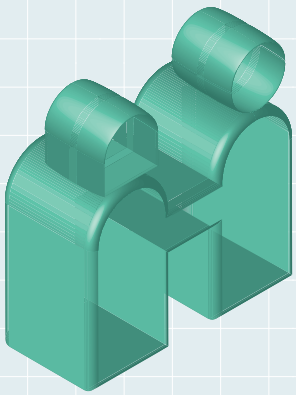

2022-2023
Annual Report
全民健康保險年報
NATIONAL
HEALTH
INSURANCE



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署長的話

臺灣實施健保27年了，健保27年來守護民眾健康，在2020到2022年COVID-19疫情席捲全球的期間，也不例外。COVID-19疫情期間，健保署運用「健保醫療資訊雲端查詢系統」、「健保卡註記TOCC」、「遠距醫療」，讓防疫更加即時且民眾更容易取得醫療照護。此外，「全民健保行動快易通｜健康存摺」APP（以下稱健保快易通APP）幫助民眾照顧自身的健康，透過健保快易通APP，可查看COVID-19病毒檢測結果及疫苗接種紀錄資訊，亦可連結至「數位新冠病毒健康證明系統」，使民眾更方便下載疫苗接種、檢驗結果及接觸者隔離等證明文件。PCR檢測結果若是陽性，可透過本署LINE@及APP連結「COVID-19確診個案自主回報系統」回報，簡化作業流程。

為推動數位轉型健保服務，配合國人使用Line習慣，健保署整合本署全球資訊網、「全民健保行動快易通｜健康存摺APP」、智能客服及FB等跨平台，本署Line@官方帳號推出新功能，可查詢虛擬健保卡申辦方式、視訊診療院所名單、藥品及醫材價格、附近的醫療院所及藥局，並可直接預約掛號，亦可查看各項健保服務等資訊。並將持續開發新功能，提供民眾個人化數位服務。

近年來由於人口老化，醫療新科技發展，醫療費用逐年上升，對健保財務產生壓力，為了健保永續，健保署推動改革，以分級醫療及負擔公平為主軸，並強化使用者付費精神。如果全臺灣每人都減少一次就醫，就可省下三百七十八萬點數，讓真正需要新藥、新科技、新特材等治療的病人獲得照顧，醫學中心回歸緊急重症照護之角色，醫療資源更有效率運用，全民共同珍惜健保資源，讓健保永續經營。

配合政府新南向政策，疫情期間健保署持續以視訊會議方式與國際交流，長期與菲律賓、泰國及越南進行深度雙向交流。2022年辦理「APEC數位健康照護與創新研討會」，邀請會員經濟體包括美國、日本、韓國、泰國、菲律賓、澳洲及加拿大等經濟體共同與會，討論交流各國發展數位健康照護的經驗，並透過本次研討會持續與國際交流互動，展現我國醫衛軟實力，提升我國國際形象及聲譽。

健保署持續落實醫療平權及照顧弱勢，並營造病醫雙贏的醫療生態環境，為Health for All目標努力，共創健保、醫療提供者與被保險人三贏。

衛生福利部中央健康保險署　署長 李伯璋

Message from the Director General

Over the past 27 years, Taiwan's National Health Insurance (NHI) program has played a key role in safeguarding the public's health. The period between 2020 and 2022—when the COVID-19 pandemic ravaged the world—was no exception. During this pandemic, the National Health Insurance Administration (NHIA) drew on such tools as the NHI MediCloud System, TOCC's marks on the NHI card, and telemedicine. These services provide the public with timely medical care and reduce the risk of infection. In addition, the NHI/My Health Bank APP (hereinafter referred to as the NHI APP) enables the public to take care of themselves. Through this app, people can check COVID-19 test results and vaccination records and tap the hyperlink to the Digital COVID-19 Certificate website to download such documents as vaccination records, test results, and isolation certificates for contacts with confirmed cases of COVID-19 infection. In the event of a positive PCR test result, it can be reported via the NHIA's LINE@ official account or the aforesaid app to Taiwan CDC's COVID-19 Self-Reporting System.

Local people's preference for LINE for instant communications is given special consideration in the digitization of NHI services. As such, the NHIA decided to integrate services across platforms—its website, the NHI APP, smart customer service, and Facebook page—as a number of new features on its LINE@ official account. LINE users can now learn about the way to apply for virtual NHI cards, list of medical institutions offering video consultation, prices of drugs and medical devices, medical institutions and pharmacies in one's neighborhood, and other NHI services, as well as make appointments with medical institutions. In the days ahead, the NHIA is ready to develop more new features in the way of personalized digital services.

Population aging and advances in medical technologies have driven a steady increase in Taiwan's medical care spending in recent years, thereby pressuring the NHI system financially. The NHIA has thus implemented wide-ranging reforms to ensure NHI sustainability. Priority is given to promoting the referral system and fair distribution of the premium burden while faithfully enforcing the user-pays principle. If everyone in Taiwan could seek one less medical visit, as many as 3.78 million payment points can be saved, thereby making available new drugs, technologies, or special medical devices to patients desperately in need of them and allowing medical centers to do what they are meant to do, that is, caring for emergency and acute cases. To ensure NHI sustainability, medical resources deserve to be treasured and used more efficiently.

In tandem with Taiwan's New Southbound Policy, the NHIA kept up bilateral dialogues with such countries as the Philippines, Thailand, and Vietnam via videoconferences even as the pandemic persisted. In 2022, the NHIA hosted APEC Conference on Digital Healthcare Innovation – COVID-19 Response by Health Information Utilization, bringing together participants from member economies including the U.S., Japan, Korea, Thailand, the Philippines, Australia and Canada to share their respective experiences on this front. In addition to keeping Taiwan in touch with the international community, this conference served as a platform for demonstrating the country's soft power in medical and health care and enhancing its international reputation accordingly.

Committed to promoting medical equality, caring for the disadvantaged, and creating a win-win medical environment for both care providers and recipients, the NHIA is set to keep striving for the goal of health for all that benefits NHI, the insured, and medical care providers.

Po-Chang Lee

Director General
National Health Insurance Administration,
Ministry of Health and Welfare

Chapter 1

組織沿革　承先啟後

Organization Structure and History

組織沿革　承先啟後

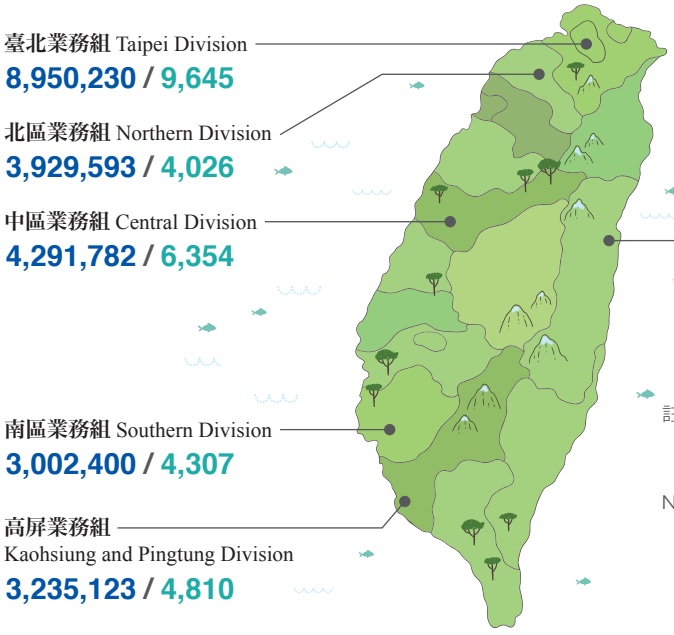
健保署前身為「行政院衛生署中央健康保險局」的金融保險事業機構，於1995年整併當時僅約59%國民可參加之勞保、農保、公保三大職業醫療保險體系，秉持永續發展、關懷弱勢的原則，擴展至全民納保的完整社會保險制度，期間歷經2010年改制行政機關及2013年政府組織整併，最終成就現行的全民健康保險公辦公營、單一保險人模式的組織體系。

全民健康保險為政府辦理之社會保險，以衛生福利部為主管機關。衛生福利部設有全民健康保險會，以協助規劃全民健保政策及監督辦理保險事務之執行，並設有全民健康保險爭議審議會，處理健保相關爭議事項。健保署為保險人，負責健保業務執行、醫療品質與資訊管理、研究發展、人力培訓等業務；健保署所需之行政經費由中央政府編列預算支應。

為有效推動全民健保各項服務，健保署除依業務專業性質設置專業組室，規劃各項業務措施之推動，在各地設有6個分區業務組（表1-1、圖1-1），直接辦理承保作業、保險費收繳、醫療費用審查核付及特約醫事服務機構管理等服務，同時設置22個聯絡辦公室，服務在地民眾。至2021年12月31日，在職員工計有3,032名。

表1-1　中央健康保險署各分區業務組

Table 1-1　The NHIA's Regional Divisions



保險對象人數／特約醫事服務機構
Numbers of the insured and contracted medical institutions

總計 Total
23,861,265 / 29,802

東區業務組 Eastern Division
452,137 / 660

註：1. 各主要縣市及金門、澎湖等地，設立7個聯合服務中心及22個聯絡辦公室，為民眾提供在地化服務。
2. 資料統計至2021年12月。

Notes: 1. Seven joint service centers and 22 liaison offices have been established in major counties and cities and on the offshore islands of Kinmen and Penghu to deliver localized services.
2. Statistics as of December 2021.

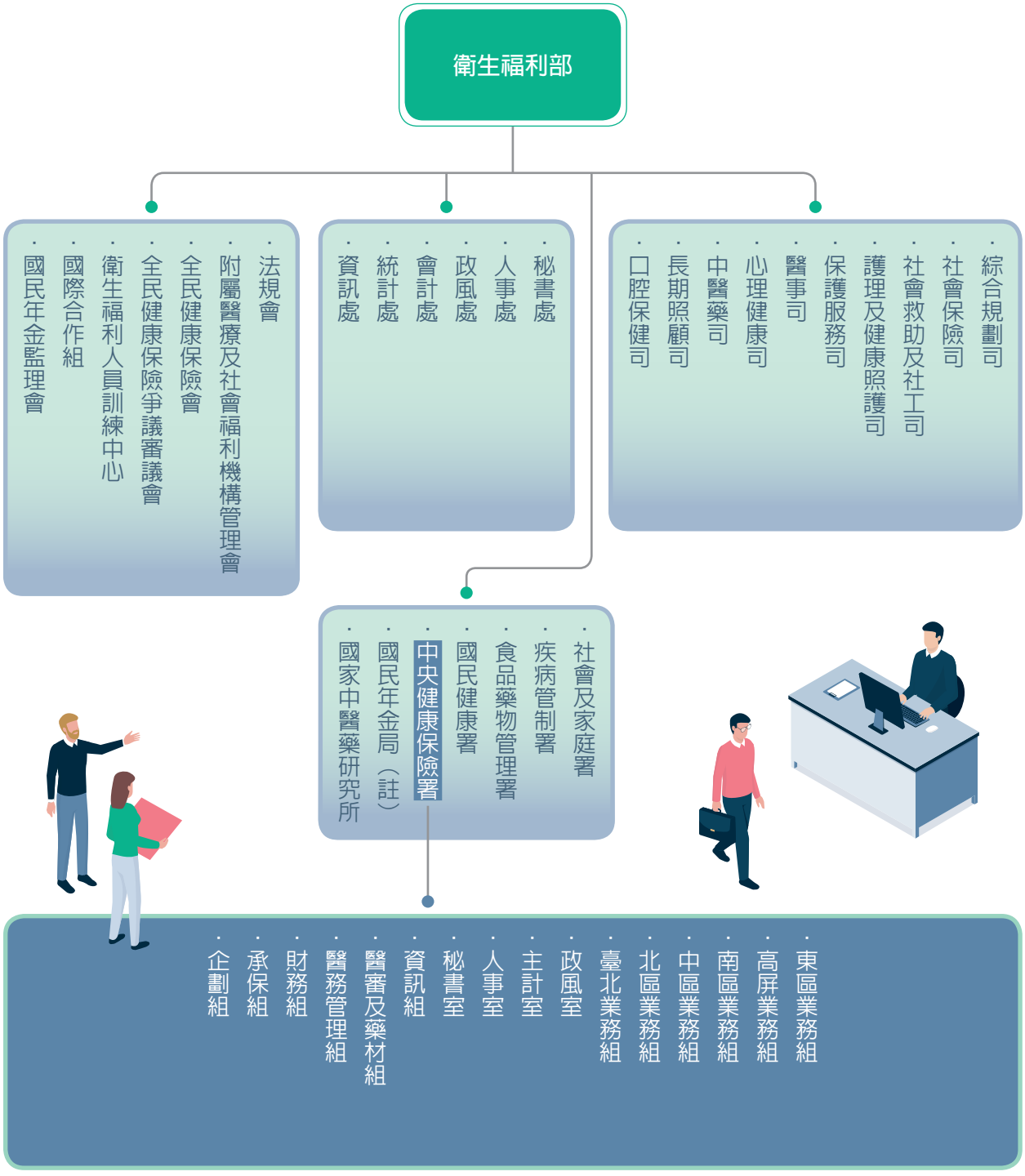
Organization Structure and History

The National Health Insurance Administration (NHIA) was formerly a finance/insurance entity known as the Bureau of National Health Insurance, Department of Health, Executive Yuan. In 1995, it was charged with integrating the country's three major occupational medical insurance systems meant for labor, farmers, and government employees that covered approximately 59% of the population at the time. On top of striving for sustainability and caring for the disadvantaged, this move was intended to develop a comprehensive social insurance regime that covers the entire population. Out of the NHIA's reorganization as an administrative agency in 2010 and the government's organizational consolidation in 2013 came today's National Health Insurance (NHI) system, which is a government-run, single-payer regime.

The Ministry of Health and Welfare (MOHW) is the competent authority of NHI, a type of government-run social insurance. Both placed under the MOHW, the National Health Insurance Committee is responsible for assisting in devising NHI policy and overseeing implementation of related affairs while the National Health Insurance Dispute Mediation Committee, settling NHI disputes. In its capacity as insurer, the NHIA is responsible for NHI affairs, healthcare quality and information management, R&D, and personnel training. The central government shall appropriate the funds the NHIA needs in the national budget.

The NHIA has established a number of departments to handle various operations essential to the provision of NHI services. Meanwhile, six regional divisions (Table 1-1 and Chart 1-1) are put in place to handle underwriting, premium collection, medical expense review and approval, and the management of contracted medical institutions. These are supplemented by 22 liaison offices throughout the country for the delivery of localized services. As of December 31, 2021, the NHIA had 3,032 employees.

圖1-1　全民健康保險組織架構圖



註：國民年金局暫不設置，衛生福利部組織法明定其未設立前，業務得委託相關機關（構）執行。

Chart 1-1　NHIA Organization Chart

Ministry of Health and Welfare

- National Pension Supervisory Committee
- Office of International Cooperation
- Health & Welfare Workers Training Center
- National Health Insurance Dispute Mediation Committee
- National Health Insurance Committee
- Hospital and Social Welfare Organization Administration Commission
- Legal Affairs Committee

- Department of Information Management
- Department of Statistics
- Department of Accounting
- Department of Civil Service Ethics
- Department of Personnel
- Department of Secretarial Affairs

- Department of Oral Health
- Department of Long-Term Care
- Department of Chinese Medicine and Pharmacy
- Department of Mental Health
- Department of Medical Affairs
- Department of Protective Services
- Department of Nursing and Health Care
- Department of Social Assistance and Social Work
- Department of Social Insurance
- Department of Planning

- National Research Institute of Chinese Medicine
- National Pension Bureau (Note)
- National Health Insurance Administration
- Health Promotion Administration
- Food and Drug Administration
- Centers for Disease Control
- Social and Family Affairs Administration

- Planning Division
- Enrollment Division
- Financial Analysis Division
- Medical Affairs Division
- Medical Review and Pharmaceutical Benefits Division
- Information Management Division
- Secretariat
- Personnel Office
- Accounting and Statistics Office
- Civil Service Ethics Office
- National Health Insurance Administration-Taipei Division
- National Health Insurance Administration-Northern Division
- National Health Insurance Administration-Central Division
- National Health Insurance Administration-Southern Division
- National Health Insurance Administration-Kaoping Division
- National Health Insurance Administration-Eastern Division

Note: The National Pension Bureau has yet to be established. The *Organic Act* for Ministry of Health and Welfare stipulates that prior to its establishment, duties of the bureau may be carried out by other government agencies (or entities).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Chapter 2

全民有保　財務永續

Universal Coverage and Financial Sustainability

全民有保　財務永續

全民有保　就醫平權

政府開辦全民健康保險的初衷，即在透過自助、互助制度，將全體國民納入健康保障。因此舉凡健康保險開辦前非屬工作人口的眷屬、榮民及無職業者，含婦女、學生、孩童、老人等，人人均能享有平等就醫的權利，當民眾罹患疾病、發生傷害事故或生育，均可獲得醫療服務。在此前提下，凡具有中華民國國籍，在臺灣地區設有戶籍滿6個月以上的民眾，以及在臺灣地區出生之新生兒，都必須參加全民健保。保險對象分為6類（表2-1），以做為保險費計算的基礎。

全民健康保險也隨著社會客觀環境的改變，在人權與公平的考量下，歷經數次修法，逐步擴大加保對象，包括新住民、長期在臺居留的外籍人士、僑生及外籍生、軍人等均納入健保體系。

二代健保施行後，為全面落實平等醫療服務及就醫之權利，矯正機關之受刑人亦納入健保納保範圍內；本國人久居海外返國重新設籍欲參加健保時，必須有在2年內參加健保的紀錄，或是在臺灣設籍滿6個月才能加入健保；外籍人士也必須在臺灣地區領有居留證明文件且連續居留滿6個月始可加入健保，以符合社會公平正義之期待。

截至2021年12月底止，參加全民健保的總人數有23,861,265人（表2-2），投保單位有929,857家。

財務平衡　永續經營

全民健保自1995年整合各社會保險系統以來，以財務自給自足、隨收隨付為原則。目前保險收入主要來自於保險對象、雇主及政府共同分擔的保險費收入，少部分來自保險費滯納金、公益彩券盈餘分配收入、菸品健康福利捐分配收入等補充性財源。

Universal Coverage and Financial Sustainability

Universal Coverage With Equal Rights to Healthcare

The government initiated the National Health Insurance (NHI) program with a view to provide the entire population with health security via a mutually assisted system. As such, NHI coverage was extended to dependents, veterans, and the unemployed—people outside the working population— whom were not covered prior to its inception; included were women, students, children, and the elderly. Inclusion of these groups in the program means that all people are equally entitled to medical services when they get sick, are injured, or give birth. On the basis of this premise, it is mandatory for all nationals of the Republic of China (Taiwan) who have had a registered domicile in the Taiwan area for six months or more and all newborns in the Taiwan area to participate in the NHI program. The insured are classified into six categories (Table 2-1), based on which insurance premiums are calculated.

To accommodate social changes and promote human rights and fairness, NHI had undergone a number of statutory amendments to phase in expanded coverage over the years. Now new immigrants, long-term foreign residents, overseas Chinese and foreign students, and military personnel are all covered by the NHI system.

To further promote equal rights to medical care, second-generation NHI included inmates in correctional facilities as beneficiaries as well. ROC nationals who have lived abroad for an extended period of time and wish to re-enroll in the NHI program must have either participated in the system at some point during the previous two years

or established residency in Taiwan for at least six months. To be eligible for NHI coverage, foreigners must also secure an Alien Resident Certificate (ARC) and have resided in the Taiwan area for at least six consecutive months. These requirements are warranted by public expectations of social fairness and justice.

As of the end of December 2021, NHI beneficiaries numbered 23,861,265 (Table 2-2) and group insurance applicants, 929,857.

Balanced Finances and Sustainable Operations

Since its integration of Taiwan's various social insurance systems in 1995, NHI has operated under the principles of financial self-sufficiency and pay-as-you-go. At present, NHI derives its income chiefly from premiums paid by the insured, employers, and the government, a few are supplemented by premium overdue charges and contributions from public welfare lottery net revenues and the tobacco health and welfare surcharge.

表2-1　全民健保保險對象分類及其投保單位

Table 2-1　Classification of NHI Enrollees and Group Insurance Applicants

類別 Category	保險對象 NHI Enrollees		投保單位 Group Insurance Applicants
	本人 Insureds	眷屬 Dependents	
第1類 Category 1	公務人員、志願役軍人、公職人員 Civil servants, volunteer military personnel, public office holders	1. 被保險人之無職業配偶。 2. 被保險人之無職業直系血親尊親屬。 3. 被保險人之2親等內直系血親卑親屬未成年且無職業，或成年無謀生能力或仍在學就讀且無職業者。 1. Unemployed spouse 2. Unemployed lineal blood ascendants 3. Lineal blood descendants within 2nd degree of kinship who are either minors and not employed or adults incapable of making a living, including those who are in school without employment	所屬機關、學校、公司、團體或個人 Agencies, schools, companies, groups, or individuals
	私校教職員 Private school teachers/staffers		
	公民營事業、機構等有一定雇主的受僱者 Employees of public/private enterprises and organizations		
	雇主、自營業主、專門職業及技術人員自行執業者 Employers, the self-employed, independent professionals and technical specialists		
第2類 Category 2	職業工會會員、外僱船員 Occupational union members, foreign crew members	同第1類眷屬 Same as the dependents in Category 1	所屬的工會、船長公會、海員總工會 Unions, Master Mariners Association, National Chinese Seamen's Union
第3類 Category 3	農、漁民 Members of farmers' and fishermen's associations	同第1類眷屬 Same as the dependents in Category 1	農會、漁會 Farmers' associations, fishermen's associations
第4類 Category 4	義務役軍人、軍校軍費生、在卹遺眷 Military conscripts, military academy students who receive grants from the government, dependents of military personnel on pensions	無 None	國防部指定之單位 Agencies designated by the Ministry of National Defense
	替代役役男 Substitute service draftees	無 None	內政部指定之單位 Agencies designated by the Ministry of the Interior
	矯正機關受刑人 Inmates in correctional facilities	無 None	法務部及國防部指定之單位 Agencies designated by the Ministry of Justice and Ministry of National Defense

類別 Category	保險對象 NHI Enrollees		投保單位 Group Insurance Applicants
	本人 Insureds	眷屬 Dependents	
第5類 Category 5	合於社會救助法規定的低收入戶成員 Members of low-income households as defined by the *Public Assistance Act*	無 None	戶籍地的鄉（鎮、市、區）公所 Administration office of the village, township, municipality, or district where the household is registered
第6類 Category 6	榮民、榮民遺眷家戶代表 Veterans, household representatives of survivors of veterans	1. 榮民之無職業配偶。 2. 榮民之無職業直系血親尊親屬。 3. 榮民之2親等內直系血親卑親屬未成年且無職業，或成年無謀生能力或仍在學就讀且無職業者。 1. Unemployed spouse 2. Unemployed lineal blood ascendants 3. Lineal blood descendants within 2nd degree of kinship who are either minors and not employed or adults incapable of making a living, including those who are in school without employment	戶籍地的鄉（鎮、市、區）公所 Administrative office of the village, township, city or district where the household is registered
	一般家戶戶長或家戶代表 Heads or representatives of households	同第1類眷屬 Same as the dependents in Category 1	

註：1. 各類眷屬及第6類被保險人均為無職業者。
　　2. 第4類矯正機關受刑人於2013年1月1日起參加全民健保。

Notes: 1. Being unemployed is a prerequisite for an insured to qualify as a dependent or a member of Category 6.
　　2. From January 1, 2013, inmates in correctional facilities were included as Category 4 beneficiaries in the NHI system.

表2-2　全民健保各類保險對象人數

Table 2-2　Number of NHI Enrollees by Category

	第1類 Category 1	第2類 Category 2	第3類 Category 3	第4類 Category 4	第5類 Category 5	第6類 Category 6	總計 Total
人數 Number of Enrollees	14,325,078	3,623,011	2,010,995	98,233	287,491	3,516,457	23,861,265
占總納保人數百分比 Percentage	60.03%	15.18%	8.43%	0.41%	1.20%	14.74%	100%

資料時間：2021年12月31日
As of December 31, 2021

然而，隨著整體環境與社會人口結構等影響，醫療支出增加速度遠較於保費收入成長速度為快，健保署除積極開源節流外，分別於2002年、2010年及2021年三次調高保險費率，更以量能負擔的精神，陸續調整投保金額分級表上下限與級距及最高付費眷屬人數、逐年將軍公教人員由本薪改以全薪投保、將未列入投保金額的六項所得計收補充保費、明確規範政府負擔比率下限等，積極穩固財務，維持全民健保系統運作及平衡。

2013年二代健保實施後建立收支連動的機制，將「全民健康保險監理委員會」（收入面監督）及「全民健康保險醫療費用協定委員會」（支出面協定）整併為「全民健康保險會」，並由被保險人、雇主、保險醫事服務提供者、專家學者、公正人士及有關機關代表組成，每年依協議訂定之醫療給付費用總額，完成各年度保險費費率之審議，嗣報衛生福利部轉報行政院核定。期透過收支連動機制，確保長期財務穩定。

一般保險費的計算

全民健保的一般保險費費率自開辦起到2002年8月底均維持4.25%，2002年9月起調整為4.55%；2010年4月為穩固健保財務，調整至5.17%。二代健保實施後，因加收補充保險費（當時費率為2%），一般保險費費率從2013年1月起調整為4.91%；2016年1月起一般保險費費率調整為4.69%，補充保險費費率調整為1.91%；惟因醫療支出成長遠高於保費收入成長的問題仍存在，健保財務短絀數逐年擴大，2021年1月1日起一般保險費費率調整為5.17%，補充保險費費率調整為2.11%。

保險費則由被保險人、投保單位及政府共同分擔。第1、2、3類保險對象等有工作者，以被保險人的投保金額×一般保險費率計算；第4、5、6類保險對象，則以第1類至第3類保險對象之每人一般保險費的平均值計算（表2-3、表2-4）。

Social and demographic changes, however, have led to NHI expenses growing far faster than premium income. In addition to broadening sources of income and conserving funds, the NHIA hiked the premium rate in 2002, 2010, and 2021 and, in keeping with the spirit of fair financial contribution, adjusted the upper/lower limits and tiers of the payroll bracket table meant for premium calculation as well as the cap on the number of dependents for whom premiums are to be collected. Measures also phased in over the years include calculating the premiums for military personnel, civil servants, and teachers on the basis of their total compensations rather than basic salaries, collecting supplementary premiums from six types of income hitherto not included in premium calculations, and setting a lower limit for government contribution. All these measures have been adopted to stabilize NHI finances and ensure that NHI can stay operational and sound.

2013, the launch of second-generation NHI introduced a revenue-expenditure linkage mechanism. The National Health Insurance Supervisory Committee (responsible for revenue oversight) and the National Health Insurance Medical Expenditure Negotiation Committee (responsible for expenditure negotiation) were merged as the National Health Insurance Committee. Comprising insureds, employers, insurance medical service providers, experts and scholars, impartial public figures, and representatives of related agencies, the committee is entrusted to review the premium rate based on the negotiated total of medical benefit payments (global budget) each year. The review outcome is then presented first to the Ministry of Health and Welfare and then to the Executive Yuan for approval. It is hoped that this revenue-expenditure linkage mechanism can help ensure the NHI system's financial stability over the long run.

Calculation of General Premiums

From its inception to the end of August 2002, NHI's general premium rate was kept at 4.25%. To uphold NHI stability, it was increased to 4.55% from September 2002 and to 5.17% from April 2010. With the levy of supplementary premiums (at 2%) upon the launch of second-generation NHI, the general premium rate was slashed to 4.91% from January 2013. Taking effect in January 2016, NHI's general and supplementary premium rates were further cut to 4.69% and 1.91% respectively. Over the years NHI's financial shortfall worsened, however, as increases in medical expenditures continued to well outpace the growth in premium income. From January 1, 2021, the general premium rate was raised to 5.17% and the supplementary premium rate to 2.11%.

NHI premiums are jointly paid by the insured, group insurance applicants, and the government. The premium payable by the insured in Categories 1 to 3 shall be calculated as the insured's premium ratable wage multiplied by the general premium rate. The premium of Categories 4-6 insureds shall be calculated according to the average actuarial premium based on the total number of Categories 1-3 beneficiaries (Table 2-3 and Table 2-4).

表2-3　全民健保一般保險費計算公式

Table 2-3　Formulas for NHI General Premiums

薪資所得者 Wage Earners	被保險人 The Insured	投保金額×一般保險費費率×負擔比率×（1＋眷屬人數） Premium ratable wage × general premium rate × contribution ratio × (1 + number of dependents)
	投保單位或政府 Group Insurance Applicant or the Government	第1類第1目至第3目：投保金額×一般保險費費率×負擔比率×（1＋平均眷屬人數） Category 1 (subcategories 1-3): premium ratable wage × general premium rate × contribution ratio x (1 + average number of dependents)
		第2、3類：投保金額×一般保險費費率×負擔比率×實際投保人數 Categories 2 and 3: premium ratable wage × general premium rate × contribution ratio × actual number of people insured
地區人口（無薪資所得者） Non-Wage Earning Individuals	被保險人 The Insured	平均保險費×負擔比率×（1＋眷屬人數） Average premium × contribution ratio × (1 + number of dependents)
	政府 The Government	平均保險費×負擔比率×實際投保人數 Average premium × contribution ratio × actual number of people insured

註：1. 負擔比率：請參照表2-4全民健保保險費負擔比率。
2. 一般保險費費率：2021年1月1日起調整為5.17%（調整前為4.69%）。
3. 投保金額：請參照表2-5全民健保投保金額分級表。
4. 眷屬人數：依附投保的眷屬人數，超過3人的以3人計算。
5. 平均眷屬人數：自2020年1月1日起公告為0.58人。
6. 第4類及第5類平均保險費：2022年1月1日起調整為1,839元（調整前為1,825元），由政府全額補助。
7. 第6類地區人口平均保險費：2021年1月1日起調整為1,377元（調整前為1,249元），自付60%、政府補助40%，每人每月應繳保險費為826元（調整前為749元）。

Notes: 1. Contribution ratios: Please refer to Table 2-4.
2. General premium rate: Raised to 5.17% (from 4.69%) from January 1, 2021.
3. Premium ratable wages: Please refer to Table 2-5.
4. Number of dependents: The maximum number of dependents is three even if the actual number is higher.
5. Average number of dependents: 0.58 from January 1, 2020.
6. Average premium for Categories 4-5 insureds: Fully subsidized by the government, the premium was raised to NT$1,839 (from NT$1,825) from January 1, 2022.
7. Average premium for Category 6 insureds: Raised to NT$1,377 (from NT$1,249) from January 1, 2021. With the government contributing 40%, each insured shall pay 60%, or NT$826 (up from NT$749 previously).

表2-4　全民健保保險費負擔比率

Table 2-4　NHI Premium Contribution Ratios

保險對象類別 Classification of Enrollees			負擔比率（%）Contribution Ratios (%)		
			被保險人 The Insured	投保單位 Group Insurance Applicant	政府 The Government
第一類 Category 1	公務人員 Civil servants	本人及眷屬 Insured and dependents	30	70	0
	公職人員、志願役軍人 Public office holders, volunteer military personnel	本人及眷屬 Insured and dependents	30	70	0
	私立學校教職員 Private school teachers and staffers	本人及眷屬 Insured and dependents	30	35	35
	公、民營事業機構等有一定雇主的受僱者 Employees of public/private enterprises and organizations	本人及眷屬 Insured and dependents	30	60	10
	雇主 Employers	本人及眷屬 Insured and dependents	100	0	0
	自營業主 The self-employed	本人及眷屬 Insured and dependents	100	0	0
	專門職業及技術人員自行執業者 Independent professionals and technical specialists	本人及眷屬 Insured and dependents	100	0	0
第二類 Category 2	職業工會會員 Occupational union members	本人及眷屬 Insured and dependents	60	0	40
	外僱船員 Foreign crew members	本人及眷屬 Insured and dependents	60	0	40
第三類 Category 3	農民、漁民 Members of farmers' and fishermen's associations	本人及眷屬 Insured and dependents	30	0	70
第四類 Category 4	義務役軍人 Military conscripts	本人 Insured	0	0	100
	軍校軍費生、在卹遺眷 Military academy students who receive grants from the government, dependents of military personnel on pensions	本人 Insured	0	0	100
	替代役役男 Substitute service draftees	本人 Insured	0	0	100
	矯正機關收容人 Inmates in correctional facilities	本人 Insured	0	0	100
第五類 Category 5	低收入戶 Low-income households	家戶成員 Household members	0	0	100
第六類 Category 6	榮民、榮民遺眷家戶代表 Veterans, household representatives of survivors of veterans	本人 Insured	0	0	100
		眷屬 Dependents	30	0	70
	地區人口 Other individuals	本人及眷屬 Insured and dependents	60	0	40

投保金額之訂定

第1類至第3類被保險人之投保金額，由衛生福利部擬訂分級表，報請行政院核定，自2022年7月1日起共有51級（表2-5）。第1類被保險人的投保金額，由投保單位（雇主）依被保險人每月的薪資所得，對照該表所屬的等級申報；第2類無一定雇主勞工被保險人的最低投保金額及第3類農民、漁民等被保險人的投保金額自2022年1月1日起為25,250元。

表2-5　2022年7月1日投保金額分級表

Table 2-5　2022.7.1 Income Brackets for Premium calculation

組別級距 Bracket	投保等級 Income Tier	月投保金額（元） Monthly Premium Ratable Wage (NT$)	實際薪資月額（元） Actual Monthly Wage (NT$)
第一組級距 1200元 Bracket 1 NT$1,200	1	25,250	25,250以下
	2	26,400	25,251~26,400
	3	27,600	26,401~27,600
	4	28,800	27,601~28,800
第二組級距 1500元 Bracket 2 NT$1,500	5	30,300	28,801~30,300
	6	31,800	30,301~31,800
	7	33,300	31,801~33,300
	8	34,800	33,301~34,800
	9	36,300	34,801~36,300
第三組級距 1900元 Bracket 3 NT$1,900	10	38,200	36,301~38,200
	11	40,100	38,201~40,100
	12	42,000	40,101~42,000
	13	43,900	42,001~43,900
	14	45,800	43,901~45,800
第四組級距 2400元 Bracket 4 NT$2,400	15	48,200	45,801~48,200
	16	50,600	48,201~50,600
	17	53,000	50,601~53,000
	18	55,400	53,001~55,400
	19	57,800	55,401~57,800
第五組級距 3000元 Bracket 5 NT$3,000	20	60,800	57,801~60,800
	21	63,800	60,801~63,800
	22	66,800	63,801~66,800
	23	69,800	66,801~69,800
	24	72,800	69,801~72,800
第六組級距 3700元 Bracket 6 NT$3,700	25	76,500	72,801~76,500
	26	80,200	76,501~80,200
	27	83,900	80,201~83,900
	28	87,600	83,901~87,600

Set Payroll Brackets for Calculating Premiums

When it comes to the premium ratable wages of Categories 1-3 insureds, the MOHW is responsible for setting a table of payroll brackets and presenting it to the Executive Yuan for approval. The table in effect since July 1, 2022 has 51 brackets (Table 2-5). The premium ratable wages of Category 1 insureds refer to the payroll of employees, based on which group insurance applicants (employers) shall pay premiums according to the corresponding bracket in the aforesaid table. Beginning January 1, 2022, the minimum premium ratable wage for Category 2 insureds with no particular employers and the premium ratable wage for Category 3 insureds—farmers and fishermen—are both NT$25,250.

組別級距 Bracket	投保等級 Income Tier	月投保金額（元） Monthly Premium Ratable Wage (NT$)	實際薪資月額（元） Actual Monthly Wage (NT$)
第七組級距 4500元 Bracket 7 NT$4,500	29	92,100	87,601~92,100
	30	96,600	92,101~96,600
	31	101,100	96,601~101,100
	32	105,600	101,101~105,600
	33	110,100	105,601~110,100
第八組級距 5400元 Bracket 8 NT$5,400	34	115,500	110,101~115,500
	35	120,900	115,501~120,900
	36	126,300	120,901~126,300
	37	131,700	126,301~131,700
	38	137,100	131,701~137,100
	39	142,500	137,101~142,500
	40	147,900	142,501~147,900
	41	150,000	147,901~150,000
第九組級距 6400元 Bracket 9 NT$6,400	42	156,400	150,001~156,400
	43	162,800	156,401~162,800
	44	169,200	162,801~169,200
	45	175,600	169,201~175,600
	46	182,000	175,601~182,000
第十組級距 7500元 Bracket 10 NT$7,500	47	189,500	182,001~189,500
	48	197,000	189,501~197,000
	49	204,500	197,001~204,500
	50	212,000	204,501~212,000
	51	219,500	212,001以上 ≧212,001

註：2022年7月1日生效。
Note: Effective from July 1, 2022

補充保險費計收

二代健保實施後，除了以經常性薪資對照投保金額所計算出的「一般保險費」之外，再加上「補充保險費」，把以往沒有列入投保金額計算的高額獎金、兼職所得、執行業務收入、股利所得、利息所得或租金收入等項目，納入「補充保險費」的計費基礎，計收補充保險費。希望藉由擴大保險費基，拉近相同所得者之保險費，達到負擔之公平性（圖2-1），低收入戶之保險對象則不列為補充保險費之收取對象。另外，雇主每月所支付薪資總額與其受僱者當月投保金額總額間之差額，亦增列為計費基礎，收取補充保險費；2021年全年補充保險費計收約581億元，占同年保險費收入8.4%。

健保財務收支情形

健保歷年保險收支自1998年起開始發生短絀，至2007年3月底，累計健保財務收支首度呈現短絀，故自2010年4月起調整保險費率，歷年累計保險收支自2012年2月開始轉虧為盈，另自2013年1月起實施二代健保財務新制，擴大費基加收補充保險費及提高政府總負擔比率等財源挹注，財務亦明顯改善（圖2-2），惟醫療支出成長始終高於保險費收入成長，自2017年起保險收支短絀數逐年擴大，故自2021年1月起調整保險費率，至2021年12月累計收支結餘為936億元（表2-6）。

圖2-1　二代健保保險費示意圖

二代健保保險費＝一般保險費＋補充保險費

保險對象：第1類至第4類及第6類收取補充保險費

一般保險費

第1類至第3類：

投保金額×一般費率×負擔比率×（1＋依附眷口數）

以第1類為例：負擔比率為30%

眷屬人數如超過3口，以3口計算

第4類至第6類：

定額保險費

補充保險費

高額獎金　執行業務收入　兼職所得

股利所得　利息所得　租金收入

×補充保險費率

註：1. 2021年1月1日起一般保險費費率調整為5.17%(調整前為4.69%)，補充保險費費率調整為2.11%(調整前為1.91%)。
2. 兼職所得：非屬投保單位給付之薪資所得。

Calculation of Supplementary Premiums

Second-generation NHI added supplementary premiums to general premiums that are collected on the basis of premium ratable wages. Hitherto uncovered items—big bonuses, part-time income, professional service income, dividend income, interest income, and rental income—are now included for calculating supplementary premiums. It is hoped that expansion of NHI's premium base can move it closer toward the goal of fair contribution (Chart 2-1) by having persons with equivalent incomes pay similar premiums. Nevertheless, the insured in low-income households are exempt from the obligation of paying supplementary premiums. Furthermore, supplementary premiums are also collected on the gap between the total salaries that employers actually pay their employees each month and the total monthly premium ratable wages adopted. In 2021, NHI supplementary premiums amounted to around NT$58.1 billion, accounting for 8.4% of all premium income for the year.

Balance NHI Revenues and Expenditures

The NHI system sustained its first annual deficit in 1998. On a cumulative basis, it was pushed into the red for the first time at the end of March 2007. A premium rate increase from April 2010 helped turn around NHI's outstanding balance from February 2012. An even more significant improvement in NHI finances (Chart 2-2) set in when its second-generation version got under way in January 2013. An expanded income base thanks to the addition

Chart 2-1　Premiums for Second-Generation NHI

Premiums for second-generation NHI = general premiums + supplementary premiums

Supplementary premiums are to be collected from Categories 1-4 and 6 insureds

General Premiums

Categories 1-3:

Premium ratable wage × General premium rate × Contribution ratio × (1 + Number of dependents)

The number of dependents is capped at 3 even if the actual number is higher.

With Category 1 taken as example, the individual contribution ratio is 30%.

Categories 4-6:

Fixed premium

Supplementary Premiums

Big bonuses; Professional service income; Part-time income; Dividend income; Interest income; Rental income

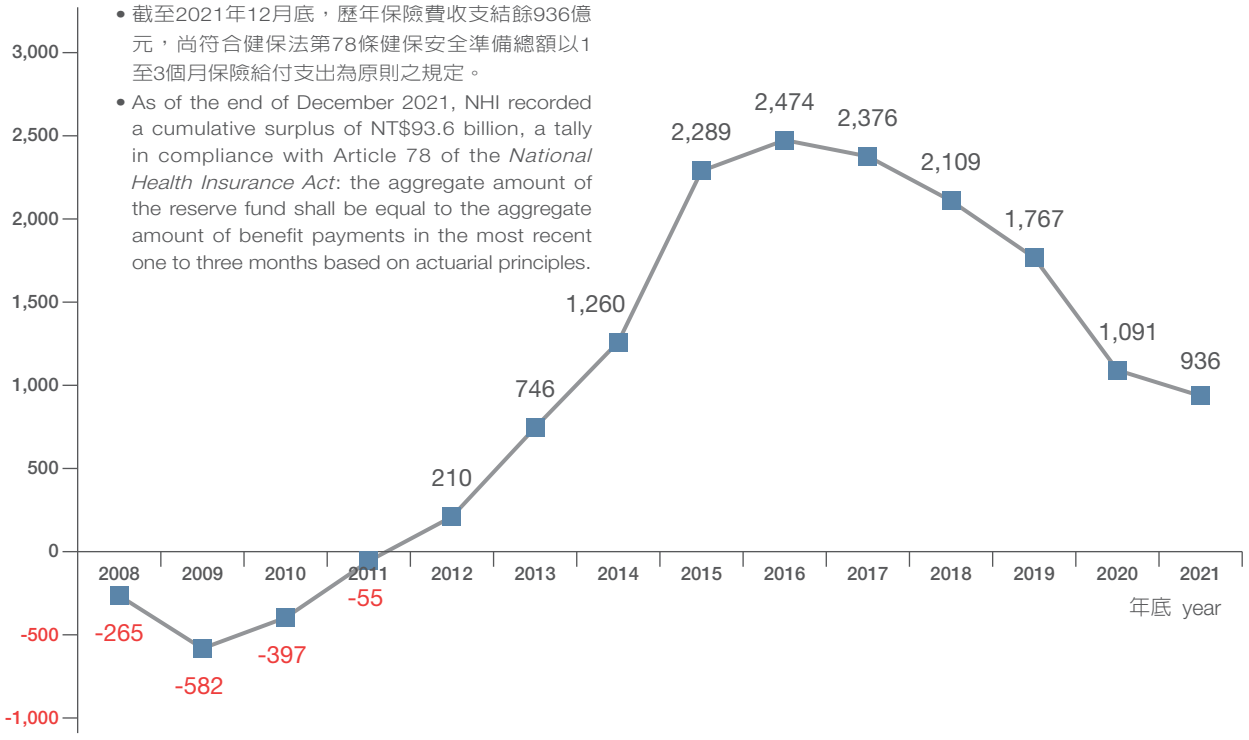
× Supplementary premium rate

Notes: 1. From January 1, 2021, the general premium rate was raised to 5.17% (from 4.69%) and the supplementary premium rate to 2.11% (from 1.91).
2. Part-time income: Income other than wages paid by the group insurance applicant.

圖2-2　二代健保實施前後財務收支累計餘絀情形

Chart 2-2　Cumulative balance before and after launch of second-generation NHI

億元
NT$100 million



財務改革措施　Fiscal reform

2010年4月
費率由4.55%
調整至5.17%

April 2010
The premium rate was raised to 5.17% from 4.55%.

2013年1月二代健保實施
- 一般保險費率由5.17%調整至4.91%
- 開始加收補充保險費（費率2%）

January 2013 Inception of second-generation NHI
- The general premium rate was reduced to 4.91% from 5.17%.
- Collection of supplementary premiums (at a rate of 2%) started.

2016年1月
- 一般保險費率由4.91%調整至4.69%
- 補充保險費率由2%調整至1.91%

January 2016
- The general premium rate was reduced to 4.69% from 4.91%.
- The supplementary premium rate was reduced to 1.91% from 2%.

2021年1月
- 一般保險費率由4.69%調整至5.17%
- 補充保險費率由1.91%調整至2.11%

January 2021
- The general premium rate was raised to 5.17% from 4.69%.
- The supplementary premium rate was raised to 2.11% from 1.91%.

of supplementary premiums and higher ratios of government contribution both helped. Medical expenditures, however, continued to increase far faster than premium income. Given a steadily widening deficit from 2017, the NHI premium rate underwent yet another hike from January 2021. As of December 2021, NHI recorded a cumulative surplus of NT$93.6 billion (Table 2-6).

表2-6　最近5年全民健康保險財務收支狀況（權責基礎）

Table 2-6　NHI Revenues and Expenditures of the Past Five Years (Accrual Basis)

年度 Year	保險收入 NHI Revenues		保險成本 NHI Expenditures		保險收支當年餘絀（億元） Annual Balance (NT$100 million)	保險收支累計餘絀（億元） Cumulative Balance (NT$100 million)
	金額（億元） Amount (NT$100 million)	成長率（%） Growth rate (%)	金額（億元） Amount (NT$100 million)	成長率（%） Growth rate (%)		
2017	5,900	0.53	5,998	5.54	-98	2,376
2018	6,061	2.73	6,328	5.49	-266	2,109
2019	6,224	2.69	6,566	3.77	-342	1,767
2020	6,278	0.87	6,954	5.91	-676	1,091
2021	7,119	13.39	7,274	4.60	-155	936
1995/3~2021/12	116,795	-	115,859	-	-	936

說明：1. 資料截至2021年12月
2. 保險收入＝保險費＋滯納金＋資金運用淨收入＋公益彩券盈餘及菸品健康捐分配數＋其他淨收入－呆帳提存數－利息費用
3. 保險成本＝保險給付醫療費用＋其他保險成本

Notes: 1. Statistics as of December 2021
2. NHI revenues = premiums + overdue charges + net investment income + contributions from public welfare lottery net revenues and the tobacco health and welfare surcharge + other net revenues – provisions for bad debts – interest expenses
3. NHI expenditures = reimbursements of medical expenses+ other insurance expenses

Chapter 3

給付完整　就醫便利

Comprehensive Benefits and Convenient Access

給付完整　就醫便利

醫療給付範圍

參加全民健保的保險對象，凡發生疾病、傷害或生育事故時，皆可憑健保卡至醫院、診所、藥局及醫事檢驗機構等特約醫事服務機構接受醫療服務。

目前全民健保提供的醫療服務包括：門診、住院、中醫、牙科、分娩、復健、居家照護、慢性精神病復健等項目；醫療支付的範圍則包括：診療、檢查、檢驗、手術、麻醉、藥劑、材料、處置治療、護理及保險病床等，可說是將所有必要的診療服務都包含在內。

就醫便利

在全民健保制度之下，民眾可以自由選擇特約醫院、診所、藥局、醫事檢驗機構，接受妥善的醫療照護服務。即使在國外，民眾因不可預期的緊急傷病或緊急分娩，須在當地醫事服務機構立即就醫，可於急診、門診治療當日或出院之日起6個月內申請核退國外自墊醫療費用，但核退費用的標準則以支付國內特約醫院及診所之平均費用為最高上限。

截至2021年12月底止，全民健保特約醫療院所合計達21,679家，占全國所有醫療院所總數92.44%（表3-1）；另有特約藥局6,868家、居家護理機構735家、精神復健機構238家、助產機構17家、醫事檢驗所210家、物理治療所32家、醫事放射所10家、職能治療所4家及居家呼吸照護所9家，保險對象可自由選擇醫療院所接受醫療照護服務。

2021年平均每人每年門診就醫次數13.12次，平均每百人住院次數13.1次，全國每人每年平均住院日數1.26日。

調整部分負擔　落實使用者付費

全民健康保險部分負擔的設計是社會保險制度重要的一環，是為避免保險對象認為已交繳健保費，就可以隨意使用健保資源，同時不致影響真正有需要的人就醫，自開辦後，門、急診之部分負擔已經調整多次，同時也藉以導正醫療資源利用，使不同層級醫療院所各司其職。

為鼓勵民眾小病到當地診所就醫，需要進一步檢查或治療時再轉診到區域醫院、醫學中心等大醫院，健保署自2005年7月15日起推出若配合轉診則不加重部分負擔之設計，門診基本部分負擔亦配合修正。其中，西醫門診基本部分負擔按「未轉診」及「轉診」兩種方式計收。民眾若未經轉診直接到醫學中心、區域醫院、地區醫院就醫，就會付比較高的部分負擔。牙醫、中醫不分層級一律計收50元。此外，民眾看病時，如藥費超過一定金額，則須加收藥品部分負擔。同一療程中接受第2次以上的復健物理治療（中度一複雜、複雜項目除外）或中醫傷科治療，每次須自行繳交50元的部分負擔費用，但凡因重大傷病、分娩、山地離島地區就醫者及其他符合健保署規定者，均免收部分負擔。

自2016年6月起健保署加強推動分級醫療，以鼓勵民眾有病症先至基層院所就醫，有需要再轉診至適當科別院所，以強化大醫院專

Comprehensive Benefits and Convenient Access

Scope of Benefits

When insureds get sick, injured in an accident, or give birth, they can use their NHI cards to receiv healthcare at contracted medical institutions, which include hospitals, clinics, pharmacies, and laboratory tests examination institutions.

The healthcare services currently covered by the NHI include outpatient care, inpatient care, traditional Chinese medicine, dental care, child delivery, rehabilitation, home health care, and chronic mental illness rehabilitation. The scope of medical payments under NHI includes diagnosis, examination, lab test, surgery, anesthesia, medication, materials, treatment, nursing, and insured beds, etc. Nearly all necessary healthcare services are covered by the NHI.

Convenient Access to Healthcare

Under the NHI system, members of the public can choose to receive appropriate healthcare services at contracted hospitals, clinics, pharmacies, and medical testing laboratories. Even when overseas, when people encounter emergency illness or injury, or emergency childbirth, and must receive immediate care at a local medical institution, they can apply for reimbursement of their self-advanced foreign medical expenses within 6 months of the date of emergency care, outpatient treatment, or hospital discharge; however, the reimbursed expenses may not exceed the average expenses paid to domestic contracted hospitals and clinics.

As of the end of December 2021, there was a total of 21,679 NHI contracted hospitals and clinics, which accounted for 92.44% of all hospitals and clinics nationwide (Table 3-1), and there were also 6,868 contracted pharmacies, 735 home care institutions, 238 psychiatric rehabilitation institutions, 17 midwifery institutions, 210 medical testing institutions, 32 physical therapy clinics, 10 medical radiological institutions, 4 occupational therapy clinics, and 9 home respiratory care institutions. As a result, insureds can freely choose the hospital or clinic at which they wish to receive healthcare services.

The average annual number of per capita outpatient visits in 2021 was 13.12, the average annual number of hospitalizations per 100 persons was 13.1, and the average annual number of days of hospitalization per capita was 1.26 days.

Adjust Copayments, Enforce the User-Pays Principle

NHI copayments are designed to be an important link in the social insurance system, and are intended ensure that insureds do not think that the payment of NHI premiums entitles them to use health insurance resources without restraint. At the same time, copayments are not meant to prevent persons from receiving care that they truly need. Outpatient and emergency care copayments have been adjusted several times since the introduction of NHI, and these adjustments have simultaneously sought to guide the utilization of medical resources and ensure that hospitals and clinics at different levels carry out their respective duties.

To encourage people to seek care at clinics when suffering from minor illnesses, and only obtaining a referral to a large hospital such as a regional hospital or medical center after further examination or treatment, on July 15, 2005, the National Health

表3-1　全民健保特約醫療院所數

Table 3-1　Number of NHI-Contracted Hospitals and Clinics

單位：機構數　Unit: Number of Institutions

	總計 Total	西醫醫院 Hospitals	西醫診所 Clinics	中醫醫院 Chinese Medicine Hospitals	中醫診所 Chinese Medicine Clinics	牙醫醫院 Dental Hospitals	牙醫診所 Dental Clinics
全國醫療院所數 Total Medical Institutions	23,452	469	11,955	4	4,073	1	6,950
特約醫療院所數 Contracted Medical Institutions	21,679	469	10,591	4	3,820	1	6,794
特約率 Percentage of Contracted Institutions	92.44%	100%	88.59%	100%	93.79%	100%	97.76%

資料時間：2021年12月31日。
Data time: December 31, 2021

注於治療急重症及醫學研究的功能，基層院所則成為提供病患全面性初級照護的第一線守門員，2017年4月15日公告修正西醫門診基本部分負擔，轉診至醫學中心及區域醫院就醫調降40元，未經轉診逕至醫學中心就醫調升60元。另急診部分負擔，則依檢傷分類級數計收，以落實雙向轉診，門診及住院部分負擔如表3-2及表3-3。

此外，於醫療資源缺乏地區就醫的民眾，部分負擔費用均可減免20%，且居家照護之部分負擔費用比率由原來5%調降為4%，以嘉惠醫療資源缺乏地區及外出就醫困難之民眾。

家庭醫師及社區藥局在地照顧

為使民眾獲得在地完整持續的醫療照護，2003年3月起推動「全民健康保險家庭醫師整合性照護計畫」，由同一地區5家以上的特約西醫診所結合社區醫院，組成社區醫療群提供醫療服務。只要透過居家附近的基層診所醫師做為家庭醫師，民眾就可獲得第一線的健康照護。家庭醫師平日為預防保健的專業顧問，建立完整的醫療資料，提供24小時健康諮詢服務專線。若病情需要進一步手術、檢查或住院時，可協助轉診，減少民眾到處找醫師所浪費的時間與金錢。

截至2021年12月底，已有623個社區醫療群在運作，參與之基層診所5,587家，參與率為53.1%，參加醫師數7,637位，參與率為46%；透過社區醫療群受益者超過601萬餘人。

在藥事服務方面，民眾可持特約醫療院所交付的處方箋，到特約藥局領藥。如有用藥的疑問，可以請藥局的藥師或藥劑生提供用藥及健康諮詢等專業服務。藥局不僅為大家的用藥安全把關，更能就近教導民眾正確的用藥知識。

Insurance Administration (NHIA) introduced a system in which patients' copayments stay low when they comply with referral procedures, and basic outpatient copayments were also revised accordingly. Under these changes, the basic Western medicine outpatient copayment is calculated on either a "no referral" or "referral" basis. If people seek care at a medical center, regional hospital, or district hospital without obtaining a referral, they must pay a higher copayment. However, dental care and traditional Chinese medicine have an unchanging NT$50 copayment regardless of the level of care. In addition, if the cost of drugs exceeds a certain amount, patients must pay an additional drug copayment. When patients must receive two or more rehabilitation or physical therapy sessions (apart from moderate-complex and complex items), or traditional Chinese medicine trauma treatment, in the same course of treatment, an NT$50 copayment must be paid for each session. However, copayments are waived in the case of major illnesses and injuries, childbirth, care in mountain and offshore island areas, and other cases meeting NHIA requirements.

Starting in June 2016, the NHIA has promoted a hierarchical referral system encouraging people to first seek care at a primary care hospital or clinic when they are ill, and then obtain a referral to an appropriate specialist hospital or clinic. This will strengthen large hospitals' focus on critical care and medical research, while letting primary care hospitals and clinics serve as first-line providers of full-spectrum primary care. On April 15, 2017, the NHIA announced a revision of basic Western medicine outpatient copayments reducing the copayment at a medical center or regional hospital with a referral to NT$40, and increasing the copayment at medical centers without a referral to NT$50. Furthermore, the copayment for emergency care is set according to triage grade, which will encourage two-way referrals. Outpatient and inpatient copayments are as shown in tables 3-2 and 3-3.

In addition, the copayments of patients seeking care in areas lacking medical resources have been reduced by 20%, and the home care copayment rate in the serious has been reduced from the original 5% to the current 4%, which will benefit people in areas with shortages of medical resources who cannot easily travel to other places.

Family Doctors and Community Pharmacies

To ensure that people can receive continuous, comprehensive medical care nearby, the "NHI Family Physician Integrated Care Project". 5 or more primary care clinics in the same region cooperate with the regional hospital to form a community health care group which uses its combined strength to care for people in the community.

1. Community health care groups set up 24-hour health care counseling hotlines that can immediately answer questions and offer uninterrupted, complete health care.
2. Providing health management and health education to teach members correct health knowledge and fortify disease screening, vaccinations, and improve self-care capabilities.
3. If a patient needs to be further examined or treated at a hospital or referred to another specialist, your family doctor will contact the partner hospital and help you transfer to its inpatient department.
   Your medical records will also be sent to the partner hospital. The hospital, in turn, will report the results of the examination and tests immediately back to the clinic. The family doctor's coordination helps you, the patient, "go to the right department and find the right specialist," and will also avoid unnecessary examinations and medications,

多元支付制度

全民健保支付制度採第三者付費機制，民眾至醫療院所就醫所花費的醫療費用，由健保署根據支付標準付費給醫療院所，因此，為求一個合理、公平及健全的全民健康保險制度，醫療費用支付制度的設計扮演重要的角色。

全民健保實施初期，為迅速整合公、勞、農保既有系統，以論量計酬（Fee-for-Service）方式為主，在公、勞保支付標準表的基礎下，配合保險給付範圍的調整及參酌醫療團體建議加以增修，但該制度容易造成醫療費用無限成長，對醫療品質亦有影響。

爰此，健保署參考其他先進國家制度，再根據不同醫療照護的特性，設計不同支付方式，例如自2002年7月起，全面實施醫療費用總額預算支付制度（Global Budget Payment System）；同時透過支付制度策略，如論病例計酬（Case Payment）、論質計酬（Pay-for-

表3-2　全民健保門診基本部分負擔

Table 3-2　NHI Copayments for Outpatient Visits

單位：新臺幣元　Unit: NT$

類型 Category	基本部分負擔 Basic Copayment			
醫院層級 Type of Institution	西醫門診 Western Medicine Outpatient Care		牙醫 Dentistry	中醫 Traditional Chinese Medicine
	經轉診 With Referral	未經轉診 Without Referral		
醫學中心 Medical Center	170	420	50	50
區域醫院 Regional Hospital	100	240	50	50
地區醫院 District Hospital	50	80	50	50
診所 Clinic	50	50	50	50

註：1. 凡領有《身心障礙證明》者，門診就醫時不論醫院層級，基本部分負擔費用均按診所層級收取新臺幣50元。
2. 門診手術後、急診手術後、生產後6周內或住院患者出院後30日內第一次回診視同轉診，得由醫院開立證明供病患使用。
3. 自2017年4月15日起公告實施。

Notes: 1. Regardless of the level of medical institution, all persons bearing proof of physical and mental disability must pay a basic copayment fixed at the clinic-level fee of NT$50 for outpatient care.
2. Patients' next follow-up visits after outpatient or emergency surgery, within 6 weeks after giving birth, or within 30 days after hospitalization shall be considered to have a referral, and hospitals shall provide patients proof of need for a follow-up.
3. This copayment schedule took effect on April 15, 2017.

reduce waiting time for a hospital bed and decrease the confusion you may experience while seeking health care at a major hospital.

4. Once your condition stabilizes, you may return to your original family physician's clinic to receive continued treatment.

As of the end of December 2021, a total of 623 community healthcare groups had begun operation, participating primary care clinics numbered 5,587, the participation rate was 53.1%, participating physicians numbered 7,637, the physician participation rate was 46%, and the beneficiaries of community healthcare groups exceeded 6.01 million persons.

In the area of pharmacy services, patients with a prescription from a contracted hospital or clinic can obtain medication at any contracted pharmacy. If someone has a question about their medication, they can ask a pharmacist or an assistant pharmacist at a pharmacy to provide medication use and health consulting services. Pharmacies not only help ensure safe medication use, but also provide accessible medication use knowledge to the public.

Diversified Payments

The NHI's payment system relies on a third-party payment mechanism, and the NHIA pays the medical expenses of persons seeking care to hospitals and clinics on the basis of the NHI fee schedule. The design of the healthcare expense payment system plays an important role in achieving a effective, efficient, and equitable NHI system.

When the NHI system was initiated, it sought to quickly integrate the existing civil service, labor, and farmers' insurance systems, and encourage hospitals and clinics to apply for health insurance contracted organizations. The fee-for-service approach was adopted as the major payment system, and taking the government and labor insurance payment standards as a basis, the NHI's payment standards were revised in conjunction with adjustment of the scope of reimbursements and the recommendations of medical groups. However, this system may lead to an uncontrolled increase in medical expenses, and affect the quality of care.

表3-3　全民健保住院部分負擔

Table 3-3　Copayment Rates for Inpatient Care

病房別 Ward	部分負擔比率 Copayment Rate			
	5%	10%	20%	30%
急性病房 Acute	-	30日內 30 days or less	31~60日 31-60 days	61日以上 61 days or more
慢性病房 Chronic	30日內 30 days or less	31~90日 31-90 days	91~180日 91-180 days	181日以上 181 days or more

註：依衛生福利部公告2021年以同一疾病每次住院上限為43,000元，全年累計住院上限為72,000元。

Note: In accordance with the Ministry of Health and Welfare's 2021 announcement that the copayment for each hospitalization for the same condition would be capped at NT$43,000, the upper limit of hospitalization copayments for each year is NT$72,000.

Performance, P4P）改革方案，改變診療行為；此外，推動山地離島地區醫療給付效益提升計畫（IDS）、家庭醫師整合照護計畫，以增進醫療服務體系整合；並以品質與結果支付，例如論質計酬支付等。另為提升醫療服務效率，更自2010年1月1日起實施全民健保住院診斷關聯群支付制度（Taiwan Diagnosis Related Groups, Tw-DRGs），並於2014年7月1日起實施第2階段Tw-DRGs。

總額預算支付制度

健保署自1998年起陸續推動牙醫、中醫、西醫基層、醫院等部門總額支付制度，至2002年起全面採行總額預算支付制度，以有限健保資源提供有效率且高品質之醫療服務，有效將醫療費用成長率控制在5%以下。全民健康保險費用總額預算研擬流程如圖3-1。歷年全民健保總額協定成長率如圖3-2，2009年起各總額部門醫療費用協定成長率如表3-4。

圖3-1　全民健保醫療費用總額預算研擬流程

Chart 3-1　NHI Global Budget Drafting Procedures

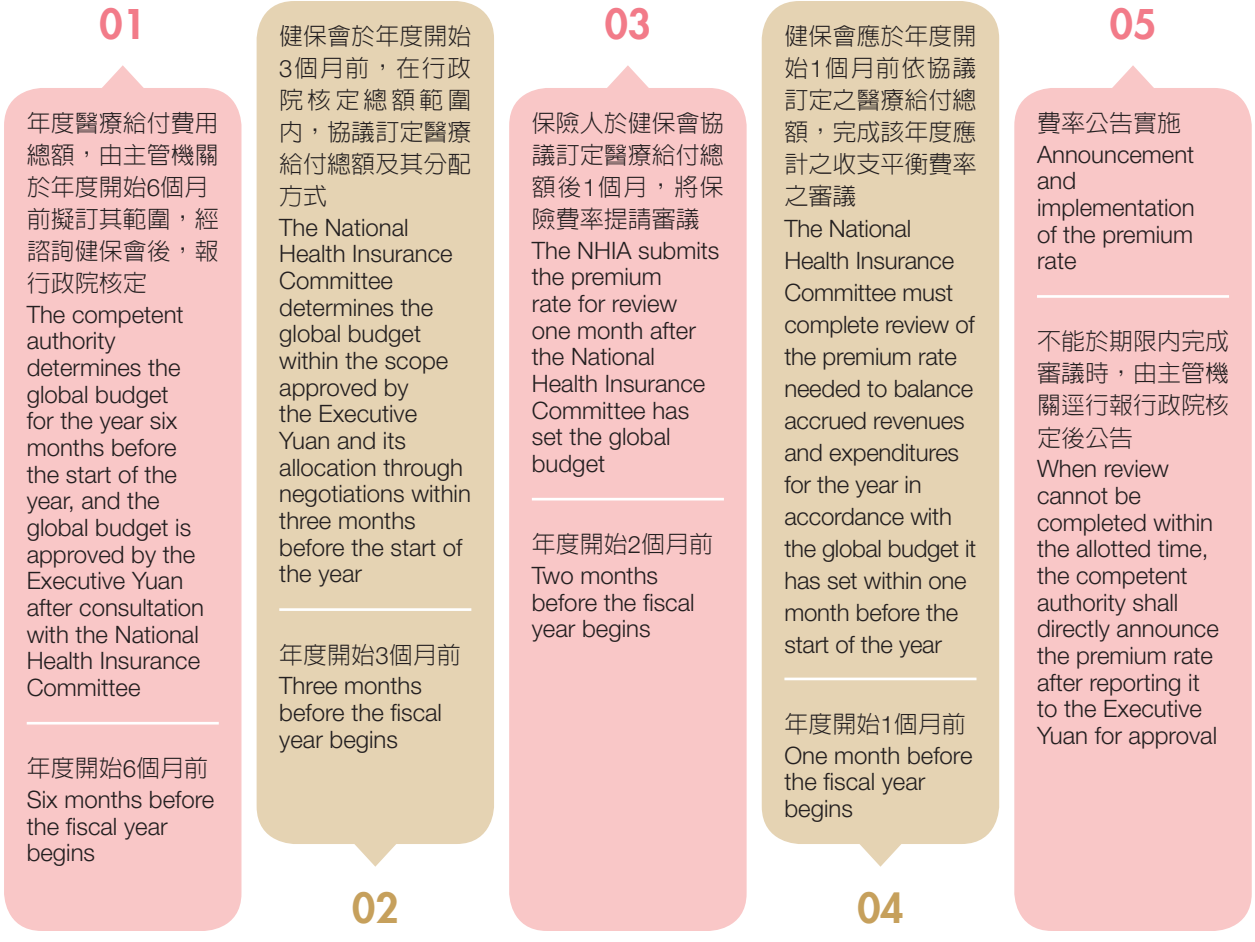
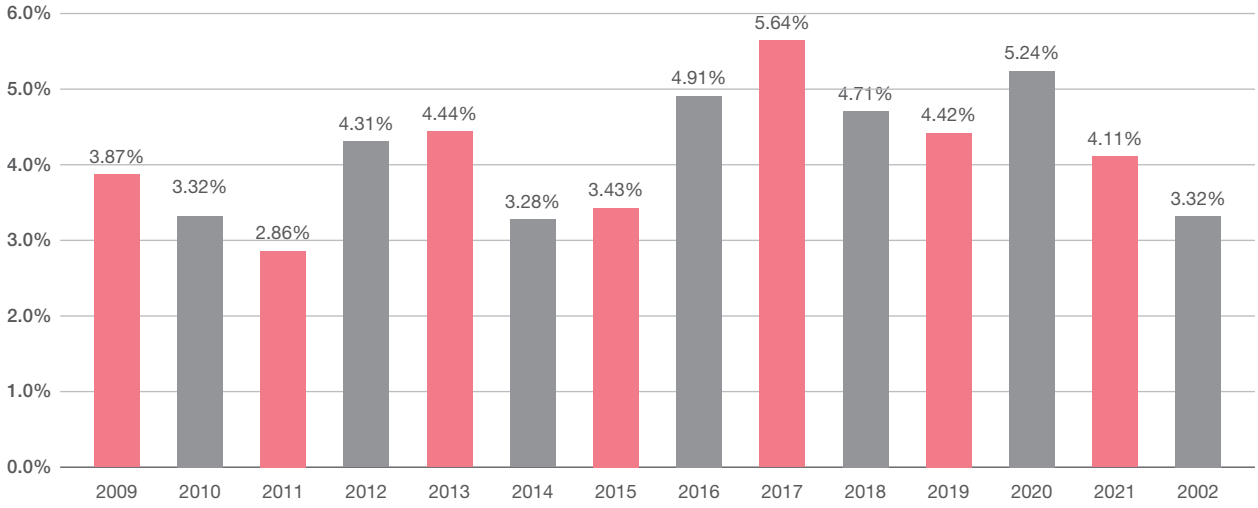


圖3-2　歷年全民健保總額協定成長率

Chart 3-2　Growth Rate of Annual Global Budget



資料來源：衛生福利部全民健康保險會委員會議全民健康保險業務執行報告。

Source: National Health Insurance Service Implementation Report, Meeting of the National Health Insurance Committee, Ministry of Health and Welfare.

Accordingly, the NHIA has followed the leading countries by designing different payment methods based on the characteristics of different types of medical care. For instance, the NHIA implemented the global budget payment system in a full scale since July 2002, and simultaneously employed different revised payment strategies, such as case payment and pay-for-performance (P4P) to change treatment behavior. In addition, the Integrated Delivery System (IDS) implemented by the NHIA in mountain areas and on offshore islands has enhanced integration of the medical service system, and the NHIA also pays the hospitals and clinics based on care quality and outcomes under pay-for-performance plans. Furthermore, to enhance patient health and medical efficiency, the NHI launched its Taiwan Diagnosis Related Groups (Tw-DRGs) program on January 1, 2010, followed by a second stage of the program, which has been in effect since July 2014.

Global Budget Payment System

The NHIA has successively implemented global payment systems for dentistry, traditional Chinese medicine, Western medicine primary care, and hospitals following 1998, and it adopted a full-scale global budget payment system in 2002. This system has provided effective, high-quality medical care using limited health insurance resources, and has limited the medical expense growth rate to below 5%. NHI global budget drafting procedures are shown in Chart 3-1, the global budget growth rate is shown in Chart 3-2, and the annual negotiated growth rate of the global budget is shown in Table 3-4.

To ensure that the quality and scope of care available at medical institutions did not change due to the implementation of a global budget payment system, the NHIA also drafts quality assurance programs for global budget sectors when negotiating global medical expense budgets. These quality

表3-4　全民健保歷年各總額部門醫療費用協定成長率

Table 3-4　Annual Negotiated Growth Rate of Global Budget

單位：% Unit: %

總額部門 Global Budget Sector	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
整體 Overall	3.874	3.317	2.855	4.314	4.436	3.275	3.430	4.912	5.642	4.711	4.417	5.237	4.107	3.320
牙醫門診 Outpatient Dentistry	3.033	2.515	1.783	2.264	1.421	1.888	2.140	3.463	3.246	4.001	3.433	3.876	3.055	2.756
中醫門診 Outpatient Traditional Chinese Medicine	2.950	2.063	2.551	2.856	2.187	2.421	2.124	3.927	4.066	3.699	4.429	5.393	4.306	4.208
西醫基層 Western Medicine Primary Care	3.756	2.742	1.874	2.986	2.818	2.391	3.191	4.274	5.157	4.053	4.067	4.401	3.552	2.744
醫院 Hospitals	4.887	3.256	3.173	4.683	5.587	3.281	3.659	5.672	6.021	4.800	4.428	5.438	4.382	3.504

為確保醫事服務機構提供的照護品質及範圍，不因總額支付制度實施而改變，在協定醫療費用總額時，同時訂定各總額部門「品質確保方案」包括：醫療服務品質滿意度調查、申訴及檢舉案件處理機制、保險對象就醫可近性監測；以及針對專業醫療服務品質訂定的臨床診療指引、專業審查、病歷紀錄等專業規範、建立醫療院所輔導系統、建立醫療服務品質指標等，並將品質資訊透明化，公開於健保署全球資訊網，做為醫療院所持續提升醫療品質的參考。

增修支付標準

為平衡醫療發展，自全民健保開辦起，配合醫療科技發展及實際臨床需要，持續新增診療項目，以提供民眾與時並進之醫療技術。截至2021年12月，支付標準共計有4,711項診療項目，經統計2004年至2021年12月，共計109次公告調整支付標準，共修訂3,088項診療項目的支付點數。

為鼓勵醫院重視臨床護理照護人力，促使醫療院所配合增加護理人力，2009年起辦理「全民健康保險提升住院護理照護品質方案」，截至2014年挹注經費累計達91.65億元，用以鼓勵醫院增聘護理人力、提高夜班費及補貼超時加班費，增加護理人員留任的意願。2015年更投入經費20億元用於調整住院護理費支付標準，除提升支付點數外，透過護病比與支付連動制度，盼減輕護理人員工作負擔。每年亦持續投入預算用以調整護理費相關支付標準，2016年投入約18億元調整各類病床護理費，2017年投入1.98

assurance programs include medical care quality satisfaction surveys, complaint and reported case response mechanisms, and insured care accessibility monitoring. The NHIA has also drafted clinical diagnostic and treatment guidelines for medical care quality, compiled standards for professional review and medical records, established a hospital and clinic assistance system, and established medical care quality indicators, and has ensured the transparency of quality information by posting it on the NHIA website, where it can serve to guide the continued improvement of healthcare quality at hospitals and clinics.

Revision of the Fee Schedule

To ensure balanced development of healthcare services, since 1995, the NHIA has continued to add new diagnostic and treatment items reflecting advances in medical technologies and clinical needs, which has enabled the public to receive up-to-date medical technologies. As of December 2021, the fee schedule contained a total of 4,711 diagnostic and treatment items. In addition, totally 109 times adjustments of the fee schedule for healthcare services were announced between 2004 and December 2021, and revisions were made to payment points for a total of 3,088 diagnostic and treatment items.

To encourage hospitals to place greater emphasis on clinical nursing manpower, a program to improve the quality of inpatient nursing care was initiated in 2009, and more than NT$9.165 billion dollars had been allocated to it as of 2014. This funding was used to encourage hospitals to hire more nursing staff, increase pay for night shifts, and subsidize extra overtime, making nurses more willing to stay on the job. Another NT$2 billion dollars was invested in 2015 to adjust the reimbursement rates for inpatient nursing services. This measure has not only increased the payment point values for the nurses' services, but also reduced nurses' burdens through the linkage of payments to the nurse-patient ratio. Every year the NHIA allocates budget to adjust related payment standards of nursing fees. In 2016, NT$1.8 billion dollars was allocated to adjust nursing fees of all wards; in 2017 NT$198 million dollars was allocated to adjust nursing fees of patients hospitalized at district hospitals. In 2018, NT$372 million dollars was allocated to improve the care quality of patients with severe diseases, and NT$614 million dollars was allocated to adjust the payment criteria based on nurse to patient ratio. In 2019, NT$475 million dollars was allocated to adjust the fees of inpatient nursing care of acute, regular and economy beds (psychiatric beds included). In 2020, NT$1.614 billion dollars was allocated to raise the nursing care fees of total hospital beds (except for chronic beds). Among all the fee adjustment, the nursing care fees for isolation beds are raised by 27.65%.

In addition, in conjunction with the promotion of differentiating levels of care, in 2017, increased budget for the "healthcare consumer price index" in the hospital global budget was used to adjust payment points for acute/severe disease items (totaling NT$6 billion dollars) and service items in remote areas and district hospitals (totaling NT$2.2 billion dollars). Beginning on October 1, 2017, the payment points for 167 service items were adjusted, markups for children in 1,513 surgery items were elevated, general principles for surgery were relaxed, and markups for ER on weekends, pediatric specialists were elevated, and raising payment points for 49 basic diagnosis and treatment in remote towns and district hospitals. In 2018 and 2020, 'additional diagnostic fee for weekend outpatient service in district hospitals' and 'a 10% increase of diagnostic fee for night outpatient service in district

億元調整地區醫院住院護理費，2018年投入約3.72億元提升重症護理照護品質及6.14億點調整護病比支付標準，2019年投入約4.75億元調升急性一般及經濟病床（皆含精神病床）住院護理費。2020年投入約16.04億元調升各類病床護理費（除慢性病床），其中隔離病床護理費調升27.65%。

另外，為配合分級醫療推動，2017年以醫院總額部門「醫療服務成本指數改變率」增加之預算，用於調整急重症項目（共60億元）及偏鄉與地區醫院診療項目（共22億元）之支付點數。自2017年10月1日起，調升167項診療項目支付點數，放寬1,513項手術之兒童加成方式，以及放寬手術通則、急診例假日加成時間、兒童專科醫師加成，另調高偏鄉及地區醫院49項基本診療支付點數。續於2018年及2020年分別新增「地區醫院假日門診診察費加計」及「地區醫院夜間門診診察費加成10%」。2021年以2020年之醫院總額部門「醫療服務成本指數改變率」增加預算，調升急診診察費及400項急重症診療項目支付點數。

為壯大西醫基層診所服務量能，擴大其服務範疇，自2017年起至2021年編列31.6億元用於基層開放表別項目，其中2017年開放「流行性感冒A型病毒抗原」等25項診療項目、2018年起開放「陰道式超音波」等9項診療項目、2019年起開放「淋巴球表面標記-感染性疾病檢驗」等11項診療項目、2020年起開放「部分凝血活酶時間」等17項診療項目及2021年起開放「無壓迫性試驗」等5項診療項目至基層院所執行。

醫療給付改善方案

全民健保醫療給付改善方案，係透過調整支付醫療院所醫療費用的方式，提供適當誘因，引導醫療服務提供者朝向提供整體性醫療照護發展，並以醫療品質及效果做為支付費用的依據。自2001年10月起，分階段實施子宮頸癌、乳癌、結核病、糖尿病及氣喘等5項醫療給付改善方案。

子宮頸癌方案自2006年起業務移由國民健康署辦理外，該年亦同時於西醫基層診所試辦高血壓醫療給付改善方案，2007年更擴及醫院執行。另結核病醫療給付改善方案，自2008年起，導入支付標準全面實施辦理。2010年1月新增思覺失調症、慢性B型肝炎帶原者與C型肝炎感染者等2項論質方案，2011年1月再新增初期慢性腎臟病論質方案，該方案自2016年4月起導入支付標準全面實施辦理。

2015年孕產婦全程照護醫療給付改善方案從衛生福利部醫療發展基金回歸至健保署；同年10月新增早期療育門診醫療給付改善方案，2017年新增慢性阻塞性肺病方案，2019年新增提升醫院用藥安全與品質方案。

糖尿病方案因執行成效良好，於2012年10月導入支付標準全面實施；高血壓方案收案對象常合併有糖尿病、慢性腎臟病等疾病，為整併照護方式，自2013年起不再列為單獨項目，而併入其他論質方案推行。近年各方案之照護率如表3-5。

hospitals' were implemented respectively. In 2021, the budget is increased based on 'healthcare consumer price index', an increase of diagnostic fee for emergency care and payment points for 400 acute/severe disease items were implemented.

To strengthen the capacity of primary-level clinics and expand their scope of service, a budget of NT$3.16 billion dollars was allocated for the year 2017 to 2021. In 2017, 25 diagnostic items, including influenza A virus antigen test, were added. In 2018, 9 diagnostic items, including vaginal ultrasonography, were added. In 2019, 11 diagnostic items, including Lymphocyte surface marker for infectious disease detection, were added. In 2020, 17 diagnostic items, including activated partial thromboplastin time, were added. Since 2021, 5 diagnostic items, including non-stress test, have been offered at clinics.

Pay-for-Performance Plans

The NHIA's pay-for-performance plans are aimed to adjust medical expense reimbursements to hospitals and clinics while providing appropriate incentives to induce healthcare service providers to develop and provide holistic healthcare. As a consequence, healthcare quality and effectiveness are taken as a basis for the reimbursement of expenses. The NHIA initiated in this pay-for-performance system in October 2001 to cover payments for the treatment of cervical cancer, breast cancer, tuberculosis, diabetes, and asthma based on well-defined clinical criteria.

The cervical cancer case management program was transferred to the Health Promotion Administration in 2006, and that same year a pay-for-performance plan for hypertension treated at Western medicine clinics was initiated. In 2007, hospitals became eligible to treat hypertension under the plan, and in 2008, pay for-performance for the treatment of tuberculosis was included in the NHI fee schedule. Two additional pay-for-performance plans were added in January 2010: for schizophrenia and for person with HBV and HCV, and another plan was introduced in January 2011 for early chronic kidney disease. Pay-for-performance plan for chronic kidney disease was covered the NHI fee schedule in April 2016.

In 2015, the NHIA took back management of the pay-for-performance program covering full-course maternal care for pregnant women, which had previously been managed by the Ministry of Health and Welfare's Medical Development Fund. A pay-for-performance plan for early treatment for development retardation was added in October of the same year, and a pay-for-performance plan for chronic obstructive pulmonary disease was added in 2017. The NHIA launched the program on improving hospital medication safety and quality in 2019.

Since the good outcomes of the diabetes pay-for-performance plan, the program was adopted in the fee schedule in October 2012. Furthermore, since the patients under the hypertension plan commonly comorbid with diabetes and chronic kidney disease, etc., to promote holistic care, these conditions were no longer listed as independent items starting in 2013, and were included in other pay-for-performance plans. The recent care rates of each plan are shown in Table 3-5.

表3-5　全民健保醫療給付改善方案照護率

Table 3-5　Percentage of Patients Treated Under NHI Pay-for-Performance Plans

方案別 Plan	2005	2006	2007	2008	2009	2010	2011
氣喘 Asthma	32.5	34.8	35.2	31.3	31.6	47.0	45.5
糖尿病 Diabetes	23.5	23.2	24.7	26.3	27.6	29.3	31.4
結核病 Tuberculosis	68.8	79.0	91.8	導入支付標準 Included in fee schedule	-	-	-
乳癌 Breast cancer	12.1	13.0	13.6	14.6	14.5	14.6	13.7
高血壓 Hypertension	未實施 Not yet implemented	基層試辦 Trial at primary care level 9.3	6.5	3.9	2.7	2.6	2.9
思覺失調症 Schizophrenia	未實施 Not yet implemented					40.7	46.9
B型C型肝炎帶原者 Hepatitis B/ Hepatitis C carrier	未實施 Not yet implemented					9.8	19.4
初期慢性腎臟病 Early chronic kidney disease	未實施 Not yet implemented						20.2
孕產婦全程照護 Full-course maternity care	未實施 Not yet implemented					由衛生福利部醫療發展基 Paid by the MOHW's	
早期療育 Treatment for development retardation	未實施 Not yet implemented						
慢性阻塞性肺病 Chronic obstructive pulmonary disease	未實施 Not yet implemented						

註：高血壓方案自2006年起於西醫基層開始試辦，2007年則擴大至醫院，其照護率因涵蓋基層診所及醫院，呈現照護率下降情形，又因病人常合併多重疾病，例如糖尿病、慢性腎臟病等，故未再以疾病別單獨另列計畫追蹤，自2013年起停止試辦。早期療育門診醫療給付改善方案自2015年10月實施、慢性阻塞性肺病自2017年4月實施。

單位：% Unit: %

2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
39.3	37.5	41.9	36.0	28.2	29.5	35.1	35.6	38.3	41.1
33.9	35.1	41.9	41.1	43.4	47.9	51.3	55.4	58.0	59.9
-	-	-	-	-	-	-	-	-	-
13.4	13.1	10.9	10.6	9.7	8.2	7.7	7.3	7.1	7.0
1.4	註 Note								
51.2	52.2	59.1	62.0	63.9	68.2	69.2	67.3	66.4	67.1
26.1	30.6	37.2	32.6	35.3	36.6	39.9	41.5	41.5	42.4
26.4	32.1	26.7	38.5	42.1	41.8	30.0	30.9	33.5	34.2
金支應 Medical Development Fund			29.3	29.5	32.3	33.4	33.3	34.0	29.9
				15.3	14.9	13.2	11.5	11.0	13.2
					24.3	38.5	35.4	40.3	45.6

Note: The hypertension plan was first implemented on a trial basis at primary clinics in 2006, and was expanded to hospitals in 2007. While the care rate of the plan encompasses both clinics and hospitals, the care rate presents a decreasing trend. In addition, because hypertension patients commonly also have comorbidities such as diabetes and chronic kidney disease, etc., these conditions were no longer tracked under other independent plans, and trial implementation of the plan was ended in 2013. An early intervention outpatient pay-for-performance plan was implemented in October 2015, and the chronic obstructive pulmonary disease plan was implemented in April 2017.

Chapter 4

專業審查　提升品質

Professional Review and Quality Improvement

專業審查　提升品質

為避免醫療浪費，保障醫療品質，醫療服務審查制度為必要機制。醫療服務審查重點為：醫療服務項目、數量及適當性。平均一年門診申報件數約3.56億件，平均每日約97萬件，一年住院約328萬件，平均每日約9千件。基於人力及行政成本考量，有關醫療服務審查可區分為「程序審查」與「專業審查」；在工具面，亦大量運用電腦科技與資料分析技術，並致力於發展「電腦醫令自動化審查」及「檔案分析」等電腦輔助審查系統以提升審查效率。

專業審查

由於申報案件量甚鉅，健保署於專業審查時採抽樣審查，即以抽樣方式調閱部分病歷送請審查醫藥專家審查，抽樣方式包括隨機抽樣與立意抽樣。隨機抽樣審查結果會以樣本的核減率按比例回推至全部母體案件進行核減，立意抽樣審查結果因屬特定案件全審非抽樣，故不予回推。

醫療專業審查注意事項之訂定，需先蒐集專科醫學會與醫師公會及醫院協會意見後，經具有相關臨床或實際經驗之醫藥專家組成分科專家諮詢會議討論後訂定。自2017年起，以醫療專業常見治療模式或手術為主題改版修訂採邏輯性編排，比照藥品給付規定進行編碼，以利資訊化勾稽，提供審查醫師參考。

運用科技提高審查效率

健保署逐步推動醫療申報電子化，累積至今，已成為全球獨一無二的全民健保資料庫。透過電子e化，健保署可快速有效率的審查醫療院所申報資料及發現異常狀態，並從大量的倉儲資料中，輔助分析協助政策方向之訂定，及啓動相關措施，避免醫療資源浪費。

電腦醫令自動化審查

針對全民健康保險醫療服務給付項目及支付標準、全民健康保險藥物給付項目及支付標準、全民健康保險醫療費用審查注意事項等給付規定，明確規範不給付（例如年齡限制、性別限制、專科醫師限制等），則建立醫令自動化審查邏輯，透過電腦邏輯程式檢核，直接核減不給付醫令項目，逐步導正醫療院所申報之正確性，以提升審查效率。

檔案分析

近年健保署也積極採行以檔案分析為主軸的審查制度，進行醫事機構醫療利用異常之審查管理，目前已採行之措施如下：

1. 依據各項統計資料分析、偵測病患就醫、醫療院所診療型態與費用申報之異常狀況，供審查參考，使專業審查重點由個案審查轉變為診療型態的審核。
2. 邀請醫界代表討論，共同發展檔案分析審查異常不予支付指標，利用申報資料對醫療院所診療型態進行審核，並針對各指標值設定閾值，就異常部分，以程序審查方式進行核減，以節省人工審查成本。

Professional Review and Quality Improvement

To avoid overutilization and ensure medical quality, the medical service review system is a necessary mechanism for avoiding healthcare waste and maintaining medical care quality. The focal points of medical service review consist of medical care items, their quantities, and their appropriateness. There is an average of approximately 356 million outpatient reimbursement claims are made every year, and roughly 970,000 such claims are made every day; approximately 3.28 million inpatient care claims are made every year, which works out to roughly 9,000 such claims every day. Based on manpower and administrative cost considerations, two types of medical care review process can be employed: procedural review and professional review. Computer technology and data analytics are used extensively in these review processes, and the National Health Insurance Administration (NHIA) is striving to enhance review efficiency through the development of computerized review systems for automated care order review and profile analysis.

Professional Review

Due to the huge volume of reimbursement claims, the NHIA employs a sampling approach in professional reviews. In this system, a sample of patient records is sent for review by medical experts. The sampling methods used include random sampling and purposive sampling. The reduction rate found in random sampling reviews is used to infer the reduction rate in the entire case population. Because purposive sampling reviews focus on all cases with certain characteristics, their results are not used for inferential purposes.

Guidelines for professional medical reviews are set after collecting the opinions of medical specialist associations, physicians' associations, and hospital associations, followed by discussion at advisory conferences of specialists from among the group of medical experts with relevant clinical or practical experience. Starting in 2017, these guidelines have been revised to put them in a more logical order on the basis of the most common modes of treatment or procedures in various medical specializations. The guidelines have also been coded in parallel with medication payment regulations in order to facilitate computerized audits and to provide a reference for reviewing physicians.

Apply Technology to Raise Review Efficiency

The NHIA has gradually promoted the computerization of medical claims, and has accumulated the globally unique National Health Insurance (NHI) database. Thanks to digitization, the NHIA can quickly and efficiently review reimbursement claim data from hospitals and clinics, and can discover any abnormal situations. In addition, analysis of the NHIA's vast amounts of accumulated data can assist the drafting of policies, and facilitate the initiation of relevant measures intended to prevent avoid the waste of medical resources.

Automated Review System

The NHIA has established automated review procedures addressing payment regulations such as NHI medical care payment items and fee schedules, NHI medical expense review guidelines, and specific

3. 健保署自2014年9月起，建置「全民健康保險中央智慧系統」（Central Intelligence System, CIS），對重要項目納入統一管控，將疑似異常耗用健保醫療資源的申報項目，由電腦自動篩選出異常案件，列入抽樣樣本或予以標記，並提供異常資訊，抽調病歷送專業審查確認是否符合健保規定，以提升審查效率。該系統目前以健保門診、住診、藥品、特定診療與處置及特定個案名單等，5項主構面開發出約150項篩異指標。

輔助專業審查

自2014年起擴大推動數位化審查作業，強化「智慧型專業審查系統IPL」整併資訊功能，自動連結健保給付規定、審查注意事項、病歷電子檔案、審查重點等資訊，並增設提醒機制、個別化設定，協助審查醫藥專家有效率進行精確審查。

推動具名審查，審查醫師資訊透明

為回應各界因審查專業見解差異而提出公開具名以示負責之建議，健保署自2016年10月起，以醫院總額醫療費用為範圍，實施「專業雙審及公開具名」試辦方案，期望達到減少個人專業見解差異，提升醫療費用核減合理性之目的，說明如下：

1. 專業雙審：為全部科別符合特定情況者，得採專業雙審方式辦理審查作業，第2審醫師可參考第1審醫師意見審查，最後以第2審醫師的

no-payment rules (such as age restrictions, gender restrictions, and specialist physician restrictions, etc.). Computer programs are used to check medical orders, and can directly weed out medical order items not eligible for payment. This approach has been gradually improving the correctness of claims made by hospitals and clinics, while improving review performance.

Profile Analysis

In recent years, the NHIA has also been adopting a review system based on profile analysis to review and manage anomalies in medical resource utilization by medical institutions. The NHIA has currently undertaken the following measures:

1. Statistical analysis is employed to detect irregularities in patient care, diagnosis and treatment patterns at hospitals and clinics, and expense reimbursement claims. The results of this analysis are provided as a review reference, which has enabled a shift in the focus of professional review from review of individual cases to the review of diagnosis and treatment patterns.
2. Representative medical personnel are invited to jointly discuss and develop indicators based on profile analysis for review irregularities where payment is not approved. Claims data is used to review diagnosis and treatment patterns at hospitals and clinics, and set threshold values for individual indicators. Procedural review can then be employed to weed out irregular cases, reducing manual review costs.
3. The Central Intelligence System (CIS) established by the NHIA in September 2014 allows the unified management of important items. Computer programs automatically detect anomalous cases suspected of involving the irregular utilization of NHI medical resources, which are then included in review samples or marked. This system also provides information on irregularities, and allows patient records to be sent for professional review to confirm whether they comply with NHI regulations. This system has improved review performance, and has enabled the development of approximately 150 irregularities screening indicators for the five areas of NHI outpatient care, inpatient care, medication, specific diagnosis, treatment, and disposition, and specific case lists.

Assisted Professional Review

The expanded promotion of computerized review processes employed since 2014 have strengthened the information integration functions of the "Intelligent Peer Review Learning System" (IPL). This system automatically links NHI payment regulations, review guidelines, patient record e-files, and review focal points, and provides reminder mechanisms and customized setting options to help medical experts efficiently perform precise reviews.

Signed Reviews and Disclosure of Reviewing Doctors

Responding to the recommendation from various quarters that reviewers should take responsibility for any differences of professional opinion by providing named reviews, the NHIA initiated a named professional double review program on a trial basis for reviews within the scope of hospitals' global budgets starting in October 2016. The NHIA hopes that named reviews will reduce differences between different individuals professional opinions, and achieve the rational reduction of medical expenses. This program has the following features:

1. Professional double review: Professional double review may be adopted to ensure that all medical specialties comply with specific conditions. The physician performing the second review may refer

審查結果作為核減結果為原則，必要時得召開共同審查會。

2. 公開具名：依審查醫師之意願，分為「個別核減案件具名」及「團體公開姓名」雙軌運作。

⑴個別具名：於小兒科、婦產科、耳鼻喉科、眼科、神經科、精神科及泌尿科等7個科別於部分地區試辦，依相關單位提報願意具名之名單，評估後按季公告具名審查之分區及科別。

⑵團體具名：全部科別皆實施，於意願徵詢完成後，按季置於「健保資訊網服務系統（VPN）」供臨床醫師查詢同意公開之專家團體名單，目前同意率約6成。

醫療品質資訊公開

健保署自2005年起建置醫療品質資訊公開平台，以藉品質資訊公開，激勵醫界更努力提升個別院所之醫療服務品質，及增進民眾對本保險醫療品質及醫療利用之瞭解，以做為民眾就醫選擇之參考，包括：「專業醫療服務品質報告」、各特約院所之醫療品質指標、服務類指標、特定疾病類指標等，供大眾瞭解國內之醫療品質概況。

除此之外，特約醫事服務機構資訊的基本資料，例如包括服務項目、診療科別、固定看診時段、保險病床比率、違規醫事機構資訊、掛號費查詢，均公開於全球資訊網。

合理調整藥價

現行藥品之支付係由醫事機構依藥物給付項目及支付標準向健保署申報藥費，健保署再透過定期藥價調查，取得實際交易價格，據以調整藥品支付價格，使其更接近藥品之市場銷售價格。

自1999年起，依據調查的結果調降藥價，除了縮小藥價差距，亦減緩藥費支出成長。每次藥價調降所節省的費用，用於加速新藥收載及給付、放寬藥品給付範圍、調整支付標準偏低之項目，以提供國內民眾享有與世界先進國家同步的醫療用藥，同時也提升了醫療品質，對於全民的健康保障，具有實質的效益。

為落實健保整體藥費之管控，健保署公告實施「全民健康保險藥品費用分配比率目標制」試辦方案，自2013年1月1日起試辦至今已有9年，主要是預設每年藥費支出「目標值」，並與實際藥費支出做連結，當超過目標值時自動啓動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。

給付C型肝炎全口服新藥

過去C肝治療需每週施打一次長效型干擾素，並配合每日口服雷巴威林（ribavirin），療程半年至一年。自從治療C肝的全口服新藥上市後，可提高治癒率、降低副作用並縮短療程，全民健保於2017年1月起納入給付，並於健保醫療費用總額編列專款經費做為C肝治療所需之藥品預算。2017年至2021年已投入約302.31億元預算用於給付C型肝炎用藥之治療，近五年來約有13.1萬人受惠。為達到2025年臺灣消除C肝的願景，持續編列充足治療經費，2022年預算共56.2億元，約可讓4萬人接受治療。

to the opinions of the first reviewing physician, but the results obtained by the second reviewing physician shall generally form the basis for rejection of claims, although a joint review meeting may be held when necessary.

2. Open naming: In accordance with the preferences of the reviewing physicians, naming may be performed either as individual naming of rejected cases or open naming of group members.

   (1) Individual naming: This approach has been adopted on a trial basis in certain areas in the specialties of pediatrics, gynecology/obstetrics, otorhinolaryngology, ophthalmology, neurology, psychiatry, and urology. When relevant units express willingness to provide a list of names, following assessment, the district and department of the named reviews are announced on a quarterly basis.

   (2) Naming of group members: This approach has been adopted in all the specialties. When all relevant departments have agreed to implement this approach, the list will be placed on the NHI information service system's virtual private network to allow clinical physicians to consult the list of expert group members who have allowed their names to be disclosed. The agreement rate is currently approximately 60%.

Disclosure of Medical Quality Information

The healthcare quality information disclosure platform established by the NHIA in 2005 relies on the disclosure of quality information to encourage medical personnel to enhance the quality of medical care at their hospitals and clinics. The disclosure of quality information also enhances public understanding of NHI healthcare quality and medical resource utilization, which can serve as a reference for people's healthcare choices. The quality information include professional healthcare quality reports, healthcare quality indicators for each contracted hospital and clinic, service indicators, and indicators for specific illnesses. This information can give members of the public a better understanding of the state of healthcare quality in Taiwan.

Furthermore, other basic information concerning contracted medical institutions, such as service items, medical departments, fixed visit hours, insured bed ratios, information on medical institutions that have violated regulations, and registration fee consulting, is disclosed on the NHIA's website.

Reasonable Drug Price Adjustments

Under the current drug payment system, after medical institutions have made reimbursement claims to the NHIA in accordance with drug dispensing items and fee schedules, the NHIA will then obtain the actual transaction price through regular drug price survey, so as to adjust the drug payment price to make it closer to the marketing price of the drugs.

Since 1999, drug prices have been reduced based on the survey results, which not only narrowed the gap between drug prices, but also slowed down the growth of drug expenditures. The cost savings from each drug price reduction can be used to accelerate the approval of payment for new drugs, expand the scope of drug payments, and adjust the items with low payment standards, so as to provide people in Taiwan with medical drugs that are synchronized with the world's advanced countries, while improving healthcare quality and achieving tangible benefits in protecting people's health.

In order to implement the control of the overall NHI drug costs, the NHIA has announced the trial "NHI Drug Expenditure Allocation Ratio Target System," which has been trail for 9 years since

民眾自付差額特材

由於醫療器材產業迅速發展，新醫療器材日新月異，健保署明白民眾醫療的需求，與時俱進，在財源合理下編列預算，逐步將新醫療器材納為健保給付的特材（健保收載給付之醫療器材稱為特殊材料，簡稱健保特材）。新醫療器材雖改善現有健保收載特材之某些功能，但是價格也較原健保給付類似產品昂貴許多。為使民眾使用到適當且符合效益的新醫療器材，健保署自1995年起陸續將新增功能類別之特殊功能人工心律調節器、冠狀動脈塗藥支架、特殊材質人工髖關節、特殊功能人工水晶體、特殊材質生物組織心臟瓣膜、腦脊髓液分流系統、治療淺股動脈狹窄之塗藥裝置、治療複雜性心臟不整脈消融導管及特殊功能及材質髓內釘組等9類列為民眾自付差額項目（表4-1）。若民眾選用自付差額特材品項，健保按現行類似品項之支付標準給付，超過費用由民眾自行負擔。

表4-1　民眾關心之自付差額特材一覽表

Table 4-1　Special Medical Devices Covered via Balance Billing

項目 Item	開始實施時間 Effective Date
特殊功能人工心律調節器 Special Function Pacemaker	1995/08/03
冠狀動脈塗藥支架 Drug-eluting Coronary Artery Stent	2006/12/01
特殊材質人工髖關節 Special Materials of Hip Prosthesis	2007/01/01
特殊功能人工水晶體 Artificial Intraocular Lenses	2007/10/01
特殊材質生物組織心臟瓣膜 Special Materials of Bio-prosthetic Heart Valves	2014/06/01
腦脊髓液分流系統 Cerebral Spinal fluid Shunt Systems	2015/06/01
治療淺股動脈狹窄之塗藥裝置 Drug-device Combination Products for Superficial Femoral Artery Stenosis	2016/05/01
治療複雜性心臟不整脈消融導管 Ablation Catheters for Treatment of Complicated Cardiac Arrhythmia	2017/11/01
特殊功能及材質髓內釘組 Intramedullary nail with Special Function and Materials	2018/06/01

January 1, 2013, mainly to preset the “target value” of annual drug expenditure, and create linkage with the actual drug cost, and accordingly perform the annual adjustment of drug price when the target value is exceeded, so that the rage of drug cost can be remained stable and reasonable.

Payment for New Oral HCV Medications

In the past, treatment of hepatitis C required weekly injection of pegylated interferon, combined with daily oral ribavirin for six months to one year. Since the launch of direct-acting antiviral agents for hepatitis C, which can improve the cure rate, reduce side effects and shorten the cost of treatment. NHI has covered these drugs since January 2017, and the total health insurance medical expenses have been allocated as a special fund for the drug budget required for hepatitis C treatment. From 2017 to 2021, a total budget of NT$30.231 billion has been invested in the treatment of hepatitis C drugs, benefiting 131,000 people in the past five years. To achieve Taiwan's vision of eradicating hepatitis C by 2025, the NHIA will continue to allocate adequate treatment funds, with a total budget of NT$5.62 billion in 2022, which can allow approximately 40,000 people to receive treatment.

Medical Devices Covered via Balance Billing

More and more new medical devices have come into use thanks to the rapid development of the medical device industry. The NHIA is aware that people’s medical needs are changing with the times, and is gradually covering new medical devices as NHI special materials (medical devices covered by

有關2017年8月1日收載為民眾自付差額特材之客製化電腦輔助型顱顏骨固定系統，因臨床使用占率高已成為臨床主流，經評估後健保署已於2018年12月納為全額給付。另外健保署更於2020年針對民眾自付差額特材改革，依臨床實證支持的臨床效果，訂出合理差額費用及合理的健保給付比例，希望在兼顧健保的財務下，讓創新醫材以自付差額方式納入健保給付，增加民眾使用創新醫材可近性。

為保障民眾權益，針對2019年12月31日以前已收載的自付差額特材（義肢除外），健保署積極與公、學、協會溝通討論，由臨床依照自付差額特材的功能與材質進行分類，並提供淺顯易懂的分類說明供民眾參考，同時訂出各分類專業認為合理的收費極端值，自2020年8月24日以符合專業自主的方式進行管理。此外，醫療法規定醫療院所應於手術或處置前讓民眾充分獲得資訊。此外，醫療院所也應將病患使用自付差額特材之品項名稱、品項代碼、收費標準（包括醫院自費價、健保支付價及保險對象負擔費用）、產品特性、副作用、與健保已給付品項之療效比較等相關資訊，置於醫療院所之網際網路或明顯之處所。另健保署亦會將民眾自付差額特材與健保全額給付特材之價格及功能資訊，置於健保署全球資訊網站，民眾可至健保署全球資訊網「醫材比價網」搜尋各醫院收費價格，了解後再與醫師討論選用合適的特材。

NHI are referred to as "special materials") within a reasonable financial budget. Although new medical devices can improve on certain functions of special materials, their price is often much higher. For the public can benefit from the use of appropriate, effective new medical devices, since 1995, the NHIA has added the nine categories covered via balance billing, including special function pacemakers, drug-eluting coronary artery stents, special materials of hip prosthesis, artificial intraocular lenses, special materials of bio-prosthetic heart valves, cerebral spinal fluid shunt systems, drug-device combination products for superficial femoral artery stenosis, ablation catheters for treatment of complicated cardiac arrhythmia, and intramedullary nails with special functions and materials (Table 4-1). If people opt to use balance billing special materials item, NHI will provide reimbursement according to the fee schedule for a similar existing item, and the difference must be paid by the users.

Customizable cranial and facial bone fixation systems, which was included as a balance billing special materials on August 1, 2017, has been provided full coverage after entered the clinical mainstream, the NHIA since December 2018. In addition, the NHIA determine a reasonable ratio of differential expense to NHI payment for items according to empirical support of their clinical effectiveness, in order to reformed its balance billing special materials system in 2020. While taking NHI's finances into consideration, the NHIA hopes to include more new medical devices coverd via balance billing, which will give people greater access to innovative medical devices.

In order to protect the public's rights and interests, the NHIA embarked on a discussion with guilds, and associations concerning special materials covered via balance billing (apart from prosthesis) prior to December 31, 2019. The participants classified special materials covered via balance billing by function and material, and provided an easy-to-use classification scheme for the public's reference. At the same time, the participants also determined what experts believed to be the reasonable extreme price for each category. Starting from August 24, 2020, the devices in these categories were put under management in keeping with professional autonomy. In addition, the *Medical Care Act* specifies that hospitals and clinics must give the public adequate access to information before any surgery or other treatment. Also, hospitals and clinics must consequently place the names of special materials covered via balance billing, their item codes, fee standards (including self-pay price, NHI reimbursement, and insured copayments), product characteristics, side effects, and a comparison of the efficacy of the item and that of other items currently covered by NHI on their website or other easily visible location. Furthermore, the NHIA also provides price and function information for special materials covered via balance billing and other fully covered special materials on its website. People can visit to the "Price Comparison Platform of Self-Paid Medical Devices" section of the NHIA website to obtain the prices charged by individual hospitals, and they can discuss the choice of appropriate special materials with their doctor after getting a better understanding of the options available.


MEDICAL
Health Ca
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Pharmacis
Nurse
Dentist
First Aid
Surgeon
Emergenc

Chapter 5

健康科技　服務加值

Health Technology and Value-Added Services

健康科技　服務加值

醫療資訊上雲端　調閱分享無弗屆

全民健保累積20多年的健保申報資料，堪稱是全國最大的個人資料庫，近年來大數據（Big Data）觀念興起，健保署在資安確保下，開始逐步彙整各域資料，透過雲端運算技術提供醫師臨床專業判斷或將健保資料回饋給民眾。2013年7月健保署建置完成以病人為中心的「健保雲端藥歷系統」，透過健保的VPN系統，提供特約醫事服務機構於診療需要時，可即時查詢病人過去6個月的用藥紀錄，作為醫師處方開立或藥事人員用藥諮詢參考，以提升民眾就醫品質，減少不必要之醫療資源重複使用。

分析「健保雲端藥歷系統」使用情形，顯示醫師利用系統查詢之病患，用藥日數重疊率已明顯降低。此外，特約醫事服務機構整合健保雲端藥歷資訊及院內用藥管理系統，紛紛建置院內專屬之用藥管理機制，如設立門住診標準化雲端藥歷系統查詢作業流程、設置敬老領藥窗口、發展雲端藥歷智慧判讀程式、追蹤不當藥物等；或鼓勵住院病人改服用自行攜入（他院或門診開立）之藥品，提升藥事人員用藥安全角色功能，並強化用藥安全環境，顯示健保雲端藥歷系統已有成效。

Health Technology and Value-Added Services

NHI MediCloud System for Sharing Information Anytime, Anywhere

National Health Insurance (NHI) has accumulated over twenty years of health insurance reimbursement claim data, which may form the nation's largest database. With the emergence of the big data paradigm in recent years, the National Health Insurance Administration (NHIA) has begun to gradually compile data from various fields, and uses cloud computing technology to provide doctors the data they need for clinical judgments and offer health insurance data to the public. In July 2013, the NHIA established the patient-centered "NHI PharmaCloud System", which allowed contracted medical institutions to immediately query patients' medication records of the previous 6 months for diagnostic or treatment purposes via the NHI VPN system. By providing reference information can help doctors made out prescriptions or pharmacy personnel to provide medication consulting to patients, enhancing people's care quality and reducing the redundant consumption of medical resources.

Analysis of use of the NHI PharmaCloud System indicates that when doctors use the system to query information about their patients, the patients' duplicated days of medication use are reduced significantly. In addition, contracted medical institutions are integrating information from the NHI PharmaCloud System with their own medication management systems, and thereby establishing dedicated in-house medication management mechanisms. These include standardized outpatient/inpatient NHI PharmaCloud system query procedures, drug pick-up counters for the elderly, smart medication record interpretation programs, and tracking of inappropriate prescriptions. Application of the NHI PharmaCloud System has also been used to encourage in patients to use drugs they have brought with them (prescriptions from other hospitals or clinics). This processes have helped pharmacists to better fulfill their role in enhancing the medication safety, and have improved the overall “medication safety” environment, reflecting the profound usefulness of the NHI PharmaCloud System.

Based on the NHI PharmaCloud System, the NHIA developed the expanded "NHI MediCloud System" in 2015 according to users' feedback and practical clinical needs. The new system encompasses not only the continuously improving PharmaCloud System, but also expanded to function a total of 12 query systems, including Chinese medicine prescription use records, examination and test records and results (including the results of adult preventive care and screening for four cancers conducted by the Health Promotion Administration, MOHW), surgical records, dental treatment and surgical records, drug allergy records, special controlled drug and specific coagulation factor use records, rehabilitation records, hospital discharge summaries, and Taiwan Centers for Disease Control vaccination records. Furthermore, there are also sections presenting medical records regarding Hepatitis B and C. All of the information mentioned above has been brought together on the same single platform. The system also provide a user-friendly query interface and active reminder mechanisms (such as reminder windows display the most recent date specific tests, a timeline showing visits to medical practitioners and recent medical care, and the mechanism that automatically reminds physicians

基於前述推動基礎，健保署參考使用者回饋意見及臨床實務需求，自2015年起擴大發展「健保醫療資訊雲端查詢系統」，除持續精進雲端藥歷系統，並增建中醫用藥紀錄、檢查檢驗紀錄、檢查檢驗結果（含國民健康署成人預防保健及四癌篩檢結果）、手術明細紀錄、牙科處置及手術紀錄、過敏藥物紀錄、特定管制藥品用藥紀錄、特定凝血因子用藥紀錄、復健醫療紀錄、出院病歷摘要及疾病管制署預防接種紀錄等共12類主題式資料，以及專區呈現B、C型肝炎就醫資訊。各項查詢系統建置於同一查詢平台，並發展提示功能、友善查詢介面及主動提醒機制（例如特定檢查項目最近一次執行日期提示視窗、就醫用藥時間軸及主動提醒醫師當次處方與病人餘藥是否有重複開立、藥品交互作用或含有過敏藥等），以縮短使用及閱讀所需時間，並有助於醫師、藥師及特定醫事人員臨床處置專業判斷，提供病人更好的照護品質。

雲端加值服務　健康存摺運用

從健保大數據分析發現，控制不必要的檢驗檢查及用藥是提升醫療資源使用效率之重要關鍵。因此自2015年起，鼓勵醫療院所上傳病患各項檢驗檢查結果。2018年1月起，各大醫院為病患執行CT、MRI、超音波、胃鏡、大腸鏡及X光檢查，其他的基層院所即可透過健保醫療資訊雲端查詢系統調閱影像及報告內容。對民眾而言，至同層級醫院尋找第二醫療意見或在居家附近基層院所接受後續照護，只要由雲端調閱資料，就可看到檢驗檢查報告，節省等待醫院作業流程與金錢花費，也降低重複檢查的潛在健康風險。藉此落實分級醫療「社區好醫院，厝邊好醫師」的理念，提升病患就醫品質及方便性，也減少醫學中心壅塞的問題。

另外，健保署個人化雲端服務的「健康存摺」系統提供已註冊健保卡的民眾免插卡即可登入系統查詢的服務，運用一目瞭然的視覺化資訊圖表，搭配篩選及分類功能，讓民眾快速瞭解個人最近的就醫紀錄、檢驗檢查結果及預防保健資料，直接掌握本身的健康狀況，進行自我健康管理。民眾也可以下載個人健康存摺資料加值運用或利用行動裝置登入「全民健保行動快易通｜健康存摺APP」之「健康存摺」，隨時查詢個人就醫資料，或於就醫時提供醫師參考，預期可縮短醫病間醫療資訊的不對等，提升醫療安全與效益。

健康存摺自2014年推出以來，使用人數不斷上升，截至2021年12月31日止，健康存摺使用人數約740萬人，使用人次已達1億6,200萬人次。約9成使用者認同透過健康存摺可瞭解個人就醫情形，有助於掌握自我健康情形，顯示健康存摺對於促進民眾自我健康照護有正向幫助。

邁向AI健保　輔助精準審查

1.專業審查系統主動智慧提示

為匯集審查所需的各項資訊，並減少專審醫師查找資訊的人工作業，健保署透過大數據分析於專業審查系統主動提示各式審查重點，以醫療費用案件為例，系統會主動呈現保險醫事服務機構是否為篩異指標抽審對象與篩異原因、該保險醫事服務機構之各項醫療利用統計資訊、歷史核減情形等；另以事前審查案件為例，主動呈現癌症免疫藥品不得合併使用標靶藥物、類風濕關節

whether there is a duplicated prescription, drug interaction or allergic agent). These upgrades to the system make it easier for medical professionals to gain quicker access to vital information by shortening the time needed to read information and use the system. This enables physicians, pharmacists and specific healthcare professionals to make better clinical judgment and provide patients with even better care quality.

Value-Added Cloud Services: My Health Bank

NHI big data analysis has revealed that curbing unnecessary tests, examinations, and medication is the key to more efficient use of medical resources. As a consequence, starting in 2015, the NHIA has encouraged hospitals and clinics to upload patients' testing and examination results. And since January 2018, when patients undergo CT, MRI, ultrasound, gastroscopy, colonoscopy, and x-ray examination at a large hospital, other primary care hospitals and clinics can use the NHI MediCloud System to view the patients' images and reports. As a result, when members of the public wish to obtain a second opinion from a hospital at the same level, or receive follow-up care at a primary care hospital or clinic near their home, medical personnel need only obtain their data from the cloud, and can then view the patients' testing and examination reports. This saves patients' money and time spent waiting for hospital procedures, and also lessens the potential health risk of multiple examinations. This also realizes the hierarchical healthcare ideal of "a good hospital in the community, a good doctor nearby," boosts the quality and convenience of healthcare, and eases congestion at medical centers.

Furthermore, the NHIA's individualized cloud "My Health Bank" system enables people with valid NHI cards to log onto the system and make queries without needing to insert a card. My Health Bank presents information as easy-to-understand charts and tables, and offers filtering and classification functions. By letting people quickly view and understand their most recent healthcare records, testing and examination results, and preventive care data, it enables them to monitor their health status and perform health self-management. Members of the public can also make value-added use of downloaded My Health Bank data, or use a mobile device to log onto My Health Bank from the "National Health Insurance Action Express/ My Health Bank app," which allows them to query their personal healthcare data, which can also be viewed by doctors during visits. The My Health Bank system is expected to lessen the information asymmetry between doctors and patients, while also enhancing medical safety and effectiveness.

My Health Bank's user base has increased steadily since its introduction in 2014. As of December 31, 2021, it had approximately 7.4 million users, and had been used more than 162 million person-times. The fact that roughly 90% of users agree that My Health Bank can help them understand their healthcare situation and monitor their state of health indicates that My Health Bank can significantly promote better health self-management among the public.

Applying AI to Enhance Precision of NHI Reviews

1. Smart Prompts in the Professional Review System

In order to gather the various types of information needed for reviews, and reduce the time reviewing physicians spend searching for information, the NHIA relies on big data analysis to actively provide prompts indicating various review focal points in the professional review system. Taking the case of medical expenses as an example, the system will actively indicate whether a contracted medical

炎免疫藥品提示個案不適合用藥之情形、傳統抗風濕病用藥歷程及檢驗結果等資訊，協助審查醫師迅速掌握審查重點，簡化翻查病歷與比對給付規定之人工作業。

2. 人工智慧（AI）輔助精準審查

健保署應用大數據與AI科技輔助，結合結構化費用申報資料與非結構化檢驗檢查影像與報告，在尊重醫療專業的前提下，發展智能輔助精準審查機制，以下舉「影像或報告品質監測」及「影像重複或相似度偵測」為例說明。

⑴特約醫事服務機構申報前的上傳影像或報告品質監測：

推動鼓勵保險醫事服務機構即時上傳醫療影像、檢查文字報告以及檢驗結果，並針對CT與MRI檢查文字報告、C肝及腎功能檢驗結果等資料，健保署已建置上傳品質監測系統，可透過大數據分析瞭解保險醫事服務機構上傳資料品質是否穩定，例如比對影像檔案資訊與該筆上傳醫令項目是否一致、影像文字報告內容是否含有影像發現或臆斷、檢驗結果值是否為空值等。以監測結果適時回饋提醒保險醫事服務機構改善上傳資料的品質，增進健保資料庫審查應用價值並提升雲端共享效能。

⑵特約醫事服務機構申報後的送審影像重複或相似度偵測：

運用AI技術自行開發重複醫療影像偵測、牙科影像及白內障影像相似度偵測等審查輔助工具，能將影像自動分群，在5秒內完成1千張影像重複偵測、6分鐘完成1千對牙科及白內障影像相似度偵測，輔助審查醫師快速判讀是否有不同個案送審重複及相似度高的影像之異常情事。

institution is part of an irregularity screening indicator review sample and the reason for irregularity screening, the medical institution's various medical utilization statistics, and its historical reduction situation. Taking pre-review cases as an example, the system will provide active notification of cases in which immunotherapy drugs for cancer cannot be used in combination with targeted drugs, cases in which immunotherapy drugs cannot be used to treat rheumatoid arthritis, and information such as rheumatic disease medication historic site and test results. This information can help reviewing physicians to quickly grasp review focal points, while simplifying manual patient record searches and reference to payment regulations.

2. AI-assisted Precision Review

While respecting the medical profession, the NHIA employs big data and AI technology to combine structured claim data with unstructured testing and examination data, imaging, and reports, and develop AI-assisted precision review mechanisms. The following is an overview of the examples of "monitoring of imaging and report quality" and "image repetition or similarity detection."

(1) Monitoring of the quality of images and reports uploaded prior to claiming by contracted medical institutions:

To encourage contracted medical institutions to promptly upload data such as medical images, text examination reports and test results, etc. For text CT and MRI examination reports, and hepatitis C and kidney function test results, the NHIA has established an upload quality monitoring system. This system employs big data analysis to provide an understanding of whether the quality of the data uploaded by contracted medical institutions is stable. For instance, the system checks whether image file data is consistent with the corresponding care order item, whether text imaging reports contain discoveries or conclusions, and whether any test values are not exist. Monitoring results are provided to contracted medical institutions when needed to encourage them to improve the quality of uploaded data. This monitoring has increased the value of database review applications and the effectiveness of data sharing via the cloud.

(2) Detection of image repetition or similarity after claiming by contracted medical institutions:

The NHIA uses self-developed review-assisting tools employing AI technology, including repeated medical image detection, and dental image and cataract image similarity detection tools, to perform automatic grouping of images. These systems can automatically detect repeated images among 1,000 within 5 seconds, and can detect similar images among 1,000 pairs of dental or cataract images within 6 minutes. The systems can help reviewing physicians to quickly determine whether cases have been sent repeatedly for review and whether there are any images with an abnormally high degree of similarity.

3. Application of AI in the Fight Against Covid

The NHIA has teamed up with National Cheng Kung University Hospital to jointly develop an "image-assisted chest X-ray Covid-19 research platform." After patients receive a chest X-ray examination, their doctor can upload the X-ray images via this system, and can then obtain automatic AI assessment of risk of pneumonia or Covid-19 within one minute. The location of focus of infection is marked on the resulting images, giving doctors a reference for precision diagnosis and early treatment. The system's results can provide a warning of the

3. 應用AI科技防疫加值

健保署與成大醫院共同合作開發「胸部X光影像輔助研究新冠肺炎系統」，病患就醫照完胸部X光後，由醫師在該系統上傳X光影像，可以在1分鐘內取得AI模型自動判讀肺炎與新冠肺炎風險值，以及標註病灶位置的結果影像，以供醫師精準診斷和提早治療之參考，並作為新冠肺炎（COVID-19）防疫工作之警示，達到利用AI技術加值科技防疫效益。

電子申報提升作業效率

自全民健保開辦以來，健保署即鼓勵特約醫事服務機構採用網際網路、媒體、VPN等方式申報費用，統計資料顯示，特約醫事服務機構採醫療費用電子申報之比率已近100%。

2004年配合健保卡全面上線後，健保署建置健保資訊網（Virtual Private Network, VPN）作為與特約醫事服務機構雙向溝通之專用網路，特約醫事服務機構除了可透過VPN進行健保卡連線、認證、更新、上傳作業以外，更可進行費用申報等網路申報服務，提供更有效率之連線服務管道，目前對於特約院所各申辦作業如：醫療費用申報、個案管理以及院所續約等作業，健保署亦逐步完成電子化作業。

另為因應近年來醫療院所e化的腳步逐漸加速，健保署於2006年9月建置完成並啓用「電子化專業審查系統」，建立了醫療費用專業審查（含文字及影像資料）作業e化環境，以期協助醫療院所進行醫療專業審查電子化申請或申報，並經由醫療影像儲傳系統（PACS: Picture-Archiving and Communication System）傳遞送審案件之影像檔案；建立個人病歷件歸戶平台，提供審查醫師優質作業環境，於2017年完成醫療影像及相關電子化檔案集中化管理，並強化事前審查、醫療費用抽樣審查案件資料處理功能，並將門診申復案件、住院申復案件、住院Tw-DRGs案件、重大傷病案件、牙位更正等之專業審查納入，同時串接健保署內部之醫療給付相關系統，使整個審核流程更加自動化，並提升原有人工審查作業的效率，降低行政作業成本。

為鼓勵更多醫療院所採用網路方式申報醫療費用，所有特約醫事服務機構申報作業以健保署健保卡資料管理中心（IDC）為單一入口，集中由全民健保資訊網路連線申報，健保署也配合作業需求，持續提供特約醫事服務機構更多更便捷的電子申報服務。同時亦期望透過推動跨院所間的醫療影像檔上傳與調閱作業，減少不必要的重複檢驗與檢查，促進跨醫院間的資訊流通。

健保卡加速電子化管理

為提升民眾就醫便利性，自2004年1月1日起，健保卡全面正式上線，整合原有的健保紙卡、兒童健康手冊、孕婦健康手冊和重大傷病證明卡4種卡冊的就醫紀錄，並將原本卡冊上明示之登記事項，以隱性及代碼方式，登記於晶片內，除具便利性，同時保障就醫隱私，另外，因醫療資訊雲端查詢系統之資料呈現約有2-3天的落差，但透過健保卡登錄藥品及檢驗（查）項目，可讓醫師在診療時即時參考。

因民眾每次就醫紀錄，醫療院所均於健保卡登錄並於24小時內傳送至健保署，每天的門診與住院人次即可及時統計，針對某些異常就診

presence of Covid-19, and show how value-added AI technology can effectively assist in epidemiology prevention work.

Enhancing Efficiency via Electronic Claims

Since the introduction of National Health Insurance, the NHIA has encouraged contracted medical institutions to use the Internet, media, or the NHI VPN to report reimbursement claims, and statistics reveal that contracted medical institutions' electronic medical expense claim rate has reached close to 100%.

After NHI cards were fully linked to the Internet in 2004, the NHIA established the NHI virtual private network (VPN) as a dedicated network for two-way communication with contracted medical institutions. Apart from use in data uploading and online authentication and updating of NHI cards, contracted medical institutions can also use the VPN for online reporting services, such as making expense claims, and it provides more effective online service. Contracted hospitals and clinics currently use the system for making medical expense claims, case management, and renewal of their contracts with the NHIA, and the NHIA is also gradually adding more online functions.

Furthermore, in view of the growing adoption of online operations by hospitals and clinics in recent years, the NHIA introduced an online professional review system in September 2006. This system has established an online environment for the professional review of medical expense claims (including both text and images), and can help hospitals and clinics to make online expense claims and applications for professional review. In addition, the NHIA's "Picture-Archiving and Communication System" (PACS) can facilitate the transmission of image files in cases submitted for review, and the NHIA's individual patient record file platform provides reviewing physicians a superior working environment. The NHIA completed a centralized medical image and associated e-file management system in 2017, and has enhanced its data processing functions for pre-review and medical expense sampling review cases. Professional review of outpatient appeal cases, inpatient appeal cases, inpatient Tw-DRGs cases, severe illness and injury cases, and orthodontics cases can also be handled via the VPN, which is linked with the NHIA's internal medical payment system. As a consequence, review procedures as a whole have been more fully automated, existing manual review processes have been made more efficient, and administrative costs have been reduced.

To encourage even more hospitals and clinics to adopt online reporting of reimbursement claims, all claims reporting by contracted medical institutions is performed via the NHIA's IC Card Data Center (IDC), which has centralized online claims reporting. To meet their operating needs, the NHIA has also made it a point to provide contracted medical institutions more readily accessible electronic claims services. At the same time, the NHIA also hopes that its promotion of the transmission of medical image files between different hospitals and clinics will reduce unnecessary and redundant tests and examinations, and promote increased sharing of information between medical institutions.

Accelerating Digital Management of NHI Cards

IC NHI cards were were formally introduced on January 1, 2004 in an effort to make people's access to medical care more convenient. These IC cards have integrated the medical records and information originally contained in paper NHI cards, children's health booklets, maternal health

的行為，健保署可及早發現而加以追蹤輔導。此外，保險對象器官捐贈或安寧緩和醫療意願或預立醫療決定之檔案，亦可註記於健保卡。

多重機制縱深防禦確保資訊安全

健保卡不僅確保民眾個人隱私，也代表臺灣醫療網路的資訊平台聯繫更加順暢，健保卡在安全管理上也多次獲得國際肯定。為保障資訊安全，健保卡採取多重防偽處理，晶片採多重相互驗證機制，以確保資料安全。

在網路系統上，則採用健保資訊網封閉性專屬網路，設有多道防火牆，可降低駭客入侵系統或盜取資料之風險；健保卡紀錄均以代碼登載及亂碼傳輸，有效保障個人隱私。

為強化健保卡和健保資料的安全管理機制，健保署自2003年8月即成立「資通安全小組」，負責相關工作及推動認證，另外，健保署為落實資訊安全工作，全面推動資訊安全管理系統（ISMS）建置作業，讓資訊安全確實向下扎根。健保署為強化整體資通安全，對外網路採單一入口並建構縱深防禦機制，布建各式偵測及防禦機制（如SOC、防火牆、郵件過濾、入侵偵測、應用系統防火牆、防毒防駭軟體、進階持續性威脅攻擊防禦措施），以進行全年無休之網路及電子郵件安全監控作業，於資料庫內可資識別個人資料之欄位加密方式儲存，以確保健保署整體資通安全。

健保雲端科技協助防疫

2020年全球遭受嚴重特殊傳染性肺炎（COVID-19）疫情影響，臺灣健保制度在防疫過程中扮演關鍵角色。健保資料庫及多年來建置之雲端系統成為協助防疫之利器之一，透過雲端系統連結各醫療院所，交換防疫過程中所需之資訊，而協助防疫之作為，皆依據「傳染病防治法」及「嚴重特殊傳染性肺炎防治及紓困振興特別條例」相關規定執行，在保護個人隱私方面維持最小侵害性原則，以謀求最大之公共衛生安全利益。

1.「健保醫療資訊雲端查詢系統」——智慧雲端　科技防疫

2020年初新冠肺炎（COVID-19）疫情在全球各國逐漸蔓延，健保署配合中央流行疫情指揮中心指示，運用健保VPN網路及雲端系統已廣布於各醫療院所的優勢，快速將武漢旅遊史及疾管署匡列之與確診個案接觸者相關提示，建置於雲端系統，插入病人健保卡，就會立即跳出視窗提醒醫療院所留意病人狀況。爾後又依據整體防疫作為，陸續擴增至各國旅遊史、特定高風險職業別及群聚史、轉診採檢提醒、病人10日內曾被開立流感抗病毒藥劑等，透過整合衛生福利部、內政部移民署、交通部民用航空局、國軍退除役官兵輔導委員會等跨部會資料（圖5-1），提供各級醫療院所（含健保特約及非特約醫事機構）、長照機構、行政機關（內政部消防署、法務部矯正署及各地方檢察署）可透過線上查詢（有/無健保卡）、批次下載或API介接等多元管道，掌握進出人員TOCC（Travel history旅遊史、Occupation職業別、Contact history接觸史及Cluster是否群聚）等防疫相關資訊（圖5-2），減少院內、群聚和社區感染擴散風險，降低醫事人員及執行業務人員之內心壓力及感染

booklets, and catastrophic illness certificates, and the information originally recorded in these cards and booklets has been recorded on the NHI cards' chips in encrypted and encoded form. Apart from offering greater convenience, the IC cards also better protect medical privacy. In addition, although it takes data approximately 2-3 days to appear in the NHI MediCloud System, doctors can immediately use the medication and testing information recorded on NHI cards as a reference for their diagnosis and treatment.

Because hospitals and clinics must record people's care records on their NHI cards and transmit this information to the NHIA within 24 hours, the NHIA is easily able to compile statistics on daily outpatient visits and inpatient person-times, and can promptly detect, track, and correct any irregular medical actions. Furthermore, organ donation, hospice and palliative care wishes, and advanced medical decision files can also be recorded on NHI cards.

Multiple Mechanisms for Ensuring Information Security

NHI cards not only protect personal privacy, but also facilitate the smooth flow of information in Taiwan's medical information system. NHI cards' security safeguards have earned international recognition on numerous occasions. To maintain information security, NHI cards employ multiple security measures, and the card's chip uses several mutual authentication mechanisms to ensure data security.

Online health insurance information is transmitted through the NHIA's closed VPN system, which has multiple firewalls to reduce the risk of hackers breaking into the system or stealing data. In addition, to protect personal privacy, NHI card records are entered in encoded form and transmitted after encryption.

To strengthen NHI card and health insurance data security management mechanisms, the NHIA established an information security task force in August 2003 to bear responsibility for relevant tasks and promote certification. In addition, in order to further bolster information security, the NHIA has established an information security management system (ISMS). The NHIA's information security measures have included establishment of a single network entry point, in-depth defense mechanisms, and various detection and defense mechanisms (such as an SOC, firewalls, e-mail filters, intrusion detection, application system firewalls, anti-virus/anti-spyware software, and advanced continuous threat and attack prevention measures). There is constant network and e-mail security monitoring, and personal information fields in databases is stored in encrypted form, which ensures NHIA's overall information security.

Applying NHI Cloud Technologies to Tackle Pandemic

Taiwan's NHI system has played a key role in containing the COVID-19 pandemic in 2020. The NHI database and cloud system established over years have been proven as effective tools to tackle pandemic. Medical institutions are linked through the cloud system to exchange the information necessary during this period of time. All relevant measure comply with "*Communicable Disease Control Act*" and "*Special Act for Prevention, Relief and Revitalization Measures for Severe Pneumonia with Novel Pathogens*". The ultimate goal is maximizing public health benefits while minimizing intrusion of privacy.

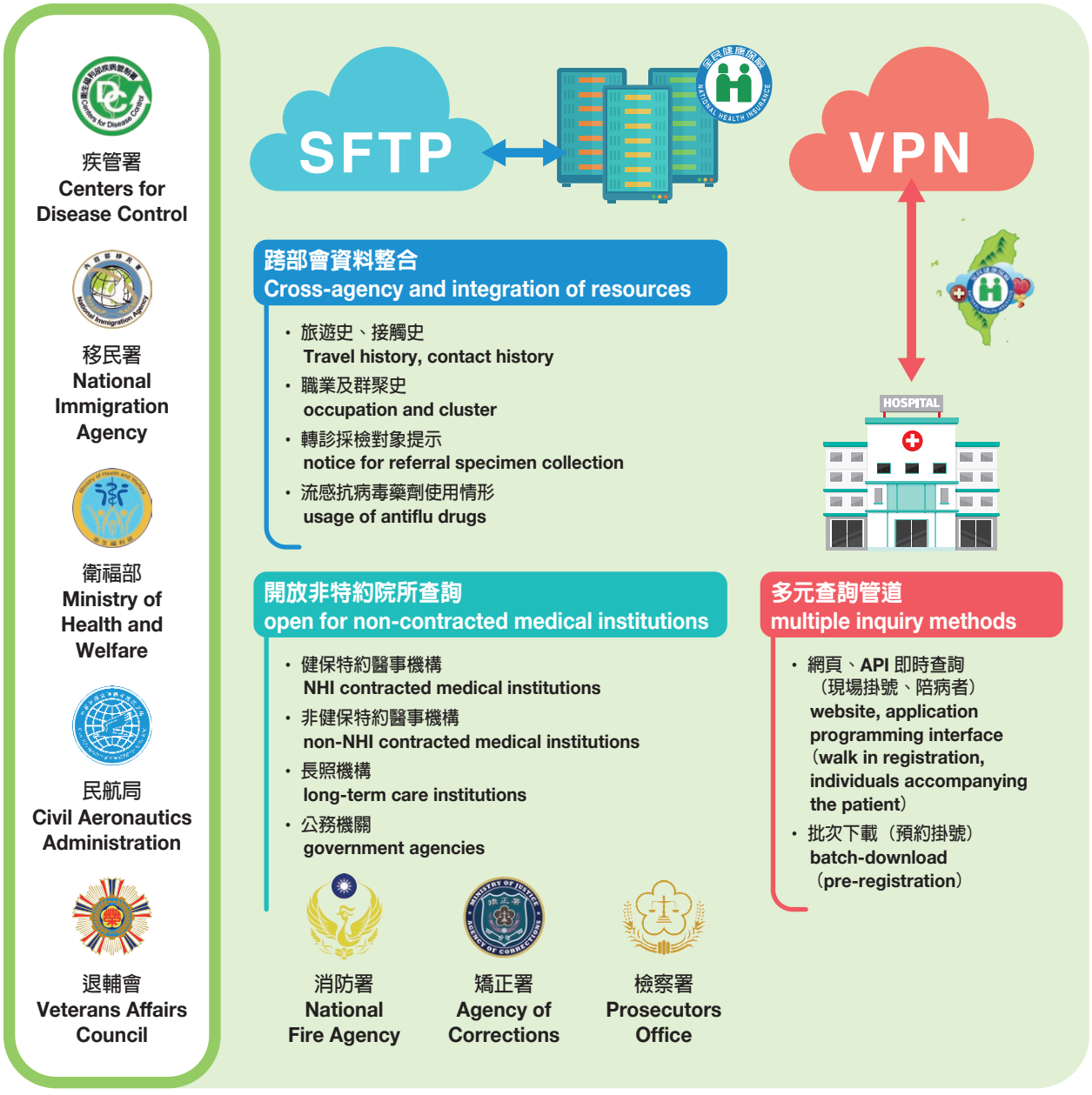
1. "NHI MediCloud System"—Using cloud system and technology to tackle the COVID-19 pandemic

Since the outbreak of COVID-19 pandemic worldwide in the beginning of 2020, the NHIA cooperated with the Central Epidemic Command Center and made use of VPN and NHI MediCloud System, which have already been widely used in

風險，有效掌握疾病流向及全面防堵群聚感染。統計2020年2月至2021年12月為止，TOCC提示之總查詢次數已高達近13.96億人次。善用資訊系統快速提供具臨床實務參考價值的資訊，並再與醫事人員習慣的院內醫療資訊系統（Hospital Information System, HIS）結合，進行

圖5-1　跨部會資料整合　全民防疫守門人

Chart 5-1　Cross-agency and integration of resources safeguard national health



medical institutions. With the insertion of NHI card, the medical institutions are able to have quick access to individual's travel history to Wuhan area and listed contacts with confirmed cases via the system, and medical institutions can thus be aware of patients' condition.

Subsequently, in conjunction with general epidemic prevention efforts, the NHIA gradually expanded this system to include individual's travel history of every countries, occupation, cluster, notice of referral for specimen collection and testing and prescription of anti-influenza drugs within the past 10 days. With cross-agency and integration of data from the Ministry of Health and Welfare, National Immigration Agency, MOI, Civil Aeronautics Administration, MOTC, and Veterans Affairs Council, etc. (Chart 5-1), the medical institutions (including NHI contracted and non-contracted medical institutions), long-term care institutions, National Fire Agency, Ministry of the Interior, Agency of Corrections, Ministry of Justice and local prosecutor's offices) can use online services (with/without the NHI card), batch-download or application programming interface to get access to individual's TOCC (Travel history, Occupation, Contact history, Cluster) (Chart 5-2). The efforts are aimed at reducing the spread of COVID-19 within the hospital, clustering and community, lessening the pressure and risk of infection endured by medical staff and professional practitioners, understanding the current development of pandemic and containing the COVID-19 pandemic.

From February 2020 to December 2021, the number of TOCC inquiry has reached up to 1.396 billion times. With instant information that responds to clinical practice and hospital information system that is familiar to medical staff, the NHI MediCloud System optimizes its value via active reminding system and value-added application.

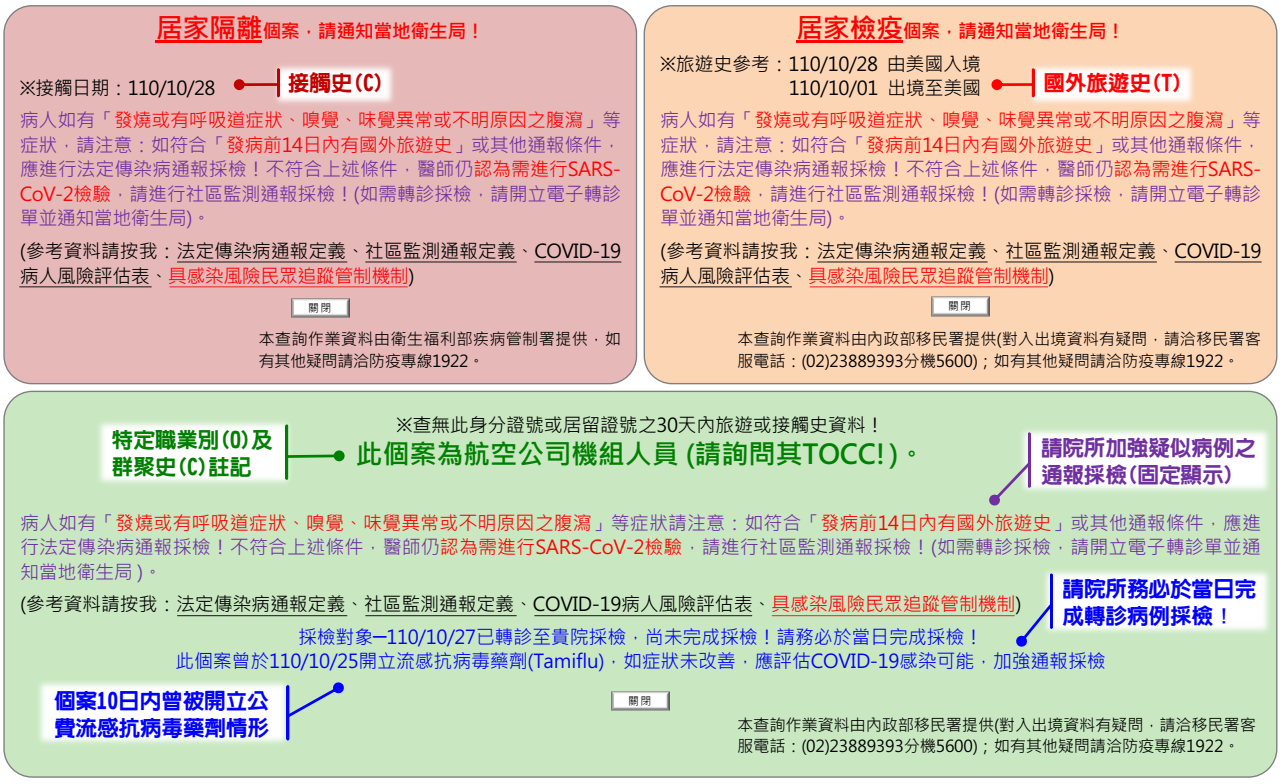
NHIA is now constantly optimizing the NHI MediCloud System and subsidies medical institutions for expanding network bandwidth, which further offers user-friendly environment. In response to the COVID-19 pandemic, NHIA works in collaboration with policies that regulates quarantine and measures for containing pandemic. If people who are undergoing home isolation, home quarantine and self-health management as well as individuals listed by CECC need urgent medical care, and have been evaluated suitable for conducting telemedicine by physicians from medical institution designated by Department of Public Health, the physician is authorized to query the NHI MediCloud System by entering patient's ID number after gaining the consent from the patient. The physician can thus get access to patient's recent medical records, which avoid duplicated medication, drug interaction or allergies and safeguard patients' safety.

Thanks to the flexibility, immediacy and convenience, the MediCloud System gives full play to its additional value during the COVID-19 pandemic. Under CECC's instructions, the NHIA provides medical institutions with instant and accurate TOCC information of patients. This measure helps avoiding medical information asymmetry, reducing medical staff's risk of infection and maintaining medical capacity.

2. Using Value-added AI Technology to Fight Covid

To assist in the fight against Covid-19, the NHIA used NHI big data and AI technology to jointly develop the "image-assisted chest X-ray Covid-19 research platform" in conjunction with National Cheng Kung University Hospital. This research platform employs AI modeling to interpret X-ray images and provide patients' Covid-19 risk values within only a few seconds. While effectively increasing X-ray image interpretation capabilities, the system can promptly warn medical personnel, enabling them to quickly

圖5-2　雲端系統TOCC等防疫資訊提示視窗示意圖



主動提示及加值運用，使效益最大化，更是雲端系統整體價值所在。

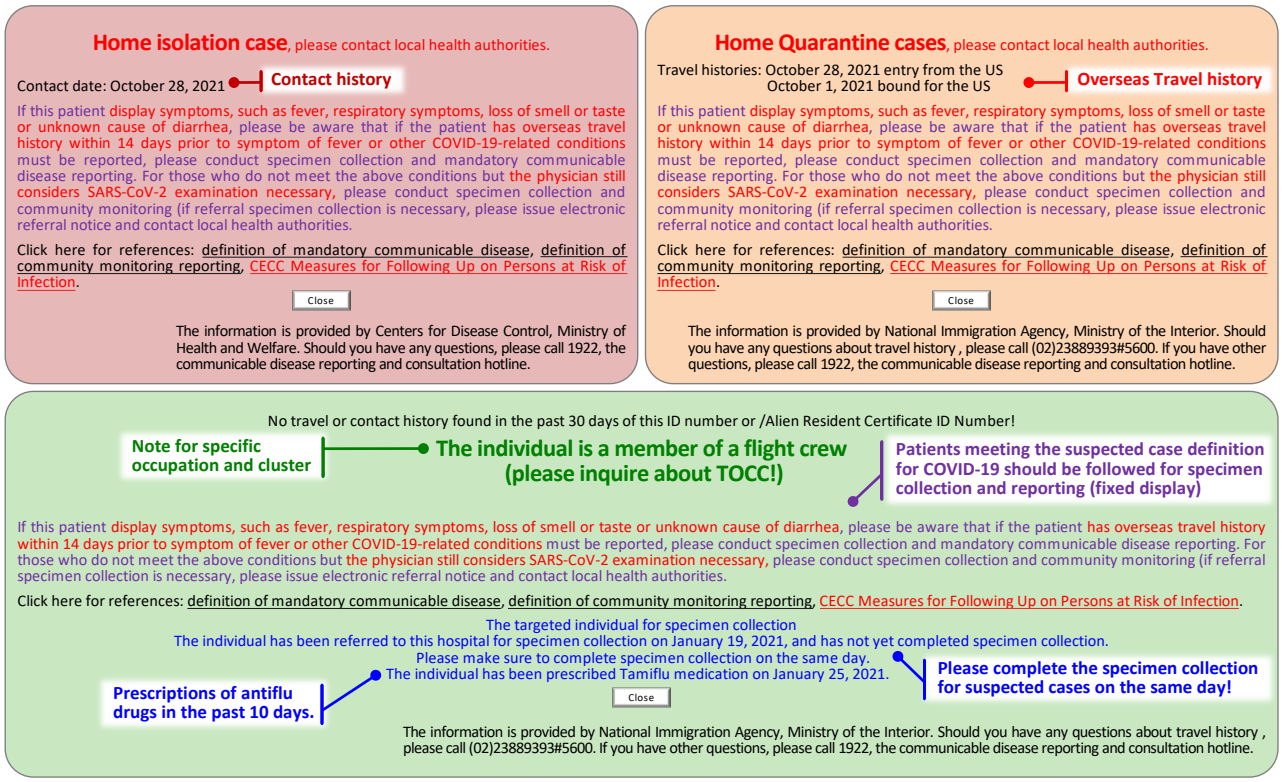
具資料串接彈性、查詢即時性及方便性之健保雲端系統，疫情期間發揮強大的附加價值，在中央流行疫情指揮中心指示下，提供醫療院所查詢即時且正確之病人TOCC資訊，避免醫療資訊不對稱，減少醫事人員染疫之風險，維持醫療量能。

2. 全民健保導入AI技術　加值科技防疫

健保署為協助新冠肺炎（COVID-19）防疫工作，運用健保大數據導入人工智慧（AI）技術，與國立成功大學醫學院附設醫院共同合作開發「胸部X光影像輔助研究新冠肺炎系統」。透過AI模型，可於數秒鐘內快速判讀X光影像，提供病人COVID-19風險值，有效提升X光影像判讀量能，並可警示醫療人員，使其可依據風險值快速分流病患，降低感染風險，有效防堵疫情。

在醫療資源分布不均的情形下，醫療資源缺乏的地區可能面臨因放射科醫師有限，造成需長時間等待檢驗結果的情形。「胸部X光影像輔助研究新冠肺炎系統」建置於健保資訊服務系統（VPN），使其他醫療院所不需額外添購AI設備，只要上傳X光影像，即可於1分鐘內取得AI模型判讀新冠肺炎（COVID-19）之風險值以及標註病灶位置之影像。

Chart 5-2　Information such as TOCC Displayed on NHI MediCloud System



perform patient triage, reduce risk of infection, and effectively block the pandemic's spread.

Due to the uneven distribution of medical resources, shortages of radiologists in areas with fewer medical resources may lead to long waits in obtaining examination results. Addressing this situation, the "image-assisted chest X-ray Covid-19 research platform" established on the NHI VPN enables hospitals and clinics to obtain AI interpretation of Covid-19 risk values and images with the focus of infection marked on them within one minute after uploading X-ray images, and the hospitals and clinics using this platform do not need to purchase additional information equipment.

By boosting image interpretation capabilities, the platform's AI modeling has ensured that delayed diagnosis does not cause patients' illnesses to worsen and avoids gaps in the defense against Covid. In addition, the experience of clinical physicians nationwide can also be used to continue to improve the interactive AI model. This service is being shared with hospitals and clinics throughout Taiwan, freeing patients from geographical restrictions, enabling them to obtain the highest quality medical service, and effectively improving public health.

3. Addition of Designated Community Institutions for Specimen Collection to the NHI Electronic Referral Platform, Facilitating Referral, Acceptance, Triage, and Care

To establish COVID-19 specimen collection within the community, enlarge the capacity for

AI偵測模型可提升影像判讀的量能，避免因延遲診斷造成疾病惡化或形成防疫破口。互動式AI模型亦可結合全國臨床醫師經驗，讓AI模型持續精進，並分享醫療服務至全臺灣各個角落，使民眾不受到地理環境的限制，得到更高品質的醫療服務，有效改善民眾健康。

3. 健保電子轉診平台增加「指定社區採檢院所」促進轉診收治分流就醫

為建立COVID-19社區採檢網絡，擴大醫療服務防疫量能，避免疑似COVID-19個案集中於大醫院採檢，防止急診壅塞及杜絕院內傳播，進而影響醫療院所服務量能。健保署與疾管署合作，針對COVID-19疑似需採檢之個案，於健保電子轉診平台增加「指定社區採檢院所」名單，以利醫師協助轉診，並於「健保醫療資訊雲端查詢系統」顯示尚未完成轉診採檢之提示訊息，促進轉診收治分流就醫，落實病人適當之安置。

4. 健保給付視訊診療協助居家隔離、居家檢疫與應自主健康管理者之就醫需求

因應COVID-19疫情，配合防疫措施進行居家檢疫、居家隔離或自主健康管理之民眾，如有急迫醫療需要且無發燒或呼吸道症狀，應聯繫當地衛生局協助安排就醫，經衛生局確認就醫需求後轉介至指定醫療機構進行視訊診療，若偏遠地區等特殊情形無法視訊時，個案得採行電話診療；考量疫情嚴峻，暫訂自2021年5月15日起至中央流行疫情指揮中心公告全國三級警戒降級或解除之次月底為止，放寬照護對象至門診病人，同時開放病情穩定之慢性病複診病人醫師得選擇以電話問診，另為顧及民眾隱私，醫師應於醫療機構診間內進行視訊診療，透過視訊診療之醫療費用亦納入健保給付。截至2021年12月31日衛生局指定之通訊診療醫療機構計11,215家，其中醫院417家、診所10,798家；累計接受視訊診療民眾計216,405人次。

5. 健保卡支援口罩實名制協助防疫

「口罩實名制」運用健保卡作為購買口罩的憑證，購買方式從「1.0實體通路」至藥局及衛生所購買，增加「2.0網路通路」，民眾透過健保卡、自然人憑證登入eMask口罩預購系統，或是藉由「全民健保行動快易通｜健康存摺APP」進行身分認證和手機認證，即可進行口罩預購，使民眾更方便購買口罩，後續與全臺超商合作，推出更便利的「3.0超商預購」，讓民眾可以直接在超商事務機插健保卡預購口罩。健保卡支援「口罩實名制」販售，協助疾管署及食藥署公平地分配防疫物資，提供民眾最周全的防疫保護，作為臺灣最堅強的防疫助手。

containing pandemic, avoid suspected cases gathering for specimen collection in big hospitals, avoid overcrowding in emergency department and infection within the hospital that further reduce the medical capacity, NHIA works in collaboration with CECC to add a list of 'Designated community institutions for specimen collection' on NHI electronic referral platform that helps with the referral, presents a list of uncompleted information regarding referral specimen collection on NHI MediCloud System, facilitate referral and triaging for patients who are seeking medical attention.

4. Using NHI payments for Telemedicine to Meet the Medical Needs of Persons in Home Isolation, Home Quarantine, and Performing Self-Health Management

Under the COVID-19 pandemic, if persons who are subject to home quarantine or home isolation, or must perform self-health management, due to epidemic prevention measures have urgent medical care needs, but have no fever or respiratory symptoms, they should contact the local health bureau for help in arranging care. After the health bureau has confirmed their care needs, they may be referred for telemedicine from a designated medical institution. And if such persons with medical needs live in an isolated area, or have other special circumstances preventing telemedicine, they may receive telephone care. In consideration of the severity of patients' conditions, from May 15, 2021 until the end of the month in which the Central Epidemic Command Center announces the downgrading or lifting of the nationwide Level 3 epidemic alert, the NHIA has temporarily broadened the scope of patients who may receive telemedicine care to outpatients. At the same time, the NHIA also lets doctors opt to conduct consultations with patients with stable conditions who require follow-ups for chronic diseases. To maintain patients' privacy, doctors must conduct telemedicine sessions from examination rooms at medical institutions, and the expense of telemedicine will be included in NHI payments. As of December 31, 2021, health bureaus had designated 11,215 medical institutions performing telemedicine, including 417 hospitals and 10,798 clinics, and a cumulative total of 216,405 telemedicine sessions had been performed.

5. Use of NHI cards to Support a Name-based Mask Distribution System

Under the "name-based mask distribution system," members of the public can use their NHI card as verification when purchasing face masks. After the implementation of purchase method 1.0 (physical channels), which allows the purchase of facemasks from pharmacies and local health stations, the NHIA also added method 2.0 (online purchase), which lets people use their NHI card or natural person certificate to log on to the eMask face mask ordering system, or to order face masks after using the "National Health Insurance Action Express | My Health Bank APP" to perform identity and cell phone authentication. To enable the public to obtain masks even more conveniently, the NHIA subsequently joined forces with convenience stores throughout Taiwan to promote purchase method 3.0—ordering from convenience stores. This measure allows people to order masks directly after inserting their NHI card into a convenience store service kiosk. The use of NHI cards to support face mask sales under the name-based mask distribution system has helped the CDC and Food and Drug Administration to distribute masks fairly, which has provided the public with the most thoroughgoing protection from the pandemic.

Chapter 6

照顧弱勢　守護偏鄉

Caring for the Disadvantaged, Watching over Remote Areas

照顧弱勢　守護偏鄉

對經濟弱勢民眾的補助措施

全民健保採強制納保，社會上難免有一部分繳不起保險費的低收入戶及經濟邊緣人口，如何貫徹全民納保政策，有賴多項協助措施，以確保社會安全網的穩固，更彰顯自助互助的精神。為了照顧癌症、洗腎、血友病、精神病等重大傷病患者，以及經濟困難弱勢民眾的就醫權益，健保署提出多項協助繳納保險費的措施。另外，對於罕見疾病、重症患者及偏遠地區民眾，亦提供醫療及經濟上的協助。現行的協助措施包括保險費補助、紓困貸款及分期繳納等，執行成果請見表6-1。

表6-1　繳納健保費之協助措施成效

Table 6-1　Results of Premium Payment Assistance Measures

項目 Item	對象 Assistance recipients	期間 Period	人（件）數 No. of persons / cases	金額 Amount
保費補助 Premium subsidies	政府對特定弱勢者補助健保費，包括低收入戶、中低收入戶、無職業榮民、失業勞工及眷屬、身心障礙者、未滿20歲及55歲以上之無職業原住民 The government provides premium subsidies for members of underprivileged groups, including low-income households, near-poor households, unemployed veterans, unemployed workers and their dependents, the physically and mentally disabled, and unemployed indigenous citizens who are under the age of 20 or over the age of 55	2020.1~12	358.5萬人 3.585 million persons	285.8億元 NT$28.58 billion
		2021.1~12	363.3萬人 3.633 million persons	316.2億元 NT$31.62 billion
紓困貸款 Relief fund loans	符合衛生福利部所訂經濟困難資格者 Persons meeting economic hardship requirements set by the Ministry of Health and Welfare	2020.1~12	2,135件 2,135 cases	1.72億元 NT$172 million
		2021.1~12	1,747件 1,747 cases	1.51億元 NT$151 million
分期繳納 Installment payment plans	欠繳保險費無力一次償還者 Persons who cannot immediately repay owed premiums	2020.1~12	8.5萬件 85,000 cases	26.18億元 NT$2.618 billion
		2021.1~12	7萬件 70,000 cases	23.39億元 NT$2.339 billion
愛心轉介 Referral to charities	無力繳納健保費者 Persons who cannot pay premiums	2021.1~12	3,988件 3,988 cases	1,680萬元 NT$16.80 million
		2021.1~12	4,391件 4,391 cases	2,683萬元 NT$26.83 million

資料時間：2020年1月1日～2021年12月31日。
Data period: From January 1, 2020 to December 31, 2021.

Caring for the Needy and Safeguarding Remote Areas

Subsidies for the Economically Disadvantaged

After the NHI initiated mandatory health insurance enrollment, there have inevitably been some low-income households and people living on the margins of society who cannot afford their premiums. In order to fulfill the government's blanket enrollment policy, the NHIA provides a number of assistance measures to strengthen the social safety net and realize the spirit of mutual help. In order to care for patients with cancer, hemophilia, severe mental illness, or receiving dialysis, and underprivileged persons experiencing economic difficulties, the NHIA has introduced several premium payment assistance measures intended to protect these persons' right to healthcare. In addition, the NHIA also provides medical and economic assistance to persons with rare diseases and critical illnesses, and those living in remote areas. Current assistance measures include premium subsidies, relief loans, and installment payment plans; see Table 6-1 for the results of implementation.

Premium Subsidies for Underprivileged Groups

Governments at different levels are providing premium subsidies to the members of various underprivileged groups, including low-income households, near-poor households, unemployed veterans, unemployed workers and their dependents, the physically and mentally disabled, and

弱勢群體保費補助

各級政府對特定弱勢者補助健保費，包括低收入戶、中低收入戶、無職業榮民、失業勞工及眷屬、身心障礙者、未滿20歲及55歲以上之無職業原住民，2020年全年補助人數約358.5萬人，補助金額約285.8億元。另，2021年截至12月底止，補助人數約363.3萬人，補助金額約316.2億元。

紓困貸款

提供經濟困難的民眾，無息申貸健保費用及應自行負擔而尚未繳納之醫療費用，以保障就醫權益。2020年全年共核貸2,135件，金額1.72億元。2021年截至12月底止，共核貸1,747件，金額1.51億元。

分期繳納

對於不符合紓困貸款資格，但積欠健保費達2,000元以上，因經濟困難無法一次繳清者，2020年全年辦理分期繳納共8.5萬件，合計26.18億元。另2021年截至12月底止，辦理分期繳納共7萬件，合計23.39億元。

轉介公益團體補助保險費

對於無力繳納健保費者，健保署提供轉介公益團體、企業及個人愛心捐款，以補助其健保費。2020年全年轉介成功個案計3,988件，補助金額共1,680萬餘元。2021年截至12月底止，轉介成功個案計4,391件，補助金額共2,683萬餘元。

保障弱勢民眾就醫權益

為落實醫療平權之普世價值，及蔡總統競選時之醫療主張，有關符合健保投保資格就可憑健保卡就醫，全面廢除健保欠費鎖卡政見，健保署2016年6月7日起實施「健保欠費與就醫權脫鉤（全面解卡）案」，推動健保全面解卡，給予國人就醫權益的公平性保障，民眾只要辦理投保手

unemployed indigenous citizens who are under the age of 20 or over the age of 55. A total of NT$28.58 billion in such subsidies was provided to 3.585 million persons in 2020, and a total of NT$31.62 billion was provided to 3.633 million persons throughout 2021.

Relief Fund Loans

To protect people's right to healthcare, the NHIA provides interest-free loans to members of the public who are suffering economic difficulties so that they can pay their premiums and unpaid copayments for medical care. The total of NT$172 million in such loans was given to 2,135 persons in 2020, and NT$151 million was given to 1,747 persons throughout 2021.

Installment Payment Plans

The NHIA offers installment payment plans to persons who owe premiums totaling more than NT$2,000 but are not eligible for relief loans, and cannot pay their owed premiums at one time due to economic hardship. Installment payment plans for a total of NT$2.618 billion were provided in 85,000 cases during 2020, and installment plans for a total of NT$2.339 billion were provided in 70,000 cases during 2021.

Referral to Charitable Groups for Premium Assistance

With regard to persons who cannot pay their health insurance premiums, the NHIA also provides

續，均可安心就醫。健保全面解卡象徵著醫療人權更上一層樓，受惠對象絕非過去欠費遭鎖卡者，而是藉著廢除鎖卡制度，才能夠真正去除弱勢民眾心中恐懼欠費而無法就醫的枷鎖，更加落實政府照顧弱勢，保障全民就醫權益之宗旨。

全民健保對弱勢民眾積極提供各種保障措施，建構完整的健保經濟困難民眾保護傘，排除民眾參加健保之經濟障礙，使經濟困難民眾隨時享有妥適之醫療照護，協助其辦理投保、健保費紓困、轉介、分期繳納等。

爭取公益彩券回饋金協助弱勢族群

為落實照顧弱勢族群，保障其就醫權益，健保署除既有分期繳納、紓困貸款及愛心專戶等協助措施外，自2008年起爭取公益彩券回饋金協助弱勢族群減輕就醫負擔，主動篩選並發函通知符合資格的民眾，協助其繳納健保相關欠費等。迄2021年12月底，累計補助金額已達46.52億元，累計補助人數達25萬354人（表6-2）。

表6-2　最近2年公益彩券回饋金補助成果表

Table 6-2　Public Welfare Lottery Contributions During the Most Recent Two Years

年度 Year	計畫名稱 Program name	人數 Persons	金額（新臺幣） Amount (NT$)
2019	協助經濟弱勢民眾重返健保醫療照護計畫 Plan to help economically disadvantaged to regain NHI coverage	6,880	2.31億元 NT$231 million
	協助更生人、新住民、未成年、特殊境遇及急難救助之民眾脫離健保欠費困境計畫 Assists reformed prison inmates, new immigrants, youths, and other persons in special situations or requiring emergency assistance to obtain relief from unpaid NHI premiums and fees	378	0.07億元 NT$7 million
2020	協助經濟弱勢民眾重返健保醫療照護計畫 Plan to help economically disadvantaged to regain NHI coverage	7,487	2.31億元 NT$231 million
	協助重大傷病者、新住民、未成年及隔代教養之經濟弱勢家庭脫困計畫 Provides financial relief to persons with catastrophic illnesses and injuries, new immigrants, youths, and economically underprivileged skipped generation households	165	0.03億元 NT$3 million
2021	協助弱勢青年及貧戶家庭脫離健保欠費困境計畫 Plan to assist underprivileged youths and low-income households to obtain relief from unpaid NHI premiums and fees	13,021	2.15億元 NT$215 million
2008/1~2021/12 Total		250,354	46.52億元 NT$4.652 billion

註：資料時間截至2021年12月底。

Note: The data period extended to the end of December 2021.

referral to charitable groups, companies, and individuals for donated premium assistance. Such referrals were made in 3,988 cases involving total assistance of NT$16.8 million in 2020, and in 4,391 cases involving assistance of NT$26.83 million throughout 2021.

Protecting the Right to Healthcare of the Underprivileged

In order to realize the universal value of equal right to healthcare, and fulfill the campaign promises President Tsai Ing-wen, all persons who NHI eligibility requirements can use their NHI cards to obtain care, and the government has abolished card blocking when persons owe NHI premiums. In the wake of the "decoupling of right to healthcare from unpaid NHI premiums and fees" implemented by the NHIA on June 7, 2016, the NHIA has unblocked all NHI cards, which has given all citizens equal protection of their right to healthcare. As long as people complete insurance procedures, they can rest assured that they will receive the care they need. The unblocking of all NHI cards signifies greater protection of the right to healthcare, and beneficiaries will absolutely not have their cards blocked because of owed premiums and fees. The abolishment of the card blocking system has also freed underprivileged persons from fear they would not receive needed care due to owed payments, and further fulfills the government's goal of caring for the underprivileged and protecting all citizens' right to healthcare.

The NHIA provides various safeguards to underprivileged persons, which has created a healthcare safety net for citizens facing economic hardships. By removing obstacles to health insurance coverage, the NHIA has enabled persons facing economic difficulties to obtain adequate medical care at any time. In addition, the NHIA also assists such persons with health insurance enrollment, premium relief, referrals to assistance, and installment payment plans.

Using public welfare lottery contributions to help underprivileged groups

In order to realize care for underprivileged groups and protect their right to healthcare, apart from assistance measures such as installment payment plans, relief loans and referral to charitable assistance, the NHIA has used public welfare lottery contributions to ease the medical burdens of members of underprivileged groups since 2008. The NHIA actively locates qualified underprivileged individuals, and sends them notification of assistance in paying relevant NHI premiums and fees. As of the end of December 2021, a cumulative total of NT$4.652 billion in assistance had been provided to 250,354 persons (Table 6-2).

Easing the Copayment Burden of Patients in Specific Categories

Persons who have received a disability certificate need only pay a basic outpatient copayment of NT$50 (which is based on the clinic-level copayment) when seeking care at any level of hospital or clinic, and this copayment is lower than that paid by the general public (NT$80-420).

In the case of patients with cancer, chronic mental illness, conditions requiring dialysis, rare diseases, and congenital disorders who have received a major illness/injury certificate, such persons do not need to provide a copayment to receive medical care for these conditions. In order to protect the rights of patients with rare diseases, NHI pays for all medications announced by the MOHW as needed for the treatment of rare disorders via an earmarked budget, which has significantly eased the economic burden of medical care for these persons.

減輕特定病患就醫部分負擔費用

對於領有「身心障礙證明」者，門診就醫時不論醫院層級，門診基本部分負擔費用均按診所層級收取50元，較一般民眾（80～420元）為低。

對於包括癌症、慢性精神病、洗腎、罕見疾病及先天性疾病等領有重大傷病證明的病患，免除該項疾病就醫的部分負擔費用。另為保障罕見疾病患者權益，凡屬於衛生福利部公告的罕見疾病必用藥品，健保均以「專款專用」方式給付，實質減輕其就醫經濟負擔。

對疾病弱勢族群照護

身心障礙者

健保署自2002年起施行「牙醫門診總額特殊醫療服務計畫」，以醫療服務加成支付方式服務，鼓勵醫師提供先天性唇顎裂患者及特定身心障礙者牙醫醫療服務。

至2006年起放寬可由各縣市牙醫師公會或牙醫團體組成醫療團，定期至身心障礙福利機構服務、支援未設牙科之精神科醫院或特殊教育學校提供牙醫特殊巡迴醫療服務。2011年7月1日起，更進一步針對特定身心障礙類別且符合居家照護條件者，提供到宅服務。2013年1月1日起，新增提供入住身心障礙機構之長期臥床者牙醫服務。2014年1月1日起增加政府立案收容發展遲緩兒童機構者機構服務。2015年1月1日起進一步提供衛生福利部所屬老人福利機構內，長期臥床者牙醫診療服務。2016年1月1日新增提供重度以上重要器官失去功能者牙醫服務。2020年1月1日起新增出院準備個案及經衛生福利部護理及健康照護司擇定之一般護理之家牙醫服務。2021年1月1日起新增腦傷及脊髓損傷之中度肢體障礙者牙醫服務。

重大傷病患者

現行健保署公告的重大傷病範圍有30類，包括癌症、慢性精神病、洗腎及先天性疾病等，這些疾病醫療花費極高，凡領有重大傷病證明的保險對象，因重大傷病就醫便可免除該項疾病就醫之部分負擔費用。

截至2021年12月底，重大傷病證明有效領證數約有98萬餘張（人數為92萬9千餘人，約占總保險對象的3.8%），而2021年全年重大傷病醫療費用約2,369億餘元（占全年總醫療支出的29.8%），健保藥品費用中，每年約有806億元（近3.6成）用於重大傷病，顯示重大傷病的醫療費用支出比重高，全民健保的確為他們提供實質的協助。

罕病患者

罕見疾病屬重大傷病範圍項目，就醫時可免除部分負擔，截至2021年12月衛生福利部公告的罕見疾病種類有232項，截至2021年12月底止，重大傷病罕見疾病項目領證數共12,241張。經統計2021年罕見疾病之藥品費用約為61.6億元。

為照顧罕見疾病患者，凡經通過列為罕見疾病患者治療藥品，皆加速收載於「全民健康保險藥物給付項目及支付標準」列入給付，使罕見疾病患者受到應有的照顧，減輕醫療照護的負擔。

多重慢性病患者

多重慢性病患乃是我國醫療照護系統中最重要的資源使用者，隨著我國人口結構的逐年

Care for the Medically Vulnerable

Persons with Disabilities

Introduced by the NHIA in 2002, providing dental services to persons with disabilities offers higher reimbursements to encourage dentists to provide dental care to persons with congenital cleft lips and palate, and other groups with specific disabilities.

The NHIA eased regulations in 2006 allow local dentist associations or groups to establish dental teams to provide regular services to institutions caring for people with disabilities. The teams can provide roving dental services to psychiatric hospitals without dental departments and special education schools with special needs. Since July 1, 2011, dentists from the teams have provided in-home dental services to persons with designated disabilities who meet residential care criteria. On January 1, 2013, the teams began providing dental care to bedridden patients at institutions caring for the disabled, and on January 1, 2014, the teams began providing services at government-registered institutions caring for developmentally delayed children. The scope of teams' service was further extended to bedridden persons at elderly care facilities under the Ministry of Health and Welfare on January 1, 2015. On January 1, 2020, dental care services for preparation for discharged in selected by Department of Nursing and Healthcare, Ministry of Health and Welfare are available. On January, 2021, dental services for people with moderate functional disability due to brain and spine injury are available.

Persons with Catastrophic Illnesses and Injuries

The 30 types of catastrophic illnesses and injuries currently recognized by the NHIA include cancer, chronic mental illness, conditions requiring dialysis, and congenital disorders. These illnesses entail extremely large medical expenditures. The copayments of all insureds who have received a major illness/injury certificate have been waived for treatment of these catastrophic illnesses and injuries.

As of the end of December 2021, a total of more than 980,000 valid major illness/injury certificates had been issued (to more than 929,000 persons, who accounted for roughly 3.8% of all insureds). Total medical expenditures for catastrophic illnesses and injuries totaled over NT$236.9 billion throughout 2021 (accounting for 29.8% of all medical expenditures for the year). A total of approximately NT$80.6 billion (close to 36%) is spent each year on NHI-covered drugs for catastrophic illnesses and injuries, which indicates that catastrophic illnesses and injuries account for a very large share of medical expenses, and NHI had been consequently been a godsend for patients with these conditions.

Persons with Rare Diseases

Since rare diseases constitute catastrophic illnesses and injuries, copayments are waived when patients seek treatment rare diseases. As of December 2021, the Ministry of Health and Welfare had announced 232 rare diseases, and 12,241 major illness/injury certificates had been issued for rare diseases. Drug expenditures for rare diseases totaled NT$6.16 billion throughout 2021.

In order to care for patients with rare diseases, payments for all drugs needed in the treatment of these diseases are quickly added to the "National Health Insurance Drug Dispensing and Fee Schedule." This has ensured that persons with rare diseases receive the care they need, and has eased their healthcare burdens.

Persons with Multiple Chronic Conditions

Persons with multiple chronic conditions are the largest resource users in Taiwan's healthcare system. Due to Taiwan's aging population, the prevalence of multiple chronic conditions has been increasing steadily, and the care of these persons is becoming

老化，多重慢性病的盛行率逐年升高，其醫療照護課題也將愈趨重要。為使多重慢性病的民眾可以獲得整合性照護服務，避免重複不當用藥或處置等，影響病人安全，健保署自2009年12月1日起，推動「醫院以病人為中心之整合照護計畫」，提升醫療照護品質。

本計畫執行多年，每年收案照護對象平均就醫次數較上年同期呈現減少，施行成效良好。每年參與照護，提供整合服務之醫院約160餘家，接受整合照護對象人數約14萬餘人。

對山地離島、偏鄉及醫療資源缺乏地區族群的照護

依據健保法第43條暨施行細則第60條，經公告之醫療資源缺乏地區就醫之門診、急診與居家照護服務，減免20%部分負擔，除此之外，健保署亦實施下列計畫以提升山地離島地區或醫療資源缺乏地區之醫療服務：

全民健康保險山地離島地區醫療給付效益提昇計畫

山地離島地區因地理環境及交通不便，醫療資源普遍不足；因此健保署規劃由有能力、有意願之醫療院所以較充足的醫療人力送至山地離島地區，自1999年11月起，陸續在山地離島地區實施「全民健康保險山地離島地區醫療給付效益提升計畫（Integrated Delivery System, IDS計畫）」，鼓勵大型醫院至該地區提供專科診療、急診、夜診等定點或巡迴醫療服務。

目前全國公告之山地離島鄉計有50鄉，共26家特約院所承作30項計畫，服務民眾達48萬餘人，當地民眾對計畫之平均滿意度為94%。

醫療資源不足地區改善方案

2022年投入8.69億元，持續辦理醫療資源不足地區改善方案，以「在地服務」的精神鼓勵中、西、牙醫醫師至醫療資源不足地區執業，或是以巡迴方式提供醫療服務。2021年共有603家特約院所至醫療資源不足地區巡迴，服務民眾達65.3萬餘人次。

醫療資源不足地區之醫療服務提升計畫

為加強提供離島地區、山地鄉及健保醫療資源不足地區民眾的在地醫療服務及社區預防保健，增進就醫可近性，2012年起實施「全民健康保險醫療資源不足地區之醫療服務提升計畫」，以專款預算、點值保障方式，鼓勵位於上述區域或鄰近區域的醫院，提供24小時急診服務，及內科、外科、婦產科及小兒科門診及住院醫療服務，強化民眾就醫在地化，2021年計有94家醫院參與。

an important issue. To ensure that people with multiple chronic conditions can receive integrated care service, and avoid redundant or incorrect medications or treatments that might affect patient safety, the NHIA implemented the "Patient-centered Hospital Integrated Care Program" on December 1, 2009 to enhance medical care quality.

During the time that it has been implemented, the average number of medical visits of persons accepted in this program has decreased steadily, showing its excellent effectiveness. Each year, approximately 160 hospitals participate in the program, and roughly 140,000 patients receive integrated care through the program.

Providing Care in Medically Underserved Isolated Areas

According to Article 43 of the *National Health Insurance Act* and Article 60 of its enforcement rules, persons seeking outpatient, emergency, and home care services in areas officially recognized as lacking in medical resources shall receive a 20% discount on their copayments. In addition, the NHIA has also implemented the following programs to enhance healthcare services in mountain areas, on offshore islands, and in other medically underserved areas:

NHI Integrated Delivery System for Medically Underserved Isolated Areas

Due to their geographic location and poor transportation, mountain and offshore island areas commonly tend to be medically underserved. The NHIA has consequently asked willing hospitals and clinics with sufficient capacity to send personnel to mountainous areas and offshore islands. Starting in November 1999, the NHIA initiated an integrated delivery system (IDS) program for mountainous areas and offshore islands encouraging large hospitals to provide specialized medical service, emergency services, and overnight care in mountain areas and on offshore islands at fixed locations or through roving services.

There are 50 townships currently officially recognized as being in mountainous and offshore island areas. At present, 26 contracted hospitals and clinics are managing 30 service programs in these areas, and are providing service to over 480,000 people. Local people have indicated an average satisfaction rate of 94% in these programs.

Improvement Project for Regions Deficient in Medical Resources

The NHIA provide NT$869 million for Improvement Project for Regions Deficient in Medical Resources in 2022. In keeping with the spirit of serving local communities, these plans encourage dentists and doctors of Chinese and Western medicine to provide medical services in regions lacking medical resources on a rotating basis. In 2021, 603 contracted hospitals and clinics provided rotating services more than 653,000 person-times in medically underserved areas.

Medical Service Improvement Program for Medically Underserved Areas

In order to strengthen access to medical service and community preventive care among people living on offshore islands, in mountain areas, and in other medically underserved areas, the NHIA initiated the "NHI Medical Service Improvement Program for Medically Underserved Areas" in 2012. This program relies on an earmarked budget and a guaranteed point value delivery approach to encourage hospitals located in underserved areas or nearby locations to provide 24-hour emergency care service, and outpatient and inpatient internal medicine, surgery, gynecology/obstetrics, and pediatric service. A total of 94 hospitals participated in this program in 2021, which has served to enhance local access to medical care.

Chapter 7

民眾滿意　國際肯定

Public Satisfaction and International Recognition

民眾滿意　國際肯定

健保經驗　蜚聲國際

臺灣的全民健保採行集中、統籌資源且適用層面廣的單一保險人體制，相較於其他國家健康照護體制，行政成本較低並可達保險費公平性及一致性的優點，也是許多國家取經的重點，每年均吸引大量國外專家學者或官方代表前來我國考察健保制度，在疫情期間亦持續以視訊方式與國際交流。

全民健康覆蓋（Universal Health Coverage）為聯合國永續發展目標的重要項目之一，其宗旨是為了保障每個人都能獲得基本的醫療照護服務，而我國自1995年開辦健保至今，即是為了讓全體國民均享有平等就醫的權利，提供民眾高可近性且低負擔的就醫環境。根據CEOWORLD雜誌（世界著名商業雜誌）在2021年針對世界89個國家的「健康照護指標」評比中，臺灣名列世界第二，2022年全球資料庫網站Numbeo公布的健康照護指標（Health Care Index）評比，臺灣在95個國家當中亦排名第一，展現我國醫療衛生軟實力。

2020年全球籠罩在COVID-19的疫情之下，臺灣積極成功的防疫作為受到國際肯定，國際頂尖學術期刊《BMJ》的部落格在2020年7月21日出版的專欄中刊登一篇「What we can learn from Taiwan's response to the COVID-19 epidemic（我們可以從臺灣面對COVID-19的防疫經驗中學到什麼？）」，文中介紹了本次防疫過程中健保署的兩項關鍵技術，一個是透過健保卡讓醫療院所能及時上傳民眾之醫療資訊，另一個則是透過「健保醫療資訊雲端查詢系統」分享就醫民眾之就醫紀錄及醫療資訊，提供醫師在診斷及開立處方時參考，這篇文章讓世界各國了解臺灣如何運用醫療資訊科技與完善的醫療基礎設施和前瞻性的計畫相結合，作為遏止全國疫情大流行的強效工具。

在國際組織方面，亞太經濟合作會議（APEC）為我國參與之重要國際組織之一，衛生議題亦是我國積極參與之領域，健保署於2019年獲得APEC經費補助辦理APEC醫療資訊分享國際研討會後，2020年再次於APEC衛生工作小組（HWG）提出「APEC Conference on Digital Healthcare Innovation-COVID-19 Response by Health Information Utilization」提案，同樣也獲得APEC同意經費補助，將於2022年邀請各經濟體參與研討會，就數位資料、科技在COVID-19之應用進行研討與分享。

配合政府新南向政策，健保署長期與菲律賓、泰國及越南進行深度雙向交流，成果豐碩。2020年在COVID-19疫情無法實體交流下，健保署仍以視訊方式繼續發展我國與新南向國家醫療衛生領域之交流，經駐外人員協助接洽後，健保署分別邀請泰國國家健康安全局（NHSO）及菲律賓健保公司（PhilHealth）共辦理2場視訊會議，分享與交流健保體系如何因應COVID-19疫情之經驗。

Public Satisfaction and International Recognition

Internationally Acclaimed NHI Achievements

Taiwan's National Health Insurance (NHI) adopted a single-payer system that is widely applicable and optimizes the resources. Compared to the healthcare system in other countries, the NHI in Taiwan features its lower administrative expenditures as well as its fairness and consistency. These advantages make it a worthy subject of study for other countries. Many foreign experts, scholars, officials, and representatives visit Taiwan every year to investigate the National Health Insurance system, and the National Health Insurance Administration (NHIA) has stayed in contact with counterparts in other countries via videoconferencing during the COVID-19 period.

Achieving Universal health coverage is foundation of the health-related Goals, and the goal ensures that each individual has access to basic medical care. Since the inception of the NHI system in 1995, it has enabled all citizens to enjoy an equal right to medical care, and provided the public with a highly accessible, affordable medical care. According to the 2021 healthcare index (focusing on 89 countries) in the CEOWORLD magazine (a prominent international business magazine), Taiwan was ranked second in the world. In addition, the Health Care Index on the Numbeo database website ranked Taiwan first among 95 countries in 2022, showing Taiwan's overall quality of healthcare system.

During the COVID-19 pandemic in 2020, Taiwan's active and successful efforts to contain the spread of the virus have received extensive international recognition. The blog of the leading journal BMJ published the article "What we can learn from Taiwan's response to the COVID-19 epidemic" on July 21, 2020; this article introduced two of the NHIA's key information technologies in the pandemic preparedness and control, namely the use of NHI cards to allow hospitals and clinics real-time access to upload patients' medical information, and also the use of the NHI MediCloud System to share the medical records and information of people seeking care, which has provided doctors with reference information to guide their diagnoses and prescriptions. This article explained to the world how Taiwan has used medical information technology and well-developed public health infrastructure in conjunction with forward-looking plans to effectively contain the spread of the COVID-19 within Taiwan.

With regard to international organizations, the Asia-Pacific Economic Cooperation (APEC) is one of the major international organizations in which Taiwan participates, and Taiwan has been active in the APEC topic of health. After the NHIA was subsidized by APEC to host the APEC international conference on medical information sharing in 2019, the NHIA again submitted the proposal "APEC Conference on Digital Healthcare Innovation-COVID-19 Response by Health Information Utilization" to the APEC Health Working Group (HWG) in 2020. APEC has funded this proposal, and member economies will be invited to discuss the application of digital information and technology to combat COVID-19 in 2022.

In conjunction with the government's New Southbound Policy, the NHIA has engaged in long-term, in-depth, two-way interchange with the Philippines, Thailand, and Vietnam, and this engagement has yielded impressive results. While COVID-19 pandemic prevented in-person contact during 2020, the NHIA used videoconferencing to

全民健保　民眾滿意

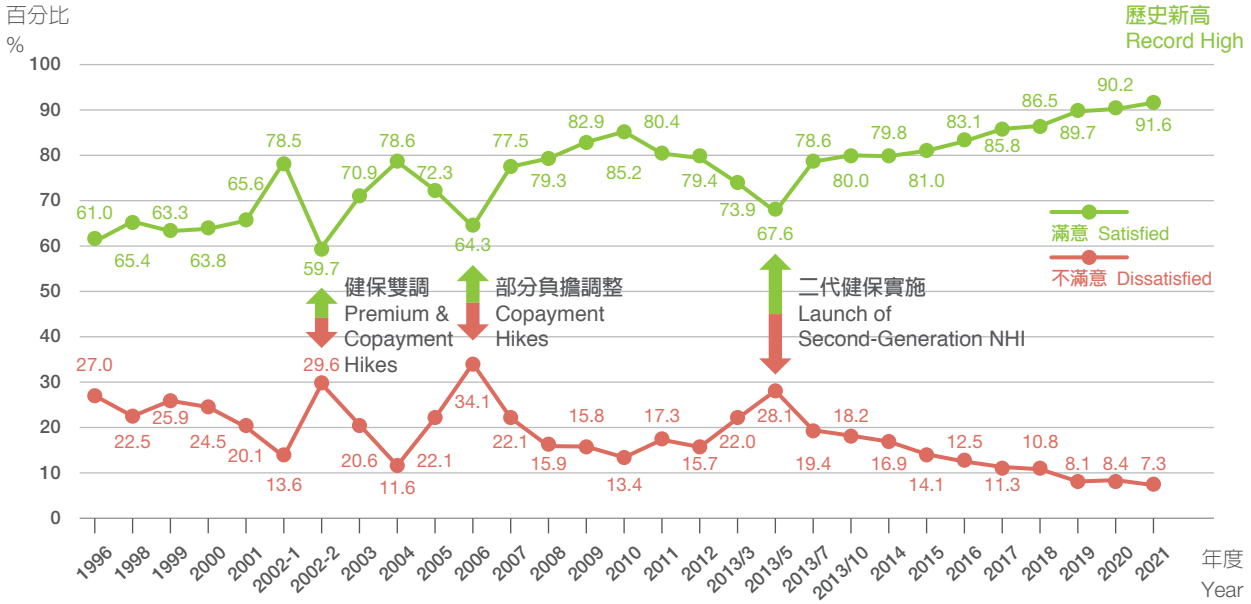
全民健保實施曾面臨諸多困難，從一開始的滿意度不到4成，到目前持續成長至8成以上，顯見民眾十分肯定健保。其中雖曾因2002年度保險費率及部分負擔調整，以及2005年度開始進行多元微調，導致民眾對全民健保的滿意度稍有下降，但隨後即快速回升至7成以上。2013年1月起二代健保實施，針對所得收入高者加收補充保險費，滿意度曾一度下滑後隨即回穩至8成左右，2021年民眾對健保的滿意度更創下高峰達到91.6%（圖7-1），我國因有全民健保，對經濟弱勢民眾的健康照護更能提供完善的醫療保障。

充分發揮　互助功能

全民健保的核心價值在於透過社會互助，以「社會保險」的形式，來分擔保險對象罹病時的財務風險。重大傷病人口占全體保險對象人數的3.9%，醫療費用卻高達健保總醫療支出的29.8%。其中，癌症、洗腎及血友病等重大傷病之平均醫療費用是一般人的6.3倍到97.0倍不等，顯示健保充分發揮了社會保險互助的功能，使重大傷病患者不致因病而貧（表7-1）。

圖7-1　全民健保滿意度趨勢圖

Chart 7-1　Public Satisfaction with NHI



註：1. 2002年，保險費率及部分負擔調整。
2. 2005年，投保金額上限、軍公教人員投保金額及菸品健康捐金額等調整。
3. 2013年，二代健保實施。
4. 自2021年起採市話及手機雙底冊調查

Notes: 1. The premium rate and copayments were increased in 2002.
2. The upper limit of payroll brackets, payroll brackets for military, civil service, and teaching personnel, and the amount of tobacco health and welfare surcharges were adjusted in 2005.
3. Implementation of Second Generation NHI in 2013.
4. Dual frame telephone surveys were adopted from 2021.

stay in continuous contact with medical and health agencies in New Southbound countries during this period. With the assistance from diplomatic personnel, the NHIA invited Thailand's National Health Security Office (NHSO) and the Philippines' Philippine Health Insurance Corporation (PhilHealth) respectively and held video conferences to jointly share experience concerning how health insurance systems has responded to the COVID-19 pandemic.

High Satisfaction with NHI

Although the implementation of NHI faced many difficulties, and public satisfaction was initially less than 40%, it has currently risen to over 80%, indicating that NHI enjoys a high level of public approval. And despite the drop in public satisfaction rating following increases in the premium rate and copayments in 2002, and in the wake of some fine-tuning of the system in 2005, satisfaction quickly rebounded to over 70%. Although satisfaction again dropped after the imposition of supplementary premiums on high-income households following the implementation of Second-Generation NHI in January 2013, it soon returned to around 80%, and then began a steady climb. Public satisfaction subsequently reached a peak of 91.6% in 2021 (Chart 7-1). Thanks to NHI, Taiwan is able to provide a comprehensive medical protection to even economically underprivileged people.

Maximizing the Power of Mutual Assistance

The core value of the NHI system is its reliance on mutual assistance to have all of society share the financial risk of caring for those who get sick through a “social insurance” mechanism. For instance, although persons with catastrophic illnesses and injuries account for only 3.9% of all patients, they also account for as much as 29.8% of all NHI medical expenditures. In particular, such catastrophic illnesses as cancer, conditions requiring dialysis, and hemophilia have medical expenses ranging from 6.3 times to 97.0 times average medical expenses. This shows how NHI is realizing the mutual assistance function of social insurance, and ensuring that patients with major illnesses are not driven into poverty (Table 7-1).

表7-1　健保醫療資源利用情形

Table 7-1　Utilization of NHI Medical Resources

類別 Category	醫療費用（點） Medical expenses (points)	平均值倍數 Multiple of average
全國每人平均 Nationwide average	33,355	1.0
每一重大傷病患者 Each catastrophic illness patient	241,904	7.3
每一癌症患者 Each cancer patient	220,348	6.6
每一罕病患者 Each rare disease patient	740,754	22.2
每一洗腎患者 Each dialysis patient	635,831	19.1
每一呼吸器患者 Each ventilator patient	791,203	23.7
每一血友病患者 Each hemophilia patient	3,010,029	90.2

註：以2021年重大傷病年度統計資料為例。
Note: Based on annual statistics for catastrophic illnesses and injuries in 2021.

Chapter 8

跨步精進　展望未來

Progress and Future Outlook

跨步精進　展望未來

全民健保經過多年的耕耘，其豐碩的成果在全球建立聲望，不僅獲得世界各國讚揚，也成為各國建立或改革健保制度的研究對象。走過從前、邁向未來，環境及社會結構變動的議題，在醫療資源有限的情況下，全民健保將持續滾動式檢討改善，朝下列方向推動革新措施，並規劃遠景藍圖：

珍惜健保資源、加強分級醫療

為逐步推動分級醫療，已擬定「提升基層醫療服務量能」、「導引民眾轉診就醫習慣與調整部分負擔」、「調高醫院重症支付標準，導引醫院減少輕症服務」、「強化醫院與診所醫療合作服務，提供連續性照護」、「提升民眾自我照護知能」及「加強醫療財團法人管理」等六大策略及相關配套措施依序實施，短期內朝壯大基層醫療實力，建構基層診所與醫院良好的合作機制等方向努力。提升醫療品質與量能，讓基層提供民眾優質的照護服務，亦可減輕大型醫院之負荷，並能更專注提供急重症醫療，達成病人分流之目的。醫療院所間組成「垂直整合策略聯盟」，藉由聯盟進行上下游垂直整合、醫院及診所間分工合作，運用電子轉診平台及雲端資訊之上傳及分享，落實雙向轉診，提供病人連續性、以病人為中心的醫療照護、並提升照護品質。

從社區到醫院連續性全人照護

居家醫療整合照護

全民健保自1995年開辦起，陸續推動行動不便患者一般居家照護、慢性精神病患居家治療、呼吸器依賴患者居家照護、末期病患安寧療護等7項居家醫療照護，2015年接受居家醫療服務之人數超過10萬人。在照護過程中，患者之照護需求將隨病程發展轉變，如病情穩定時，由接受一般居家照護改為居家醫療訪視，或病程發展到末期時，由接受一般居家照護轉為安寧療護；在轉換服務項目時，可能需要轉換至有提供服務的機構。

為改善不同類型居家醫療照護片段式之服務模式，自2016年2月起健保署將一般居家照護、呼吸居家照護、安寧居家療護等4項服務，整合為「居家醫療照護整合計畫」。計畫的特色為擴大照護對象、強化個案管理機制，且著重於促進社區內照護團隊之合作，包括各類醫事人員間之水平整合，及上、下游醫療院所之垂直整合，以病人為中心提供完整醫療服務。自2019年6月起計畫擴大服務內容，納入中醫師及藥師服務，並加重居家主治醫師的責任，病患之整體照護需求，由居家主治醫師整體評估，必要時再連結中醫師、護理師、呼吸治療師等其他醫事人員服務；而病人也需要配合居家主治醫師整合用藥、接受完整照護，如果無法配合，則維持原有就醫模式於門診就醫領藥，將有限的居家醫療人力，留給真正有需要的行動不便患者。

截至2021年12月，有3,047家醫事服務機構組成224個團隊，就近照護約7.5萬人。健保署將持續鼓勵組成社區內照護團隊，並均衡分布

Progress and Future Outlook

After many years of development, NHI's impressive achievements have given it an international reputation. It has not only earned praise from abroad, but also become a model for countries that are establishing or reforming health insurance systems. Looking ahead to future changes in the environment and social structure, in view of the limited nature of medical resources, the NHI will continue to conduct rolling reviews and improvements, draft a blueprint for the future, and promote reform measures targeting the following aspects:

Cherishing NHI Resources, Strengthening the Referral System

In order to gradually promote a multi-tier healthcare system, the NHIA has drafted the six strategies of "enhancing primary care medical service capacity," "accustoming the public to the referral system and adjusting copayments," "increasing payments to hospitals for critical illnesses, urging hospitals to reduce service for minor illnesses," "strengthening cooperation between hospitals and clinics in order to provide continuous care," "enhancing the public's self-care knowledge and skills," and "improving management of medical institutions." These strategies, along with their accompanying measures, are being implemented in sequential fashion. In the short term, the NHIA will strive to strengthen primary care capabilities, and establish effective mechanisms for cooperation between primary care clinics and hospitals. In order to enhance healthcare quality and capacity, the NHIA will ensure that primary care clinics provide the public superior healthcare services. This will also ease the burden on large hospitals, which can better focus on emergency and critical illness care, and achieve the goal of patient triage. The upstream-downstream integration brought about by the "vertically-integrated strategic alliances" between hospitals and clinics will promote cooperation and a division of labor between medical institutions. Furthermore, the use of the NHIA's electronic referral platform and the uploading and sharing of cloud information will facilitate two-way referrals, provide the public with continuous, patient-centered care, and increase care quality.

Continuous, Holistic Care from Communities to Hospitals

Integrated home healthcare

Since the initiation of the NHI system in 1995, the NHIA has introduced seven home care measures, which have included home care for patients with impaired mobility, home treatment for patients with chronic mental illnesses, home care for ventilator-dependent patients, and hospice care for end-stage patients. A total of more than 100,000 persons received home care services in 2015. In the home care process, patients' care needs will change with the course of their illnesses; if their condition stabilize, their service status may be changed from general home care to home care visits, and if their illness progresses to the end stage, they may shift from general home care to hospice care. In addition, as patients' service items shift, it may become necessary to transfer them to an institution.

To improve on the piecemeal nature of different home care services, the NHIA integrated four types of service, including general home care, respiratory home care, and hospice home care,

於各區域，以照顧更多行動不便患者，讓病患回歸社區生活，減少不必要之社會性住院。

安寧療護維護生命品質

為緩解病人因得到威脅生命疾病所造成的身心靈痛苦，提供個別性的全人照顧，全民健保提供安寧療護服務項目，包含「住院安寧」、「安寧共同照護」及「安寧居家療護」，由醫療團隊人員依病人需求，提供自入院、出院至居家完整的安寧整合性照護服務。

安寧居家療護，提供不須住院治療之末期病人，在醫師診斷轉介後，可於家中或機構中接受安寧居家療護服務，包括醫師、護理師、社工、心理師等人員的訪視及病人止痛，不僅提供病人自住院至居家的完整照護，提升照護品質。

為推動社區化之安寧照護，健保署持續結合居家醫療整合團隊及家庭醫師群來推動，由住家附近之醫療院所提供服務，讓末期病人回歸社區與在地安老。2021年接受全民健保安寧居家服務人數為14,993人（較2020年成長11%），顯示接受安寧居家療護的末期病人，逐漸成長。

提供急性後期照護

全民健保2014年開始推動急性後期照護，經醫院協助轉介至居家附近有「急性後期照護團隊」之社區醫院，對急性期後功能下降且有復健潛能之病人，提供短期積極性之復健整合照護，初期選擇腦中風試辦，2015年9月納入燒燙傷病人。

2017年7月1日起實施擴大照護對象範圍，除腦中風、燒燙傷病人外，新增創傷性神經損傷、脆弱性骨折、心臟衰竭及衰弱高齡病人，另新增急性後期整合照護居家模式，並鼓勵更多醫療院所組成跨院、跨專業的合作團隊服務，讓病人回歸社區醫療。

as the "Integrated Home Healthcare Program" in February 2016. The main features of this program include its expanded scope of recipients, enhanced case management mechanisms, and promotion of cooperation among care teams in the community; this cooperation takes the form of horizontal integration between various types of medical personnel, and vertical integration between hospitals and clinics, and seeks to provide comprehensive patient-centered service. Starting in June 2019, the NHIA expanded home care service content to include the services of pharmacists and doctors of traditional Chinese medicine, and increased the responsibilities of home care attending physicians; home care attending physicians are now responsible for overall assessment of patients' care needs, and may call on such other medical personnel as doctors of traditional Chinese medicine, nurses, and respiratory therapists to help provide service. In addition, patients must also comply with the attending physician's medication use instructions as part of comprehensive care; if they do not or cannot comply, then their original outpatient care and drug pick-up service format will be continued. This approach will ensure that limited home care manpower is used for service to mobility-impaired patients who are truly in need.

As of December 2021, 3,047 medical institutions had organized 224 teams to provide home care services to approximately 75,000 patients. The NHIA will continue to encourage the formation of community-based care teams, and will strive to ensure that they are evenly distributed in different areas, so that they can care for even more mobility-impaired patients. This will allow more patients to return to their lives in the community, and minimize unnecessary "social hospitalization."

Maintaining quality of life through hospice care

To avoid physical, mental and spiritual suffering from life-threatening conditions, the NHIA provides various hospice care services, including "hospital hospice care," "hospice shared care," and "home hospice care." Depending on patients' needs, medical teams can provide them with integrated hospice care services from hospital admission and discharge to home care.

The home hospice care is provided to terminally ill patients who do not require actively inpatient treatment. After diagnosis and referral by their doctor, such patients may receive home hospice care service either in their homes or in institutions. This service involves visits by physicians, nurses, social workers, and psychologists, aiming to give patients effective,pain relief; The holistic approach not only provides comprehensive hospital to home care, but also improve the quality of care.

To promote hospice care within the community, the NHIA has extended its efforts to increase local hospital participation in integrated home health care teams and family doctor care teams. This initiative enables terminal patients to return to the community and live out their lives in dignity. A total of 14,993 persons received NHI home hospice care in 2021 (an increase of 11% compared with 2020), indicating that a gradually increase in the number of terminal patients who received home hospice care.

Providing Post-acute Care

The NHIA began promoting post-acute care in 2014. After hospital refers a patient to a community hospital with a "post-acute care team" near the patient's home, the post-acute care team can provide proactive integrated short-term rehabilitation to patients with rehabilitation potential and post-acute functional impairment. This service was initially provided to stroke patients on a trial basis, and was extended to burn patients in September 2015.

Apart from stroke and burn patients, the scope of care recipients was further expanded to include

推動迄今，全國共有218家醫院組成38個醫院團隊參與，2021年各項疾病收案超過1萬7千人，其中腦中風、燒燙傷、創傷性神經損傷、脆弱性骨折、心臟衰竭約九成病人整體功能有進步，由嚴重依賴進步至初步可以生活自理的程度，約八成病人成功返家回歸社區，也能降低病人的再住院率與急診率。

擴大家庭醫師整合照護計畫

為重視社區基層醫療，因應人口老化、慢性病之增加，提倡預防醫學，促進分級醫療，健保署自2003年起，推動辦理「全民健康保險家庭醫師整合性照護計畫」，在臺灣建立本土化之家庭醫師制度，由5個以上的基層診所組成社區醫療群，以群體力量提供「以病人為中心」的全人醫療照護，對民眾健康管理及衛教，提升預防保健執行率與基層醫療品質，並建立基層醫療院所與醫院之合作關係，共同辦理轉診、個案研討、社區衛教等活動；另設置24小時諮詢專線，提供民眾周全性、協調性與持續性的服務。

截至2021年12月底，有5,587家基層診所與296家醫院共同組成623個醫療群，共同照護超過601萬名收案會員。健保署將持續鼓勵社區醫療群結合藥局、衛生所、物理治療所、檢驗所並建立醫療群合作診所，提供復健科、眼科及精神科醫療服務，以提升社區醫療群照護能力，落實在地化、社區化的全人照護與醫療。

便民服務貼近民眾需求

關懷偏鄉住民一直是健保署持續推動之工作重點，自2016年起規劃與鄉、鎮、市（區）公所跨機關合作辦理在地製發健保卡便民服務，讓偏遠地區民眾換發健保卡時有更多選擇，可就

traumatic neurological injuries, fragility fractures, heart failure, and frail elderly patients on July 1, 2017. In addition, a post-acute integrated home care service was also added, and more hospitals and clinics were encouraged to form inter-institutional, inter-professional cooperative service teams providing care to patients who have returned to the community.

To date, 218 hospitals have organized a total of 38 hospital teams to participate in this program, and more than 17,000 new cases were accepted in 2021. More than 90% of the participating patients suffering from stroke, burns, traumatic neurological injuries, fragility fractures, and heart failure enjoyed overall functional improvement, and progressed from severe dependence to a level where they were able to take care of themselves in daily life. Approximately 80% of the patients were able to return home successfully, and the program reduced the patient re-hospitalization rate and emergency care rate.

Expanding Family Doctor-Centered Integrated Care

To place greater emphasis on community primary care, respond to demographic aging and the increase in chronic illnesses, promote preventive medicine, and encourage referrals, the NHIA implemented the "NHI Family Doctor Plan" in 2003. This plan has brought about the establishment of a localized family doctor system in Taiwan by encouraging five or more primary care clinics to organize community healthcare groups, which rely on their collective capabilities to provide "patient-centered" holistic healthcare, as well as public health management and health education. The plan has successfully increased the preventive care implementation rate and healthcare quality at the primary care level, and has also established cooperative relationships between hospitals and primary care institutions, including joint referrals, case investigations, and community health education activities. Furthermore, a 24-hour consulting hotline has been established to provide the public with comprehensive, coordinated, continuous service.

As of the end of December 2021, 5,587 primary care clinics and 296 hospitals had jointly organized 623 healthcare groups, which had provided care to more than 6.01 million patients. The NHIA will continue to encourage community healthcare groups to establish cooperative healthcare group clinics in conjunction with pharmacies, local health stations, physical therapy clinics, and testing laboratories. These healthcare group clinics will offer rehabilitation, ophthalmology, and psychiatric care services, and will enhance the care capabilities of community healthcare groups, and realize localized community holistic care and medicine.

Convenient and Responsive Services

Because caring for the residents of remote areas has consistently been one of the focal points of its work, the NHIA established a convenient local NHI card issuance service through interagency cooperation with city, district and township, office in 2016. This service provides people living in rural areas with more options when they need to apply for or replace an NHI card. Residents of these areas can now apply for issuance of an NHI card at the nearest city, district and township, office, and can receive a new NHI card within only 15 minutes. This service spares residents the time and expense of repeatedly visiting the distant regional NHIA service center or service office when applying for an NHI card, and people no longer need to wait until a card has been sent to them. As of December 2021, the NHIA was cooperating with 20 district offices to provide this convenient card application and production service, including public offices in eastern Taiwan (including Guangfu Township, Chenggong Township, Dawu

近至附近鄉、鎮、市（區）公所現場申辦，並在15分鐘內領取新的健保卡，以節省申辦健保卡往返健保署各聯合服務中心或各縣市所屬聯絡辦公室的交通路程、交通費或等候新卡寄送時間。截至2021年12月健保署已與花東地區之光復鄉、成功鎮、大武鄉及關山鎮，新北市金山區、宜蘭縣宜蘭市及南澳鄉、桃園市復興區、新竹縣尖石鄉及五峰鄉、苗栗縣泰安鄉、南投縣埔里鎮及水里鄉、彰化縣芳苑鄉、雲林縣虎尾鎮、嘉義縣阿里山鄉、台南市佳里區、屏東縣春日鄉及潮州鎮及車城鄉等20處公所合作，提供民眾在地製卡便民服務。

健保署對外的所有服務據點為簡化現場申領健保卡等待時間，自2013年底全面進入無紙化作業，以電子化作業取代原紙本申請，大幅縮短民眾等待時間。另配合現代電子錢包的趨勢，健保署對外服務據點依其地方屬性提供不同電子票證種類繳交健保費及健保卡工本費，已於2016年下半年推行信用卡臨櫃刷卡服務，以減少櫃檯人員收存現金、辨識鈔票真偽之風險，提高行政效率，讓民眾有多元的繳費方式及免攜帶現金的服務。

未來健保署將提供健保「創新智慧服務平台」服務，打造健保全渠道（Omni-channel）雲端智慧客服系統，使民眾與健保署之溝通渠道不再受到地點與時間之限制，民眾將可運用多元載具（包括室內電話、手機、智慧型行動裝置、電腦等）透過多媒體服務管道，如：線上文字客服、視訊客服、傳真等，隨時隨地取得健保業務諮詢服務。如遇緊急事件發生時，透過即時啓動跨區的備援機制，提供民眾更及時、完整、便利與高品質的服務。

Township, and Guanshan Township), Jinshan District in New Taipei, Yilan and Nanao Township, in Yilan County, Fuxing District in Taoyuan, Jianshi Township and Wufeng Township in Hsinchu County, Tai-an Township in Miaoli County, Puli and Shuili Township in Nantou County, Fangyuan Township in Changhua County, Huwei in Yunlin County, Alishan Township in Chiayi County, Jiali District in Tainan, and Chunri Township, Chaozhou, and Checheng Township in Pingtung County.

In order to shorten waiting time when applying for an NHI card, all NHIA service locations have fully adopted paperless operations since the end of 2013. The adoption of electronic procedures instead of paper applications has greatly shortened people's waiting time. In addition, in keeping with the growing popularity of "electronic wallets," the NHIA's service locations offer different electronic payment options for NHI premiums and NHI card handling fee. The service counter credit card payment service introduced by the NHIA during late 2016 has reduced the need for counter personnel to handle cash and assess the authenticity of checks, enhanced administrative efficiency, and allowed the public to use multiple payment options and avoid carrying cash.

Looking ahead to the future, the NHIA will provide the innovative "Smart Services Platform," which will consist of an "Omni -channel" intelligent cloud service system. This platform will ensure that the public's communication with the NHIA is free from restrictions of time and place, and the public will be able to use a variety of devices (including home phones, cell phones, smart mobile devices, and computers, etc.) to obtain NHI consulting services at any time or place via various multimedia service channels, including online text customer service, videoconferencing customer service, and fax, etc. When emergency situations occur, the real-time activation of inter-regional backup mechanisms will ensure that the public can receive even quicker, more comprehensive, more convenient, and higher quality service.

Relying on My Health Bank to Enhance Self-Care

The NHIA is continuing to develop patient-centered holistic care, and is adopting the cloud computing in big data concepts to provide online services. In particular, the NHIA has established "My Health Bank" containing personal medical information to take advantage of the convenience of the Internet of Things. My Health Bank provides individuals with online services, realizes the right to know, and helps people perform self-care. By serving as a channel of communication between doctors and patients, My Health Bank can also reduce medical information asymmetry, and enhance the security and effectiveness of medical care.

My Health Bank employs images and charts to visualize information, and its personal health insurance data selection and classification functions enable people to quickly view and understand their healthcare situation, including their doctor's judgments, treatment, medication use, testing and examination results, and medical images. Furthermore, My Health Bank can forecast probability of developing liver cancer during the next ten years and give a prognostic risk assessment in cases of kidney disease. My Health Bank provides individuals with a portable personal health manager.

At a time when the focus of the healthcare system is shifting from the treatment of illnesses to self-care and prevention, the NHIA is continuing to promote interagency health data integration in conjunction with the Ministry of Health and Welfare's "Taiwan Health Cloud." The NHIA has already integrated data including the Department of Medical

健康存摺提升自我照護知能

健保署持續發展以人為中心的全人照護，結合雲端運算（Cloud Computing）及巨量資料（Big Data）概念，以網路取代馬路，運用互聯網（Internet of Things）的便利性，串聯個人資料（My Data），建置「健康存摺」，提供個人線上數位服務，落實知情權，協助民眾做好自我健康管理，並可利用健康存摺做為醫病間溝通橋樑，減少醫病間醫療資訊的不對等，提升就醫安全與效率。

健康存摺透過視覺化資訊圖表，搭配個人健保資料篩選及分類功能，讓民眾可快速瞭解個人的就醫情形，包括醫師臆斷、處置、用藥、檢驗（查）結果及醫療影像等資料，還能預估未來10年罹患肝癌的機率與腎臟病預後風險評估，於是，健康存摺在手，就是每個人的隨身健康管理師。

在這個醫療照護由疾病治療，導向自我照護及預防的時代，健保署配合衛生福利部臺灣健康雲計畫，持續推展跨機關健康資料整合，目前已整合之跨機關資料包括醫事司器捐或安寧緩和醫療意願、疾病管制署預防接種資料、國民健康署成人預防保健結果、四癌篩檢結果及金門縣政府補助縣民自費健檢結果等資料。另外，為便利民眾申請健康存摺，於2018年5月導入手機快速認證，本國籍、外國籍之保險對象，手機門號是自己的名義申辦，且為月租型搭配行動上網（4G/5G），就能完成「全民健保行動快易通｜健康存摺」APP註冊及綁定，免出門即可隨時隨地線上查詢及申辦健保業務。

健康存摺除提供個人就醫資料外，亦提供APP推播，主動提醒應接受洗牙、癌症篩檢、成人預防保健，內建行事曆功能，主動串聯就醫紀錄，並可匯入及匯出，讓民眾更清楚掌握就醫行程，另有「兒童預防接種時程提醒」，讓家長不要忘了孩子的常規疫苗施打，增進使用黏著度。

健保署持續擴充健康存摺資料的豐富性及服務範圍，包括鼓勵健檢機構若民眾簽署同意書，則協助將「自費健檢」結果傳送健保署載入其個人的健康存摺，或可由民眾自行登錄健檢資料。並自2019年5月7日起新增眷屬管理功能，民眾在取得長輩同意後，即可以查閱長輩健康存摺，協助照顧長輩健康，民眾如有未滿15歲以下子女依附加保，系統會將子女就醫資料自動帶入家長之健康存摺中，協助家長照顧未成年子女健康。

為利民眾可以自主運用個人健康存摺資料，健保署自2019年3月釋出「軟體開發套件（Software Development Kit, SDK）」功能，讓當事人下載資料後，可依自主意願，將資料提供給信任的第三方APP、健康管理服務系統，或其他公私立單位進行後續加值服務，讓健康存摺更能彰顯其價值，作為民眾最可靠的健康管理助手。

另為協助控制COVID-19疫情，健康存摺新增口罩購買紀錄、COVID-19檢測結果、COVID-19疫苗注射紀錄，未來將持續精進健康存摺功能，改善操作介面及操作流程，提供使用者友善的操作介面及流暢的操作流程，並增加疾病管理功能，以擴大使用人數。

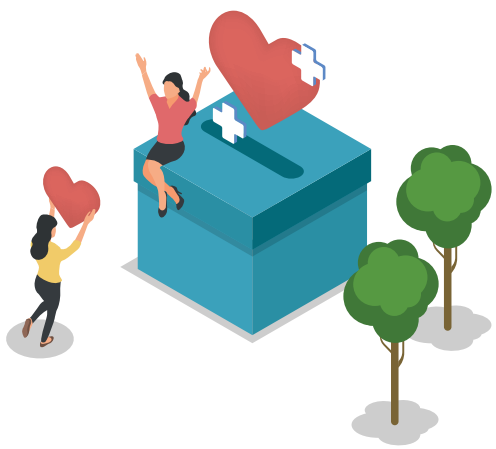
Affairs organ donation and hospice and palliative care wish information, the Centers for Disease Control's immunization data, the Health Promotion Administration's adult preventive care results and screening results for four types of cancer, and the results of self-paid health examinations subsidized by the Kinmen County Government. Furthermore, to facilitate applications for My Health Bank, the NHIA adopted rapid smartphone authentication in May 2018, which allows citizens and foreigners to use their cell phone numbers to apply for My Health Bank in their own names. Applicants can use their monthly mobile data plans (4G/5G) to complete registration and binding using the "National Health Insurance Action Express | My Health Bank" app, and can then use My Health Bank to perform online queries and apply for NHI services at any time or place.

Apart from providing personal healthcare data, My Health Bank also includes an app providing active reminders that the users should receive tooth cleaning, cancer screening, and adult preventive care; it has a built-in calendar function, and automatically links to medical records, which can be imported and exported. My Health Bank provides users with a clear understanding of their medical visits, and its "reminders of children's scheduled inoculations" ensures that parents make sure that their children receive their routine inoculations, which has increased user loyalty.

The NHIA is continuing to expand My Health Bank's service scope and data content, such as by encouraging physical examination organizations to transmit self-paid physical examinations results to the NHIA for inclusion in the individuals' My Health Bank after the individuals have signed consent forms, and individuals can also enter their own physical examination data. Starting on May 7, 2019, the NHIA added a dependent management function allowing individuals to view an older family member's My Health Bank after that person has given his or her consent, which allows people to better care for older relatives' health. When a parent enrolls a child under the age of 15 in NHI as a dependent, the system will automatically send the child's medical data to the parent's My Health Bank, which helps parents care for their children's health.

To facilitate the autonomous use of My Health Bank data by members of the public, the NHIA allowed use of software development kit (SDK) functions in March 2019. This has enabled users to provide downloaded data to trusted third party apps, health management service systems, and other public and private units for use in value-added services. This has enhanced My Health Bank's value as a trustworthy health management assistant.

Furthermore, as part of the fight against COVID-19, My Health Bank has added face mask purchase records, test results, and vaccination records. In the future, the NHIA will continue to My Health Bank's functions, provide users with an even easier-to-use operating interface and smoother operating procedures, and add more disease management functions, which will increase the number of users.



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