision in economic planning that started in the 1970s has, by and large, presented

the growing mobilisation of medical professions by the state, contextualised in critical political shifts.

Overall, the Taiwanese case has important implications for studies on the determinants of state health policy. That is, health care reform is not only a consequence of economic development but also politically tailored to fulfil particular requirements of the state, in that political ideology is highly relevant to the growth of state attention to health care with the changing nature of the state. Equally important is the fact that Regime theory sees post-war Taiwan as a Confucian-type welfare system, stressing the importance of family welfare in replacing state support, with combined Conservative-Bismarckian elements (Goodman & Peng, 1996). In other words, Taiwan represents a model that is status-segregated and relies on market forces as the determinant of access to resources, together with an emphasis on the role of state sectors in providing residual welfare (Goodman & Peng, *ibid*; Esping-Andersen, 1990). In terms of this, the NHI has become a very significant reform, which represented some kind of shift from a Conservative-Confucian regime (Esping-Andersen, *ibid.*) to a more social citizenship model. There will be further discussion of the implications of this change in the next two chapters, when we turn our attention to the NHI's influence on citizenship.

This chapter and the previous one have presented a comprehensive historical account of the political-economic dynamics of the health care state in Taiwan, and sought to gain insights into the formation of health care reforms at both the macro- and meso-levels. We will now move on to examine the empirical evidence in relation to the construction of medicalisation and medical dominance in the context of the NHI.

CHAPTER SIX

GOVERNING MEDICINE AND CONSTRUCTING MEDICALISATION

6.1 Introduction

This chapter and the next chapter represent in the thesis an empirical investigation of the contemporary Taiwanese health care state, contextualised in the NHI system, in an attempt to explore the situation of professional medicine in Taiwan as well as to make more sense of the role of Taiwan's state in shaping the processes of medicalisation. In terms of medicalisation, we are concerned with the growth of medical power, linked to concepts surrounding professional dominance leading to doctors being a significant pressure group (Freidson, 1970a). Also, based on the cultural critique perspectives, we explore the extent to which medicine as a culture has formed a dominant tendency towards relying on technical forms of modern medicine, in which trusting doctors is included. This investigation is by and large motivated by our earlier arguments about the development of Taiwan's health care state, focusing on an important issue: the provision of NHI has come to be associated with a new system of governance and consumption of medical services, as part of a more liberal society, at a time when the authoritarian power of the state is declining fast. Referring to the analytic framework of the thesis (Chapter 2), these two chapters look at accounts at both meso and micro levels, concerning the extent to which the NHI has extended or constrained the influence of medicine. This is an attempt to explore the internal dynamics that affect the practice of medicine as well as the process of medicalisation.

In this chapter, we focus on the contradictory notions of 'power' and 'regulation',

and identify the changing relationships between the state and the medical profession. In this context, we aim to examine the situation of the medical profession under the contemporary NHI regulatory system, with a concern to elaborate the dual role of the NHI in legitimising medical intervention and eroding professional autonomy. Based on the consideration that health care reforms may signify shifts of medicalisation, this chapter evaluates the NHI reforms through an investigation of the social construction of medicalisation, with particular attention being paid to the social-cultural dimension of health care.

The main body of this chapter is separated into three parts. Part one provides the background information about the NHI. It begins with an exploration of the acceptability of social insurance over taxation, and continues with explanations of the NHI eligibility, funding, organisation and benefits in separate sections. Drawing upon the interviews of specific stakeholders, the second part is an investigation of the formation of medicalisation, contextualised in the NHI regulatory system. This is concerned with two levels of governance: legal regulation and fiscal control from the state bureaucracy as the external regulator, and the professional governance from medical associations as the internal regulators. Here, the influence of policy intervention on people's health help-seeking behaviour is also explored, in an attempt to provide a complete and satisfactory framework of medicalisation.

The third part centres on the medical profession's reactions against the NHI regulation. It addresses the main strategies adopted by the professionals, typified by the increase of outpatient visits, of check-ups and examinations, excessive prescription, and transitional medical specialities. In the conclusion, we end by offering an overall assessment of the NHI regulatory system, with a view to

pinpointing the causes of medical dominance and of the concern for over-medicalisation.

6.2 A Brief Introduction to the NHI System

6.21 Why social insurance?

It has been observed in the previous chapter, the Taiwanese state managed to develop a social-insurance based system for health care throughout the post-war development era¹; the NHI, as the first-ever health care scheme that incorporates virtually the entire population, has been no exception. Why has a social-insurance approach dominated the development of the Taiwanese health care state? To what extent has the implementation of the NHI represented a shift from an insurance and work-based system of entitlement to a more general right to health care? We seek for explanations from three dimensions, i.e. the cultural, political and financial dimensions.

- *The cultural dimension*

To begin with, the cultural dimension is concerned with the notion of individual self-help as a fundamental part of the traditional notions of welfare in Taiwan. That is, an individual is responsible for his/her own well-being, and meanwhile is encouraged to feel responsible for the welfare of other people, while the state role of welfare provision is less stressed. In one way, this notion seems to have a close link with the Confucian notion of benevolence or common good (*ren*), in terms of a moral norm: that a man (particularly a man of virtue) should help other people to stand on their

¹ An exception is the Health Insurance for Low-Income Households implemented in 1990. Although this scheme was entitled 'health insurance', it was not a 'social insurance' *per se* owing to a lack of the financial mechanism of risk-sharing. That is, the insured people did not need to pay any insurance contributions; instead, the government subsidised the whole of the contributions.

own two feet, on the grounds that he should empathise with those who are weaker than him.

The Taiwanese state has made good use of such a cultural norm to promote the notion of the individual's obligation to pay insurance contributions, which contribute to maintaining sound finance as an essential requirement for a social insurance system. In the case of the NHI, the government has publicised that the NHI is a system that can facilitate self-help as well as mutual help through collective efforts, i.e. all individuals pay contributions (Xu, 1995: 29; DoH, 1996: 3; BNHI, 1998a: 6 & 18; Wang M., 1999: 9, Chang H-J, 2002b & 2003).

Equally relevant is another traditional notion of welfare in relation to mutual help. That is, a man (a man of virtue) should take care of his own aged parents and young children first, and then extend the same care to aged people in general and the youngsters of others, as indicated by Mencius. Obviously this notion has been employed as a moral norm to uphold an important value of the NHI – that one generation should look after another generation on the basis of a long-term viable NHI. As Xu Li-De, the former Deputy Primer, indicates:

'Nowadays some young people feel that they are forced to pay [NHI] insurance contributions to look after young children and the aged, on the grounds that they have a better health status. However, some questions need to be raised. Which family does not have any children? Who will not become old? Who can guarantee that he will never meet with an accident and never contract a serious disease? Through these questions, everyone should be able to understand that the social insurance system [the NHI] implies that one generation may look after another generation....'

(Xu, 1995: 29-30)

Such a moral strategy does make sense, for the previous health-care system excluded children and the aged, except those of specific Guomintang clientele (see Chapter 5).

- *The political dimension*

The second dimension is political, referring to the fact that a social-insurance based model would easily be accepted by the general public, at a time when the state was eager to launch an NHI. The reason is that over half of the Taiwanese had become used to the model of social insurance under the previous system, and accordingly the government could take advantage of this 'public custom' by simply approving a similar model. As Mr. X4, the former Manager-General of the BNHI, pointed out:

'The governments dared not ask for increased taxes, because the public had got used to paying insurance contributions...58 percent of the population used to pay insurance contributions, and they thought this was correct. So, as regards the other 42 percent of the population, we [the government] could just tell them: "Other persons are paying compulsory contributions, why shouldn't you pay?" Once begun, a system of social welfare has no way returning back! Since a payroll-tax type has been adopted from the beginning, then that's it! Except for causing a political revolution, it will be difficult to make any major change in the existing way of funding in such a national health care scheme.'

(Interview Notes, No.1-04, 1998)

To be sure, Taiwan lacked any foundations for a taxation-funded health care system, and accordingly the rulers viewed the reform involving taxation as a political risk of losing the support of the electorate. Mr. X3, a scholar in social welfare financing and the Manager of the Department of Finance of the BNHI, posited that:

'Nobody is willing to pay more tax. Since there had been no space to adjust [raise] the existing insurance rates, it was even more impossible to increase people's tax! I think this is the reason why Taiwan always adopts social insurance systems. Considerations of

finance would only have become a problem [if a taxation-based system has been adopted]!’

(Interview Notes, 1-03, 1998)

- *The financial dimension*

Lastly, a compulsory scheme may have a more stable financing status, compared with a taxation-based model, owing to a higher possibility of being free from political influences (Taylor-Gooby, 1996: 117). In terms of this, insurance contributions are a ‘hypothecated tax’: that is, the way of funding through compulsory contributions cannot be easily altered without an explicit change in the related law.

Referring to the NHI, the NHI Act stipulates that the DoH, as the competent authority, can adjust the insurance contribution rate (which will be explained later) under the approval of the Executive Yuan, when adjustment is necessary (Article 19, Paragraph I). The government subsidised only the deficits incurred during the first two years after the commencement of the NHI (Paragraph II). In fact, this is the first time in the history of the development of Taiwan’s social insurance systems that the government delimited the boundary of state subsidy through announcing a termination date for subsidising. In part, this arose out of the worsening governmental finances after the late 1980s, which caused the government to attempt to shed unlimited financial responsibility for deficits incurred by social insurance schemes, as already noted in Chapter 5. On the other hand, the government learnt from experience that indefinite responsibility for subsidy would result in the bankruptcy of the system, as the increasingly heated party competition had given rise to more political interventions in social welfare schemes, particularly regarding issues like how much the electorate needed to pay. A typical case was the LI scheme, which had a serious

problem of insufficient reserve funds for paying old-age benefits. Despite the fact that the LI Act authorised the competent authority to increase the contribution rate when necessary, the administrative bureaucracies had never succeeded in doing it, owing to legislators always voting against such adjustment. It was when it was decided that the NHI scheme would be launched in a short time, that the LI gained the opportunity to adjust its contribution rate, on the grounds that medical-benefits would be transferred from the LI to the NHI and the LI rate would have to be reduced. In truth, the LI administrative bureaucracies took full advantage of this perfect timing to increase the LI reserve fund, by means of reducing the contribution rate by only 0.5%, which was far from the general expectation – that the LI contribution rate should be reduced by 4.25%, as the new system would impose such a rate on the public for the provision of health care. In this context, we consider that the NHI, as well as extending coverage, represents more of a means of capping expenditure by ending subsidies.

We will now move on to a brief introduction to the NHI system, namely the eligibility, funding, organisation, and benefits, in order to make more sense of the contexts in which change in the interactive relationships within the medical triangle, i.e. the state, the medical profession and the public, were initiated.

6.22 NHI eligibility – a citizenship right?

The NHI incorporates virtually the entire population, with the exception of prisoners. The citizens who have been registered as the residents of Taiwan for four months and above are eligible for the scheme. Besides, a national's newborn and foreign employees with resident permits are also eligible. All eligible persons are compulsorily required to enrol; otherwise they will receive a fine. Employers are

responsible for the enrolment of their employees. At the end of November 2001, 21.59 million people were enrolled in the NHI plan, accounting for 96.25% of the target population (BNHI, 2002a: 6-7).

In some ways, the current NHI has more of a citizenship character (Ku Y-W, 1998) due to the changed basis of entitlement to join the public health-care scheme, from a work-based insurance entitlement (on which the previous system was mainly formed) to a citizenship right. This is true in two ways. Firstly, all citizens were required to join the NHI scheme. Secondly, after unifying all of the previous government-administered health-care schemes under the NHI, the strata of health care provision among the different social groups was levelled by offering the same insurance benefits to all.

We may consider citizenship to be a western concept, for it is rooted in the philosophy of western welfare states. Referring to this, T. H. Marshall (1992) in his well-known work, *Citizenship and Social Class*, originally written in 1949, formulated the classical welfare conceptions of citizenship: that is, a gradual evolution of the content of citizenship covering civil rights then political rights and finally social citizenship, situated within the British context from the eighteenth to the mid-twentieth centuries. In the case of Taiwan, the NHI as a more general 'right' to health care appeared shortly after Taiwanese people had enjoyed some degree of civil and political rights, linked to the increase of democratisation after the lifting of martial law in 1987. The NHI funding is mainly from insurance premiums. The government has certainly emphasised the importance of paying premiums and using medical care as a statutory two-way relationship. In other words, paying premiums is an essential prerequisite of using NHI medical services. Furthermore, the government

encourages people to pay premiums by resorting to moral reasoning. The NHI is described as a self-help system made possible by mutually funding the system, as already noted. The role of state in this 'mutual help relationship' is not clear, in that the government seems to avoid tackling this issue. Meanwhile, the government in every way possible has publicised the conception that the NHI is not social welfare: it is not free. In this sense, the NHI lacks an important element of citizenship in terms of the state's attitude to the system. As Fu Li-Yeh (1995b) puts it, the NHI was used by the authoritarian state as a political tool to trade partial realisation of social citizenship rights for more fulfilment of political citizenship rights, at a time when a new civil society emerged demanding greater democratisation.

The degree of NHI citizenship has been deepened after a new principle was established in Interpretation No. 472 made by the Council of Grand Justices, which is in charge of explaining all national laws, on January 29th 1999. This Interpretation stipulates that the state should not reject the demand for access to the NHI medical care from those who are not eligible to pay NHI premiums; instead, it has to provide a proper assistance for them in accordance with the intention of the constitution. In response to this new requirement, the BNHI has set a NHI Hardship Relief Fund since June 2001, which offers a non-interest premium loan for people who have financial difficulty. Although this new policy has improved the problematic design of financial-based NHI eligibility to some degree, it seems that a complete concept of citizenship is still far away.

6.23 Funding

The NHI funding is primarily based on insurance contributions, collected from the

insured, employers and government on the basis of divergent percentage shares of contribution varying from 0-100 per cent, depending on beneficiary categories (NHI Act, Article 27). Those eligible for NHI, i.e. so-called NHI beneficiaries, are divided into two general groups: the insured and the dependants (Article 7). The insured are further divided into six categories comprising 13 sub-groups (see Table 6-1), according to their occupational status (Article 8). Dependants of the insured should be subscribed to or be withdrawn from the NHI together with the insured (Article 13).

Table 6-1 NHI Beneficiary Categories and Premium Sharing Percentages

Category	Beneficiary	Government	Employer /The Group Insurance Applicant*	The Insured
Category 1	Employees of public or private enterprises	10	60	30
	Civil servants or government employees		60	40
	Teachers and administrators in private schools	30	30	40
	Self-employed persons; employers			100
Category 2	Occupational union members without specific employers; seamen serving on foreign vessels	40		60
Category 3	Members of the farmers' association or the fishermen's association	70		30
Category 4	Active military officers, non-commissioned officers, servicemen and military cadets	100		0
Category 5	Low-income households	100		
Category 6	Veterans	100		
	Veterans' dependants	70		30
	Other populations under the aegis of district government populations	40		60

Source: BNHI, 1998a: 25; the NHI Act of 2001.

Note: * A group insurance applicant is in charge of the NHI matters on behalf of the insured people and their dependants, regarding enrolment, withdrawing and collecting contributions. In most instances, employers are the group insurance applicants.

The amounts of contribution paid by the insured, employers and government vary, as a result of applying different contribution equations, as shown in Table 6-2. In general, the shares of contribution reveal that 39% is contributed by the insured, 33% by employers, and 28% by the government (BNHI, 2003a). The amounts of contribution are primarily payroll-related.

Table 6-2 The NHI Contribution Equations for Salary Earners

<p>The insured:</p> $\text{Premium} = \text{Insured amount}^* \times 4.25\% (4.55\%)^{**} \times \text{Share of premium} \times (1 + \text{Number of dependants}^{***})$
<p>Employer:</p> $\text{Premium} = \text{Insured amount} \times 4.25\% (4.55\%) \times \text{Share of premium} \times (1 + \text{Average number of dependants}^{****})$
<p>The government:</p> $\text{Premium} = \text{Insured amount} \times 4.25\% (4.55\%) \times \text{Share of premium}$

Source: BNHI, 1998: 24.

Notes:

* Insured amount is payroll-related and depends on the monthly salary of the insured person. As of August 2002, the NHI insured amount included a scale of NT\$15,840 (approximately US\$528) to NT\$87,000 (approximately US\$2900) on the basis of 38 brackets.

** The NHI contribution rate remained at 4.25% from the inception of the scheme up to the end of August 2002, and afterwards it became 4.55%.

*** The number of dependants was set at a ceiling of 5 in the beginning, and 3 since June 22nd, 1999.

**** The average number of dependants was 1.36 in the beginning, and since then has been adjusted several times to 0.78 as the current standard.

Abel-Smith (1994: 179) indicates that a compulsory scheme can avoid risk-rating and accordingly has several social advantages, namely the four key principles of ‘solidarity’ or ‘equity’:

- A. Risks are spread between those with high needs for health services and those with low needs.*
- B. Those in healthy occupations are made to cross-subsidise those in occupations subject to greater health risks.*
- C. The cost of covering dependants is spread among those currently with none and those with many.*
- D. The higher paid cross-subsidise the lower paid by contributions related to earnings.*

Does the NHI system fulfil all of these? In one way, the NHI indeed plays an important role of risk-sharing between people with high needs and low needs for medical services, in that the difficulty² of the previous system in performing cross-subsidisation between schemes with higher risk (for example, FI) and those with lower risk has been diminished. In this sense, the NHI has reached the benchmarks of *Item A* and *B* above. Related to *Item C* is the regulation about the number of dependants for calculating the compulsory premium that the insured people need to pay. Initially, this number was set a ceiling of up to 5. At that time, the NHI had little gain of cost-sharing between families with many dependents and those with few or none, because this number was much higher than the average number of family members, which was 3.67 in 1995 (MoI, 2003). In particular, the working class

² Lin G-M (1998: 16) posits that the Taiwanese state was incapable of performing cross-subsidisation between different health care schemes in the system prior to the NHI, where all schemes were independent from each other in financing. In the case of FI, which was a scheme with high risk, because its insured people consisted of older farmers who had a high utility of medical care but were normally economically disadvantaged, the Guomintang state was unwilling to charge farmers with the ‘reasonable’ contributions in terms of following the actuarial result, because the Guomintang needed farmers’ political support, at a time when Taiwan’s politics was experiencing a critical transition towards democratisation.

families which had many family members were at a distinct disadvantage economically after the inception of the NHI. It is in this regard that the later reforms, reducing the ceiling to 4 then 3, represented more of the nature of social equity, for they helped those with many dependents to lessen the cost of covering them.

As regards *Item D*, we need to take account of two relevant factors: the NHI insured payroll-related amount and the shares of contribution. Firstly, the system of the NHI insured amount has considerable redistributive effects, owing to it being payroll-related. The current system, started from August 2002, includes 38 income brackets, ranging from the minimum wage to an amount which equals to 5.5 times the minimum wage. Besides this, the DoH is authorised to increase the highest level of the insured amount when the number of the insured applicable exceeds 3 per cent of the total number of the insured for 12 consecutive months (NHI Act, Article 21, Paragraph III).

Secondly, the various rates of contribution between different insurance beneficiaries represent the divisive nature of the Taiwanese social insurance system. In terms of this, the health care schemes prior to the NHI were characterised by being status-segregated according to people's occupational affiliations. Despite the fact that the NHI has by and large contributed to diminishing the segregation of social groups in health care schemes through integrating the entire population into one scheme, the system of the NHI rates of contribution, which varies between different insurance beneficiaries, is an indication that the new system carries on the existing approach of 'social division', in that the existing problem in relation to unfair obligations to pay contributions between different social groups (see Chapter 5, Section 5.32) seems to be difficult to resolve.

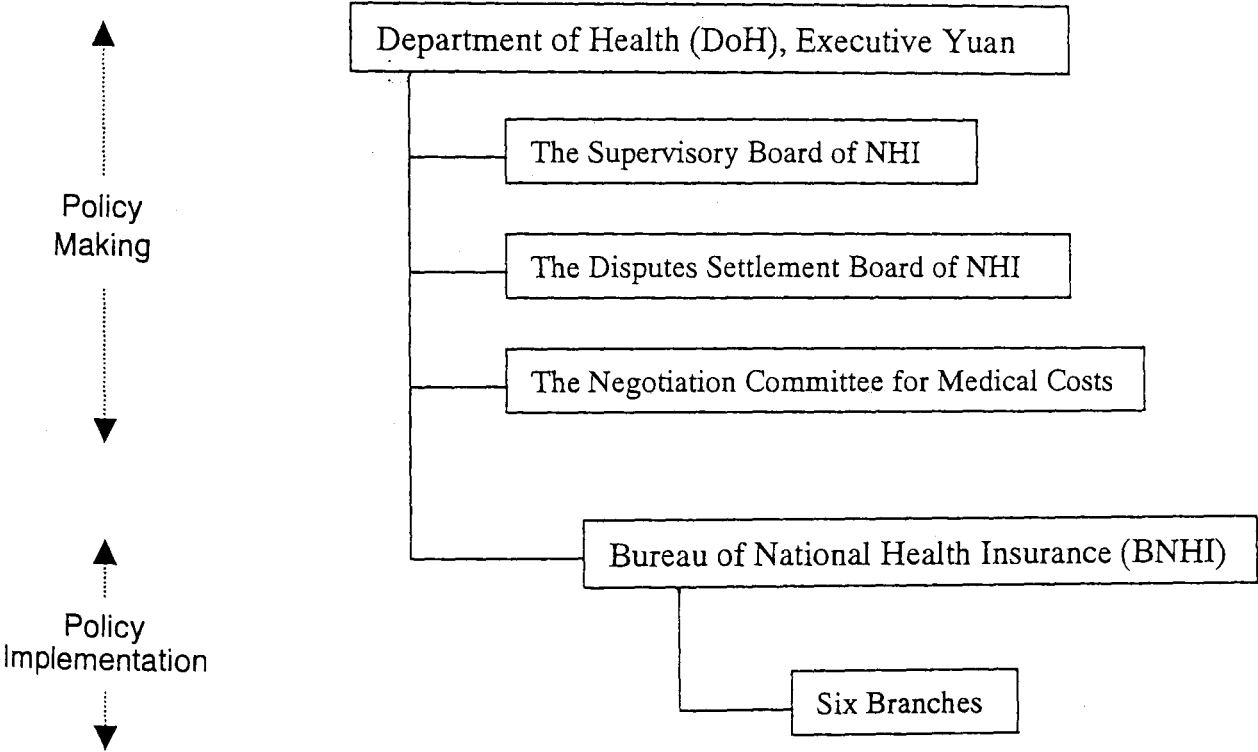
6.24 Organisation

The NHI is a government-run health care system. In terms of the organisation of the NHI, we are concerned with two levels of policy process: policy-making and policy implementation (Figure 6-1). At the policy-making level, the Department of Health (DoH), affiliated to the Executive Yuan, is the competent authority in charge of the policy-making of the NHI, as the highest health authority responsible for national-level health policy and administration. In addition, three committees have been set up under the DoH to direct specific functions. First, the Supervisory Board of NHI is in charge of supervising the operations of the insurance business and providing consultations or suggestions on the NHI policy and relevant laws. It consists of representatives of relevant government authorities, the insured people, employers, and NHI-contracted health-service organisations (NHI Act, Article 4). The second committee is the Disputes Settlement Board of NHI, in charge of settling disputes arising from cases approved by the BNHI and raised by insured people, group insurance applicants or contracted health care organisations (for further discussion see Chapter 7). It comprises representatives of the DoH and experts in law, medicine and insurance (Article 5). The Negotiation Committee for Medical Costs, the third committee, is responsible for coordinating the allocation of NHI medical costs under a global-budget payment system (see Section 6.32). It includes one-third each of the representatives from health care organisations, premium payers and experts, and relevant government authorities (Article 48).

As regards the policy-implementing level, this involves only one governmental agency: the Bureau of National Health Insurance (BNHI). The BNHI is the so-called insurer in charge of the NHI general operations, including planning and supervision, research and development, manpower training, information management and

inspection (BNHI, 2003a). In addition, under the umbrella of the BNHI, six NHI Branches have been established in different areas of Taiwan to discharge local insurance operations, such as underwriting enrolment, collecting contributions, reviewing and reimbursing medical expenses, and governing NHI contracted medical-service institutions (*ibid.*).

Figure 6-1 The Organisation of the NHI



According to Walt (1994), a top-down model of policy process is characterised as follows: *'policy formulation occurs within national government ...between donors and national policy makers. Once devised it is a largely technical process to be implemented by administrative agencies at the national or sub-national levels'* (p.153); by contrast, a bottom-up model reveals that *'implementers often play an important part in policy implementation, not merely as managers of policy percolated downwards, but as active participants in an extremely complex process that informs policy upwards too'* (p.155). In the case of NHI, obviously its administration has more of the nature of a top-down model, on the basis of a clear sharing of policy formulation and policy execution between the DoH and the BNHI. At the same time, a bottom-up approach to the NHI administration can be observed, on the grounds that a powerful BNHI, which actually commands the greatest governmental budget among all government agencies, plus various sorts of interest groups which stand outside the government, has often caused an overturning of the DoH's previously determined policy. We will explore this issue in more detail later on in this chapter and the next one, when we go through specific issues relating to governing medicine.

6.25 Benefits

The NHI provides insurance beneficiaries with medical services at its contracted medical-service institutions in the event of illness, injury and maternity. Generally speaking, what the NHI offers is a comprehensive benefit package, including ambulatory care, inpatient care, dental services, childbirth, ancillary services, home health care, prescription drugs, and essential preventive services. Both Western-type medicine and Chinese medicine are provided.

6.3 Governing Medicine

We will now enter into a detailed and systematic analysis of the formation of medicalisation in the NHI, based on the viewpoint of governing medicine. In terms of this, there are four issues that will be examined here: access to medical services, external governance, internal governance and medical computing.

6.31 Access to medical services

The NHI uses an 'NHI card' to ensure that an individual pays his/her premium before using medical services. An 'NHI card' is an insurance voucher with six spaces to record doctor visits, and can be traded in for a new one after six visits have been recorded. An insured person will not be given an NHI card or trade it in for a new one until he/she pays the premium. In addition, a programme of using an IC card, which is an electronic card with a chip that contains NHI-related and medical-service records, to replace the existing paper card has been launched recently to pursue the target that all insured people will get an individual IC card by the end of 2003 (BNHI, 2003a).

The NHI is a medicine-centred health care system. It provides easy public access to medical services, as the BNHI has contracted with the majority of medical care institutions. At the end of November 2002, a total of 16,911 hospitals and clinics had been contracted, or 92.7% of all hospitals and clinics nation-wide (BNHI, 2003b). Holding an NHI card, an insured person can visit any NHI contracted medical care institution at will. No patient-referral is required.

In some ways the relaxation of the insurance reimbursement requirement seems to have changed people's health care aspirations, particularly those who were not covered in any previous insurance scheme, accounting for 41% of the population, and

those who had suffered major illness or injuries. The easy access to medical care has fuelled people's health help-seeking behaviour to such a degree that a 'consumer culture' has developed (to be elaborated in Chapter 7) involving a certain over-use of outpatient visits. As Mr. X7, who is a consumer's representative in the Supervisory Board of NHI and a Standing Councillor in the National Trade Union, indicated:

'Nowadays 20 percent of the NHI fee has been wasted on medical expenditure! In other words, it has become so easy to see doctors. Hospital-shopping is just like window-shopping. It's becoming too easy! Consequently, we have waste!'

(Interview Notes, No.1-07, 1998)

On the administrative side, the BNHI has often complained about people's ignorance of the notion of cherishing medical resources (such as BNHI, 1998a: 74; Weekly Medical News, 1999; Chang H-J, 2001). In other words, the public is considered to have developed an attitude problem – that of 'taking advantage' of the system. As Mr. X13, a former Manager in Taipei Branch of BNHI and a Executive Secretary of BNHI, posited:

'I think the current situation of access [to medical services] is really good. Except in some remote areas and areas lacking medical resources, others are EXCESSIVELY good, to be honest. The disadvantage of excessively good access is that the public do not cherish medical resources.... Some patients' attitudes are: if I don't use medical services, I'll just waste my money [insurance contribution]! Thus they like, more or less, hospital-shopping and clinic-shopping.'

(Interview Notes, No.1-13, 1999)

In a sense patients themselves are encouraging medicalisation, because they are demanding modern medicine besides traditional Chinese medicine. Recent studies have cast light on the use of multiple healings by Taiwanese patients. Wu (1981) finds

that in excess of 60 per cent of Taiwanese families generally adopt multiple healings, including Western medicine, Chinese medicine and folk healing. Jiang & Su's research (1990), focusing on farmers, shows that 21.4% of their interviewees (200 farmers), did not settle on just one type of medical care, but rather that they used both Western and Chinese medicine at the same time. According to Lee *et al.* (1995), a relatively high rate of outpatients in Chinese medicine institutions tended to seek treatment from more than two sources. Specifically, among the 1,700 interviewees, 46.6% of them had seen another Chinese medicine physicians before they came to the current physician, and 59.2% had seen a Western medicine doctor for the same illness already.

The increase of the NHI medical expenditures has been dramatic in the past few years (Table 6-3). Specifically, the total medical expenditure increased significantly at a rate of 7.42% in 1996-97, 11.26% in 1997-98, and 8.45% in 1998-99 respectively; the increase rate then dropped to only 1.88% in 1999-2000, and climbed to 4.96% in 2000-01. The increase of outpatient expenditure showed a similar trend. That is, it saw manifest growth in terms of a rate of 9.18% in 1996-97, 11.93% in 1997-98, and 8.09% in 1998-99 respectively, but it dropped to only 0.41% in 1999-2000, then grew to 4.15% in 2000-2001. By comparison, the growth of the inpatient expenditure in the beginning was mild, revealed as an increase by 3.92% in 1996-97. It then significantly increased at a rate of 9.84% and of 9.21% in the subsequent two years, but this was followed by a drop to 4.99% in 1999-2000 –down about half from the previous year, which was different from the trends in the total expenditure and the outpatient expenditure; it then grew slightly to 6.60% afterwards.

Table 6-3 NHI Medical Expenditures: Amounts and Increase Rates
(1995-2001)

Unit: NT\$ hundred million dollars; %

	Total Medical Amount	Increase Rate	Outpatient Amount	Increase Rate	Inpatient Amount	Increase Rate
1995 (Mar-Dec)	163.96	-	106.92	-	57.04	-
1996	224.80	-	149.79	-	75.01	-
1997	241.48	7.42	163.54	9.18	77.94	3.92
1998	268.67	11.26	183.06	11.93	85.61	9.84
1999	291.37	8.45	197.87	8.09	93.50	9.21
2000	296.84	1.88	198.68	0.41	98.16	4.99
2001	311.55	4.96	206.92	4.15	104.63	6.60
1996-2001 Average	272.45	6.79	183.31	6.75	89.14	6.91

Source: BNHI (2002b), *NHI Annual Statistical Report of Year 2001*.

Based on the fact that the rapid increase of medical expenditure often threatened the NHI, the government administrators learnt to manage the NHI financing in a better way. In terms of this, since 1999 the BNHI has aimed to open new sources of income, such as by enhancing the collection of premium arrears, as well as cutting down medical expenses, referring to strengthening the inspections on both provider's and patient's sides (BNHI, 2003a). These administrative measures have proved to be very successful, for the year after the BNHI carried out these reforms saw a dramatic decrease in the growth rates of both the total medical expenditure and the outpatient expenditure.

Equally relevant is the change in the number of outpatient visits from a

continually increasing growth to a decrease which occurred in 2000. As Table 6-4 shows, the number of outpatient visits per person per year gradually increased from 12.8 visits in 1995 to 15.4 in 1999, but was followed by a slight decline in 2000, in which it was 14.7, and also in 2001, in which it was 14.5. On average, the NHI's outpatient services utilisation rate during 1996-2001 was 14.7 visits/person/year. Apparently, the growing trend of patients' outpatient visits has been brought under control.

Table 6-4 The NHI Outpatient Visits
Per Person Per Year

Year	Outpatient Visits
1995 (Mar-Dec)	12.8
1996	13.8
1997	14.5
1998	15.1
1999	15.4
2000	14.7
2001	14.5
<i>1996-2001 Average</i>	<i>14.7</i>

Source: See Table 6-3.

Note: The numbers are calculated by the author, based on the following computation:

Outpatient visits per person per year = number of outpatient visits / number of the insured persons (at the end of the year)

6.32 External government

In terms of the external government, this section is concerned with the role of the state in regulating the provider-client relationship in a therapeutic procedure by means of

NHI administrative governance. In truth, from the BNHI's viewpoint, there is a buyer's market for medical services, for the BNHI is the biggest buyer on behalf of the whole population. Alongside its rather dominant bargaining position, the BNHI has a legitimate authority, sanctioned by the NHI Act, to govern the medical profession. It is in this regard that the BNHI's bureaucrats can operate various regulatory strategies, falling roughly into two groupings: regulation by contract and law, and fiscal control. We will now move on to explore these in more detail.

- *Regulation by contract and law*

To begin with, a medical-service institution must apply to the BNHI for permission to become an NHI contracted medical institution, and it needs to accept the pre-decided contract articles together with relevant regulations and laws. This is followed by a review process conducted by the BNHI's branch in order to make a decision about the application. Generally speaking, the BNHI contracts widely with the medical-service institutions which have already been approved to conduct medical care by the health authorities. Mr. X₁₃, the Executive Secretary of the BNHI, considered this as an indication of an existing policy in relation to providing easy public access to medical services; however, this policy entailed a problem of variable medical quality, on the grounds that 'bad' institutions were also included in the system as long as they could meet administrative requirements (Interview Notes, No.1-13, 1999). A contract period is two years; afterwards, the BNHI may renew or annul the agreement. Since the NHI has a large population of consumers, it is rare that a medical-service institution does not want to become a contracted organisation.

When a contracted organisation contravenes the NHI contract or regulations, the

BNHI can respond in a number of ways, such as by disciplining the organisation, deduction of reimbursements, suspending a contract, and ending a contract, as stipulated in the Regulations of Contracting and Governing the NHI Medical Service Organisations. When an institution receives such punishment, it is allowed to appeal, in terms of applying to the BNHI for a re-examination, by written forms within ten days after receiving the BNHI's decision (Article 17). However, medical-service institutions generally think that policies are just rules of gamesmanship, with the BNHI playing the part of ball-player and referee at the same time. In practice, institutions sometimes look for help from outside the BNHI's rules and procedures. According to one high-ranking BNHI's officer, who wished to remain anonymous, a typical conduct of such institutions was that they sought 'relationship intervention' (*guan-shuo*) from Legislators or local Councillors, if the BNHI tried to enforce its policy decisions with penalty actions. He emphasised that this kind of political intervention had proved to be a major difficulty facing the local-level BNHI's administrators.

In fact, the NHI's competent authority, i.e. the DoH, agrees with the viewpoint that the BNHI is playing the part of ball-player and referee at the same time. As Zhan Qi-Xian, a former Health Minister, said in the Chiefs of the Executive Yuan Affiliated Agencies Press Conference on December 6th, 1997:

'Initially, the NHI was established on the basis of a government-owned and government-run model, for there existed specific historical and contextual conditions,...Nevertheless, the government-owned and government-run model contains several negative influences, due to the over-heavy role of the government in intervention. Accordingly, along with the functions of unifying legislation, implementing the laws and operation the system, the government has also become a target of various interest groups during dispute, so that it has been criticised for playing the part of ball-player and referee at the same time.'

(Zhan, 1997: 3)

In spite of the existence of this kind of criticism, it seemed that the BNHI was not seriously concerned to change the rules of gamesmanship until it was compelled to do so. In terms of this, a new principle to define the 'gamesmanship' of the NHI contracts has been established in Interpretation No.533 made by the Council of Grand Justices, which is the supreme body for explaining all national laws, on November 16th 2001. This Interpretation stipulates that a NHI contracted medical-service institution may file an accusation in public law, instead of a civil accusation, against the BNHI, if it is dissatisfied with the result of the re-examination made by the BNHI relating to disputes over executing a contract. Obviously this new policy has important implications for the existing interactive relationship of the BNHI and its contracted institutions: that is, it plays the role of a compensatory measure to raise the judicial position of the latter, who used to be allowed to file only a civil accusation in a specified court, predetermined by the BNHI's contract. It is in this context that we think a substantial change in the BNHI's affiliations with medical providers might occur in the near future.

- *Fiscal Control*

The NHI is a third-party payment system. That is, patients are not charged for medical services at the point of treatment, except for a fixed rate of co-payment (to be explained below), but rather the BNHI will reimburse medical institutions afterwards based on their claim. Generally speaking, a third-party payment system is often accompanied by a consequence of over-use or waste of medical resources, occurring on both supply and consumption sides. In response, the BNHI has developed several strategies, covering both providers and patients, towards alleviating excessive

consumption of medical resources.

The patients' side: Cost-sharing

Firstly, on the consumption side, patients are asked to bear co-payment at the point of medical service. This is concerned to encourage the conscientious utilising of medical resources so as to prevent waste (BNHI, 1998a: 21). Co-payments for outpatient and inpatient visits are based on different systems. Patients are charged with user-fees for their outpatient visits, varying for different types of health care institutions (Table 6-5). From the insurer's standpoint, the system of outpatient co-payment aims to 'discourage access to tertiary care facilities for services that can be treated in a less sophisticated facility' (Johns Hopkins University, 1997: IV-D-2), on the basis that there is no mechanism for promoting patient-referrals under the NHI system.

For outpatient care, the BNHI originally used a two-rate co-payment system, under which outpatients paid NT\$50 or NT\$100 depending on the level of providers (BNHI, 1998a: 21). A three-rate system was adopted in May 1997. Specifically, a patient must pay NT\$50 when he/she visits a primary care clinic or a district hospital, NT\$100 when he/she goes to a regional hospital, and NT\$150 in a medical centre. In view of a rapid increase of pharmaceutical expenditure, the BNHI further carried out a programme of additional co-payments levied on pharmaceutical expenses on July 1st, 2001 (BNHI, 2003a). Also, the three-rate system has been targeted again recently, and accordingly co-payments for regional hospitals and medical centres have been raised to NT\$140 and NT\$210 respectively, dated from September 1st 2002.

Table 6-5 Co-payments for Outpatient Care

Unit: NT. Dollars

Level of Service Provided	Outpatient Care	Dentistry	Chinese Medicine	Emergency
Local Clinic	50	50	50	150
District Hospital	50	50	50	150
Regional Hospital	140	50	50	210
Medical Centre	210	50	50	420

Date: As of September 1, 2002

Source: BNHI (2003c), *Bureau of National Health Insurance*.

For inpatient care, patient cost-sharing is based on a system of co-insurance, in terms of paying a portion of hospitalisation costs (Table 6-6). The co-payment rates for inpatient care depend on the duration of stay: the longer the stay is, the higher rates of co-payment which apply. Acute care and chronic care wards charge differently. For an acute care ward, a patient must pay 10 per cent of the bill for the first 30 days, 20 per cent from the 31st to the 60th day, and 30 per cent from the 61st day onwards. For a chronic care ward, an inpatient is charged 5 per cent of the bill for the first 30 days; 10 per cent from the 31st to the 90th day, 20 per cent from the 91st to the 180th day, and 30 per cent from the 181st day onwards.

Table 6-6 Co-payment Rates for Inpatient Care

Type of Ward	Co-payment Rate			
	5%	10%	20%	30%
Acute	--	30 days or less	31 st – 60 th days	61 st day and up
Chronic	30 days or less	31 st – 90 th days	91 st – 180 th days	181 st day and up

Date: As of March 1, 1995

Source: see Table 6-5.

As Table 6-7 shows, the share of outpatient medical expenses covered by patient co-payments has generally increased from 9.71% in 1997 to 11.92% in 2001, except 1998, in which it was 9.38%. By contrast, the share of inpatient medical expenses covered by patient co-payments during the same period did not see any significant change.

Table 6-7 Share of Inpatient and Outpatient Medical Expenses Covered by Patient Co-payment (1997-2001)

Unit: %

Year	Share of Outpatient Expenses	Share of Inpatient Expenses
1997	9.71	5.67
1998	9.38	5.69
1999	10.39	5.50
2000	11.90	5.29
2001	11.92	5.33

Source: BNHI (1998c, 1999a, 2000a, 2001b, 2002b), *National Health Insurance Annual Statistical Report*.

Although a cost sharing policy may contribute to a better result of cost containment as well as discouraging medicalisation that is due to patients, the increase of patient co-payments will doubtless result in a serious social consequence: it will become a barrier preventing access to necessary health care for lower income individuals and families (Johns Hopkins University, *ibid.* p.IV-C-8) – therein lies a concern over social inequity. In fact, this point has often become a heated political

argument, alongside public debates, each time the DoH attempted to increase patient co-payments. In the case of the most recent reform in relation to raising outpatient co-payments and the NHI premium rate at the same time so as to solve the financial crisis of the NHI system, the political tension was so great that it finally resulted in the resignation of the Health Minister, Li Ming-Liang, on the eve of launching the new policy.

The providers' side: price controls

The other side of the NHI's fiscal control is concerned to tackle the increase of medical expenses caused by the abuse of professional dominance. In general, this involves two levels of fiscal control. First, a state-dictated payment system plays an important role of cost control, in that medical professionals and organisations appear to have considerably lost their arbitrary powers of deciding prices for medical services. Second, under the NHI repayment system for medical expenditures, the BNHI further reviews providers' medical claims by auditing. Auditing is performed by the BNHI routinely. There are two types of audit: administrative audit and professional audit. The former is conducted by the BNHI's administrators, in an attempt to detect whether a provider's medical claims appear abnormal, compared with his/her previous historical data as well as the data of other institutions of a similar size. A professional audit is an advanced stage of auditing carried out by NHI-commissioned medical professionals, who focus only on the problematic items of medical treatment proposed by BNHI's administrators, plus the examination of some special medical treatments, such as very costly ones.

In terms of the payment system, it should be the most powerful instrument that

an insurer can use to control medical-care providers' tendency to increase their medical expenses. Initially, the NHI medical expenses were reimbursed to medical services institutions on a fee-for-service basis using a Fee Schedule which detailed the prices of medical items, plus a few items of case payments for hospitals, including Caesarean section and normal delivery. A well-known problem of a fee-for-service system is the so-called 'supplier-induced demand', in terms of the provision of additional services due to the motivation of physicians, which was considered as a major problem facing the system prior to the NHI (Johns Hopkins University, *ibid.*, p.IV-E-1; CEPD, 1990b: 259). However, based on a consideration to reduce the impact of the new NHI on providers, the government continued to use a fee-for-service model borrowed from the previous system when the NHI scheme was launched, and at the same time a gradualist approach to payment reforms, towards reducing the importance of fee-for-service, was also set up (DoH, 1997b).

Thus, a programme of NHI payment system reforms has been continually promoted in the past few years. In view of the fact that the BNHI vis-à-vis medical providers bears most of the NHI's financial risks, in terms of the growth of medical expenditure, the reforms have focused on the transference of financial responsibility from the former to the latter (Liu J-X, 1999). Overall, the relevant reforms implemented to date have appeared to be across-the-board, and have covered both the macro and micro levels.

The macro level of reform is typified by the implementation of the global-budget payment system, whose coverage has been extended in a gradual way: from dentistry first in July 1998, to Chinese medicine in July 2000, then to primary care clinics practicing Western medicine in July 2001, and finally to hospitals in July 2002.

Simply stated, the thrust of the global-budget payment system is a predetermined 'expenditure cap', which is a fixed amount of budget established for all providers in the same 'global-budget group' on an annual basis. This amount is drafted by the DoH first, and then set through negotiation within the NHI Negotiation Committee for Medical Costs (NMC), which consists of representatives from medical service organisations, premium payers and experts, and relevant government authorities. The NMC is responsible for deciding the criteria of budget allocations as well as the allotments between different medical groups and areas. Under the global-budget system, individual institutions still claim their medical expenditures from the BNHI, but the peer review of medical expense claims has been handed over to medical associations (NMC, 2000; BNHI, 2003d).

) In comparison with the macro-level reforms, which focus on controlling the growth of medical expenditure from a 'grand-total' viewpoint, the micro-level payment reforms are concerned to control additional medical treatments at the institutional level. In other words, micro-level strategies serve the purpose of heightening providers' cost awareness as well as creating an incentive for them to improve efficiency, based on the exercise of a system of predictable and accountable reimbursement. Major reforms include, for example, extending coverage of case payments, capitation³ for those hospitals which contract with the BNHI to provide integrated medical care for people in areas lacking medical resources, and DRGs (diagnosis related groups) -based prospective payment for hospitalisation expenditure (Lai M-S, 1998; Liu, *ibid.*; Chang H-J, 2002b; BNHI, 2003a).

In addition, volume-adjusted outpatient visit payment rates have been established

³ Capitation refers to 'a fixed payment to a provider for each enrolled person per period of time.' (Johns Hopkins University, 1997: IV-E-9).

gradually in an attempt to create disincentives for supplier-induced demand as well as to promote better quality of care (Johns Hopkins University, *ibid.*, p.IV-E-2; DoH, 1997b: 119). Simply stated, this measure is based on a clear principle: when outpatient volume increases to a certain level, its payment rate will decrease to a lower level. Primary care clinics and hospitals apply different standards of volume-adjusted outpatient visit payment rates. Specifically, if a primary care clinic treats less than 30 patients in a day, it is paid NT\$230 per patient. If the number of visits is between 31 and 50, the clinic is paid NT\$220 per patient. When the number reaches between 51 and 70 and between 71 and 150, the clinic is paid NT\$180 and NT\$120 per patient respectively. When a clinic receives more than 150 patients in a day, it is reimbursed only NT\$100 per patient (DoH, *ibid.*, p.119).

Secondly, the volume-adjusted outpatient visit payment rates for hospitals depend on the interplay of three indicators based on the previous year: the volume of outpatient visits per day, the number of attending physicians and the number of acute beds (DoH, *ibid.*; BNHI, 2000c). Accordingly, a hospital is paid NT\$213 per outpatient visit when the number of visits is less than the predetermined volume. It is paid only NT\$120 per visit when the actual volume reaches beyond the predetermined volume.

Commentators have mixed opinions about the above-mentioned payment system reforms. Li Yu-Chun (1998a; 1998b; 1998c: 3), who has a public health background and is the Convenor of the Payment System Team, NHI Planning Group, DoH, supports the contemporary approach to NHI payment reform, and considers that the NHI reform is now in the 'right' direction, revealed by the fact that the government is leading the development of delivery systems through making good use of the payment

system instead of through over-regulation. Mr. Y₂, an expert on medical affairs management and the former Prime Secretary of the Health Minister, Zhan Qi-Xian, also approves of the reforms. He argues that administrative regulation generally acts as just a 'nuisance' to providers, because its regulatory effects cannot last for long; by comparison, payment system reforms can have long-term influences on providers (Interview Notes, No.2-02, 2000). Lin Kuo-Ming (1997: 77), however, considers that the state's efforts will be in vain, in the sense of reforming the abuse of professional power, as long as doctors still can retain a dominant role in determining the clinical processes to counteract the state's price controls (we will elaborate on this later). From the providers' standpoint, Wu Yun-Dong (2000), the president of the National Physicians' Federal Association, believes that the ways the NHI pays doctors can have a tremendous effect on medical equality, but that unfortunately this part has often been ignored by the administrators as they focus only on the solutions to the NHI's financial difficulties.

In sum, the NHI payment reforms suggest the importance of state technical bureaucrats in diagnosing the ills of the NHI payment system as well as in finding solutions to the NHI's financial troubles, with the adoption of a carrot-and-stick approach to force providers to change. On the one hand, the reforms have more of the nature of expansionist regulation in the way the bureaucrats manage to govern the medical profession, who have shown a growing tendency to abuse their freedom to pursue economic interests. Added to this is a potential for failure to self-regulate existing within the medical profession, as Friedson (1970a) indicates. Yet the reforms are not just about the erosion of medical dominance: in turn they also hand over power to the profession, typified by the implementation of the global-budget system,

where medical professionals are empowered to perform more self-scrutiny. In this sense, it seems that the liberalisation of professionalism has come to the fore. It should be noted, however, that this state-sanctioned autonomy is a paradox, in that medical professionals are by and large dependant on the state's authorisation of a legitimate position; in effect, most of the jurisdiction of the medical profession sanctioned by the state mainly involves technical matters (for example, providing medical cost indicators), as indicated by Hardey (1998: 69).

6.33 Internal government

As medicalisation is linked to the growth of medical power, attention should be paid to health care politics, referring to the development of professional dominance leading to doctors being a significant pressure group. According to Freidson (1970a: 23-46), medicine's control over its work is based on state-sanctioned autonomy through the employment of self-scrutiny within occupational organisations. Thus, he argues (p.24) that '*the autonomy of the individual practitioner exists within social and political space cleared and maintained for his benefit by political and formal occupational mechanisms.*' In this regard, medical professionals may operate their own governance within their own groups by means of professional autonomy (Moran, 1999: 99 & 129). As already noted in the previous chapter, it has been observed that the Taiwanese medical profession started to constitute itself as a social actor with a powerful potential in the political sphere as a result of the post-war 'Americanisation of Taiwanese medicine'. As we shall see in this section, this process has been accelerated since authoritarianism started to decline. In terms of this, the section will look at the organised autonomy of the medical profession in relation to its use of regulatory

strategies of professionalism, through an investigation of the internal regulation employed in the case of the NHI global-budget payment system.

Briefly, the implementation of a global-budget payment system serves to decrease administrative regulation and meanwhile to empower the medical profession with more space for self-governance. The main thrust of this self-governance is that the power of budget allocation and the execution of peer review of medical expense claims are now in the hands of medical associations. On the one hand, the new system has contributed to relieving the tension between the medical profession and the BNHI, which used to be blamed for playing the part of ball-player and referee at the same time. However, on the other hand, this change seems to have caused new tension between individual physicians and their associations. We will elaborate this issue as we go through the case studies of dentistry and Chinese medicine below.

Dentistry first applied the NHI global-budget payment system from July 1st 1998, as a result of the interplay of the government's regulatory strategy and dentists' need for greater autonomy. The administrative regulatory strategy refers to the promotion of a programme of global-budget payment system, under which dentistry was selected as the first 'guinea-pig' for several reasons. First, the growth of medical expenses in dentistry vis-à-vis the other professional categories, such as Western medicine, was quite stable, and this made sound financial sense for developing a method of estimating a global expenditure (Lan S-Z, 1998: 24). Second, given that the Taiwanese dentists had already performed dental prevention for some period of time, they were assumed to have greater awareness of cost containment in comparison with other professional groups (Li Y-C, 1998a: 97; Lan, *ibid.*). Third, the dentistry system consisted of local dental clinics run by practising dentists, representing 92 per cent,

and hospitals, representing only 8 per cent. Based on the fact that it was more difficult to bargain for cost control with hospitals than with local clinics, dentistry had a good structure, in the sense of being open to experiment with ideas relating to budget control (Li, *ibid.*).

The dentists themselves, on the other hand, had a different motivation for accepting a new payment system. Simply speaking, they were compelled to give it a go, for the original payment system had treated them unfairly. The increasing rates of NHI medical benefit payments for dentistry had often been inferior to those of Western medicine (Li, Y-C, *ibid.*). According to Chen Shi-Zhong, the President of the National Federation of Dentists' Association, the point was not that the BNHI offered dentists a good deal, but rather that they could no more endure being at disadvantage in the NHI payment system, under which their professional autonomy was dominated by external regulators (Qiu, 1998b). It is in view of having the power of budget allocation in their own hands that the dentists' association decided to compromise with the BNHI. Moreover, Chen highlights the fact that the dentists' community, as a professional group, wanted to perform self-scrutiny through quality controls and benefit payments, in an attempt to 'gain dignity even cannot earn money' (*ibid.*, p.209). In this sense, we may suggest that the global-budget system helps the medical profession to present the positive side of professional autonomy, in terms of a model of organised autonomy beneficial to the quality of medical care.

Concerning the matter that the NHI global-budget system started with dentistry, Mr. Y₂, who was deeply involved in promoting the relevant programme during his post as the Manager of the Planning and Evaluation Department of the BNHI, considers that the BNHI had really good fortune. That is, the BNHI negotiated with

Chen Shi-Zhong, who had a high interest in the experiment programme, and who was also a forward-looking person in the context of the general NHI reforms (Interview Notes, No.2-02, 2000).

In terms of professional autonomy, the global-budget system should be viewed as a positive reform, but the other side of the coin is that new tensions between individual physicians and their associations have also come to the fore. Basically, the new system has caused a substantial change in the relationship between member physicians and medical associations: from limited communication to closer contact, due to the need for determining the ways of budget allocating. As Mr. Y₁₀, who is a practicing Chinese medicine physician and the Deputy of the Chang-Geng Chinese Medicine Hospital, indicates:

'Now the global-budget payment system has been implemented, consequently new changes are occurring. In view of the fact that the bread [the budget] will soon be distributed, everybody suddenly finds that communication is very important. In the past, the situation in the Chinese Medicine Association was: "you do your business, I do mine." "well water will not flow into a river." It did not matter that people did not see each other in ten years. Nowadays these ways will not work. "Is this your money or mine?" If no result has been reached, everybody must sit and talk.'

(Interview Notes, No.2-10, 2000)

Equally important is the system of peer review, which serves to keep the total finance of the 'global-budget group' in balance. Reviews are performed by the authorised physicians commissioned by doctors' associations. As a result, the existing blame for the erosion of professional autonomy has been shifted from the BNHI to associations and their authorised physicians.

Overall, physicians' associations have benefited the most from the global-budget payment system, as they are granted legitimate privileges from the state. There are

two points worth stressing in this regard. First, associations now have a legitimate position to bargain with the BNHI for a specified budget, separated from the other medical groups. Second, doctors have been liberated to some considerable extent, in the way they are granted the power of making regulations relating to budget allocation and the 'quasi-judicial' power regarding professional audit. This has important implications for the development of doctors' collective power, which was under-developed in the previous system owing to the across-the-board authoritarian governance. In this regard, we suggest that the NHI payment system reform has contributed to the liberalisation of professionalism.

6.34 Medical computing

In terms of medical computing, we are concerned with the utilisation of computing techniques functioning as a major requisite for 'certified' medical reimbursement, which in turn causes changes in the practice of professional medicine. In tune with the arguments presented above, we will focus on the policy impact on medical autonomy.

To begin with, the dramatic innovation of computer technology in the past few decades has brought about an overall impact on medicine, including practice, research and teaching. Accordingly, both clinical and administrative procedures can no longer be free of computers or computerised concepts in most modern health-care systems. In this context, medical affairs management has emerged as a new profession, in that health care managers are generally motivated with a mission to maximise the interests of their institutions and are expected to place the value of efficiency, financial efficiency in particular, above all other interests (Blakemore & Symonds, 1997: 227). Thus, in a sense the expansion of medical computing has a close link with the

development of hospital managerialism.

External to the medical community, the emergence of modern insurance systems also plays an important role in introducing computerised systems into clinical procedures so as to pursue greater administrative efficiency. In the case of NHI, owing to an urgent need to lessen the BNHI's work in evaluating payment claims⁴, a programme of computerisation of NHI reimbursement has been continually carried out since the beginning (DoH, 1997b: 162-4). Accordingly, many administrative requisites for making medical benefit claims electronically have been upheld by medical providers, on the grounds that the BNHI was able to make good use of fiscal means as below.

Overall, there are three methods of making medical benefit claims under the NHI system: a paper claim, electronic-medium claim and Internet on-line claim (*ibid.*, p.162). A paper claim, namely filing benefit documents in a written form, is a legacy of the previous system, which proved to be labour-consuming and time-consuming for both providers and the BNHI. The second method is the electronic-medium claim, involving filing claims through electronic media such as magnetic tapes or diskettes. A common problem involved was that mistakes appeared during the procedure of transforming providers' files to BNHI files by BNHI administrators (*ibid.*, pp.164-5). Thus, the BNHI gave up promoting electronic-medium claims and turned to supporting Internet on-line claims, in that a carrot-and-stick approach has been adopted to uphold this policy.

⁴ Based on the fact that the NHI incorporates virtually the entire population, together with the chaotic situation caused by the launching of NHI in a hurry, the BNHI was faced with great pressure of dealing with reimbursement during the immediate months after the inception of NHI. In 1996, on average, there were 22,728,626 cases of outpatient benefit claim every month, and 195,725 cases of inpatient benefit claim (BNHI, 1997c: 176). The relevant administrative work was so heavy that BNHI's administrators in fact did not reimburse all providers within the deadline stipulated by the relevant law (BNHI, 1997b: 171).

Essentially, all NHI contracted medical-service institutions are required to submit their claim documents for each month's medical expenses by the 20th of the following month (the Review Regulation for Medical Services Provided by NHI's Contracted Medical-Service Institutions, Article 10, Paragraph I). However, a provider can transmit its claim data electronically twice every month, if he/she adopts the method of Internet on-line claim (DoH, *ibid.*, pp.162-3). The BNHI needs to review claim documents and make reimbursement within 60 days after it receives claims (Paragraph III). In practice, a provisional payment has been often made first. For those institutions which file their claims through the Internet, they will get a provisional payment of up to 100 per cent of the actual payment within 15 days. A provisional payment of up to 90 per cent of the actual payment will be made within 30 days, if the claim is submitted in writing (BNHI, 1998a: 27).

Moreover, the BNHI differentiates financial penalties between providers that file their medical orders electronically and those who do not. Essentially, the BNHI can punish a provider by deducting his/her claim by a certain percentage, when the claim is considered to be contrary to the NHI relevant laws in an administrative audit (the Review Regulation for Medical Services Provided by NHI's Contracted Medical-Service Institutions, Article 4, Paragraph II). Even worse, the BNHI may apply this deduction rate to all other claims made by the same provider, according to the relevant regulations. In practice, however, providers who file their medical orders electronically are excluded from the application of this principle (the Operation Points for Conducting NHI Medical Benefit Expense Audit, Article 4; DoH, *ibid.*, p.169).

Obviously the carrot-and-stick approach has worked out very well. In the immediate months after the inception of NHI, only 12 per cent of the NHI medical benefit claims were made electronically. However, over 99 per cent of NHI claims

were made through Internet by the end of 2000 (BNHI, 2001a: 20)!

In addition, the NHI-related computerisation reforms have affected clinical procedures to some considerable extent. An important change which has been observed is the standardisation of clinical procedures. That is, nowadays medical professionals tend to carry out their treatments in a way which can meet NHI's standardised requisites, so as to avoid the failure of a full claim in the future. Added to this, computer companies have involved themselves in helping medical providers to standardise and simplify their clinical procedures and administrative flow by means of the use of various packages of computer programmes. The underling logic is that professionals may conduct more treatments inasmuch as they save more time. In fact, the NHI has contributed to opening a new market of information technology (IT), in that IT companies and medical providers help each other to make greater profits. According to the Common Health Magazine (2000), there is a popular software now used in Taiwanese medical encounters. As this magazine reported:

'Nowadays the Taiwanese computer software companies assist hospitals in designing proper computer programmes which enable doctors to perform practices quicker. What a doctor needs to do includes: first, key in the patient's complaint; second, select treatment items from the list of suggestions, where all possible check-ups and examinations are listed with details of the NHI payment. Simply press his mouse, and the doctor will immediately get another list of suggested prescriptions, which contains all possible ways of medication ... When the patient goes to have a check-up, his/her medicine is under preparation at the same time.'

(Common Health Magazine, 2000: 34)

In the light of the information presented here, we may now identify some important issues relating to medical autonomy throughout the development of medical computing. First, under the NHI payment system, doctors are induced to use computers, compulsorily and profitably. As a result, computers and the insurance

payment system seem to have gained a commanding position in defining the conditions for medical intervention. Second, the interplay of modern medicine and computer technology embedded in the process of diagnosis seems to have led to deeper alienation in the doctor-patient relationship. In other words, medical practices are performed in order to pursue technical forms of legitimation, with less concern for being humane. Also embedded in this process of 'rationalisation' is the reinforcement of medical dominance. This occurs because the medical profession can now rely more on modern technology, in that the competence gap existing between professionals and lay people seems to have been enlarged.

6.4 Reactions against Governing: Providers' Strategies

In a way the NHI regulatory system has controlled the medical marketplace and has circumscribed professional power to such a degree that medical professionals and institutions have now lost their dominant powers of deciding prices arbitrarily. In practice, however, medical providers have developed a variety of strategies to thwart the external government. This section examines the relevant evidence, towards gaining an insight into the formation of medical dominance that entails over-medicalisation.

6.41 An increase of outpatient visits

As already noted, medical providers have employed the strategy of conducting more ambulatory services in order to claim more fees from the BNHI, on the basis of the fee-for-service based payment system. In some ways the increase of outpatient visits has been proved to be an efficient means to resist the price controls of the BNHI. As

Mr. X8, the Manager of the Medical Management Centre of Chang-Geng Memorial Hospital⁵ and a National Policy Advisor to the President, pointed out:

'The price has been controlled: we, therefore, must increase the volume. Once the volume is growing, our cost decreases.'

(Interview Notes, No.1-08, 1999)

Mr. X14, the Chairman of Li-Xin Hospital⁶ also said that:

'The NHI diagnosis payment is only so little; thus what a doctor can do is to take a quick look at a patient. Most Taiwanese doctors, from medical centres down to primary care, see outpatients very quickly,.. There are two reasons for this: first, fee-for-service; second, [NHI] payment is not enough.'

(Interview Notes, No.1-14, 1999)

According to Zhang Jin-Wen (cited from Qiu H-M, 1998a: 196), the President of the Taiwan Hospital Association, in Taiwan a normal allocation of hospital costs between inpatient and outpatient services normally represents 90:10, but the allocation of hospital's income between inpatient and outpatient has been represented as 50:50 since the implementation of NHI. In other words, outpatient services vis-à-vis inpatient services have better financial returns. In view of this, hospitals are likely to carry out more outpatient services. The BNHI's data (2000c) shows that the number of outpatient cases in all medical centres had increased at a rate of 10% in 1997, 13% in 1998, and 12% in 1999 respectively; and meanwhile the amount of outpatient diagnosis fees in the same institutions had increased at a rate of 11% in 1997, 13% in 1998, and 12% in 1999 respectively. It is in this context that the BNHI determined to

⁵ This hospital is a medical centre, being well-known for excelling in making profits through making the best use of medical affairs management.

⁶ This hospital is a district hospital. It has a reputation for good quality of medical services as well as for using innovative ways of medical affairs management.

apply volume-adjusted outpatient visit payment rates in hospitals from January 1st 2001 (BNHI, *ibid.*).

Related to the increase of outpatient services becoming a norm among NHI contracted medical institutions is the NHI medical expenditures consisting of large outpatient outlay with small inpatient outlay. As Table 6-8 shows, over 65 per cent of NHI medical expenditures have been spent on outpatients every year since the implementation of this scheme, while under 35 per cent have been spent on inpatients yearly. It should be noted that 1999 is a turning point, at which the continual increment of outpatient outlay started to decline and the continual reduction of inpatient outlay began to rise. Given the evidence presented previously, we suggest that the NHI's payment system reforms, for example the adoption of volume-adjusted outpatient visit payment rates, and the reinforcement of inspection by the BNHI since 1999, must have played influential roles in facilitating such a change.

Table 6-8 NHI Medical Claims by Outpatient and Inpatient

Unit: NT\$ hundred million dollars, %

	Total Medical Amount	%	Outpatient Amount	%	Inpatient Amount	%
1995 (Mar-Dec)	163.96	100.00	106.92	65.21	57.04	34.79
1996	224.80	100.00	149.79	66.63	75.01	33.37
1997	241.48	100.00	163.54	67.72	77.94	32.28
1998	268.67	100.00	183.06	68.14	85.61	31.86
1999	291.37	100.00	197.87	67.91	93.50	32.09
2000	296.84	100.00	198.68	66.94	98.16	33.07
2001	311.55	100.00	206.92	66.42	104.63	33.58
1996-2001 Average	272.45	100.00	183.31	67.29	89.14	32.71

Source: BNHI (2002b), *NHI Annual Statistical Report of Year 2001*.

Just as the public has tended to develop an attitude of 'taking advantage' of the NHI system, medical service providers also have an attitude of 'viewing the NHI as other people's business'. In other words, although providers admit that fee-for-service is the crucial reason for over-expenditure in the outpatient sector, they do not think this should be their concern. As Mr. X8 stated:

'Amongst all payment systems, fee-for-service is the best. ...In fact, the NHI is turning at a loss. However, since it still is 300 or so hundred million dollars in credit, nobody is willing to be responsible for changing it before bankruptcy forces that change.'

(Interview Notes, No.1-08, 1999)

He revealed a common view of providers:

'Whether other hospitals want to speak out or not, I will certainly voice a different point of view in public. In public I must say 'take responsibility for the society', because I am a National Policy Advisor. I cannot support the saying: "dig until it [the NHI] gets bankrupt"! However, -- I speak as a hospital manager-- the truth is just like that, to be honest.'

(*ibid.*)

It is obvious that fee-for-service has increased medicalisation to a substantial extent, in that medical providers are entirely to blame for the fact that they have abused their autonomy to pursue financial interests.

6.42 The battle of competing for outpatients

Initially, the design of the NHI delivery system was based on a prioritised patient-referrals route, in terms of a route prioritised by level of institution: from grassroots level clinic (primary care clinic; local clinic) through district hospital, then regional hospital to medical centre. If a patient did not follow the referred way, then he/she

needed to bear the extra co-payment. However, this new policy suffered serious challenges from both hospitals and the public, and accordingly it was abolished just a few weeks after its implementation. The majority of patients did not like the new system because they used to have a complete freedom to go to any insurance contracted institution without co-payment. For the medical care providers, opinions were divided – local clinics supported this new policy but hospitals opposed it. The reason was obvious: competition for patients.

Generally speaking, Taiwanese people have a common view of the value of medical visits: ‘the bigger the hospital, the better the service’. This is because large-sized hospitals have better resources in terms of doctors, specialities and medicines. The failure of gate-keeping has enabled the development of consumers’ autonomy towards a complete freedom to visit large hospitals anytime and anywhere, as long as co-payment does not become a concern. As Mr. X₁₅, the Secretary-General of the Taiwan Labour Front, pointed out:

‘Nowadays their [workers’] habits [of seeing doctors] have seen a big change – now they like to see doctors in large hospitals, because they can get more medicines from there...Large hospitals have more doctors, so that a patient can be treated for several illnesses at one time. This is similar to shopping in a superstore – you can buy more things from there [compared with in a corner shop]!’

(Interview Notes, No.1-15, 1999)

On the other hand, the failure of gate-keeping has also contributed to the development of a medical care delivery system favouring the large-sized hospital, which is thereby benefited by receiving more NHI patients. Consequently, grassroots level clinics are faced with great challenges. In some ways, it can be said that primary care is decreasing in importance. According to my survey of the grassroots level clinicians in Taipei who closed down their clinics in 1998 (see Chapter 3, Section

3.32), except for age (over one third of the clinicians in this survey were over 70 years old at the time of closure), having difficulty in operation was an apparent feature shared by the respondent clinics. As far as the change of medical organisation is concerned, decreasing numbers of outpatients as a result of the competition from hospitals or the policy of separating dispensing practice from medical practice (to be explained later) was one of the most common factors relevant to the closure of the clinics. Related to this, jointly-run clinics emerged as a strategy to cope with the competition for outpatients from hospitals for those clinicians who continued to practise in another place after they had closed their original clinics.

The competition for outpatients was the main thrust of the battle between primary-care clinics and large hospitals. In terms of this, primary care clinicians were strongly against the NHI reform proposal to set up multiple private insurance carriers to replace the BNHI or against adopting an HMOs (Health Maintenance Organisations) system (Shi X-Y, 1997; PCA, 1997), under which a large hospital would normally obtain the leadership of an HMO and could decide its membership as well as operational policy. The battle between various medical care providers was so obvious that primary care clinicians even joined the Alliance to Rescue the National Health Insurance, which was basically a consumer group. This Alliance consisted of labourers' organisations, child-benefit promotion groups, feminist groups, disability groups, sociology and health policy scholars, Legislator's assistants, and primary-care doctors' associations. This organisation opposed the NHI reforms towards privatisation, and has ever been an important pressure group for monitoring NHI policies for some certain period of time. The combination might look odd, that doctors could share a common interest with consumers; the primary care doctors were worried

about being put under the control of hospitals, so that they decided to stand with consumers in the front line of the fight against privatisation reform (Shi X-Y, Interview Notes, No.1-06, 1998).

In one way, the rapid development of large hospitals has created a more dominant doctor self-image, at the same time causing the doctor-patient relationship to become more indirect. It is in this sense that the development of corporatisation has facilitated the transformation of the context of medical dominance, as noted by Haug (1998). As a consequence of this development, the experience of going to hospital becomes more alien. Ms. Y₁₈, a dietician in Taipei Veteran General Hospital and a Commissioner of the Consumers' Foundation, described this as 'walking in a maze' (Interview Notes, No.2-18, 2000).

6.43 Excessive check-ups and examinations

Under the NHI system, the variety of treatments that an institution is allowed to perform is dependent on its level in the hierarchy – the higher the level, the more treatments. It can be said that the fee-for-service system has motivated medical institutions to perform more check-ups and examinations so as to make greater profits. Added to this, institutions like to undertake more treatments in order to attract consumers. The situation of excessive check-ups and examinations in hospitals is out of control to such a degree that harsh criticism has even been voiced within the medical profession. For example, Chen Kai-Mo, the President of Guo-Tai Hospital⁷ and a senior surgeon generally recognised as an authority on surgery, strongly criticised Taiwanese surgeons for their over-use of medical technology due to financial concerns, in a Press Conference entitled 'Self Clean-up and Self Discipline

⁷This hospital is a medical centre.

from the Medical Community towards Reducing Improper Medical Treatment' held by the DoH on November 1st 2002. He used breast surgery as an example and argued that:

'Breast photography and ultrasound scan have been overused! It's so common that unmarried young women receive a lot of unnecessary examinations. Doctors depend on medical devices, instead of using their eyes, hands and ears; they are not doing observation diagnosis, touching diagnosis and listening diagnosis!'

(China Times, 2002b).

He put it even more strongly:

'Some doctors operated unnecessary surgeries to make profits, and the corollary of that is some patients died without being aware of the real reason why they died!'

(*ibid.*).

The situation of excessive check-ups and examinations is especially obvious in large-sized hospitals, where managerialism is generally considered as a key to reach cost-effectiveness. The most famous example in Taiwan's medical industry is at Chang-Geng Hospital, where the principle of 'profit-centre' has been thoroughly practiced. Each doctor or each speciality is viewed as an individual profit-making unit; all staff salaries depend on the 'profit-physician' and his/her department. This hospital first created the so-called 'physician fee' as the main way to set a doctor's pay. That is, a doctor is not guaranteed to be paid until he/she gets patients. The doctor then shares a certain percentage of income with the hospital for each patient and medication performed. Consequently, doctors are motivated by this payment system to conduct treatment with a view of financial returns, rather than the patient's real needs. It should be noted that the 'Cheng-Geng model' has been widely imitated

by other hospitals in the past two decades. Mr. Y2 interpreted this phenomenon as follows:

'Doctors are a group that are difficult to govern. So, hospitals give up governing directly and govern doctors by money instead. Give a doctor pay when he works; no work no pay! Then, doctors will work hard at their hospital's direction.'

(Interview Notes, No.2-02, 2000)

In other words, hospital managers govern medical professionals by exploiting human frailty. Consequently, doctors are increasingly seeking to extend their professional autonomy over treatment in the medical encounter. One point is worth stressing in this regard. The shift from salary to fee-for-service in most instances, for example in the British NHS, was made so that the latter gives doctors more freedom. In the case of Taiwan, however, it has more of the nature of controlling doctors' work through squeezing their labour in the name of creating a common interest.

Concerning the reasons for over-treatment, more check-ups or examinations are welcome by patients because they are comparatively lacking in knowledge on the one hand, and no extra payment is required from them on the other. From the medical professional standpoint, Mr. Y2, an attending physician of family medicine at Xin-Zhu Hospital, considered this to be by no means beneficial to patients. As he said:

'Patients need to spend more time on a lot of check-ups that might be useful and might not. However, one thing can be certain is – that [medical] quality is by no means better than before!'

(Interview Notes, No.2-06, 2000)

Facing the waste of medical resources caused by excessive check-ups and examinations, the BNHI has adopted various administrative measures in relation to

both the supply and the demand sides. To medical providers, the BNHI focuses on the monitoring of expensive check-ups and examinations. To patients, additional co-payments have been levied on check-up and examination expenses since July 1st 2001. The latter has caused harsh criticism, on the basis that patients in most instances merely exercising passive acceptance of doctors' decisions, so that doctors should be held more accountable for the waste of medical resources (Liu M-J, 2001; Ye M-L, 2002; China Times, 2002a).

6.44 The growing use of high-tech medical devices

In terms of the over-use of check-ups and examinations, there is one more point worth noting: that is, the growing use of high-technological (high-tech) medical devices, referring to the ideological predisposition of the health authorities. What we are concerned with is that the DoH, as the highest health authority, has been keen to promote the development of medical technology, on the basis of a preference for the modern bio-medical model, which requires strong support from bio-chemical science and technology (DoH, 1994: 184-190). It is in this context that medical-care institutions have been encouraged to use high-tech medical devices, which consequently has given rise to a 'technology race' between medical institutions (Chen X-P, 1998: 4-26). There are two reasons for such a contest. First, the use of high-tech medical devices can bring generous remuneration for institutions, as long as institutions can perform many check-ups, which means a high level of NHI repayments afterwards. Second, the use of high-tech. medical devices is one of the evaluation items in hospital assessment routinely undertaken by the health authorities, in that the holding of high-tech medical devices entails a possibility that an institution

can be approved to upgrade to a higher level (Chen, *ibid.*, p.4-30).

In fact, the number of high-tech devices approved in Taiwan has mushroomed in recent years. As Table 6-9 shows, from 1990 to 2001 the growth rate in CTs (computed tomography scanners) was 2.5 times, in MRI (magnetic resonance imaging) was 8.3, in ESWL (electrohydraulic shock wave lithotripsy) was 15.1. However, the growth rate in population in the same period was only 1.1 times⁸.

Table 6-9 Number* of High-Tech Medical Devices Approved
(1990-2001)

Unit: Set

Year	CTs (Computed Tomography Scanner)	MRI (Magnetic Resonance Imaging)	ESWL (Electrohydraulic Shock Wave Lithotripsy)
1990	124	10	9
1991	147	14	20
1992	175	23	23
1993	202	32	40
1994	230	34	47
1995	264	38	56
1996	294	47	70
1997	317	50	86
1998	353	61	100
1999	390	72	116
2000	416	85	133
2001	434	93	145
<i>1990-2001 Growth Rate</i>	<i>2.5</i>	<i>8.3</i>	<i>15.1</i>

Source: DoH, *Health and Vital Statistics of Year 2002*.

Note: * The numbers listed here are the cumulative numbers at the end of the year.

⁸ The total Taiwanese population in 1990 was 20,401,305, and in 2001 was 22,405,568.

We are also concerned with a comparative understanding of the condition of Taiwan's high-tech medical devices. In Table 6-10, we list the numbers of high-tech medical devices, in terms of CT, MRI and ESWL, in Taiwan and specific OECD countries. A rough comparison is that the numbers of CT and MRI per million of population in Taiwan is between that of the USA and Canada. Comparing Taiwan with the UK, the number of CTs per million population in Taiwan is about three times that in the UK; the number of MRI per million population in Taiwan is slightly less than that in the UK. For the ESWL, the number per million population in Taiwan is above all other countries.

Table 6-10 Number of High-Tech Medical Devices
in Taiwan and Some OECD Countries

Unit: Set

		Taiwan	UK	USA	Canada	Japan
CT	No. (year)	390 (1999)	360 (1999)	6955 (1993)	245 (1997)	8768 (1996)
	No. per million population (year)	17.7 (1999)	6.1 (1999)	26.9 (1993)	8.1 (1997)	69.7 (1996)
MRI	No. (year)	72 (1999)	270 (1999)	4200 (1995)	53 (1997)	2360 (1996)
	No. per million population (year)	3.2 (1999)	4.6 (1999)	16.0 (1995)	1.7 (1997)	18.8 (1996)
ESWL	No. (year)	116 (1999)	N/A	364 (1990)	12 (1995)	309 (1990)
	No. per million population (year)	5.3 (1999)	N/A	1.5 (1990)	0.4 (1995)	2.5 (1990)

Source: DoH (2000), *Health and Vital Statistics*; OECD (2000), *Health Data 2000*.

It should be noted that due to 'selfish departmentalism', the insurer and the competent authority of the NHI have very different views on the growing use of high-tech medical devices in relation to NHI medical expenditure. Simply stated, what the BNHI cares about the most is cost containment, while the DoH concentrates on the pursuit of outstanding medical care and technological innovation. In a way, the DoH is proud of the result of the development of high-tech medical devices, revealed as a rapid increase in their number. In this regard, the growing use of high-tech medical devices is considered an indication of improved quality of medical care. As Mr. Y9, the Director of Department of Medical Affairs, DoH, said:

'Considering the number of population, at present we have beaten all other countries at the number of ESWL. Taking account of the fact that Taiwan is such a tiny island and has a small population, we should consider that we have also beaten all other countries at the number of MRI. So, our [medical] high technology is not behind anybody!'

(Interview Notes, No.2-09, 2000)

From the standpoint of policy implementer, the BNHI otherwise disagrees with the DoH, on the grounds of a concern for the increase of medical expenditure. It considers that the NHI has spent too much on high-tech medical treatment. As Ms. Y5, the former Director of the Medical Affairs Management Department of the BNHI, pointed out:

'The NHI has spent too much on high-tech medical items. The situation is that the items approved by the DoH will generally get paid in the NHI system. Now a difficulty is facing the NHI: whether there should be a long-term evaluation about the extent to which the NHI should pay for high-tech items – this system needs to be established! At present, it can be said the NHI is a very generous system!'

(Interview Notes, No.2-05, 2000)

In a conference relating to the NHI finances (BNHI, 1998d), Yeh Jin-Chuan (a former Manager-General of the BNHI) used an interesting illustration to demonstrate the tension between the BNHI and the DoH, referring to the issue of whether the rapid growth of high-tech medical devices represented an over-input of medical resources. As he said:

*'The person in charge of distributing resources [i.e. the DoH] is adding more and more wood from the bottom; meanwhile he shouts at the person on the top: "Blow! Quickly blow!! As long as you blow it to a little colder, it won't be boiling!" At the same time, the DoH continues to add more wood with all of its might. Consequently, Mei-Shu Lai [the Manager-General of the BNHI] must "**Hu! Hu! Hu! Hu!**" [sound of blowing]'*

(Cited from Yeh's speaking in the 'Cross-2000: The NHI Finance Conference', held by BNHI on December 11th 1998.)

It seems that the battle between the policy maker and the policy implementer will not be easy to end, because the former by and large holds a patriarchal attitude towards the high-tech programme, whereas the latter actually plays an active role in implementing the relevant policies. As Mr. Yeh indicated:

'Controlling medical expenditure is BNHI's duty. What we are concerned with is the quality of medical care. That is, you (medical care institutions) cannot allow an unqualified person to handle a [high-tech] machine.'

'Don't be confused. The BNHI is a BNHI OF the DoH! It is not a BNHI of any other department, say, the Ministry of Interior. We are unified! If we have approved, it [the BNHI] certainly must pay. However, the truth is – when it simply doesn't want to pay, we are unable to push it any further!'

(Interview Notes, No.2-09, 2000)

Embedded in the selfish departmentalism is an important issue that is implicit in the existing state ideological predisposition. That is, the question as to what extent

high-tech medical care has brought iatrogenic damage to patients is one that has never been seriously considered in the drafting of Taiwan's health policy.

6.45 Excessive prescription

This section focuses on another particular type of over-treatment: excessive prescription, as an efficient means commonly adopted by the medical profession to thwart the state's price controls. Related to this is an important indicator: about one fourth of NHI expenditure is used on drugs every year, which has often been brought to the attention of the public by the NHI authorities as a reminder of the undue consumption of medical resources (Central Daily News, 1997; Min-Sheng News, 2001; BNHI, 2002c). In 1999, the authorities publicised a survey that revealed that: *'for outpatient services, about a quarter of the patients only took half of the drugs prescribed and 5% of the patients did not use drugs prescribed'* (Weekly Medical News, 1999; BNHI, 2003c). This survey was an attempt to support the NHI reforms relating to cutting down drug expenditure, including new additional co-payments levied on pharmaceutical expenses on the patient's side (started from July 1st 2001) and the lowering of pharmaceutical price standards on the provider's side. Here we are not going any further into these reforms, but rather we want to explore how over-medication has become the norm in Taiwanese medical encounters. In terms of this, we are interested in the social construction of excessive prescription in an attempt to gain insights into the formation of medical dominance. We will now look at this issue from three dimensions: the Chinese medicine background, the doctor-patient relationship, and the dual role of prescribing and dispensing.

- *The legacy of traditional Chinese medicine*

In the first place, it can be said that prescription medication is a legacy of traditional Chinese medicine, in that Chinese medicine stresses the importance of ‘medicine’ for curing disease. Simply stated, Chinese medicine views illness as an unbalanced situation of the body, and accordingly the use of medication serves to restore a proper balance to the body. Traditional Chinese medicines are made of natural materials, such as animals and plants. Food is also viewed as a medicine, in so-called ‘diet treatment’. It is in this regard that medicine and also diet play a crucial part. In fact, Chinese medicine physicians usually give patients a prescription which sometimes includes normal food. As a consequence, medicine is generally viewed by patients as a very important factor in healing illness, no matter whether it is Chinese medicine or Western medicine. The situation is just like as Mr. Y₂ said:

'If a patient does not get medicine (after seeing a doctor), he will feel that he has not received good treatment.'

(Interview Notes, No.2-02, 2000)

Mr. Y₁₀, who is the Deputy Chairman of Chang-Geng Chinese Medicine Hospital, described such a cultural custom as ‘the security factor’ (Interview Notes, No.2-10, 2000). This, in a way, explains why patients have often obtained excessive medications, as well as why some patients were ‘wasteful’ of medicines prescribed, as the BNHI’s survey indicated. Mr. X₆, who is a primary care doctor, pointed out:

'In Taiwan, seeing a doctor is mainly for getting medicine. If you don't give him [the patient] medicine, he will fight with you!'

(Interview Notes, No.1-06, 1998)

In short, in a sense traditionalism is still affecting modern medicine in Taiwan. Also, patients are encouraging excessive prescription, because they demand modern medicine. Put another way, over-medication meets both the needs of patients and doctors.

- *Short diagnosis time*

Secondly, the fact that the majority of Taiwanese doctors do not take the time to explain the use and purpose of their medication could be another reason for over-medication. As mentioned previously, short diagnosis times are the norm in Taiwanese medical surgeries due to the fee-for-service system. Equally relevant is that the public even admire this and think a good physician is a doctor who sees many patients, not a doctor who sees patients slowly and considerately (quoted from Mr. Y6, Interview Notes, No.2-06, 2000). Being placed in such a medical encounter, where a doctor is in full control of medical jurisdiction, what a patient can do is to take more medications as a guarantee of better treatment (Liu M-J, 2001.). Therefore, in a sense prescribing more medications becomes a trade-off.

It seems that over-medication is especially serious in hospitals, as hospitals vis-à-vis local clinics have more medicines, as well as being allowed to offer prescriptions that cover longer periods. Referring to this, hospital-based doctors tend to prescribe more medicines for patients, so as to meet the needs of the consumers who come in order to receive more medicines (China Times, 1997; also see Section 6.42). Besides, doctors and their hospitals can make money from medicine sales, which actually are very profitable⁹. As regards the situation of excessive prescription in hospitals, Mr. X6 said that:

⁹ From the viewpoint of the BNHI, one of the major problems concerning the reimbursement of

'Hospital-based doctors always prescribe a lot of medicines. If you [the patient] tell a doctor: "I don't need so many medicines", a common reply you will get is: "Never mind! Just take them home!" In that case, the patient will think that he had better just take everything with him.'

(Interview Notes, No.1-06, 1998)

It is worth stressing that such a medical discourse indicates the power relationship embedded in the therapeutic procedure: that is, patients have a fear of offending their doctors due to the considerable gap of knowledge between themselves and the healers. In a sense the existence of the 'competence gap' forms the basis for the exercise of professional power, and further contributes to enhancing the dominance of professional medicine. It is in this regard that the therapeutic relationship by and large includes a potential for an exploitative relationship (Waitzkin, 1979; Hardey, 1998: 80).

- *The dual role of prescribing and dispensing*

The last point is concerned with the dual role of prescribing and dispensing, in terms of a joint practice which has been popular in both Chinese medicine and Western medicine for decades in Taiwan. That is to say, a physician has a legitimate right to not only prescribe but also to dispense medicine, and a medical institution normally includes a pharmacy or pharmaceutical department inside it. How has this been constructed? We suggest the important role of cultural factors. Chinese people are not accustomed to pay for labour in a service. In other words, labour is not normally an independent item of the expressed price. This gives doctors grounds for insisting that

pharmaceutical expenses is a so-called 'black hole', in terms of the great profit an institute can make between the claimed price and the real price, which is difficult to know for the BNHI. In a way the pharmaceutical companies help doctors and institutions to operate in this way; then they also benefit by sharing the results of the practice.

they do not only prescribe medicines, but that they also make up medicines on the premises. In terms of this, doctors tend to view the profit from medicine sales as a necessary compensation for their labour, as Mr. Y₂ indicates (Interview Notes, No.2-02, 2000). In a similar regard, Ms. Y₅, the Executive Secretary of the NHI Supervisory Board, argues that doctors will feel ashamed to charge a patient if they do not give the patient any medicine (Interview Notes, No.2-05, 2000). In a sense, we can find that traditionalism is still affecting modern medicine in Taiwan.

6.46 The transitional medical specialities

Considering the influences of the NHI on the medical marketplace, it has been observed that a few medical specialities have undergone a transition in the past few years. Overall, the changes can be separated into two categories: the transition of a physician's place of practice from hospital to local clinic or from local clinic to hospital, and the growth or reduction of some specific specialities.

The first type of transition is about changing places of practice between hospitals and local clinics. For those specialities where a physician can quickly conduct many outpatient visits, for example, E.N.T. and ophthalmology, the physicians tend to leave hospitals and open an independent clinic of their own. In addition, local paediatric clinics have significantly increased because the NHI care covers children. Also, paediatricians need to provide an easier access for their patients, therefore paediatric clinics are more suitably located in a community rather than as a speciality within a hospital.

On the other hand, physicians in obstetrics and gynaecology are moving from

local clinics to hospitals, this change being caused by patients more than the professionals themselves. In the past, the LI Scheme provided benefit-in-cash for child-delivery. So, an insured female preferred to deliver her baby in a local obstetric clinic rather than a hospital, because she could then save her fixed-amount benefit. Nowadays the NHI Scheme provides benefit-in-kind for child-delivery. Therefore since no cash benefit will be paid to insured females, pregnant women generally like to deliver their babies in a well-equipped hospital. This has influenced those physicians who originally worked in clinic-based obstetrics and gynaecology, in that they now tend to change their clinics into gynaecology or family medicine clinics.

In terms of the second type of transition, i.e., the growth or reduction of some specific specialities, obviously the expected financial return from the NHI has affected medical students' choice of career in some specific specialities to large extent. It can be seen that those specialities where treatment is easier or only takes a short time and training times are shorter, for example, E.N.T., rehabilitation, dermatology, and ophthalmology, are becoming popular for medical graduates. By contrast, those specialities where treatment is difficult or takes longer with a comparatively unreasonable pay, for example, surgery, are losing their attraction to medical graduates (Qiu H-M, 1998a).

We suggest that the NHI payment system has been a very important factor in stimulating these changes. It is worth stressing that these changes imply not only a crisis of supply shortages in some specialities but also an imbalance in the internal structure of the provider's system. This development entails a serious problem – that those specialities that cannot make money may possibly lack doctors in the future. In sum, the transitions of medical specialities in Taiwan reveal a very important lesson

about the dominance of professional medicine: that is, the medical profession is not so much a vocation that serves to provide altruistic and disinterested services, as claimed by the functionalists (such as Parsons, 1951 & 1978), but rather it is similar to other enterprises that excel at making profits through the employment of calculated and coherent strategies.

6.5 Conclusion

In this chapter, we have examined the recent developments of Taiwan's health care state in relation to the NHI as a new regulatory system serving to govern medical services and consumption in the post-Kuomintang authoritarian era. In terms of governing medicine, this chapter suggests that the NHI has created a new bureaucratic structure, which has led to a simultaneous increase and decrease in medical power.

Specifically, the NHI, as a medicine-centred health care system, has contributed to the development of professional medicine, in that the compulsory insurance system now provides a continuous resource of patients for physicians on the one hand, and people's health care aspirations are translated into deeper dependence on modern medicine due to easy access to NHI care, on the other. A consequence of this is that doctors are increasingly seeking to extend their professional autonomy over treatment in the medical encounter, because they have an enhanced legitimate position to perform medical intervention, which entails a potential for the abuse of professional freedom, typified by the increase of provider-induced demand and the reduction of diagnosis time. Added to this is the growing emphasis on managerialism within medical organisations, in particular large hospitals, which in a sense has encouraged over-medicalisation in that hospitals squeeze doctors' labour through changing the

payment system from salary to fee-for-service in the name of creating a common interest.

In addition, the growing utilisation of medical computing, as a response to BNHI's administrative requisites for making medical benefit claims and as a financial strategy for pursuing cost-efficiency based on the standardisation of clinical procedures, has given rise to a more dominant doctor self-image, at the cost of the doctor-patient relationship, which has become more indirect, together with the enlargement of the competence gap between professionals and lay people. However, the other side of the coin is that doctors are faced with losing autonomy in identifying medical treatments, for computers and the NHI payment system seem to have gained a commanding position in defining the conditions for medical intervention.

In terms of the decrease of professional power, the NHI has enabled a new system of governance of medical services in pursuit of cost containment, in that the medical profession has been put under more state scrutiny due to the employment of administrative targets and fiscal controls. In this sense, it can be seen that professional autonomy is eroded. However, the reality is more complicated than merely a loss of autonomy. The medical profession have developed a variety of strategies to oppose the state governance, notwithstanding the fact that the state bureaucrats have taken various regulatory measures to tackle the increase of medical expenditure. Therein lies the problem of professional expansionism, referring to the roots of over-medicalisation: in some instances medical providers have caused iatrogenic damage, for example in the over-use of check-ups and examinations, over-medication, and patient dependency.

Embedded in the development of the liberalisation of professionalism in the

Taiwanese medical encounter is the change in the medical approach to the view of the body and the construction of medical knowledge, as discussed by social constructionists (such as Foucault and Armstrong). That is, biomedical knowledge and practice are not so much a factor of science, which claims to be objective and independent, but rather a consequence of the exercise of clinical techniques, which serve the economic purposes of capitalism for profit. Related to this is the point that professional autonomy, as a legitimate privilege sanctioned by the state, enables doctors to define and satisfy the needs of patients in a seemingly altruistic manner that in fact involves the pursuit of self-interest *per se*, as addressed by Johnson (1972). Medicine is not a neutral and ahistorical enterprise (Hillier, 1991: 180; Nettleton, 1995: 18). In the case of Taiwan, in some ways traditionalism is still affecting the construction of medical knowledge and practice, for example in the case of excessive prescription and the doctor's dual role of prescribing and dispensing.

To sum up, the NHI system has extended the influence of doctors and medicalisation, but provides the basis by which medical autonomy has been undermined, with the exception of the recent payment system reform relating to the global-budget system, where the medical profession is empowered with more capacity for self-governance. An important contrast to the development of medical dominance is the erosion of patient autonomy, in that the NHI care is departing from patient-centred medicine. Referring to this, the NHI is established on a rational model, which employs a belief that the application of medical care is based on its effectiveness, in that the state has taken medical intervention for granted and relies on the rationality of calculation, on the basis that the NHI has often been in a financial crisis over these years.

The next chapter is an extension of our concern with medical dominance. We will focus on a specific theme: consumerism, concerning the role of patients as consumers, and assess its relevance to present-day developments of medical power.

CHAPTER SEVEN
CONSUMERISM, MEDICAL DOMINANCE
AND HEALTH POLICY

7.1 Introduction

This chapter continues our concern with medical dominance, focusing on the role of patients as consumers in health-care consumption. In view of the phenomenon of greater patients' dependence under the current NHI system, as presented in the previous chapter, we will now look at methods that may facilitate change in the doctor-patient relationship. It is in this regard that we will explore the social construction of 'consumerism', as a concept involving a less hierarchical approach to the 'sick role' (Parsons, 1951) and a challenge to aspects of 'medical autonomy'.

By consumerism is meant a concern with how it represents some kind of challenge potentially to aspects of the subordination of patients within the sick role, which includes just trusting doctors. In one way, the emphasis on consumerism reveals a consequence of post-modernity being associated with less trust of professionals and experts, due to the exercise of the reflexivity of knowledge that enables lay people to be sceptical of expert systems (Giddens, 1990). Equally relevant is the employment of consumer choice, acting as a means to reinforce individuality in the social and economic life of a post-modern society, which entails an emphasis on preference and customer satisfaction (Bury, 1998: 4-5).

Based on our interest in the health care state, this chapter argues that the NHI has had an impact on the development of the consumer culture, and explores this with a view to examining the extent to which consumerism has stimulated challenges to

current medical dominance. Given that a thorough analysis of the issues surrounding medicalisation and governance of medicine in the current NHI context has been conducted in the previous chapter, the discussion in this chapter will be brief. That is, this chapter centres on the increased emphasis on consumerism in the NHI from both the civil society and the state, and views it as an indicator of critical responses to the growing medicalisation of Taiwanese society.

As regards the arrangement of arguments, a broad field for the study of consumerism is identified by the chapter, involving relations between the formal consumer movement, the litigation system, the medical profession and the NHI administration. In terms of this, this chapter elaborates three areas of discussion. Firstly, it addresses the recent development of medical malpractice settlement procedures with a view to exploring the implications for health consumerism, in terms of an investigation of the extent to which consumerism has impacted significantly on the medical profession. Secondly, it charts how patients' self-help movements have emerged in recent years as a result of dissatisfaction with the unequal distribution of health-care resources, which is illustrated through the analysis of specific concrete examples. Thirdly, it reviews the NHI reforms in relation to the growing emphasis of consumerism within the BNHI, in an attempt to make clear the realities behind the political rhetoric issuing from the government. At the end of this chapter, I conclude by pinpointing the gap between the objectives of the civil society and the state regarding developing consumerism in the NHI, as well as by indicating the policy implications for fostering social equity.

7.2 The Litigation System vs. the Medical Profession

To begin with, it is essential to give a brief introduction to the development of consumerism in Taiwan. Simply stated, consumer rights were ignored by the government as well as the general public in the past, due to the influence of authoritarian governance, which discouraged the development of the consciousness of civil rights. Consumer rights gradually became a public issue with the creation of the Consumers' Foundation in 1980. The Foundation is a non-profit-making private organisation, originated by the Taipei Junior Chamber, as an active urban middle-class organisation consisting of business people, technical professionals and academics. It was founded one year after two major disputes regarding food poisoning caused by poor quality rice-bran oil and fake alcohol respectively. These two events gave rise to the suffering of a great number of victims, the majority of whom were especially economically disadvantaged. These victims suffered not only physically but also financially, since the manufacturers escaped their legal responsibilities (CFCT, 2001). At a time when it was difficult for social mobilisation to take place under the martial regime, the Foundation was set up with the operational principle to perform only non-political activities (Zhang M-G, 1989: 49). Thereafter this organisation played a decisive role in leading Taiwan's consumer movement. As a consequence of this organisation's endeavours, together with the change in the political system, referring to the decay of authoritarianism that facilitated the growth of social movements, the Consumer Protection Law was promulgated and came into effect on January 11th 1994, and afterwards a Consumer Protection Board was established by the Executive Yuan on July 1st in the same year.

One of the most notable achievements of the Consumer Protection Law is the no-fault consumer compensation claim, which sets a new statutory right for the injured

consumers or an injured third party to claim compensation from the entrepreneur who has produced the relevant commodity or provided the service, without finding fault in the entrepreneur (Article 7). Compared with the previous system, which required proof of negligence on the part of the commodity-producing manufacturer (so-called negligence liability), under the new law the consumer only has to show damage or loss has occurred (so-called strict liability). There were fiery debates about whether medical services should be included in the so-called 'services' stipulated in this Law, particularly after a special case¹ involving medical malpractice was first resolved under the Consumer Protection Law by the District Court in 1997 and was further approved by the High Court in 1999. This case established a milestone in the civil system by extending strict liability to medical services. It therefore caused opposition from the professionals.

Admittedly, this legal step was effected mainly because of the litigation system rather than consumer movement (quoted from Ms. Y8, Interview Notes, No.2-08, 2000), in that the courts played the most crucial role in this case by extending the scope of Consumer Protection Law to medical services. Besides, there were a few lawyers who had been pressing for the same change for a long time (*ibid.*). Compared with the strong performance of the litigation system, the consumer groups have been largely ineffective as a result of shortage of resources and lack of support from the government. After the case, the Consumer Foundation could only hold a few

¹ This case occurred in Ma-Jie Hospital, which was a district hospital and was famous for its gynaecology and obstetrics. The accident happened to a multigravida, who had had a smooth natural delivery previously and had a potential possibility of having diabetes due to being over-heavy. Notwithstanding the woman's inquiry about the necessity to have a caesarean section, the accused physician determined to adopt a natural delivery, on the basis that the ante-natal checks two weeks before giving birth showed that the foetus was normal-sized (3,500 grams). However, the scan result was far from the truth – the baby weighed 4,198 grams at birth. Owing to his large size, the baby experienced a shoulder-dystocia, so that the doctor conducted a MacRoberts Maneuver. Then, the baby was born but had a permanently disabled right arm (Quoted from Yang H-I, 2000: 245-6).

discussions with judges after the introduction of the Law and organise a forum for the China Times newspaper, in which doctors debated the 1997 verdict (*ibid.*). Through these activities, the Foundation tried to convey the concept of consumer rights to the public.

In comparison with the largely ineffective consumer movement, the medical-care providers showed a forceful attitude towards the litigation system. In response to the verdicts passed by the courts, they set out to change the law. They lobbied legislators as well as the DoH officers to amend the existing legal system. A comprehensive set of strategies were adopted, which involved three legislative actions: they drafted Article 7, Amendment of the Consumer Protection Law, which stipulates that medical service is excluded from the Law; they raised a Medical Malpractice Settlement and Compensation Bill, which stipulates that a medical dispute should be put into negotiation procedure before it is brought to a lawsuit and proposes a compensation fund for no-fault medical injury; finally they submitted the Medical Care Law Amendment, which sets out the principle of negligence-based liability for medical injury (Yang H-I, 2000: 254). The first two amendments were proposed by Shen Fu-Xiong, a legislator and ex-doctor; the last one was drafted by the DoH. Faced with these developments, Ms. Y8, the Secretary General of the Consumers' Foundation, proclaimed that '*the medical profession has arranged the legislation to accommodate the new situation*' (Interview Notes, No.2-08, 2000). She also noted that the legislative actions of the DoH

'were mainly from the doctors' groups. But the DoH supported doctors (to do those things), because the majority of the DoH officers have a background of medicine. So, consumers could have only little voice!'

(Interview Notes, No.2-08, 2000)

Commentators suggest that doctors will be more aware of their obligation of disclosure in their daily practices as a result of the 1997 and 1999 verdicts (Yang, *ibid.*; Interview Notes, No.2-01, 2000). The performance of the courts has been welcomed because they have demonstrated formal opposition to the paternalistic medical professionals. Some observers claim that the doctor-patient relationship in Taiwan has always been paternalistic (Yang H-I, *ibid.*; Qiu Q-H, 1999): that is, doctors not only control medical history information without sharing it with patients but also dominate decision-making regarding treatment. Yang (*ibid.*) portrays this relationship as 'doctor commands and patient obeys'. This medical culture has made it almost impossible to expect doctors to accept the obligation of disclosure in their daily practices, which is necessary if the widely unequal power relationship between doctor and patient, the status quo, is to be improved. In other words, patient autonomy will be empowered in the future, and meanwhile the medical profession will be faced with new pressures, if the achievements of the courts can be widely applied to medical practices.

7.3 Medical Malpractice Settlement and Medical Dominance

Although the courts have extended the coverage of consumer protection to medical service through applying strict liability to doctors in a specific medical malpractice case, the medical malpractice resolution system is still beset with problems. These are typified by the lawsuit system, which is ineffective in finding solutions. Overall, there are two major problems that have been observed.

Firstly, the medical malpractice review system, whose function is to identify the degree of medical negligence when a medical injury occurs, has been criticised as

doctor-directed and extremely unfavourable toward patients. Lacking medical knowledge, the judges normally submit their medical injury cases to another medical review process before giving a verdict. Such a medical review process is performed by the experts of the Medical Review Board of the Department of Health. This Board is composed of 14 to 24 commissioners, the majority of whom are doctors. The review procedure includes two phases. A Preliminary Peer Review is conducted in the first phase, in which the Board is likely to send the case to a teaching hospital outside the institution where the accused physician is working. In the second phase, the Board conducts a Secondary Peer Review of its own based on the report of the first review. In theory, the Board is supposed to provide a neutral and solely *medical* judgement about the appropriateness of the treatment given by the accused physician. In other words, it should establish whether the treatment given to the patient fell short of the standard of care accepted at that time. In reality, however, the Board uses legal considerations when deciding the defendant's negligence liability, which should be left to the courts. Commentators have questioned the objectivity of the Board, since 'doctors are inclined to protect other doctors' (Qiu Q-H, *ibid.*; Yang, *ibid.*). This probably explains why doctors in charge of the Preliminary Peer Review tend either not to find the accused doctor negligent or find him guilty of a less serious charge (Yang, 1997; 2000).

Secondly, there is a cultural factor at work in Taiwanese medical malpractice settlements. It has been observed that in Taiwanese medical malpractice lawsuits patients are apt to file criminal accusations before filing civil accusations (Yang, *ibid.*, from which the following discussion borrows heavily). This phenomenon arises for three reasons. Firstly, Taiwanese people commonly think that the intimidatory nature

of the criminal court will bring greater pressure on the negligent physician and might help to gain higher compensation. Secondly, it is thought that a criminal accusation has a stronger deterrent effect because the punishment, e.g. imprisonment, is more severe. Thirdly, the application of general laws of evidence to civil medical malpractice suits has given rise to the burden of proof being the responsibility of patients.

Given their extremely weak position in medical treatment owing to a lack of medical knowledge and the fact that documents related to treatment are in the hands of doctors and institutions, patients obviously have great difficulty in collecting sufficient evidence to support their claims. One typical example is the patient record (medical record), to which 'patients by no means have easy access' (Yang, 1997: 60). According to the Medical Care Law of 1986, patients have a statutory right to ask for a copy of their medical record summary when discharged from hospital (Article 52). In reality, it is difficult to get a truly comprehensive summary from the accused hospital, especially since the hospital itself may not want to incriminate themselves. It is for these reasons that patients turn to seek proper redress from the court by filing a criminal lawsuit, which can require full patient records as part of statutory evidence procedure.

It is clear that the courts tend to accept the result of the Medical Review Board. According to Yang's research (*ibid.*, p.v), the courts tend to 'resist delivering guilty verdicts against physicians'. Yang (*ibid.*, p.161) suggests that there is a cultural viewpoint existing among the Taiwanese judges, who think 'medicine is so complex that a person who has earned the title 'doctor' should not be quickly condemned by hindsight'. Although the current legal system provides a mechanism for giving

criminal punishment to negligent physicians, the courts in practice react in the opposite way. Even worse, 'de-criminalisation of medical malpractice' has become a widespread 'ethic' in the medical community, in that legislative strategies have been employed to de-structure the existing legal system, which already provides only limited protection for patients. Also, on the administrative side, the DoH generally supports the medical profession. Consequently, we can see that patients are at a great disadvantage in this medical malpractice resolution system. Overall, it seems that in the near future at least, patient autonomy will not improve to any notable degree.

7.4 Consumer Groups: Fighting Back against Disadvantageous Situations

At the risk of over-simplification, we may suggest that Taiwanese consumer groups which involve themselves with the issue of medicine/medical care can be separated into two groups: patient groups and non-patient groups. Patient groups make up the majority, but only a few of them have made any strides in obtaining public policy reform. The non-patient groups, in contrast, have acted more ambitiously in pursuing the improvement of the health care system.

7.41 Patient groups

A patient group's function is to provide mutual support and a means of exchanging information and experiences for those suffering from the same illness. Most Taiwanese patient groups run in the following way. These groups are normally organised by patients or their family members, but sometimes the organisers are professionals in related fields, such as social workers, nurses and doctors who have been involved in treatment. Groups are either associations or foundations. The form of

organisation reflects the financial situation of the patient group, and the financial status will further decide the scope of activity by the group. Associations, as the most common type, have very little funding. In contrast, foundations have more stable finances and consequently have a greater opportunity to fight for public policy reforms. One notable case is the Taiwan Foundation for Rare Disorders (TFRD), which is generally considered as successful in comparison with the majority of patient groups, which are short of either capable workers or 'good fortune'.

The TFRD was initially organised by a few patients' family members, most of whom were parents whose children had rare diseases. These people originally struggled on their own to seek out sources of rare medicines and special food, which are usually very expensive and have to be imported (TFRD, 1999b). Learning from real experiences, they gained an insight into their major difficulty - i.e. that as an extremely vulnerable patient group, their voice would hardly be heard, and consequently their interests would not become a priority for the government (Chen L-Y, Interview Notes, No.2-04, 2000). Therefore, they decided to form a foundation pressure group. So far, it would seem that this Foundation has a well-structured operational plan, including short-term micro goals, e.g. finding patients with rare disorder diseases and helping them and their families to obtain medicine and financial funding, as well as longer-term macro goals, e.g. forming alliances with similar patient groups to improve the medical system (TFRD, *ibid.*).

This particular Foundation has impressed Taiwan society through its successful legislative strategy. Firstly, they invited a few academics, lawyers and medical professionals to draft a 'Prevention and Treatment of Rare Disorder Diseases and Medicine Bill'; then, they managed to win over the support of certain Legislators to

sign this Bill and submit it into the Legislative Yuan. The TFRD was successful, where other interest groups, which had adopted similar legislative strategies, were not. There was support for this Bill largely because its help for the very disadvantaged and its promotion of a justified allocation of medical resources gave Legislators political credibility. Unlike other social service policies, requiring long controversial debates about budget rationing, this Bill did not cause many arguments, because it was related to only a very small group of people. It did not take long before the Bill was approved in the Legislative Yuan and then implemented (promulgated on February 9th 2000; enforced in August 2000).

Apart from the legislative approach, the TFRD has employed effective methods to persuade government administrators to loosen the regulation policy on rare disorder diseases. For example, they asked the DoH to allow the import of a number of special medicines. They also requested that they should be granted exemption from co-payment under the NHI scheme. Analysts approve of the TFRD's effective performance in the patient rights movement. According to Wu Jia-Ling (2000), key factors leading to TFRD success were familiarity with the governmental bureaucratic system based on previous experiences, and active support from experts in various relevant fields. One parent member in the TFRD is a scholar of social welfare who has contributed very much to theoretical studies and has associations with the academic community.

However, most Taiwanese patient groups and other social movement groups are relatively unsuccessful within the patient rights movement. They are short of both funding and staff, and have little voice in the politics-driven governmental systems. The Promoting Patient Rights Association (PPRA) is one such a group. It is composed

of the victims of medical malpractice and their family members. In common with the TFRD, this Association offers help for victims of medical injury on an individual basis. However, there is a big difference between these two organisations. The PPRA fights the medical system and the litigation system, both of which are fairly unfavourable towards medical malpractice claims. The PPRA is trying to improve the resolution systems of medical malpractice disputes through short-term and long-term strategies. As the Association has stated (PPRA, 2000), their short-term goal is to bring the medical malpractice review system operated by the Medical Review Board of the Department of Health into the public domain. The long-term goals include actions to promote the legislation of a Patient Rights Act, requiring a compulsory medical liability insurance system.

The PPRA impressed the general public by creating a 'Doctors' X File' - a list of negligent doctors and their medical malpractice cases - and publishing it on its website in July 1999. But almost immediately the PPRA's website was forced to close down by the authority, since this action caused doctors great anger and anxiety. Thereafter, the PPRA disappeared from the public eye, except for one occasion, when it promulgated a Taiwanese Patient Rights Index Report in December 2000 (China Times, 2000), which was an evaluation of the overall situation of the Taiwanese medical care system.

7.42 Non-patient groups

Let us now move on to the non-patient consumer groups that participate in patient rights movement. The Consumer Foundation mentioned in the earlier section is a good example. The recently established Taiwan Health Reform Foundation (THRF),

whose spadework started back in May 2000 and which was formally founded in October 2001, is a specific pressure group that makes great efforts to promote better quality medical care based on medical care system reform. In parallel with the well-known TFRD, the THRF has received strong support from academics. In fact, the organiser, Dr. Zhang Li-Yuen, and most key staff are academics. This Foundation, therefore, has been able to produce a well-structured organisational agenda with some striking success: for example, conducting public opinion polls of Taiwan's medical quality, holding meetings regarding medical system reforms with other non-profit making organisations, actively responding to new health policy and specific matters in relation to medical system improvement.

In general, the THRF has a comprehensive perspective in evaluating the overall medical system, which it considers to be in a worsening situation. In terms of this, 'the NHI is nearly bankrupt; medical institutions have become more and more profit-directed and anti-trust; working conditions are changing adversely for medical personnel; medical treatment is of poor quality; patient rights have been neglected as more medical malpractice disputes happen; and doctor-patient relationships are becoming hostile' (THRF, 2001). The THRF has also showed its distinction by proclaiming the importance of offering better practising circumstances for doctors through medical system reforms. This is very different from popular criticism, which blames doctors for violating their obligation of looking after patients.

In a capitalist society like Taiwan, it seems to be unavoidable that medicine becomes a profit-making commercial industry. This development is based on the so-called 'logic of capitalism'. Patients, therefore, in all ways are at a disadvantage within the doctor-patient relationship. In total, faced with worsening medical

circumstances, the general public have a widespread dissatisfaction associated with worry. Patients, however, have responded with little action. They have a general fear of telling doctors about this anger, since the latter dominate their treatment, which means their health and even their lives. For those patients and patients' families who felt the need to organise a patient group, they have been at an even worse disadvantage, because they are either suffering from their sickness or bearing the tiring burden of care. This is the predestined inferior condition for patient rights movements as posited by Wu Jia-Ling (2000: 401-2).

In view of the lack of proper channels through which to express their discontent about doctors and hospitals, patients turn to the state for help. They request the state to regulate the unrestrained medical profession. Also, they require a better distribution of public resources among different social groups. For instance, patients with rare disorder diseases used to pay the costs on their own for their medicines and special formulae, which were normally very expensive and not covered by the NHI benefit list. Therefore, the TFRD's endeavours have significantly improved their financial situation through the implementation of new NHI policies. All of these patients are now entitled to apply for an NHI Catastrophic Illness/Injury Certificate, which grants exemption from medical co-payment. Also, those patients with the specific rare disorder diseases are granted payment of medicine. In this sense, the state can be considered as an able body with the potential power to break the capitalist structure of medical commoditisation (Wu, *ibid.*, p.397); thus, the state becomes a hope for Taiwan's patient rights movement.

7.5 Consumerism in the NHI

As noted in the previous chapter, the NHI represents a shift from an insurance to a citizenship model. However, a further transformation into a consumerist model has been observed, stressing seeming market values. This section is concerned with investigating such a shift with relevance to its implications for health policy, accounting for three dimensions: NHI privatisation, the emphasis on public satisfaction with the NHI, and gaining an insight into the growing use of consumerist terminology.

7.51 Privatisation: consumer choice or social exclusion?

It has been noted that the government also adopted the rhetoric of consumerism to promote privatisation reforms within the NHI, as a consequence of the increased emphasis of consumerism in health care. Related to this was the NHI Act Amendment of 1999, which stipulated a proposal of reorganising the NHI towards a system of multi-carriers (namely, multiple insurers), under which people would be able to perform 'consumer choice' of NHI carriers/insurers. The BNHI would be transformed into an NHI Foundation, which would need to compete with the other private carriers for insurance business. The underlying logic was that competition would promote much-needed efficiency in the BNHI, generally considered an ineffective government bureaucracy².

² This proposal was highly promoted under the ex-Health Minister, Zhan Qi-Xian, who introduced deregulation in the medical delivery system. Owing to strong opposition from the public as well as within the government, this proposal still has not been carried out. In fact, a new proposal entitled 'the Second-Generation of NHI' has been initiated and gradually developed since May 2001, under which the current NHI structure, in terms of including only one government agency, will be remain (DoH, 2003b).

It has been observed that the government policy proposals of NHI reform toward privatisation has spread worry amongst consumer groups. They commonly think competition, consumer choice and other market forces will weaken the role of the state, which is thought to be the more reliable body in comparison with profit-making private companies. Two specific examples will be used to elaborate these observations.

The first example is the above-mentioned TFRD. The key staff were forced to accelerate their preparation work for establishing a foundation when they heard the NHI proposals for privatisation reform in the early months of 1998. As Ms. Y4, the key originator of the TFRD and the mother of a patient with hyperammonemia, said:

"On February 12th 1998, the NHI Amendment Bill drafted by the Executive Yuan, which included privatisation reform, was approved and submitted to the Legislative Yuan. I was shocked when I heard this news. In privatisation, we will have no hope!"

(Interview Notes, No.2-04, 2000)

In the eyes of Chen Li-Yin and her group of people, who suffer from rare disorder diseases, they simply equate health care privatisation with profitisation or commodification, with distrust of the capitalist system. Being a small minority among all kinds of patients, they describe themselves as 'orphans' in the current medical care system (TFRD, 1999b). Also, their medicines are called 'orphan drugs', because few manufacturers have shown interest in producing these drugs. An obvious reason is that these drugs are not 'commodities', because they cannot bring profits for the manufacturers. As Wu Jia-Ling (*ibid.*) indicates, the determinant of producing medical products is profit rather than medical need in any capitalist society like Taiwan.

Politics further seals the fate of this group of people. Ms. Y₄ learnt a cruel lesson after her requirement regarding the import of orphan drugs paid by the current medical care system was rejected by some high-ranking DoH officer, who told her: *'this is related to political priorities – we are controlled by political pressure'* (Interview Notes, No.2-04, 2000). Ms. Chen, therefore, woke up to the political reality and decided to form a pressure group, i.e. the TFRD. Furthermore, there was a fear that people in the TFRD would suffer from insurance system inequalities, apart from the existing obstacles from the medical system, if privatisation was enacted. (*ibid.*; Wu J-L, 1999: 10). The reason was that private insurance companies would be very likely to set stricter conditions for joining, and patients like those in the TFRD would be excluded from privatised health care schemes.

In order to promote the NHI privatisation proposals, the government endeavoured to promote the concepts and advantages of market forces, such as increasing consumer choice, enhancing public participation, and improving administrative efficiency (Yang H-Q, 1998). Lin Kuo-Ming (2000b) accuses the government of advocating the 'political logic of privatisation', by which he means that the origin of the government's privatisation proposal is 'to de-politicise the decision-making process of the national health insurance in order to achieve fiscal balance'. Furthermore, he argues that the privatisation reform will not help to solve the political problems, which are rooted in a lack of political capacity to deal with cost control, but will bring new problems: in particular, it will undermine social solidarity.

In terms of social solidarity, it should be noted to what extent a new public policy will enhance or undermine the existing social divisions. In theory, a welfare policy should not deepen divisions among different social groups, and especially

should not load more disadvantages on vulnerable groups. Based on this consideration, it is important to note the possible policy effects of NHI privatisation reform. The Alliance to Rescue the National Health Insurance (ARNHI), as the second example in this section, has endeavoured to oppose NHI privatisation. They consider consumer choice to be merely political rhetoric, which will by no means increase patient empowerment. Rather, it will limit patient's options of choice for medical services (ARNHI, 1998). At present patients have great freedom in choosing NHI contracted institutions. In contrast, under the proposed new system, in which multiple private carriers undertake health-care services by contracting out to other health-care institutions, a patient will be allowed to go to only his/her carrier's contracted institutions.

In parallel with the TFRD, the ARNHI has shown their concern about a weakened state role in a privatised NHI system. The same concern is expressed regarding vulnerable citizens such as the elderly or people with serious illnesses. As stated already, it is very likely that these people will be excluded from the new system, since private carriers will take over the power of choosing 'consumers' under limited government supervision. Consumer choice, therefore, would become carrier choice. On the other hand, it is very probable that a new social division based on health status will form under the privately-managed NHI system.

To sum up, the NHI proposed privatisation reforms have caused concern among consumer groups who have presented their cases from two angles. Firstly, in general people do not have much faith in a medical market, because they basically believe that in such a market the weak fall victim to the strong – the law of the jungle. They think that the government should be responsible for protecting vulnerable members of

society. This expectation appears to have a close link to the tradition of the paternalistic state. In other words, since the Japanese colonial government, Taiwanese people seem to have become used to the nature of state-run public services. On the one hand, public policy operates through a top-down approach outside public scrutiny. On the other hand, fierce competition between different political parties and among individual Legislators has contributed to shape the attitude of the consumer groups. It is a widespread thought among consumer groups that it is much easier to bargain with the government in comparison with private companies. The reason is that all governments care about their political credibility.

The second dimension refers to the way in which the government and consumer groups view consumer choice. Generally speaking, the concept of the consumer is used in private commodities markets, in which consumer choice is a matter of doctrine. In contrast, provision of public services is considered as part of government responsibility and is normally delivered by a bureaucratic system, in which the consumer is an alien concept. Although complaints concerning public services are common, the public can achieve very little. In a way consumer choice or user choice for public services is related to the extent of democratic participation, of which the public has little experience since Taiwan's history of democratisation is still short. Therefore, it is possible that the government has taken advantage of this, by using the rhetoric of consumerism in promoting NHI reform. More analyses of this will follow in the next section.

7.52 Public satisfaction with the NHI

It has been observed above that the BNHI has endeavoured to shape a new image of itself as a creative and innovative governmental agency in charge of the largest scale

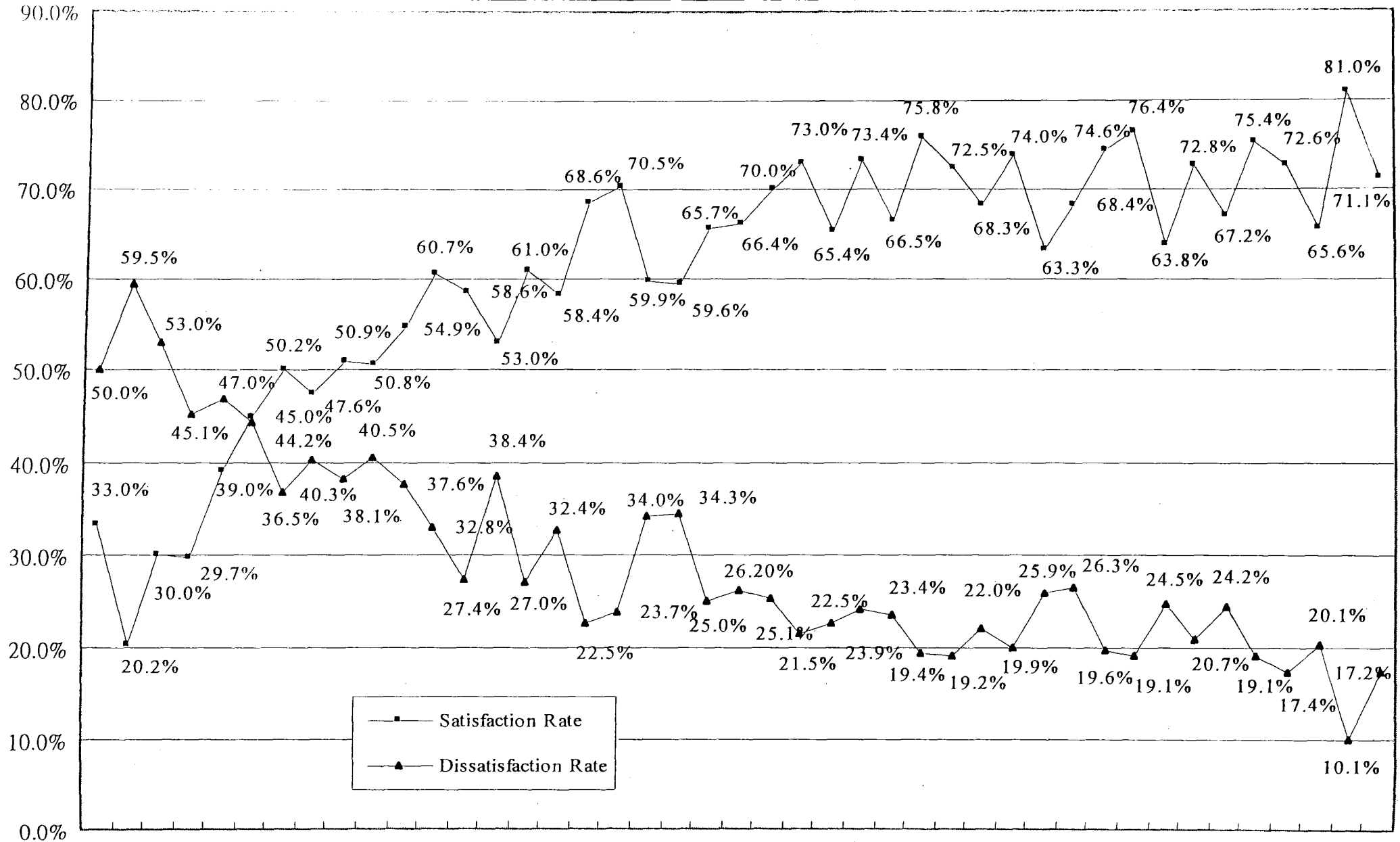
public service in Taiwan. As the BNHI declared, *'positive adjustments will also be made ...with an emphasis on building a new era in health insurance on the cornerstone of service'* (BNHI, 1998a). In part, the BNHI has laid ever more stress on administrative efficiency by carrying out a variety of administrative reforms, many of them borrowed from the private sector, for example re-engineering the NHI (Lee C-H, 1996; Wang M., 1999: 8) and executing TQM (total quality management), typified by quality control circles and ISO (International Organisation for Standardisation) 9002 assessments (Wang M., *ibid.*; BNHI, 1999b: 192-3 & 2000d: 106 & 2002a: 24). In addition, the BNHI has introduced consumerist terminology. For example, there seems to have a tendency to use 'consumer' to replace of 'citizen' or 'the public' (Xu L-D, 1995; BNHI, 1997b & 1998a; Chang H-J, 2001), both of which are often used in public services.

As a result of its emphasis on consumerism, the BNHI has been inclined to show concern for public satisfaction. One strategy often adopted was to publicise the result of public opinion polls, which were from a variety of sources including NHI commissioned agents, other governmental agencies, and private institutions. In the NHI launching period, there were a number of NHI public polls conducted by the BNHI commissioning bodies and other private agencies, because the NHI was a new scheme which was inaugurated at a time of great dissatisfaction among the general public and medical-care institutions. Then, a public opinion poll was conducted from time to time when the public and institutions became familiar with the new system.

Overall, the NHI public polls have shown a general rising trend of public satisfaction with the NHI services since the introduction of the scheme on March 1st 1995. According to the BNHI's published data (BNHI, 2002d) (Figure 7-1 & Table 7-

1), the public satisfaction rate with the NHI service was only 33.0% when the first public poll was conducted in April 1995 (20.2% according to one poll). Then, it started to rise, reaching 58.6% in March 1996 (one year after the introduction of NHI), and peaking at 70.5% in February 1997. It then dropped to 59.9% in March 1997 (two years after the introduction of NHI), and even to 59.6% in April in the same year. Afterwards, it fluctuated between 60% and 81%. Significantly, it reached a peak of 75.8% in May 1998, 76.4% in February 2000, and 81.0% in October 2001 separately. It dropped to 71.1% in December 2001.

Figure 7-1 Public Satisfaction with the NHI
(Apr 1995 -- Dec 2001)



Source: BNHI (2002d), *Public Satisfaction with the NHI*

Table 7-1 Public Satisfaction and Dissatisfaction Rates with the NHI

Unit: %

Survey Time	20/04/95	24/04/95	28/04/95	25/05/95	29/05/95	12/09/95
Publicity Agent	United Evening News	China Times	United Times	Public Health Association	BNHI	Central Policy Committee
Satisfaction Rate	33.0%	20.2%	30.0%	29.7%	39.0%	45.0%
Dissatisfaction Rate	50.0%	59.5%	53.0%	45.1%	47.0%	44.2%
27/09/95	06/10/95	25/10/95	16/01/96	18/01/96	06/02/96	04/03/96
BNHI	Taiwan Province Gov't	DoH	Independent Evening News	RDEC*	DoH	RDEC
50.2%	47.6%	50.9%	50.8%	54.9%	60.7%	58.6%
36.5%	40.3%	38.1%	40.5%	37.6%	32.8%	27.4%
19/05/96	10/06/96	10/08/96	02/12/96	15/02/97	02/03/97	10/04/97
DoH	BNHI	DoH	DoH	DoH	RDEC	RDEC
53.0%	61.0%	58.4%	68.6%	70.5%	59.9%	59.6%
38.4%	27.0%	32.4%	22.5%	23.7%	34.0%	34.3%
16/05/97	23/06/97	08/08/97	18/11/97	07/01/98	05/02/98	28/04/98
DoH	Election Research	DoH	DoH	BNHI	DoH	BNHI
65.7%	66.4%	70.0%	73.0%	65.4%	73.4%	66.5%
25.0%	26.20%	25.1%	21.5%	22.5%	23.9%	23.4%
07/05/98	26/08/98	14/11/98	08/02/99	31/05/99	13/09/99	18/10/99
DoH	DoH	BNHI	DoH	BNHI	BNHI	BNHI
75.8%	72.5%	68.3%	74.0%	63.3%	68.4%	74.6%
19.4%	19.2%	22.0%	19.9%	25.9%	26.3%	19.6%
09/02/00	27/03/00	29/09/00	26/10/00	07/12/00	20/04/01	19/06/01
DoH	BNHI	DoH	BNHI	DoH	DoH	BNHI
76.4%	63.8%	72.8%	67.2%	75.4%	72.6%	65.6%
19.1%	24.5%	20.7%	24.2%	19.1%	17.4%	20.1%
19/10/01	27/12/01					
DoH	BNHI					
81.0%	71.1%					
10.1%	17.2%					

*RDEC: the Research Development and Evaluation Commission, the Executive Yuan

By means of continually publicising the results of public polls referring to satisfaction and dissatisfaction rates with the NHI services, the BNHI seems to have cultivated the image of an innovative and reformative governmental agency which esteems public opinion highly. Typical sayings often publicised by the BNHI are like: *'Predicated on the best interests of the general public, the BNHI's service measures have continued to earn the approval of Taiwan's citizens.'* (BNHI, 1998a: 64); *'That the satisfaction rate with the NHI saw a gradual increase from 33% in the NHI launching period to 71.1% in 2001 signifies the general public's approval of the BNHI's endeavours over the past six years. Given this, the BNHI will continue the same attitude and efforts in pursuit of providing better services for the public and the medical community.'* (BNHI, 2003a). There are two points worth noting in this regard. First, the consistency of the survey results is in doubt because they were conducted by a number of different research bodies instead of the same one, in that it is problematic whether the questions and definitions were uniform between all of these surveys. Second, to express public satisfaction with the NHI by means of satisfaction and dissatisfaction rates is an over-simplified dichotomy. In terms of this, patient views and experiences about the NHI care are simplified and limited to either satisfied or dissatisfied, so that the extent to which the individual's need for care has been met is difficult to know, and neither the divergences between different geographical areas and social groups have been taken into account.

We suggest that seeing the growth of satisfaction rates as public demonstration of support for the NHI misses the point that a prime aim of the emphasis on consumer-oriented service is to serve the needs of the consumers, i.e. the need for easy access to health services as well as for better quality of care, which by no means

can be easily quantified in the name of 'satisfaction rates' and 'dissatisfaction rates'. Moreover, 'public satisfaction with the NHI' is an ambiguous term, in that it mixes up two things: the experience of health care consumption in the medical marketplace and the experience with the administration of the BNHI as a government agency.

7.53 The myth: what remains beyond terminology?

Faced with the shift of terminology from citizens/the public to consumers/service users in NHI reforms, there is, at least, one question worth asking – to what extent has the NHI lost its citizenship character? In a way, 'consumerism' has an underlying meaning with regard to individualism, in that a service user is a consumer rather than a client (Gabe & Calnan, 2000). Extending this to NHI consumers, they are individuals who shop for health services on their own in the medical marketplace. A consumer would seem not have the statutory right to request state assistance in dealing with his/her trouble with the medical profession or the medical system in the marketplace, as long as he/she is guaranteed the freedom in choosing NHI contracted institutions. Instead, a patient as a consumer of the medical care system is expected to look for help from the lawsuit system, in terms of filing an accusation against the medical provider who provided problematic services. In comparison, citizens are a collection of individuals who have vested interests; they can voice their demands for proper health care. Within citizenship rights, the state cannot escape its responsibility for looking after the people's demands for health care. In this sense, citizenship rights make individuals become clients, in that the public should be offered better protection of their rights to access health services. For those who are at a disadvantage in the medical marketplace, the state is obliged to help. If the state does not perform such a

duty, an individual, as a client, may raise a request or a claim for compensation through the litigation process.

Given this, we think that the growing use of consumerist terminology within NHI reform is not so much a factor of improving consumer rights as such, which should be based on patient-centred medicine, but rather an attempt to transfer public attention to the NHI from the government's inability to deal with the NHI cost control. Equally relevant is that the state seems to have been feeble in waging battle with the medical profession concerning the growing medicalisation that has weakened patient autonomy but enhanced medical dominance. It is in this regard that consumerism functions more as a political tool to reduce the tension between the state and the civil society, and pursues a trade-off between cost containment and public demand for greater social equity in medical provision.

7.6 Conclusion

In terms of the NHI, there has been a shift going on both towards a more 'social citizenship' model and a consumerist one, in contradictory ways. Referring to the former, 'the provision of citizenship tends to require the expansion of regulation, control and surveillance from the state', as Turner (1995: 217) indicates, and as we have argued in the previous chapter is the situation in Taiwan. Concerning the latter, I have examined in this chapter a broad field of consumerism in health care within the contemporary context of the NHI system, involving relations between the formal consumer movement, the litigation system, the medical profession and the NHI administration.

To sum up, firstly, a significant achievement of consumerism in health care has

been effected by the courts in a specific medical malpractice case through extending the coverage of consumer protection to medical service, referring to the application of strict liability to doctors. However, it seems difficult to apply this achievement widely to medical practices, as the DoH supported the legislative demands of the medical profession, related to setting out a limited liability for medical injury. Except for this case, the medical malpractice resolution system otherwise is ineffective in finding solutions to doctors' dominance over the medical encounter, because doctors, as professionals, are generally held in high esteem by the Taiwanese courts.

The second part was concerned with the recent patients' self-help movements, which have revealed an important theme: the state is a focus of hope for Taiwan's patient rights movements, in the way it is considered as an able body with the power and ability to regulate the unrestrained medical profession and furthermore break the capitalist structure of medical commoditisation. Ironically, our study finds that this expectation will be difficult to fulfil, because on the one hand the DoH generally supports the medical profession, and on the other the BNHI is often preoccupied by the NHI financial crisis and the political intervention from Parliament.

Finally, the growing emphasis of consumerism within the BNHI has more the significance of administrative reform than any implications for improving patient rights, on the basis that the bureaucracies are not tackling the problem of medicalisation due to doctors' dominance, but rather are compounding patients' experience of health care consumption with their experience with the administration of the BNHI. In view of the BNHI's role as regulator and overseer in the NHI marketplace, we suggest that consumerism functions more as a political tool to reduce the tension between the state and the citizens, who ask for greater social equity in

medical provision. Added to this, the BNHI seems to be concealing the problem of deteriorating NHI finances from the public by emphasising its concern for public satisfaction. In terms of this, although consumerism has impacted the state machine to some degree, the tradition of the authoritarian state has not changed too much *per se*.

In summary, we can say that the increased emphasis on consumerism in the NHI from the civil society and the state is indicative of critical responses to the growing medicalisation of Taiwanese society. However, the objectives of the two parties differ significantly. For the civil society, a more powerful state is expected in order to regulate the medical profession. For the state, cost containment is the main objective of reform, with little effort to improve the worsening position of patients at the medical interface. In particular, the state has adopted consumerist terminology within NHI reform in pursuit of fiscal balance, without showing much concern about the effects in weakening citizenship rights. It is important to highlight this gap. Also, it is essential to reflect on whether Taiwan can bear the social costs of the trade-off between cost containment and public demands for greater social equity.

CHAPTER EIGHT

HEALTH UNDER GLOBALISATION:

GLOBAL INFLUENCES AND LESSONS IN THE TAIWANESE CASE

8.1 Introduction

So far, we have analysed the development of the Taiwanese health care state with special reference to the construction of medical dominance and medicalisation within the domestic arena, covering both the micro and meso levels. This chapter extends arguments to the international domain, i.e. the macro level, and focuses on the ongoing debate about globalisation, referring to its influences on population health and state health care. Particular attention will be paid to the social consequences of globalisation, in an attempt to explore the extent to which the domestic political-economic system has been influenced by globalised forces in the case of Taiwan.

In terms of the analytical approach, the Taiwanese globalised economy is considered as an intermediate element which links economic growth with the improvement of population health. In this regard, we explore how a 'health miracle' was created alongside the 'economic miracle' in Taiwan at a considerable social cost, referring to health inequalities particularly. Through exploring the social-political dynamics within which the trajectory of Taiwan's health care system was shaped and developed, this chapter attempts to establish a linkage between the micro, meso, and macro levels of discussion, towards comprehending the interactions between levels that are important. At the same time, there is an attempt to argue for the necessity of the explanation of divergent trends, in contrast to the claims of the convergence thesis.

The main body of this chapter consists of four parts, i.e. Sections 2 to 5. In Section

2, we address the initial meaning of globalisation, referring to the growing openness of economies, and furthermore assess its relevance to the development of state welfare and health improvement internationally. Section 3 is concerned with the influences of globalisation on Taiwan's economy and health. Particular attention is paid to various health inequalities, as a result of Taiwan's successful development of a globalised economy. In response to the convergence thesis in the field of health care, it is argued in Section 4 that an explanation of divergent trends is needed, and the impacts of the Asian Financial Crisis of 1997 are explored as an example. The final part, Section 5, is an evaluation of Taiwan's struggle to be involved in the international health and economic community, in order to gain an insight into the underlying logic of global political and economic processes. In the conclusion, we end by indicating the global influences on Taiwan's health policy reforms as allowed for in Mohan's meso-level of analysis, which is briefly summarized and connects with previous chapters, the aim being to elucidate the actual practices of globalisation linked to health policy.

8.2 Globalisation and Global Health

8.21 Globalisation and the development of state welfare

Nowadays 'globalisation' has become a buzzword (Carpenter, 2000) with a protean face (Gough, 2001) across a variety of academic fields. Given this, at the outset it is necessary for me to indicate that the original meaning of globalisation was contextualised in the growing openness of economic activities. According to Gough (*ibid.*, p.164), focusing on the capitalist development in the past two centuries, globalisation in its primary context meant free trade, direct foreign investment, multinational production, and deregulation of financial markets. Put another way,

globalisation is a form of capital mobility between capitalist societies. It is because of this mobile particularity of capital, which includes threatening 'exit' as a means of disciplining modern states, that globalisation appears to have great structural power to influence individual nations' policy-making at the domestic level (Gough, *ibid.*; Gough and Farnsworth, 2000).

Outside the context of global economy, globalisation seems to have more political implications for the development of modern welfare state. In terms of this, functionalists sometimes argue that the modern welfare state 'was caused by globalisation and the insecurities it engendered in the context of the international gold standard' (Kapstein and Milanovic, 2001: 200). This refers to the strengthening function of social policy utilised by the state to maintain its political legitimacy and fulfil certain necessary tasks. Sociologists started to be concerned with the importance of comparative studies within both industrial and non-industrial countries after World War II and have laid particular stress on the similarity of social development through debates around the 'convergence thesis', which became popular in the 1970s and 1980s (Scase, 1989). From a functionalist approach, convergence theorists argue that industrialisation plays an urgent and necessary role in pushing modern societies to impose a number of common constraints offered by mass production technology and factory organisations; consequently all societies become more similar in their institutional forms of welfare provision and cultural features (Kerr *et al*, 1962; Scase, *ibid.*).

On the basis of this convergence approach, we may indicate that the development of health care systems within the industrialised countries in the post-war period has signified a process of convergence, for several reasons. Firstly, socialised health or

compulsory social insurance has become a popular type. Secondly, high medical dependency has become a norm in health care models. Thirdly, most health care systems are facing or have at some time experienced fiscal pressures caused by rising costs of health care, and accordingly cost containment and securing greater efficiency have often taken priority over all other issues on the governmental agenda of health care reforms. Finally, there is a shift of policy concerns from those concerned with access to medical care to those issues surrounding rationing. It is in this context that there has been observed a convergent development in the diffusion of health policy ideas towards promoting specific policy measures, such as cost containment, budgetary control and strengthened managerialism (Bjorkman & Altenstetter, 1997: 2; Moran & Wood, 1996: 129; Ham, 1998: 8-9).

On the other hand, the convergence thesis has been criticised for its tendency to overstate the dimension of homogeneity/common attributes due to its strong faith in technological determinism. Moreover, this thesis does not show much concern about the continuing differences in the degree and nature of welfare provision between societies (Mishra, 1981), nor about the various social-political factors such as ideology, culture and political processes, which will make sense only when they are embedded in the context of individual countries (Scase, *ibid.*; Glazer, 1988). In response, recent critics have devoted their attention to the national differences through comparative studies of state welfare arrangements. For example, Esping-Andersen (1990) argues for the importance of the correlation between welfare systems and national welfare regimes, namely social and political orders, located in wider political processes. However, it should be noted that this renowned 'regime theory' can be applied easily on to the western capitalist societies or to the so-called North. By comparison, Gough

(2001) extends Esping-Andersen's framework to cover the South, and highlights the role of domestic 'political settlements' in affecting or shaping the welfare regime of those societies. Ginsburg (1992) praises Esping-Andersen for his successful attempt to establish a model of class analysis for comparative social policy, but he points out that this analysis of 'race' and gender is inadequate. Instead, he suggests a comprehensive approach to the analysis of the national variations between different welfare states: that is, an emphasis on the role of domestic 'structured diversity', namely the uniqueness of political, cultural, social, and economic context, in shaping the structure of the welfare nation.

In addition, the 'world-system' theory, which highlights the significance of a global system of political economy, has provided an alternative approach to comparative studies of modern societies. Simply stated, the initiation of this theory dates back to the 1970s, when Immanuel Wallerstein published his well-known three volumes entitled *The Modern World-System* (1974). According to Wallerstein, contemporary countries can be separated into three types: core, semi-peripheral, and peripheral, deriving from the nature of economic exploitation associated with capitalism. Recently this school of analysts (Hopkins *et al*, 1996) has further developed Wallerstein's framework to a more complete and delicate model that contains concrete indicators to examine the evolving institutional domains of the post-World War II global system. This model postulates the 'six vectors of the world-system', which are interrelated: the interstate system, the structure of world production, the structure of the world labour force, the patterns of world human welfare, the social cohesion of states, and the structure of knowledge. Among the six vectors, 'the patterns of world human welfare' is considered more crucial, for it reflects the political stability and economic efficacy of the global system

(Hopkins & Wallerstein, 1996: 5). It is in this regard that Hopkins *et al* (Hopkins & Wallerstein, *ibid.*, pp.5-6; Pelizzon & Casparis, 1996: 117-147) point out a long-term welfare convergence which has been observed: an increasing human welfare in the welfare states (the core zone) in the post-war period, and a downward shift since 1967/73 owing to fiscal crises of governmental funding. They also argue that this shift has resulted in the increase of inequality worldwide (p.118), on which we will elaborate in more detail later when we go through the issues surrounding health inequalities.

8.22 Global health: Convergence and divergence

Based on the concern with the shift in global health, we suggest that two noteworthy convergent changes have been observed in the past few decades. First, population health has been continually improved worldwide until recently – we would have to say that there have been recent reverses in some post-communist societies, and in Africa due to AIDS – and consequently global health status has been generally improved, typified by lengthening life expectancy and decreasing infant mortality. Second, an ‘epidemiologic transition’ (Omran, 1971; Olshansky & Ault, 1986) has appeared in modern societies, in particular developed countries, characterised by the change in the type of disease threatening people’s lives most, from infectious and acute diseases to non-infectious and degenerative diseases.

As far as the first is concerned, researchers use different measures to present the progress in life expectancy. Concerning the developed countries, Wilkinson (1999a: 29) finds that ‘*two to three years are added to life expectancy at birth with each decade that passes*’. Referring to the developing world, Roemer’s research (1993: 320), focusing on the improvement of the 30-year period from 1950-1955 to 1980-1985, shows that life

expectancy at birth rose from 38.0 to 49.9 years in Africa, from 38.8 to 54.4 years in South Asia (largely drawn from data of India and Pakistan), and from 51.2 to 64.5 years in Latin America. The comparative study on the Asian Tigers by Siddiqi and Hertzman (2001) reveals that: there was 'a steady increase in life expectancy from the 1950s to the mid-1990s for Japan, Singapore, and Hong Kong, while Korea had a rapid increase beginning in the early 1960s'. In terms of a global picture, Carpenter (2000: 339), drawing from the 1999 UN Human Development Report, indicates that 'eighty-four countries enjoyed a life expectancy of over seventy (in 1997) compared to just fifty-five in 1990'.

Another important trend is the fact that the infant mortality rate has continued to decrease worldwide in the past few decades. According to Roemer (1993: 321), this rate in the 30-year period from 1950-1955 to 1980-1985 saw a decrease in Africa from 187 to 116 infant deaths per 1,000 live births, from 189 to 113 in South Asia (largely based on India and Pakistan), from 126 to 63 in Latin America, from 62 to 15 in Europe. In addition, focusing on the recent decade, Carpenter (*ibid.*) shows that infant mortality dropped from 76 to 58 infant deaths per 1000 live births between 1990-1997.

'Epidemiologic transition' or 'health transition', as the second convergent change, refers to the shift in disease patterns. That is, the primary cause of death saw a transition from infectious and acute diseases to non-infectious and degenerative diseases, such as cancer, cardiovascular disease and respiratory disease (Omran, *ibid.*; Olshansky & Ault, *ibid.*). In addition, accidents and psychiatric distress have become major diseases in modern societies. According to Marmot's research (1999), based on Murray & Lopez's framework (1996) for analysing the *WHO Global Burden of Disease*, chronic diseases will become more apparent causes of death than the others in all regions of the world by the year 2020. Facing this transition, commentators (such as Wilkinson) argue that this

transition has been primarily caused by changes in the social environment, in that medical science has, and will still have, little to do with finding solutions for ‘modern’ diseases. This explains why the worldwide development of health care has been directed more to cure under the support of the medical system, rather than to prevention, which is highly related with the improvement in the social environment, as posited by Pelizzon and Casparis (1996).

In terms of the determinants of population health, it has been observed that there is a marked correlation between health improvement and national economic growth, in terms of the increase in gross domestic product (GDP) (Siddiqi & Hertzman, *ibid.*, p.324). However, it should be noted that this correlation becomes weak when the GDP per capita exceeds a threshold, approximately U.S.\$11,000, according to *the 1993 World Development Report* (quoted from *ibid.*). In a similar regard, Wilkinson (1999a) accepts that there is a relationship between health improvement and economic growth in the context of raised living standards. He furthermore posits that this relationship does not exist when the living standard reaches a threshold level, from which epidemiological transition becomes a more important factor influencing population health. It is in this regard that he considers the correlation of health and economic growth as a ‘puzzling relationship’; therein lies the alternative of a psychosocial approach to health, in terms of the raising of the quality of social life as the most crucial determinant of health.

In view of the transition of income inequality between and within societies, we suggest that the role of economic growth functioning as a facilitator to promote population health is in doubt. In terms of this, the globalisation of economic activities has given rise to a new change – that the populations of those in poverty have

dramatically increased, together with the enlargement of income difference between the poorest and the remainder of the population (Carpenter, 2000). Thus, the health of all populations in general has not really benefited by the growing trend of economic globalisation, which has even done harm in many cases. For example, multi-national enterprises may transfer their dirty industries to developing countries, based on a trade-off between the provision of job opportunities from the former and loosening regulation of health and safety from the latter, as indicated by Carpenter (*ibid.*). Thus, domestic economic growth may not always bear good fruit in the sense of health improvement.

8.3 Globalisation and Taiwan's Health

We have thus far presented the puzzling relationship of economic growth and health improvement in a global domain. This section examines the influences of Taiwan's rapid economic development, generally considered an 'economic miracle', on Taiwan's health and health policy reform. To this end, we will first give a brief review of the expansion of Taiwan's globalised economy, with a view to making more sense of its link with Taiwan's health gains. Following this, the dark side of globalisation in relation to health inequalities will be elaborated through a discussion of concrete examples observed in contemporary Taiwan.

8.31 Economic growth and health improvement: in the context of Taiwan's globalised economy

As far as economic globalisation is concerned, Taiwan's rapid economic growth has been pronounced, and associated with an export-oriented process of industrialisation.

Within this process, SMEs played a crucial role in enabling Taiwan's economy to exploit the World Market in the late 1960s, with little support from the state (Zhou & Lin, 1999; Sasamoto, 1992: 29; Chen Y-X, 1992: 104). Furthermore, they have facilitated a new type of economic development, namely outward investment, since the late 1980s (see Chapter 5, Section 5.31). It is through the process of export-oriented industrialisation, in which the state played a role of investment loans and education for human capital, that Taiwan became part of the international division of labour under the world capitalist system, and meanwhile has developed an outward-looking attitude of not being afraid of global competition (Zhou & Lin, *ibid.*; Li K-D, 1993: 86). In this context, a new model of globalised economy was established in Taiwan, and consequently a world-renowned 'economic miracle' came into being.

Taiwan has been transformed from a developing to a developed economy in only a few decades. As Table 8-1 shows, the economic growth rate exceeded 6% every year before 1998, except 1990, in which the growth rate was 5.39%. The growth rate reached a peak of 12.9% in 1971, 13.86% in 1976, 11.64% in 1986, and 12.74% in 1987 separately. The increase in per capita GNP (gross national product) was also dramatic. There was an increase of two digits from US \$145 dollars in 1951 to US \$1,132 dollars in 1976. Taiwan's per capita GNP broke US \$10,000 dollars in 1992, and climbed to US \$14,216 dollars in 2000. It should be noted that the Guomintang government started to draft the preliminary NHI plan in 1988, when the per capita GNP reached US\$6,379 dollars. In 1994, the year before the introduction of NHI, the per capita GNP grew to nearly US \$12,000.

Table 8-1 Economic Development in Taiwan:
 Economic Growth Rate and Per Capita GNP
 (1951-2000)

	Economic Growth Rate (%)	Per Capita GNP (US \$dollars)
1951	-	145
1961	6.88	152
1971	12.90	443
1976	13.86	1,132
1981	6.16	2,669
1986	11.64	3,993
1987	12.74	5,298
1988	7.84	6,379
1989	8.23	7,626
1990	5.39	8,111
1991	7.55	8,982
1992	7.49	10,506
1993	7.01	10,964
1994	7.11	11,806
1995	6.42	12,686
1996	6.10	13,260
1997	6.68	13,592
1998	4.57	12,360
1999	5.42	13,235
2000	5.86	14,188

Source: Directorate-General of Budget, Accounting and Statistics, Executive Yuan (2003a),
Taiwan's Economic-Political Observation Table: By Year.

Alongside its economic miracle, Taiwan has had striking health gains, typified by the decrease in infant mortality rate and the increase in average life expectancy. As Table 8-2 shows, Taiwan's infant mortality rate saw a dramatic decrease from 44.71 in 1952 to only 5.05 infant deaths per 1,000 live births in 1991. Afterwards, there were tiny fluctuations, of between 4.8 (in 1993) and 6.66 (in 1996).

Table 8-2 Taiwan Infant Mortality Rate
(1952-2001)

Year	per 1,000	Year	per 1,000
1952	44.71	1994	5.07
1961	33.97	1995	6.43
1971	15.51	1996	6.66
1981	8.86	1997	6.35
1986	6.29	1998	6.57
1991	5.05	1999	6.07
1992	5.18	2000	5.86
1993	4.80	2001	5.99

Source: see Table 8-1.

Table 8-3 provides an overall picture of the change in the Taiwanese average life expectancy. In general, the average life expectancy of male Taiwanese rose from 53.38 years in 1951 to 72.87 years in 2001, except in 1992 and 1993, in which the life expectancy saw a slight decline. There has been a gradual rise in the average life expectancy for female Taiwanese, revealed as an increase from 56.33 years in 1951 to 78.75 years in 2001.

Table 8-3 Taiwanese Average Life Expectancy
(1951-2001)

Year	Unit: years	
	Male	Female
1951	53.38	56.33
1961	62.30	66.76
1971	67.19	72.08
1981	69.74	74.64
1986	70.97	75.88
1991	71.83	77.15
1992	71.79	77.22
1993	71.61	77.52
1994	71.81	77.76
1995	71.85	77.74
1996	71.89	77.77
1997	71.93	77.81
1998	72.20	77.96
1999	72.46	78.12
2000	72.67	78.44
2001	72.87	78.75

Source: see Table 8-1.

Equally important is Taiwan's health transition, which may embody another facet of Taiwan's health gains. In this regard the pattern of Taiwan's health transition is similar to developed capitalist countries in the West: that is, a shift from infectious and acute diseases to non-infectious, degenerative diseases and accidents, alongside the rapid development of industrialisation in the post-World War II era. This can be illustrated by the notable change in the leading causes of death, when we consider the top three causes. As we can see from Table 8-4, the top three leading causes in Taiwan over the 1950's were: 1) gastritis, duodenitis, enteritis, and colitis, 2) pneumonia, and 3) tuberculosis. In 1961, pneumonia became the top first disease; gastritis, duodenitis, enteritis, and colitis tuberculosis dropped to the second; tuberculosis dropped out of the list and was replaced by vascular lesions affecting the central nervous system. In 1966,

the top three leading causes of death saw a significant change: malignant neoplasms and accidents joined the list and hereafter they were always on the list, except in 2001, in which heart disease replaced accidents and became the third leading cause of death. Equally relevant is the fact that cerebrovascular diseases emerged and became one of the top three causes after 1971; at the same time vascular lesions affecting the central nervous system dropped out of the list. In summary, it was in the mid-1960's that a remarkable shift towards reduction of infectious diseases started, and consequently a new 'age of degenerative and man-made diseases' (Omran, *ibid.*) has gradually evolved.

Table 8-4 The Top Three Leading Causes of Death in Taiwan
(1952-2001)

Year	Rank		
	1	2	3
1952	Gastritis, duodenitis, enteritis, and colitis	Pneumonia	Tuberculosis
1956	Gastritis, duodenitis, enteritis, and colitis	Pneumonia	Tuberculosis
1961	Pneumonia	Gastritis, duodenitis, enteritis, and colitis	Vascular lesions affecting the central nervous system
1966	Vascular lesions affecting the central nervous system	Malignant neoplasms	Accidents
1971	Cerebrovascular diseases	Malignant neoplasms	Accidents
1976	Cerebrovascular diseases	Malignant neoplasms	Accidents
1981	Cerebrovascular diseases	Malignant neoplasms	Accidents and adverse effects
1986	Malignant neoplasms	Cerebrovascular diseases	Accidents and adverse effects
1991	Malignant neoplasms	Cerebrovascular diseases	Accidents and adverse effects
1996	Malignant neoplasms	Cerebrovascular diseases	Accidents and adverse effects
2001	Malignant neoplasms	Cerebrovascular diseases	Heart disease

Source: DoH (2002), *Health and Vital Statistics of Year 2001*.

There are impressive improvements by Taiwan judged by international comparisons of health status. According to *Healthcare International*, published by the Economist Intelligence Unit, which accounted for the state of health and quality of medical practice¹ within 27 selected countries (including both developed and developing countries) on a quarterly basis, Taiwan has recently become one of the top healthiest countries in the world. In terms of this, Taiwan was ranked second in 1998 (EIU, 1998: 158), fifth in 1999 (EIU, 1999), and second in 2000 (EIU, 2000: 66) of the healthiest countries.

Thus Taiwan's health improvement was substantial. The reasons for this can be analysed within the structuralist approach developed by Wilkinson (1999a; 1999b), who reminds us of the correlation between income inequality and the improvement in national health. Simply stated, the growth of national wealth, as often measured by per capita GNP, may initially contribute substantially to the improvement of population health. This association becomes weaker after the epidemiological transition has been completed, after which relative poverty, as measured by income inequality, becomes a more important factor affecting the national health.

Applying Wilkinson's theory to Taiwan, it is noteworthy that Taiwan has reached considerable income equality alongside its rapid economic growth. In terms of this, we may look at two key income inequality indices: ratio of income share of highest fifth to the lowest fifth and Gini coefficient (Table 8-5). As far as the first is concerned, it remained below 5.0 throughout 1970-91, and fluctuated between 5.38 and 5.55 in 1996-2000; then it grew to 6.39 in 2001. As to the Gini coefficient, it was below 0.3 in

¹ This survey used a range of indicators, including GDP per head, population (number and density), birth rate, death rate, life expectancy, under-5 mortality rate, maternal mortality rate, HIV infection rate, and immunisation coverage at 12 months (DPT 3, Polio and Measles).

1970-1986. It climbed to 0.308 in 1991, and saw a gradual increase from 0.317 in 1996 to 0.350 in 2001.

Table 8-5 Income Inequality in Taiwan
(1970-2001)

Year	Ratio of Income Share of Highest Fifth to the Lowest Fifth	Gini coefficient
1970	4.58	0.294
1976	4.18	0.280
1981	4.21	0.281
1986	4.60	0.296
1991	4.97	0.308
1996	5.38	0.317
1997	5.41	0.320
1998	5.51	0.324
1999	5.50	0.325
2000	5.55	0.326
2001	6.39	0.350

Source: Directorate-General of Budget, Accounting and Statistics, Executive Yuan (2002b), *Report on the Survey of Family Income and Expenditure in Taiwan Area of Republic of China, 2001*.

In general, there has been a growing trend in both statistics in the past three decades. Although this means worsening income equality, we may still consider Taiwan as a case of having relatively equal distribution of income, compared with most other countries, including low-income, mid-income and high-income countries. As Table 8-6 shows, the ratio of income share of highest fifth to the lowest fifth in the 18 selected countries (Taiwan is excluded) ranged from 4.19 in Romania (1994) to 25.52 in Brazil (1996), and their Gini coefficient ranged from 0.2632 in Romania (1994) to 0.5411 in Brazil (1996). In contrast, Taiwan's performance of income distribution was

fairly good, as its ratio of income share of highest fifth to the lowest fifth was only 4.21 in 1981 and 5.50 in 1999, and its Gini coefficient was only 0.281 in 1981 and 0.325 in 1999 (these two years are selected because the statistics of the other countries cover a range of time from 1981 to 1999).

Table 8-6 Income Inequality in Selected Countries

Countries	Year	Ratio of Income Share of Highest Fifth to the Lowest Fifth	Gini coefficient
<i>Low-income countries</i>			
Honduras	1996	17.06	0.4877
China	1998	7.90	0.3736
<i>Mid-income countries</i>			
Taiwan	1981	4.21	0.281
	1999	5.50	0.325
South Korea	1993	5.26	0.2945
Chile	1994	17.43	0.5055
Malaysia	1995	11.96	0.4428
Brazil	1996	25.52	0.5411
Romania	1994	4.19	0.2632
<i>High-income countries</i>			
Japan	1999	4.84	0.2867
Sweden	1981	4.61	0.2764
Switzerland	1982	8.58	0.3568
The Netherlands	1988	4.50	0.2720
UK	1988	9.63	0.3748
Canada	1987	7.05	0.3272
USA	1998	9.70	0.3780
Germany	1988	5.76	0.3145
Italy	1986	6.03	0.3196
Spain	1988	4.41	0.2649
France	1989	7.48	0.3372

Source: see Table 8-5.

Referring to the health transition theory, there are two points worth noting in this regard. First, Taiwan's impressive health gains (raised life expectancy, reduced

mortality, rapid epidemiological transition) were highly associated with reductions in absolute poverty. Second, the growing trend towards worsening income distribution, which entails an increase in relative poverty, may be linked to the growth of health inequality between different economic groups, as indicated by Wilkinson. For one thing, it determines individual access to health resources, which in turn moulds variations in health. Related to this, Chiang's research (1999), concerning different stages of economic development in Taiwan, shows that the association between income inequality and mortality became stronger when Taiwan changed from a developing to a developed economy. Following this we will now move on to the disadvantageous side of economic globalisation, in relation to the variations in health that has been obscured by Taiwan's economic prosperity.

8.32 Health under globalisation – the dark side

This section is an empirical investigation of the situation of health inequalities in contemporary Taiwan, towards providing a rich and divergent picture of social divisions in health. Health inequalities relate to the extent to which the existing social and economic influences have affected the social patterning of health and ill-health. In other words, we are concerned with indicators of people's social circumstances (Nettleton, 1995: 161), including unemployment, economic capacity and ethnic minority status. In addition to the inequalities within the resident population, particular attention is paid to the health situation of foreigners, including foreign workers in Taiwan and those employed by Taiwanese industries in neighbouring countries, as these are connected with the consequence of economic globalisation.

- *Within the resident population*

It is essential briefly to recapitulate two distinguishing features of the NHI scheme. First, this scheme incorporates virtually the entire population (except prisoners). Second, it provides easy public access to medical services. In this context, we are concerned to understand better how particular distinct social-economic factors have hindered the access to the NHI care for certain groups of people. Overall, the disadvantaged people may roughly fall into three groupings: the unemployed, the economically disadvantaged and the indigenous population. I will now briefly introduce and discuss each of these.

The unemployed

Based on the design whereby the NHI contribution charge varies between different insurance beneficiaries, on the basis of people's occupational affiliations, an unemployed person is obliged to change his/her enrolment from the category of employee (i.e. Category 1-1) to the category of so-called 'population under the aegis of district government' (i.e. Category 6-2) (see Chapter 6, Section 6.22). Accordingly, the BNHI charges the unemployed a new insurance contribution premium, which is the same for all people enrolled in this category. Ironically, in many instances an unemployed person needs to pay more vis-à-vis what he/she previously paid. The reason is that an employee's NHI premium is payroll-based and bears a 30% share of the premium; however, an unemployed person is charged at a fixed rate, set as the average premium of all beneficiaries and bears a 60% share of the premium. In 2000, for example, the average premium of all employees working in private enterprises was NT\$356 dollars; however, the average premium of all insured people at that time was

NT\$604 dollars. This means an employed person, on average, pays less than what an unemployed person pays. In other words, a person may need to pay more when he/she becomes jobless, if his/her previous premium was less than the average of all those insured.

It is apparent that this policy is contrary to the principle of social justice, in the way it disadvantages a person already in great difficulty. There is an explicit accent on protecting the health of employed workers in the NHI, as a heritage of the previous health care system; that is, the health care system is part of the infrastructure that supports Taiwan's economic development. Added to this is the fact that the Taiwanese welfare state does not have a tradition of socialistic solidarity (see Chapter 6, Sections 6.21 & 6.22), and accordingly a carrot-and-stick approach to social policy, connected with the work ethic (see Chapter 5, Section 5.27), is the norm.

The situation of the unemployed changed significantly when a provisional unemployment insurance scheme was implemented in 1998, as a response to rising unemployment as well as a result of party competition (Chien, 2002). Taiwan's unemployment rate saw a general increase from 1.45 in 1993 to 2.99 in 2000. It became even worse: the unemployment rate climbed to 4.57 in 2001, and to 5.17 in 2002 (DGB, 2003b). This scheme offered unemployment benefits, based on work and training requirements for those non-attempted unemployed people who had already been enrolled in the LI scheme. This scheme did not cover a medical-care benefit, in terms of the NHI premium subsidy. It was not until August 1999 that the CLA determined to subsidise half the NHI premium for the unemployed. The financial difficulty of the unemployed in paying the NHI premium was further sorted out, when a new Employment Insurance Scheme was implemented in January 2003 to replace the

provisional scheme. Under this new scheme, the unemployed are entitled to a full NHI premium subsidy from the government.

The economically disadvantaged

It has been observed that the development of Taiwan's globalised economy in the 1980's and 90's revealed the nature of the 'bubble economy' to some considerable extent (Wang Y-Q, 2001; Yang Z-X, 2003), and consequently the global economic recession since 1997, together with the strong competition from the Mainland², have finally pricked the bubble of public complacency about the economic situation. In 2001, the economic growth rate was -2.18%, which was the first-ever minus after World War II; the per capita GNP decreased by 9% from the previous year, i.e. from US\$14,188 to US\$12,876 (DGB, 2002). The economic situation did not recover very much in 2002, in which the economic growth rate grew to 3.54%, and the per capita GNP was US\$12,900 (*ibid.*). Even worse was the raising of the NHI premium rate and the co-payment rates for outpatient care in September 2002 (see Chapter 6).

As a result, it seemed that more and more people had difficulties in paying NHI premiums, typified by the reduction in the NHI premium collection rate. As Table 8-7 shows, the NHI premium collection rate has continually decreased from 98.93% in the opening period of the NHI scheme, i.e. March to June 1995, to 92.64% in 2002. As a consequence of this, for some patients financial difficulties have hindered them from accessing medical care due to the concern about being asked to pay premiums and overdue charge, as often reported in the media.

² Mainland China has maintained stable and high economic growth rates in recent years: 8.8% in 1997, 7.8% in 1998, 7.1% in 1999, 8.0% in 2000, and 7.3% in 2001.

Table 8-7 The NHI Premium Collection Rate
(1995-2002)

Period	NHI premium collection rate (%)
Mar – Jun 1995	98.93
Jul 1995 – Jun 1996	98.69
Jul 1996 – Jun 1997	98.59
Jul 1997 – Jun 1998	98.15
Jul 1998 – Jun 1999	97.50
Jul – Dec 1999	97.10
Jan – Dec 2000	96.06
Jan – Dec 2001	95.19
Jan - Jun 2002	92.64

Source: BNHI (2003b), *The BNHI Operational Brief* in January 2003.

The ethnic minority

By the ethnic minority in Taiwan in this case is meant the indigenous population, consisting of ten tribes who mainly live in mountainous areas, in contrast to the remaining population, who are, or whose ancestors were, Chinese immigrants. In the end of September 2001, the total indigenous population was 418,062, accounting for only 2% of Taiwan's total population (CIP, 2003c). There are great differences in cultural traditions, economic circumstances, educational status and disease types between the indigenous and the non-indigenous populations, and consequently this results in a significant gap in health status between them. Specifically, the average income of non-indigenous households was about 2.3 times that of the indigenous in 1997; the unemployment rate among aborigines was approximately 2.6 times that of non-aborigines in 1998. Referring to educational status, the aborigines had a lower level of education vis-à-vis the non-aborigines, i.e. 13 per cent fewer aborigines have a

junior college or higher education and 16 per cent more have a junior high education or lower (above statistical figures quoted from CIP, 2003a).

As regards the differences in health, there are three points worth noting. First, in terms of the leading causes of death, the indigenous population have higher rates vis-à-vis the average of all populations from accidents (as the first vs. the fourth), chronic liver disease and cirrhosis (as the fourth vs. the sixth), and tuberculosis (as the sixth vs. after the tenth) (DoH, 1999: 5). Second, within the mountainous communities, it has been found that accidents, suicide, liver cirrhosis, tuberculosis, pneumonia, excessive drinking and parasites are prevalent within the population, and that excessive drinking is highly relevant with many of the leading causes of death (*ibid.*). Third, the aborigines have lower life expectancy. In 2000, for example, the average life expectancy among the aborigines was 73 years for women and 62.7 years for men (CIP, 2003b), while the average among the total nationals was 78.4 years for women and 72.7 years for men (DGBa, 2003).

The worse social-economic conditions of the indigenous population are arguably a consequence of the development of Taiwan's economic modernisation, which used to pay little attention to ethnic cultures and related social-economic rights, and accordingly discriminated against aborigines so that they became a disadvantaged ethnic minority. Thus aborigines' disadvantage in social-economic conditions was the main cause of their disadvantage in health condition (quoted from Mr. Y₁₄, Interview Notes, No.2-14, 2000), i.e. due to social-structural causes (Nettleton, 1995: 186).

- *Foreign workers*

Another important dimension to health divisions is concerned with the situation of

foreign workers. At the risk of over-simplification, we suggest that health inequalities among foreign workers can be linked to two groupings: foreign workers in Taiwan and foreign workers employed by outward investors. We will explain their disadvantaged situation in health as follows.

Foreign workers in Taiwan

In the late 1980's, Taiwan's globalised economy was faced with an increasingly serious problem of an insufficient labour force in certain traditional industries, due to industrial upgrading from a labour-intensive to a capital-intensive and technology-intensive type of production (see Chapter 5, Section 5.31). A consequence of this was that the Government opened the door to foreign workers in 1989 from Southeast Asian countries, including Thailand, the Philippines, Indonesia, Malaysia, and Vietnam. The previously government-granted industries and occupations which can employ foreign workers include: major government construction projects, major investing construction, manufacturing industries, nursing workers, domestic helpers (home-maids), and crewmen. These 'foreigners' jobs' share common characteristics: low-wage, dirty or dangerous. It is in this context that commentators claim that foreign workers in Taiwan are at a distinct disadvantage, being 'cheap workers' who have a high risk of contracting occupational injuries (TAVOI, 2003; Yang G-Z, 2003). At the end of 2001, there were 304,605 foreign workers in Taiwan (CLA, 2003: 164).

In terms of health inequality among foreign workers in Taiwan, there are two points worth stressing. First, it has been observed that many foreign workers tend to delay seeing a doctor, because they generally had language difficulties in finding proper medical institutions as well as communicating with doctors, together with having a fear

that they might be sent back by their employers or employment agents if they were found to have serious diseases at their doctor visits (China Times, 2003a; Outcomer Biweekly, 1998). Second, in terms of occupational injuries, injured foreign workers often had great difficulty in obtaining occupational injury compensation, because their rights were bound by a short contract period, which was 2-years and could be 3-years while extension was granted (TAVOI, *ibid.*).

Foreign workers employed by outward investors

In addition to the above, industrial injuries have been 'exported' from Taiwan to other countries, as a result of Taiwan's recent rapid increase in outward investments in neighbouring Southeast Asian countries, particularly China (Wong, 2002). As we have explained in Chapter 5, there was a trend for 'sunset industries' (which were labour intensive SMEs that had relatively worse working conditions) to close their plants in Taiwan and transfer their capital to the neighbouring developing countries where labour was cheaper and the standards of health and environmental requirements were lower. Related to this, Wong's research (2002) found that there was a close link between the changes in Taiwan's industrial injury rate and the value of Taiwan's outward investment in China. Thus, Taiwan's industrial injury rate decreased when outward investment in China increased during 1987-1995, and this rate increased when investment in China declined during 1996-1999 (pp.31-2). Thus, we suggest that the international division of labour has important implications for the moving of occupational health between countries, in terms of the shift of occupational hazards from advanced industrial countries to less-industrialised countries in the context of economic globalisation.

8.4 The Asian Financial Crisis and Taiwan's Health

Referring to our earlier claim for the importance of divergent trends in global health, this section seeks a satisfactory explanation of the relationship between economic globalisation and domestic health in the context of Taiwan. This is concerned with the extent to which the Asian financial crisis of 1997, compared to the Depression of the 1930s (*Health Matters Issue*, 1999), has affected Taiwan, in relation to major social impacts that have important implications for health.

8.4.1 The economic impacts of the Crisis

To begin with, let us briefly review the economic impacts of this crisis. The so-called 'Asian Financial Crisis' erupted in Thailand in July 1997, and soon caused a financial collapse in Asia. Following this, an advanced financial crisis spread to other parts of the world, and accordingly affected the global capitalist system, typified by a reduction of the economic growth rate by 1.7 % in 1998 (IMF, 1999: 2). As far as its impacts on Asian economies is concerned, the crisis has caused a severe economic downturn in East and Southeast countries, in terms of two groups: the Newly Industrialised Asian (NIA) economies (the so-called 'miracle economies'), including Hong Kong, Korea, Singapore and Taiwan, and the ASEAN-4 (Association of South-East Asian Nations) economies, including Indonesia, Malaysia, the Philippines and Thailand.

Before the crisis, the average economic growth rate (real GDP) of the NIA economies was 6.9% in 1991-96, and that of the ASEAN-4 economies was 7.1% (Table 8-8). In the year of the crisis, the average economic growth rate of the former decreased to 6.4%, and that of the latter dropped to 4.3%. Dramatic impacts of the

crisis appeared in 1998, in which all economies suffered from a severe economic downturn. Apart from Singapore and Taiwan, all the other NIA and ASEAN-4 economies had negative economic growth rates. In particular, Indonesia endured the most, in terms of a dramatic reduction of economic growth rate from 4.6% in 1997 to -13.7% in 1998.

On the other hand, the crisis gave rise to changes in consumer price inflation. Almost all economies saw an increase in inflation from 1997 to 1998, with the exception of Hong Kong and Singapore. Among them, Indonesia saw an extremely striking inflation growth from 6.6% in 1997 to 60.7% in 1998.

Table 8-8 The Economic Impacts of the Asian Crisis on Selected Asian Countries:
Real GDP Growth Rate and Consumer Price Inflation

Unit: %

	Real GDP Growth Rate			Consumer Price Inflation		
	1991-96	1997	1998	1991-96	1997	1998
Newly industrialised Asian economies						
Hong Kong	5.3	5.3	-5.1	8.7	5.7	2.6
Korea	7.4	5.5	-5.5	6.0	4.4	7.5
Singapore	8.4	8.0	1.5	2.4	2.0	-0.3
Taiwan	7.0	6.7	4.6	3.7	0.9	1.7
<i>Average of NIA</i>	6.9	6.4	-1.1	5.2	3.3	2.9
ASEAN-4						
Indonesia	8.7	4.6	-13.7	8.7	6.6	60.7
Malaysia	8.7	7.7	-6.8	3.6	2.7	5.3
Philippines	2.8	5.2	-0.5	10.1	6.0	9.7
Thailand	8.0	-0.4	-8.0	5.0	5.6	8.1
<i>Average of ASEAN-4</i>	7.1	4.3	-7.3	6.9	5.2	21.0

Source: 1. Except for Taiwan, the data of the other countries are from IMF (1999), *World*

Economic Outlook.

2. Taiwan's data is from the DGB (2003c), *National Income Statistics*.

The economic impacts of the crisis on Taiwan vis-à-vis the other NIA and ASEAN-4 economies were rather mild, in that its economic growth rate still increased slightly by 0.6% in 1996-97 (see Table 8-8 & 8-9), and reduced to 4.6% in 1998, which was the best performance among all the economies in the two groups. In addition, Taiwan's inflation was not associated with the crisis to a considerable extent. In fact, Taiwan's inflation rates in the immediate years after the crisis were much lower than before: the average inflation of 1991-96 was 3.7%; inflation was only 0.9% and 1.7% in 1997 and 1998 respectively.

8.42 The social-economic impacts on Taiwan

Based on the concern for their relevance to population health, the social impacts of the Asian Financial Crisis on Taiwan are equally important. In terms of this, we will explore the implications of three indicators: unemployment rate, educational expenditure and health expenditure.

As can be seen from Table 8-9, Taiwan used to have a low unemployment rate: the average rate was only 1.78% in 1992-96. The change in 1995-96 was significant, in terms of an increase from 1.79% in 1995 to 2.60% in 1996. It then gradually grew to 2.99% in 2000, except in 1998, in which the unemployment rate was 2.69%. Secondly, the educational expenditure as a percentage of GDP in the years before the crisis was generally higher than those after the crisis; the average in 1992-96 was 6.76%. There was a gradual fall from 6.72% in 1996 to 6.29% in 1998, it then slightly grew to 6.31% in 1999, but reduced again to only 5.50% in 2000. Thirdly, the health expenditure as a percentage of GDP had a significant increase from 4.93% in 1994 to 5.27% in 1995, in which the NHI scheme was introduced, and continually went up by

0.02% in 1996. It then slightly decreased to 5.27% in 1997, but grew again in 1998 and reached 5.46% in 1999. It had a slight fall by 0.02% in 2000.

Table 8-9 Social-economic Indicators in Taiwan:
Before and After the Asian Financial Crisis

Unit: %

	1992	1993	1994	1995	1996	1992-96	1997	1998	1999	2000
Economic Growth Rate	7.49	7.01	7.11	6.42	6.10	6.83	6.68	4.57	5.42	5.86
Inflation Rate	4.47	2.94	4.10	3.67	3.08	3.65	0.89	1.69	0.17	1.26
Unemployment Rate	1.51	1.45	1.56	1.79	2.60	1.78	2.72	2.69	2.92	2.99
Educational Expenditure as % of GNP	6.75	6.98	6.80	6.57	6.72	6.76	6.61	6.29	6.31	5.50
Health Expenditure as % of GDP	4.77	4.88	4.93	5.27	5.29	5.03	5.27	5.33	5.46	5.44

Sources:

1. The data of economic growth rate, inflation rate and unemployment rate are from CLA (2003), *Monthly Bulletin of Labor Statistic*.
2. The data of educational expenditure as % of GDP is from Department of Education (2003), *Education Statistics Index*.
3. The data of health expenditure as % of GDP is from DoH (2003a), *The National Health Expenditure Statistics Report*.

Overall, the major social-economic situation in Taiwan after the Asian Crisis can be roughly summarised as: a growing trend in unemployment, a general decrease in educational expenditure, and a gradual rise in health expenditure. Admittedly, we cannot be sure how far these changes can be linked with the Asian Crisis, due to inadequate data sources. However, what we intend to present here is their implications

for population health and health care.

As far as the increase of unemployment is concerned, there might well have been higher public demand for health care after the Crisis. The main reason is that the unemployed and their families may need more medical care in general during the period of unemployment, due to increasing mental stress and worse nutrition. In reality, however, they may have less medical-care consumption on the grounds of limited budget. Referring to the second, the change in national educational expenditure may have a correlation with health and ill health, on the grounds that education could be an important determinant of individual health, in the way it generally helps the individual to improve his/her social position (Wilkinson, 1999a: 17). As regards the third, in some ways state health expenditure can be influenced by economic prosperity, particularly in countries adopting a taxation-based system. By contrast, in countries adopting social insurance, like Taiwan, people's access to health care is directly affected by capacity to pay insurance premiums. As we have already shown, Taiwan experienced a decrease in the NHI premium collection rate due to increased unemployment.

In addition to the three indicators, the increasing enlargement of income inequality in recent years has been observed as being correlated with the development of Taiwan's globalised economy, as noted already. This also has important implications for people's health: it signifies a possibility of worsening health inequalities among social groups at different economic levels.

8.43 The explanation of Taiwan's health expenditure: a 'structured divergence' approach

Although the Asian Crisis seemed to impact on Taiwan's economy to only a limited extent, Taiwan's economic growth remained rather sluggish in the post-crisis era. As far as the relationship between economic development and population health is concerned, it appears important that the understanding of why the change in Taiwan's health expenditure as a percentage of GDP was not in line with that in economic development. Thus, we will now look at the implications of the health expenditure, as an example of national 'structured diversity' (Ginsburg, 1992).

To begin with, it should be noted that Taiwan's health expenditure, in terms of national health expenditure (NHE), can be divided into two parts: the public sector, including the BNHI and the other governmental agencies, and the private sector, including households and non-profit organisations. Overall, the trend of Taiwan's NHE after the introduction of the NHI in 1995 represented that two thirds of the cost went into the public sector, in which the BNHI received the lion's share, and one third of the cost went into the private sector (see Table 8-10).

Secondly, we are concerned with the trends of health expenditure growth among different sectors. As we can see from Figure 8-1, the change in the NHE growth rate in the post-crisis era (1997-2000) was opposite to that in the GDP growth rate (i.e. economic growth rate): it peaked in 1998 and then began to fall. Specifically, there was a similar change in the BNHI's expenditure growth rate, but that in the other governmental sectors was very different: there was a sharp rise in the growth rate between 1997 and 1999, and it then began to go down. There is one thing worth stressing: the growing trend in the expenditure growth of governmental sectors was

based on a very low starting point, namely -6.26% in 1997; by contrast, the downward trend in that of the BNHI was on the basis of high growth rates, typified by 8.06% and 8.59% in 1997 and 1998 respectively. This, in a way, may signify that the BNHI has received much more favour from the authority – even economic downturn seemed to be of little relevance to BNHI's expenditure, as will be explored in more detail later.

In addition, the change in household out-of-package expenditure in 1997-2000 was similar to that in economic growth, but on the basis of larger fluctuations. In terms of this, the growth rate of household health expenditure decreased dramatically from 15.7% in 1997 to 5.59% in 1998, and then gradually rose to 11.89% in 2000. In view of the fact that the economic situation plays a crucial role in determining the individual's possibility of getting access to better medical care, it is essential to pay more attention to the sharp fall and rise in the growth rate of household health expenditure.

Table 8-10 Taiwan's Health Expenditures by Expenditure-Applying Units
(1996-2000)

Unit: NT\$ million dollars, %

	1996		1997			1998			1999			2000		
	Amount	%	Amount	%	Growth Rate	Amount	%	Growth Rate	Amount	%	Growth Rate	Amount	%	Growth Rate
Total	406,074	100.00	438,808	100.00	8.06	476,518	100.00	8.59	506,880	100.00	6.37	525,389	100.00	3.65
Public sector	270,420	66.59	287,712	65.57	6.39	315,492	66.21	9.66	335,265	66.14	6.27	335,777	63.91	0.15
Governmental sectors	45,622	11.24	42,765	9.75	-6.26	42,174	8.85	-1.38	43,336	8.55	2.76	44,057	8.39	1.66
BNHI	224,798	55.36	244,947	55.82	8.96	273,318	57.36	11.58	291,929	57.59	6.81	291,720	55.52	-0.07
Private sector	135,653	33.41	151,096	34.43	11.38	161,026	33.79	6.57	171,615	33.86	6.58	189,612	36.09	10.49
Households	112,372	27.67	130,010	29.63	15.70	137,272	28.81	5.59	150,317	29.66	9.50	168,192	32.01	11.89
Non-profit organisations	23,281	5.73	21,086	4.81	-9.43	23,754	4.98	12.65	21,298	4.20	-10.34	21,420	4.08	0.57

Source: Extracted from DoH (2003a), *The National Health Expenditure Statistics Report*, Table 4.

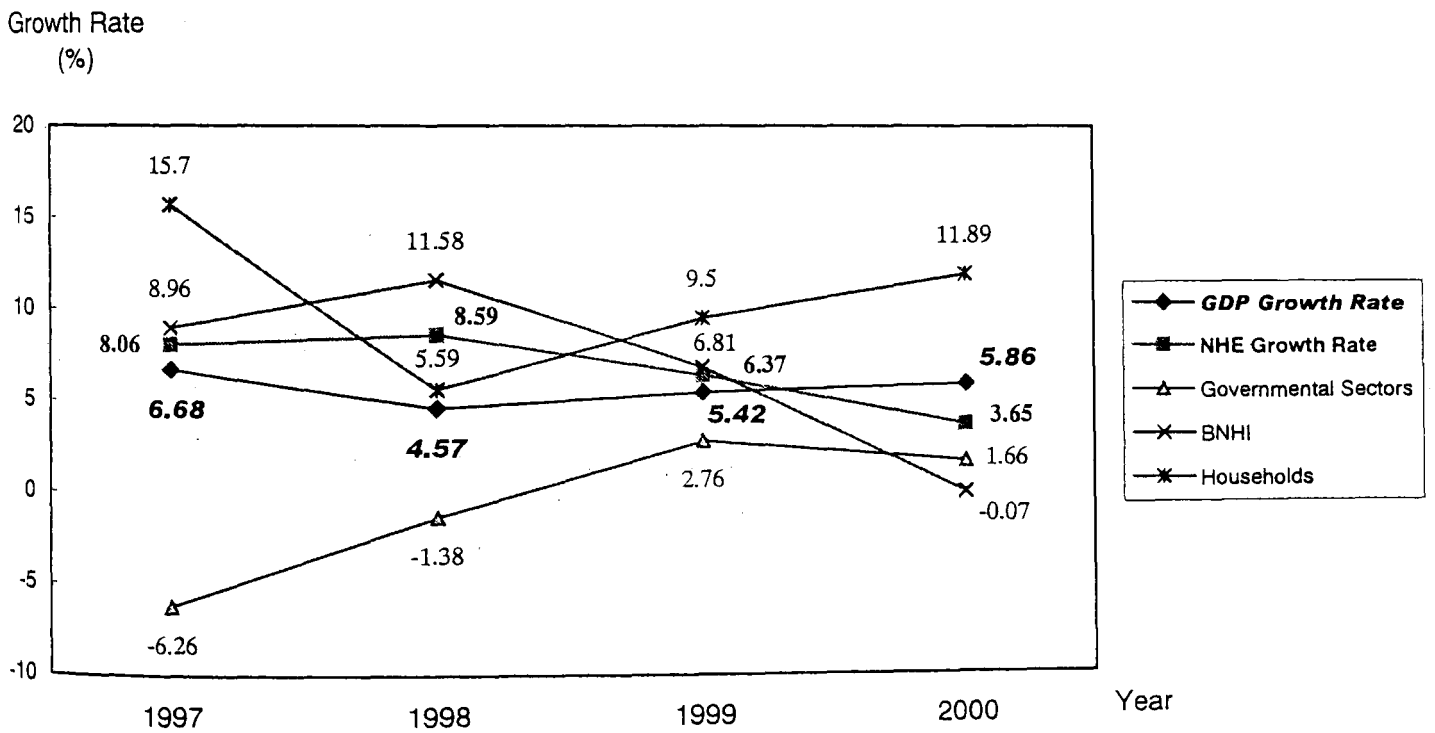
Notes:

1. The governmental sectors consist of the central government, local governments and

government-managed medical institutions.

2. The BNHI's expenditure includes NHI medical expenditure and NHI administrative expenditure. Its sources consist of government subsidies and NHI premiums paid by employers and households.
3. The health expenditure paid by households means out-of-package expenditure (the NHI premiums are excluded).

Figure 8-1 The Rates of Increase in Taiwan's Health Expenditure by Selected Sectors, 1997-2000



Source: see Table 8-10

In terms of the BNHI's health expenditure being rather free from economic influences, there are two points worth noting. First, NHI entitlement is to basic health care, which may be less affected by economic fluctuations. Second, the Taiwanese legislators are generally involved in supporting an expansionist approach to NHI care, because this may make a 'fat' profit in the sense of electoral support. It is in this sense that the curtailment of government funding for the NHI was not considered appropriate at any time among different political parties. According to Mr. X₉ (Interview notes, No.1-09, 1999), a Gaomindang's Legislator, the ruling party never considered cutting off NHI funding and benefits, regardless of the realisation that economic downturn was on its way after the Asian Financial Crisis. Similarly Ms. X₁₂ (Interview notes, No.1-12, 1999), the primary secretary of Legislator Hao Rong-Bin of the New Party, as the second opposition party at the time of the interview, explained the philosophy of the opposition parties in relation to reducing NHI funding. Curtailing NHI funding was not considered, because there could be no turning back for social welfare.

Embedded in the above seemingly altruistic political philosophy is a myth of NHI's financial obligation. That is, the general public and employers in truth have to bear the major part of the responsibility for the NHI funding. From the government viewpoint, Mr. X₄ (Interview Notes, No.1-04, 1998), an ex-BNHI Manager General, pointed out that the government would rather apply budgeting measures, such as price

control for medical-care providers and additional co-payment for patients, than curtail the existing NHI benefits. This has proved to be true in the later period, as we have clearly illustrated in Chapter 6.

In short, as the Asian Crisis affected Taiwan, several marked social impacts have been observed in the sense of correlating with the possible deterioration in health equality. However, their relevance to health care reforms, in particular the NHI, remains largely unfelt, which has by and large served the needs of political parties who need to retain public support.

8.5 Taiwan and International Organisations

We now move on to the final part of this chapter. Considering in many instances international actors and networks may have offered the routes of diffusing theories and policy proposals to domestic health care systems – the so-called internationalisation or globalisation of health policy reforms (Moran & Wood, 1996), we intend to examine the actual practice in the case of Taiwan, relating to its struggle to be included in the international health community. Concrete examples will be given and compared in the fields of health and economy respectively, in order to gain an insight into the underlying logic of the international political and economic dynamics.

8.51 Health for all? WHO and Taiwan

The first example is Taiwan's applying to join the World Health Organisation (WHO), as the most important international agency dealing with global strategies for health promotion. The WHO was one of the biggest specialised agencies under the United Nations (UN), funded in 1948. Initially, the Republic of China (ROC), later Taiwan,

was one of the founder members, but it withdrew its UN membership in 1972, as a result of its conflict of statehood with the People's Republic of China (PRC; Mainland China) in the UN. This diplomatic withdrawal caused Taiwan to be expelled afterwards from all intergovernmental agencies, for example, the World Bank and the International Monetary Fund (IMF), in both of which Taiwan's seat was replaced by China in 1980.

Then, Taiwan's diplomatic policy experienced a significant change in the late 1980's, when President Li Deng-Hui adopted a 'pragmatic' or 'flexible' approach towards developing a substantial relationship, instead of a formal relationship, between Taiwan and the other countries. It is in this regard that a programme of joining or rejoining international agencies, including intergovernmental and non-governmental organisations, was promoted, with a 'flexible stance' towards the use of the country's name (Hickey, 2000).

In this context, joining the WHO became an important task for the DoH, which originally set up 2000 as the target year (DoH, 1994a; 1997a). To this end, the DoH firstly decided to apply for a WHO observer status since 1997, with continual efforts being put into lobbying WHO member states to raise Taiwan's proposal in the steering committee of the World Health Assembly (WHA), as WHO's annual assembly. It changed its strategy in 2002, in terms of applying to become an observer with the name of 'Public Health of Taiwan', which was a 'functional health entity' (Free Times, 2002; BBC, 2002).

Apart from the government, the Taiwanese medical profession also supported this effort to a large extent, under the organisation of the Foundation of Medical Professionals Alliance at Taiwan (MPAT). In fact the MPAT organised a 'Taiwan for WHO Campaign', and has employed various active tactics, including: organising a

lobby to canvass support for Taiwan in Geneva, where the WHA is held; holding professional meetings outside the WHA, and inviting health leaders of other countries to listen to the speech given by Taiwan's Health Minister; holding international health and diplomatic affairs workshop for medical students; originating a 'One Person One Letter to Support Taiwan's WHO Participation' activity (MPAT, 2002).

To date this campaign has not reached a successful result, due to strong opposition from China, which claimed that Taiwan was part of China (as 'Taiwan Province of China') therefore was not entitled to be a member of intergovernmental organisations (Yang L-X, 2002).

Certain damaging effects, relating to Taiwan's exclusion from the WHO, have been observed. As is well known, 'excessive' death occurred at an Enterovirus outbreak spread from Malaysia to Taiwan in 1998 without the WHO sharing information regarding the spread of the epidemic with Taiwan (DoH, 2000b; Hickey, 2000). This occurred because Taiwan was excluded from the WHO's Global Outbreak Alert and Response Network (GOARN), which ensures that '*outbreaks of potential international importance are rapidly verified*' and that '*information is quickly shared within the Network*' (WHO, 2003). A case in progress is the multi-country outbreak of an atypical pneumonia, Severe Acute Respiratory Syndrome (SARS), originally appearing in East and Southeast Asia. Similarly, Taiwan's request for assistance in support of dealing with SARS after several suspected cases having been identified in March 2003 has recently been rejected by the WHO, and Taiwan has been told to seek for assistance from the Centres for Disease Control and Prevention of the USA instead (China Times, 2003b).

As regards Taiwan's application for observership being rejected repeatedly, the

WHO has been harshly criticised for serious violation of its constitution (Chan C., 1998; Hickey, *ibid.*; GIO, 2002; DoH, 2003c), which stipulates the goal of the WHO as '*the attainment by all peoples of the highest possible level of health*'. In theory, health is a fundamental human right and a value asserted to be shared by all peoples irrespective of nationality. In reality, however, health cannot avoid being affected by international political pressures, and the reality of Cold War politics

8.52 Invisible Health? WTO and Taiwan

In comparison with the experience of applying to join the WHO, Taiwan seemed to have 'good fortune' in its participation in the World Trade Organisation (WTO), the most crucial organisation in charge of global trade established in 1995, as the successor to the General Agreement on Tariffs and Trade (GATT). Parallels can be drawn between the story of Taiwan's participation in the WTO and that of Taiwan's application for WHO observership. The ROC, later Taiwan, was one of the contracting parties when GATT was signed by 23 countries in 1948. Following the retreat of the Chinese Nationalist Government from China to Taiwan, the ROC retracted from GATT in 1950. It was allowed to return with observer status in 1965, but its observership was abolished in 1971, as a consequence of its withdrawal from the UN. Taiwan applied to join GATT with the name of 'the Separate Customs Territory of Taiwan, Penghu, Kinmen and Matsu' in 1990, and was granted observership in 1992. Afterwards, the WTO was established to replace the GATT in 1995, and consequently Taiwan's original application was updated in terms of becoming an application for WTO membership. This story had a 'happy ending': Taiwan's application was passed on November 11th, 2001 and it became a WTO member on January 1st, 2002, after China joined the WTO

on December 11th, 2002 (BFT, 2002).

In short, the triumph of Taiwan's joining WTO arises for three reasons. First, WTO is not a UN agency, and accordingly the UN membership can be detached from the decision of whether the WTO membership should be granted. This was the same with the GATT, which was a multi-international agreement operated by its contracting parties. Secondly, China was not a WTO member when Taiwan was applying for membership. This certainly made a difference, in terms of political intervention, in the result. Thirdly, which seems to be more important, WTO is an economic organisation, which is devoted to promoting economic globalisation by all means. It is in this regard that Taiwan's economic liberalisation initiated since the 1980's, as well as its recent positive responses to WTO's advocacy of free trade through improving the domestic economic environment, contributed to Taiwan's WTO participation to a substantial extent (Economics Daily News, 1999). Added to this is the fact that Taiwan was, in some ways, an economic power, which certainly entailed it having a considerable voice in global economic affairs.

Comparing the two cases of Taiwan's applying to join the WHO and the WTO, one lesson can be learnt – there are paradoxical dimensions to the practicality of globalisation, depending on the importance of the field under concern judged by the authorities. In terms of this, economic globalisation is not only a supreme value but also a pragmatic course. By contrast, global health is a rather ideal objective, and in reality is short of efficient methods to improve inequities in the global system.

Referring to Taiwan's success in becoming a WTO member, there is one more thing worth stressing. In terms of WTO as an economic organisation, it seems that both the government and the media have hitherto focused only on the WTO's influences on

economic levels, including a general expectation that considerable economic gains may follow trade liberalisation, as well as repeated reminders for industries about taking precautions with the impacts on the domestic marketplace caused by an open-door economic policy³. By comparison, the social consequences of economic deregulation appeared to be of little significance and were rarely found on the governmental agenda. As far as health is concerned, we suggest that more attention needs to be paid to the negative effects of deepening economic liberalisation on population health, in terms of two points. First, the removal of restrictions in importing health-harmful commodities, such as tobacco and alcohol, may involve a change in people's health behaviours, because people are now encouraged to consume more owing to cheaper prices and more advertisements (Lu Z-X, 1997; Hu S-Z, 2000). Second, as we have noted, there is a growing trend towards worsening income distribution in recent Taiwan. Following Taiwan's joining the WTO, it is foreseeable that the progress of economic liberalisation will be speeded up, and consequently there might be an enlarged gap of income distribution. We suggest that this possible change deserves more awareness of issues like: to what extent the deepening economic liberalisation will enhance the gap of income inequality between different social groups, and in which ways this will have a subsequent effect on health inequality?

8.6 Conclusion

In this chapter, emphasis has been placed upon the implications of globalisation for health and the practical questions of global health, with a view to exploring the global influences on Taiwan's health policy reforms, i.e. a concern about the meso-level

³ Significant cases were the information publicised by the Board of Foreign Trade as a government agent in charge of international trading affairs, and the Economic Daily News, being interested in economic matters.

influences. Globalisation has been examined in two dimensions: economy and health, concerning their interactive effects. In short, Taiwan's 'economic miracle' was a result of its global economic development, and the outstanding economic growth, in turn, contributed to making considerable improvements to population health, typified by reduced infant mortality rate, raised life expectancy and rapid epidemiological transition. In addition, from a comparative standpoint, Taiwan had reached considerable income equality during the process of its rapid economic development, which implied that Taiwan had a low degree of health inequality among different social groups.

However, the development of deepening economic globalisation has brought possible damaging effects on health, in terms of new types of health division. That is, variations have been seen in the difficulty of obtaining access to health care or resources among different social groups. Firstly, while Taiwan's economy has gradually entered into recession recently, paying NHI premiums and additional co-payment for NHI outpatient services seem to have become barriers preventing access to the NHI care for the unemployed and people having economic difficulty. Secondly, the indigenous population, as the ethnic minority generally living in worse social-economic conditions, have been left at a disadvantage in health conditions, as a result of Taiwan's economic modernisation. Thirdly, outside the resident population are foreign workers, who have been introduced to Taiwan as a consequence of the global division of labour. They are at a distinct disadvantage in the context of health at three levels: they are hired under worse working conditions, namely low-pay, unhealthy or dangerous working environment; they tend to delay seeing a doctor due to language problems or a concern with being sent back if being found with a serious illness; they

have great difficulty in obtaining occupational injury compensation, despite many of them having a high risk of contracting occupational injuries. In addition, we have also stressed that the 'foreign workers' employed by the Taiwanese outward investors in neighbouring countries may have become the recipients of Taiwan's 'exported occupational hazards', as a result of economic globalisation that supported Taiwanese 'sunset industries' to do so.

In view of the importance of explanation of divergent trends in global health, we have taken into account the social impacts of the Asian Financial Crisis of 1997 on Taiwan. As far as the implications for health are concerned, there has been observed a worsening tendency that may enlarge existing health inequalities, on the grounds that rising unemployment plus a general decrease in educational expenditure have appeared in the post-crisis era. Added to this is the increase in income inequality that occurred in recent years, alongside the development of deepening economic liberalisation. This may also signify a possibility of worsening health inequalities among social groups at different economic levels. On the other hand, the changes in Taiwan's health expenditure as percent of GDP after the crisis was not consistent with that in economic development. Regarding the reason, we have showed that the BNHI vis-à-vis the other governmental departments has received much more favour, so that its health expenditure could be less affected by economic downturn. Related to this is the fact that the consideration of securing the electorate's support dominated the decision-making of the political parties, so that the curtailing of NHI funding was left untouched.

In the context of globalisation, the final part of this chapter has explored the underlying logic of the structural diversity in dominant international organisations relating to health and economy respectively. By comparing two concrete examples –

that Taiwan's participating in the WTO was successful but that its participating in the WHO was unsuccessful, it is highlighted that the analysis of granting-membership in the global agencies must be embedded in the international political and economic context, but with fundamental differences: economic globalisation is a supreme value and a pragmatic course; global health is an ideal objective being short of efficient methods to improve inequities.

Before ending this chapter, there is one more thing worth noting: NHI reform is not independent from the fashion of international healthcare reform (Ham, 1997: 24) or 'cross-national borrowing of reforms' (Bjorkman & Altenstetter, 1997: 1), despite Taiwan's diplomatic isolation from the international organisations involved in this. Examples have been many: adopting prospective budgeting strategies (e.g. global-budget payment, case payment, capitation) to attain improved cost containment (see Chapter 6), and promoting market-like mechanisms (e.g. competition, consumer choice) to increase economic efficiency (see Chapter 7). Moreover, the NHI is a health care system that upholds scientific-technological rationality under the globally popular ideology of medical dependency (Sass, 2000: 712). Nowadays it is not only in medical encounters that high technological dependency is a norm, but also generally in the governmental policy process, in which the technocrats try to find technical solutions for the unintended results of globalisation. This technical-rational approach is therefore itself a manifestation of globalisation.

CHAPTER NINE

SUMMARY AND CONCLUSIONS

Our narrative account of the Taiwanese health care state and its influence on the progress of medicalisation is now drawing to an end. It has sought to develop a 'contextual understanding' of the processes involved, by presenting the narrative of Taiwan's health care reforms in a historical policy context. The 'storyline' of the thesis has been centred on the construction and transformation of medicalisation and medical dominance, based on an analysis of the interactive relations of the 'medical triangle' involving the state, the profession and the public. In tune with a cultural approach to health policy, I have adopted an overarching framework that was concerned with the configurations of ideological factors and social forces, embedded in a broad context, integrating the macro-, meso-, and micro-levels of analysis. In short, this empirical evidence presented in this thesis has attempted to uncover the background assumptions of the policymaking and behavioural strategies that have underpinned the development of a medicalised society, as part of a broader shift to modernisation and changes in ideology and public discourse (Rueschemeyer & Skocpol, 1996: 308).

In the following section, I will first review the main issues and findings presented already in the earlier chapters, dividing them into three groups: the state and the development of medicine; the processes of medicalisation and the formation of professional dominance; and globalisation and health. During this process, I will answer the questions raised in Chapter 1 from the overall perspective of this research study, responding to sociological debates on medicine and society, and identifying

new lines of enquiry that will be useful for further research. Finally, I will draw conclusions about the patterns and consequences of Taiwanese health care reform, with special reference to the ongoing SARS outbreak in Taiwan.

9.1 The State and the Development of Medicine

As the role of the state in shaping the development of medicine and its delivery to the population is the main concern of this study, I have pointed out the significance of state ideology in enabling the legitimation of medical intervention and in affecting the construction of medical knowledge through health care reforms. Simply stated, the state played a key role in leading the Taiwanese health care system towards a biomedicine-centred model, which supports the ideology of scientific rationality, as a legitimised 'world-view' upheld in general to replace traditional notions about health and illness. Instead of a linear process, this development consisted of several transitional stages and was strongly influenced by outsiders, revealing a shift of medical paradigms. This occurred first from a traditional Taiwanese model to a model of 'missionary medicine', then to a model of colonial medicine in the mode of a German-Japanese paradigm, finally to a post-World War II American model. During these processes, significant changes in the nature of medicine and in the relationship between the profession and the state occurred, which I will now recap briefly.

Within a long historical context, I represented in Chapters 4 and 5 a political-economic approach to the analysis of the evolution of Taiwan's health care state, as far as the structural factors impinging on medicine becoming a profession are concerned. An important theme that emerged was that the development of modern medical care in Taiwan had a close link with the progress of modernisation, in that

medicine often served as a ruling tool of the state to achieve particular political or economic purposes. Contextualised in the process of Taiwan's modernisation up to 1945, I emphasised in Chapter 4 the significance of state political ideology in determining the advancement of state health measures. Specifically, Western medicine was first brought to Taiwan by European settlers from the 1620s, in the pre-modern period, and it played only a limited role in seeking to protect the health of settlers, who showed only a commercial interest in trade with Taiwan. Later, a more extensive programme of modernisation was carried out by the Chinese government in the 1880s, with the aim of realising a tentative Westernisation project, in which Western medical advances were introduced on a broader scale. However this primitive development was quickly curtailed when the Chinese empire faced financial pressures.

It was not until medicine became a tool of civilising the indigenous people by imperial nations that a substantial transplantation of the Western biomedical model to Taiwan was seriously initiated, and this consequently gave rise to the emergence of two new types of medical paradigm. Firstly, Western Christian missionaries arrived in Taiwan in the 1860s, as a result of the expansion of Western imperialism, and they introduced modern Western medicine with the aim of establishing contact with the indigenous population. A paradigm of 'missionary medicine' was thus set up and this contributed to the bringing-in of a biomedical analysis of disease, in place of the traditional notion of viewing offending gods/ghosts as the cause of sickness. Clinically-based medical training was also introduced. Relevant to this development was the heritage of Scottish medicine, which had an important influence in shaping the basic features of Taiwan's modern medical system. This is a point that has been

previously ignored in studies of Taiwan's medical history.

Secondly, the Japanese government during its colonial reign in Taiwan from 1895-1945 made significant use of modern medicine, through the establishment of an approach involving strong state interventionism in public health. Medicine achieved its great influence not only in protecting the health of settlers and soldiers, but also in facilitating a wider process of transmitting imperial ideology and practice to the indigenous society. Based on the indirect influence of German medicine, the Japanese introduced the institutionalisation of medical research funded and centrally controlled by the state, for example in the case of developing tropical medicine research. This period was an era of colonial medicine, in which we can identify a growing mobilisation of the medical profession, as a subordinated group, serving to implement the imperialistic state's colonisation plan.

The expansion of the biomedical model in Taiwan was established at the cost of the traditional system, under the guidance of Japanese-colonial governors, who valued a scientific approach to state health care and considered traditional Chinese medicine to be backward, belonging to an under-developed society. A similar viewpoint can still be found in the present-day health policy of the Department of Health (DoH), which has been keen to promote the 'modernisation' of Chinese medicine, mainly involving two dimensions of reform (DoH, 1994a: 192-9; 1997a: 130-6). First, the DoH has embarked on a programme of radical manpower reform that involves the standardisation of medical education, examination and practice, modelled heavily on the existing Western medical physician system. Second, a control system of Chinese pharmacies has been established to facilitate a programme of 'upgrading the quality of Chinese medicine to develop scientific Chinese medicines' (DoH, 1997a: 132).

Important measures are, for example, requesting Chinese medicine factories to manufacture Chinese herbal medicines to practise GMP, standardising Chinese medicine prescriptions, encouraging the performance of clinical trials. On the administrative side, Chinese medicine affairs appear to have little importance in the DoH's policy agenda. For one thing, an independent agency, the Committee on Chinese Medicine and Pharmacy, in charge of the administration of research into and development of Chinese medicine and pharmacy, was not established until November 1995, and the number of its personnel has been continually maintained at a very low level, in comparison with the DoH's other subordinate organisations (see Table 9-1).

Table 9-1 Number of Personnel in National Health Agencies
(1991-1998)

	Total	Dept of Health	National Lab. of Foods & Drugs	National Institute of Preventive Medicine	Narcotics Bureau	Quarantine Station	Bureau of National Health Insurance	Committee on Chinese Medicine & Pharmacy
1991	942	257	256	171	64	194	-	-
1992	1,037	355	250	166	65	201	-	-
1993	1,142	353	249	167	99	205	69	-
1994	1,111	336	245	178	66	211	75	-
1995	2,890	334	239	176	65	205	1,839	32
1996	2,749	353	243	174	64	212	1,668	35
1997	3,017	257	242	173	64	217	1,781	39
1998	2,721	258	250	172	66	212	1,726	37

Source: DoH, *Health and Vital Statistics*, 1998.

Notes:

1. The Bureau of National Health Insurance (BNHI) was established in March 1995.
2. There was a re-organisation of governmental health institutions in 1999. Thus, we take account here only of the statistics up to 1998.

Chapter 5 focused on the development of medicine in the post-World War II era. During this period, a third medical paradigm, that of a post-war American model, was gradually formed, linked to the reciprocal interaction between the US and Taiwan states, and dependence of the latter on the former, which facilitated a wider process of transmitting American values and medical practice to Taiwan. This ‘Americanisation’ of Taiwanese medicine entailed the development of a more collegiate professionalism, which contributed to the development of the greater individual autonomy of Taiwanese physicians, whereas the previous Japanese-German system had involved a hierarchical medical system. As a consequence of this, the medical profession started to constitute itself as a social actor with a powerful potential in the political sphere. Equally important was the forming of a new pattern of Taiwanese doctor-patient relationship, i.e. the ‘sick role’ (Parsons, 1951, 1978) of mutual obligations borne by doctors and patients, both of which require effective treatment within a ‘liberal’ system of governance.

In this thesis, the analysis of the evolution of the post-war Taiwanese health care state was embedded in the trajectory of Taiwan’s industrialisation, i.e. economic modernisation. Based on the understanding that the state health effort before the 1980s served mainly as a ‘human capital investment’ strategy pursuing the raising of labour productivity, I pointed out that ‘industrial achievement-performance’ was the main basis for welfare in the post 1950 era. In this regard, the Taiwan case could be said to have supported the perspective of the ‘logic of industrialism’ (Kerr *et al*, 1962) as well as the convergence theory, which suggests a link between economic development and the growth of welfare state spending (Wilensky, 1975). On the other hand, however, I suggested that the economic dimension only does not make it

possible to explain the changes that occurred after the mid-1970s, referring to a growing role of 'welfare' in state economic and social planning and public legitimization. I highlighted the significant role of political ideology in leading to growing state attention to health care, as the state gradually departed from being military-oriented and totally preoccupied with issues of security. Important in such an argument was the adoption of the theory of state autonomy to interpret the establishment of the medical-industrial complex being developed to match specific economic and political needs of the state. The exercise of state autonomy was clearly evident in the process of the Guomintang state's policy initiation of a social-insurance approach to health care. The initial health-care provision could be seen as an authoritarian political strategy, in that it involved a function of benevolent control over the key social groups so as to raise the internal legitimacy of the Taiwanese state, faced with a challenge to its statehood from China in the context of the Cold War order. In the context of the post-war authoritarian governance, we could say that there was a growing mobilisation of the medical profession to match critical political shifts.

As economic liberalisation and political democratisation came to the fore in the 1980s, the authoritarian state gradually lost its dominant role in controlling Taiwan's economic development. In view of this, I adopted the theory of 'pressure from below' to explain the change in state health provision in the 1980s and 90s, supporting an expansionist approach to health care provision. I suggested that this change was by and large a product of state politicking in pursuit of maintaining its legitimacy, because at that time the Guomintang was experiencing increasingly heated party competition together with greater public demand for social reforms. On the other hand, there were serious operational crises existing within the existing health care

system, including the incompetence of the government bureaucracy in sorting out the problems coming from the divergence among different health care schemes, and significant financial pressures threatened the main schemes. At a time when authoritarianism was in rapid decline, these problems remained difficult to solve, and consequently a new National Health Insurance (NHI) was launched in 1995 to reinforce the Guomindang's flagging prestige.

The analysis of the NHI case in Chapters 6 and 7 underlined the fact that the state was still a very important figure in affecting Taiwan's health care reform in the post-authoritarian era. The NHI represents systems of surveillance and control, in that the state has provided the grounds for operative influences over medical practices and the construction of medical knowledge. The NHI, as a health care system that upholds scientific-technological rationality, has contributed to the growing dominance of the Western biomedical model in Taiwan. In some instances, however, traditionalism is still affecting medical practice, for example in the case of excessive prescription. I showed that this medical practice may be underpinned by specific cultural notions related to the legacy of traditional Chinese medicine.

This thesis highlights the fact that NHI care has shown a dominant tendency towards relying on technical forms of modern medicine, in which trusting doctors is a prominent feature. The system of curative health care has been expanded with the underpinning of a medicine-centred philosophy, revealed by the fact that Taiwanese doctors and patients prefer 'quick' solutions. Important to this phenomenon is the evolution of the sick role. Within the NHI, we can see greater mutual participation of patients and doctors in the processes of medicalisation. In regard to this, the underlying logic of Taiwan's social security system is doubtless crucial to the

development of the social aspects of medicine as an institution of social control, as Parsons posits (1951, 1978). Simply stated, there is an implicit faith in the work ethic as the basis for welfare, and accordingly the period of being sick is not always paid for by the system. In this context, a sick person 'must' get better quickly. This moral norm seems still to exist in the current NHI system, typified by the arrangement whereby the NHI insurance beneficiaries are established on the basis of people's occupational affiliations. In the case of the unemployed, they are impelled to change their NHI beneficiary category and charged with a new insurance premium, which in many instances is higher than that previously paid. In addition, the NHI allows hospital shopping, which encourages over-use of NHI medical resources.

In recent years, the growing emphasis on managerialism within medical institutions together with the implementation of the NHI has caused the medical system to move more towards a profit-making direction. The relationship between the development of the medical-industrial complex and that of the capitalist system has become ever closer. Doctors are now a significant pressure group, but patients are not and experience difficulties in mobilising in relation to the state-profession alliance. In this regard, it is necessary to link this to the inherent quality of the contemporary Taiwanese health care state, and associated processes of medicalisation, to which I will now turn.

9.2 The Processes of Medicalisation and the Formation of Professional Dominance

In terms of medicalisation, this thesis examined in Chapters 6 and 7 a great deal of empirical evidence within the context of the NHI, and argued that the NHI system has played an important role in stimulating the process of medicalisation and fostering a

culture of dependency and passivity associated with medical technology and the healing relationship. This argument was grounded in the analyses of the wider context of the policy at the institutional and interactional levels, consisting of three pairs of relationships: the state-profession relation, the profession-public relation and the state-public relation (Chapter 2).

As far as the state-profession relationship is concerned, the NHI has extended the influence of doctors, but provides the basis by which medical autonomy has been undermined. Referring to the former, the growth of medical professional power has emerged as a by-product of the implementation of the NHI scheme, since the NHI now guarantees a continuous resource of patients for physicians and therefore provides the grounds for the growth of professional dominance. At a time when authoritarianism has declined fast, the NHI represents the state handing over power to the profession. Doctors have gained a legitimate position to bargain with health authorities for better medical reimbursement. Their influence has even reached the policy-making level by means of legislative action, such as lobbying legislators or DoH officers to support acts beneficial to them. In addition, recent progress in professional autonomy has been seen in the implementation of the global-budget payment system, as a major NHI payment reform in pursuit of cost containment as well as the reduction of NHI administration, where medical professionals are empowered with more space for self-governance. Based on the fact that doctors' collective power was under-developed in the previous system owing to authoritarian governance, this payment system reform has signalled that the liberalisation of professionalism is coming to the fore.

However, the other side of the coin is that professional autonomy is being

eroded, since the NHI has enabled a new system of governance of medical services. The medical profession has been put under greater state scrutiny, as a result of the employment of NHI administrative targets and fiscal controls. Faced with such a powerful state, the medical profession has developed a variety of strategies to beat the price controls of the BNHI. As a consequence of this, over-medicalisation has become a norm in Taiwanese medical encounters. In some instances medical providers have even caused iatrogenic damage, for example in excessive check-ups and examinations, and over-medication. Alongside the growth of medicalisation is the formation of a more dominant doctor self-image, which has in turn caused the doctor-patient relationship to become more impersonal.

As far as the profession-public relationship is concerned, doctors have been able increasingly to extend their professional autonomy over treatment in the medical encounter, as encouraged by the NHI fee-for-service payment system. They have shown a growing tendency to abuse their freedom to pursue economic interests, typified by the increase in provider-induced demand and the reduction of diagnosis time. Relevant to these developments is the increasing use of managerial tactics, within large hospitals in particular, as a result of the development of the corporatisation of medicine. In the case of the change in the payment system from salary to fee-for-service, hospitals have excelled at controlling doctors' work through squeezing their labour in the name of creating a common interest, and consequently over-medicalisation has been encouraged to a substantial extent.

On the patient's side, it seems that people's health care aspirations have been transformed into deeper dependence on modern medicine, due to easy access to NHI care. In this regard, patients themselves are encouraging medicalisation, because they

are demanding and over-using modern medicine, for example in the cases of hospital shopping and accepting over-treatment. On the one hand, the public seems to have developed an attitude of 'taking advantage' of the NHI system. On the other hand, the competence gap plus the paternalistic relationship existing between doctors and patients have helped to shape a culture of medical dependence. From patients' viewpoints, there is a possibility of being able to trade off over-medicalisation for better treatment. In many instances, cultural factors play an important role in affecting Taiwanese doctors' and patients' health behaviour strategies. Within the NHI, people's health help-seeking behaviour has been fuelled to such a degree that a 'consumer culture' has developed. For example, the fact that the public hold a common view of a good doctor as being capable of seeing many patients could have been a crucial factor in stimulating over-consumption of outpatient visits. Related to this, the NHI's failure in the gate-keeping of patient-referrals has enabled the development of consumers' autonomy towards a complete freedom to visit large hospitals at will, with potential reference to a cultural background that Taiwanese people have a common view of the value of medical visits: 'the bigger the hospital, the better the service'.

Concerning the change in the state-public relationship, associated with the growing emphasis on consumerism in the NHI, is some kind of potential challenge to aspects of patient subordination within the sick role. In this respect, I charted the contribution of the courts in extending the coverage of consumer protection to medical services through applying strict liability to doctors in a specific medical malpractice case. However, consumerism has not yet impacted the medical profession to any significant extent, since the medical malpractice resolution system has been

generally ineffective in finding solutions to doctors' dominance over the medical encounter. This has been facilitated by the fact that, on the administrative side, the DoH supported the medical profession in setting out a limited liability for medical injury through legislative action.

Within the civil society, patient rights movements have emerged in recent years as a result of dissatisfaction with the unequal distribution of health care, stemming from the politics-driven governmental systems, alongside the revelations about the abuse of medical professional power. In fact, the movements have gone beyond a doctor-blaming approach and have shown concern about medical system reforms, with a view to seeking solutions to problems resulting from medical commodification. The state has become a focus of hope for Taiwan's patient rights movements, due to its being considered as an able body with the power and ability to regulate the unrestrained medical profession. Moreover, there is a common ideology among social pressure groups that the state should prevent vulnerable members of society from falling victim to the capitalist system. I suggest that this expectation has close linkages with the tradition of the paternalistic state. That is, Taiwanese people have become used to the nature of state-run public services. As the emergence of the NHI represents a shift towards a more 'social citizenship' model, the state has been given grounds for the expansion of regulation and surveillance (Turner, 1995: 217).

It is in this context that the NHI proposed privatisation reforms have caused concern among consumer groups about a weakened state role in the health care system. Considering the BNHI's role as a regulator and an overseer in the NHI marketplace, this thesis has pointed out a myth embedded in the recent NHI reform relating to its shifting towards a consumerist model. That is, the growing

consumerism within the BNHI will make it difficult to improve consumer rights to any considerable extent, because the state has been impotent to tackle the problem of deepening medicalisation, which has weakened patient autonomy but enhanced medical dominance. In this regard, I argue that the NHI's consumerism has hitherto been functioning more as a political tool, serving to transfer public attention to the NHI from the government's inability to deal with NHI cost control. For one thing, governmental bureaucracies seem to have compounded patients' experience of health care consumption with their experience with the administration of the BNHI. A serious reminder has been raised: the growing use of consumerist terminology within the NHI may have the effect of weakening citizenship rights on the basis that consumerism is generally contextualised within a capitalist and market-based system, enabling the state to compromise its role of directly responding to people's demands for better quality health care.

9.3 Globalisation, Economic Development and Health

Based on the understanding that there is generally a marked correlation between national economic growth and health improvement in most countries, in Chapter 8, the last substantive chapter of the thesis, I examined the implications of Taiwan's impressive economic gain for population health and health policy. In short, Taiwan's 'economic miracle' was a result of its global economic development, initiated in the late 1960s. The outstanding economic growth and rise in living standards, in turn, contributed to making considerable improvements in population health, typified by a reduced infant mortality rate, raised life expectancy and rapid epidemiological transition. As far as health transition is concerned, it should be noted that there has

been observed an outbreak of infectious and acute diseases in Taiwan recently, referring to the reappearance of dengue fever in 1987 onwards and the outbreak of an enterovirus epidemic since 1998. Since the epidemics of both diseases are related to unhygienic environmental conditions and individual health behaviours, this new phenomenon seems to show that the epidemiological transition can suffer reversals. As this study has disclosed, there is a trend towards deepening medicalisation in present-day Taiwan, underpinned by the state's medicalised policy, which emphasises quick-fix curative medicine and continues to lack a focus on public health. Such a system may therefore not help Taiwan to face current challenges to public health.

Taiwan's substantial health improvement was also revealed by the fact that Taiwan reached considerable income equality, from a comparative standpoint, during the process of its rapid economic development. This result implied that Taiwan had a low degree of health inequality among social groups, as discussed by Wilkinson (1999a, 1999b). However, there has been observed an enlarged gap of income distribution in line with the development of economic liberalisation. This thesis argues that this tendency should lead to more attention to the negative effects of deepening economic liberalisation on existing health variations. Added to this, the recent economic recession plus the NHI reform, relating to an increase in NHI premium rate and additional co-payment for outpatient services, have further injured the economically disadvantaged, constituting a barrier preventing access to NHI care. I also identified other damaging effects brought about by Taiwan's economic globalisation, leading to structured health inequalities among disadvantaged groups. Two particular types of health division were analysed. Firstly, the indigenous population, as the ethnic minority living in worse social-economic conditions, have

been left at a disadvantage in health conditions, and this is closely related to Taiwan's economic modernisation programme. Secondly, foreign workers have been introduced to Taiwan as a consequence of the global division of labour, who are at a distinct disadvantage in the context of health, due to their inferior and unhealthy working conditions, language problems in gaining access to medical services, and practical difficulties in making a claim for occupational injury. In addition, my analysis of foreign workers was extended to those employed by Taiwanese outward investors in neighbouring countries. They may have become the recipients of Taiwan's 'exported occupational hazards', as a result of the economic globalisation that supported Taiwanese 'sunset industries'.

With a view to seeking an explanation of the divergent trends in global health, the social impacts of the Asian Financial Crisis of 1997 on Taiwan were examined in this thesis, in relation to their implications for health. Despite the fact that Taiwan's economic growth remained rather sluggish in the post-crisis era, the changes in Taiwan's health expenditure as a percentage of GDP after the crisis were not consistent with those in economic development. In view of this, I argued for a 'structured divergence' approach to the explanation of Taiwan's health expenditure. That is, in the context of Taiwan's party politics, the consideration of securing the electorate's support actually dominated the decision-making of the political parties, so the curtailing of NHI funding was left untouched. Equally important is the reminder that there is a possibility that the existing health inequalities may be enlarged, since rising unemployment plus a decrease in educational expenditure have appeared after the crisis.

On the other hand, this research has explored the underlying logic of the

structural diversity in dominant international organisations, through a comparison of the cases of Taiwan's participating in the WTO and WHO. By revealing the paradoxical dimensions to the practicality of globalisation, this thesis argues that economic globalisation is a supreme value and a pragmatic course; global health is an ideal objective but is short of efficient methods to improve inequities.

9.4 Concluding Remarks

Overall, my analysis of Taiwan's health care reform has underlined the rising importance of the state's role in facilitating the development of professional expansionism and in enabling the establishment of the 'medical empire', operating through a top-down approach, with one by-product being undermined professional autonomy due to greater state scrutiny. As far as the contemporary course of medicalisation is concerned, the NHI has furthered the process of medicalisation, on the grounds that the influence of biomedicine and medical power has been extended with the backing of state health policy, which has provided considerable grounds for increasing medical intervention in social life and social relations.

Equally importantly, this thesis has demonstrated a bottom-up approach to the construction of medicalisation with regard to the mechanism for shaping people's conceptions and behaviours towards supporting an ideology of over-using public medical resources. In summary, there are three dimensions to factors contributing to the formation of a medicalised society. Firstly, there was a lack of a parallel development of the full thrust of citizenship to the expansion of modern health care within the process of Taiwan's modernisation. In other words, despite the fact that the development of modern health care has been in tune with the progress of modernisation from the beginning, the linkage between health care and citizenship

rights was not established until very recently, referring to the implementation of the NHI. The NHI does not have strong de-commodifying effects, in spite of being universal and solidaristic. The provision of state health care has facilitated a commodification of the status of individuals to accord with the principles of the capitalist system, and accordingly the notion of 'socialistic solidarity' has been absent from the development of the Taiwanese welfare state. Added to this, the authoritarian governance of the Guomintang state gave rise to a culture of paying little attention to public affairs, involving even a lack of care about other people. Secondly, the success of Taiwan's industrialisation in the post-World War II era has not only contributed to its transition to a 'modern' society, typified by its impressive economic and health gains, but it has also cultivated a capitalist ideology that views pursuing profit as the golden rule and believes in the value of work performance in the market. People are encouraged to work hard and make the best use of their 'freedom' to pursue their greatest interests. Thirdly, the Taiwanese general public can now enjoy great freedom of political democracy, but they have not yet had much experience of social democracy. One influence of this is that Taiwanese patients have been feeble in exerting pressures for social reform. They tend either to keep quiet or turn to the state for help.

The above-mentioned backgrounds have important implications for the development of medicalisation. Towards public service, people generally do not have a notion of sharing the responsibility for maintaining its existence; instead, they tend to view it as 'other people's business'. In the case of the NHI, both the public and the profession have an attitude problem of 'taking advantage' of the system. The abuse of autonomy to pursue private interests is the norm. Also, people do not take the NHI economic crisis seriously, for they do not think the state will one day die.

In one way the NHI crisis represents the crisis of the Taiwanese welfare state. In terms of this, there is a myth embedded in the contemporary NHI reform. Established on a rational model, NHI policy drafting has been running short of concern and sensitivity in understanding the social construction of medical knowledge, and consequently this is the basis for the abuse of medical professional power. Added to this is the fact that the NHI reforms have progressed in accord with the principles of NHI politics, serving the needs of political parties which need to retain public support. In this context, in spite of the fact that the NHI governance of the consumption and provision of medical services has thus far made some impact on the increase of NHI medical expenditure, cost containment as the main goal of governance will finally end in failure. The reason is that it will be impossible for health technical bureaucrats to work out an 'accurate' calculation for the NHI without sufficient reflection on growing medicalisation, which entails an increase in excessive consumption of medical resources. In addition, the NHI is departing from a patient-centred approach to health, and the corollary of that is the state is losing the focus on public demand for greater social equity. Because the nation's health agenda is established by such a problematic system, it is difficult to implement useful solutions to the problems caused by over-medicalisation. These potential problems may turn out to be a serious political crisis and threaten the ruling legitimacy of the Taiwanese state in the future, when the civil society becomes more mature.

At this present time, SARS, as a new type of fatal infectious disease, is spreading through many areas of Taiwan, with the thrust being the rapid transmission in several large hospitals occurring since late April 2003. Health-care staff have so far suffered from high infection and fatality rates of SARS. Their infection rate has even reached 32%, at the highest, connected with the outbreak in Taipei Municipal He-Ping

Hospital (China Times, 2003c), where the first hospital infection occurred. In terms of the three major hospitals that had severe transmission inside the institution, i.e. He-Ping Hospital, Ren-Ji Hospital in Wanhua and Chang-Geng Memorial Hospital in Gaoxiong, it was reported that their SARS outbreak was highly connected with the administrative negligence of high-ranking hospital managers about concealing the information of SARS transmission from their medical workers, due to considerations of continual hospital operation – if their SARS transmission was known by the outside world, patients would no more come to the hospital; even worse, the health authority might seal off the hospital if the situation was considered serious¹. Further research into the reasons for the SARS outbreak and its social impacts on Taiwan will clearly be needed in the future. Referring to this present study, I would like to point out here that the SARS outbreak in Taiwan's hospitals must be largely related to the growing use of managerialism in medical institutions, focusing less on health workers' health and working conditions but more on their financial contribution to hospitals.

Besides this, development of Taiwan's health-care system characterised by medicalisation has given rise to medical-care institutions and staff being largely ignorant of the importance of preventive medicine. Thus, despite the fact that Taiwan has a reputation for a good quality of medical practice (see Chapter 8), its hospitals have not yet performed competently in this on-going battle against SARS. The situation of 'excessive death' of health workers and the general public resulting from new types of communicable diseases will be improved in the future, if more attention can be paid to the fact that this current health-care system is not going in the right direction.

¹ The Taipei Municipal He-Ping Hospital was sealed off by the Taipei City Bureau of Health on 24th April without any notification in advance, since its SARS transition was considered out-of-control.

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