Letters

COMMENT & RESPONSE

Further Considerations on Autism Diagnosis

To the Editor Liao and Fombonne[1] rightly caution that diagnostic inflation may dilute services for those with the highest support needs. We agree that more advantaged families navigate the medical system more effectively, but this pattern is more parsimoniously explained by social determinants—urban-rural disparities, parental education, and household resources—than by overdiagnosis itself. Attributing it to diagnostic inflation misidentifies the source of inequity; the implication is system reform, not retrenchment.

By late 2025, 24 586 individuals were registered with autism in Taiwan's national disability certification system, with 76.5% classified as mild[2]—closely paralleling the milder presentations Liao and Fombonne[1] describe. A central feature of Taiwan's response is its architecture. Single-payer national health insurance covers 99.9% of residents, with diagnostic evaluation and rehabilitation services (speech, occupational, and physical therapy) complemented by publicly funded developmental screening for children younger than 7 years, although capacity constraints, diagnostic delays, and uneven distribution persist. By contrast, autism coverage in the US is fragmented by state, payer, plan type, and age. Medicaid waivers with long waitlists, employer-exempt plans, and coverage variability can disrupt service continuity. Universal architecture does not eliminate these inequities, but it removes the structural barriers—such as insurance geography, payer type, adult-age cliffs—that compound them.

The US Centers for Disease Control and Prevention's most recent autism and developmental disabilities monitoring data (1 in 31 eight-year-olds; approximately 40% with co-occurring intellectual disability where assessed) confirm that prevalence growth is real; profound autism remains a meaningful proportion requiring lifelong support.[3] Yet autism's population-level prevalence remains lower than that of major noncommunicable diseases, which are more amenable to risk-factor modification. Reducing investment to chase that asymmetry would misdirect policy priorities: autism imposes lifelong caregiving and economic burden on families[4] that risk-factor strategies driving noncommunicable disease prevention cannot offset.

Early intervention improves developmental trajectories[4]; marginalization of children with profound autism reflects their systematic exclusion from intervention research, not diagnostic breadth itself.[5] Narrowing eligibility would compound this—girls and women, who are diagnosed later and less frequently despite comparable functional impact, would be the first excluded.[4] Eligibility tied too tightly to categorical labels rather than functional need is the architectural problem. Inequity in access—not diagnosis itself—drives adverse outcomes.

The issue is not whether overdiagnosis exists; it is whether health systems can serve as durable social protection mechanisms across the life course—from caregiver-centered early intervention, through resourced inclusive education, to adult employment and community supports—for families confronting a condition that does not pause when public attention does. Taiwan's experience, imperfect but instructive, suggests a more constructive path than narrowing the diagnostic gate.

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Published Online: August 17, 2026. doi:10.1001/jamapediatrics.2026.3408

Conflict of Interest Disclosures: Dr C.-T. Hsu is a parent of a child with autism spectrum disorder. This personal experience has informed the author's longstanding interest in autism service policy but does not represent a financial or institutional conflict of interest relevant to the submitted work. No other disclosures were reported.

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