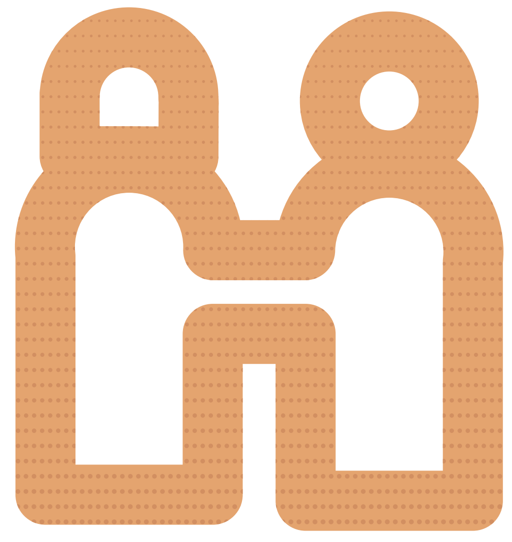
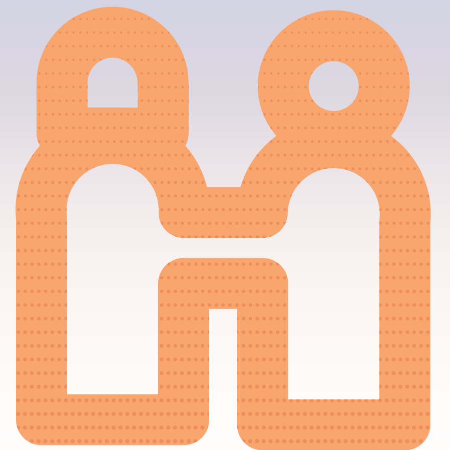


2023-2024 Annual Report

全 民 健 康 保 險 年 報

NATIONAL HEALTH INSURANCE



2023-2024 Annual Report
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NATIONAL HEALTH INSURANCE

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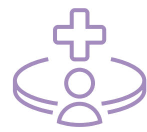

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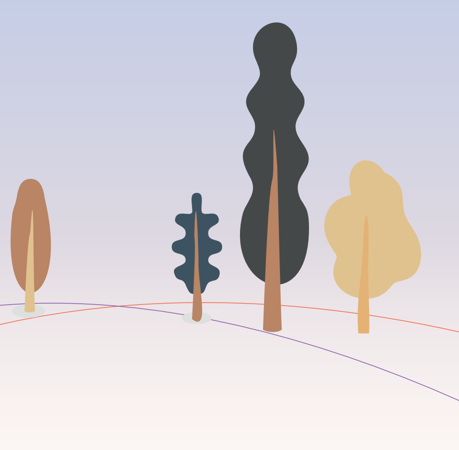

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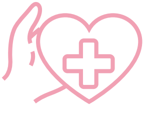

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署長的話

28年來，健保以雁行理論，一步一腳印守護民眾健康，為全國民眾提供完整且平等的醫療保障，為台灣重要的社會制度及無形資產，舉凡疾病、傷害事故及生育時所需的門診、急診、住院及藥品服務，慢性病、罕見疾病、癌症、重大傷病、居家醫療及新醫療科技等，皆為健保醫療服務範疇，讓民眾不再因病而貧、因貧而病。

隨著人口高齡化及醫療科技發展，醫療費用逐年增加，在健保資源有限的情況下，透過大家醫計畫，整合系統及平台，落實全人全程照護目標，把健保服務從醫療延伸到保健，也銜接到居家醫療及在宅急性照護，以及銜接長照服務，希望垂直整合各級醫療團隊，及水平整合各服務，讓醫療資源極大化。

為提供具實證基礎的醫療服務同時兼顧病人權益，本112年健保與英國國家健康暨照護卓越研究院（National Institute for Health and Care Excellence, NICE）共同簽訂醫療科技評估合作協定，透過交流及經驗分享，掌握新藥療效證據及效益，加速新藥收載決策，精進我國醫療科技評估效益。

健保進一步推動數位升級計畫，以數位轉型健保服務，推動遠距醫療，為偏鄉居民提供便利的醫療服務，提升醫療可近性、可負擔性及公平性，並精進健保快易通 | 健康存摺APP、虛擬健保卡、推動健康存摺SDK，同時強化資安系統，透明治理保障個資安全，完備健保資料使用及相關法規檢討修正，促進創新研發，政策擬定與推動方面，持續與各部會、醫界和民眾對話及社會溝通。

敏捷韌性是未來醫療的關鍵，敏捷可以迅速回應挑戰，韌性則能渡過危機。要建立敏捷韌性的醫療體系，需要仰賴智慧科技，建構數位健康、數位醫療的ecosystem，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 石崇良

Message from the Director General

Over the past 28 years, Taiwan's National Health Insurance (NHI) program has adopted the “flying-geese theory” for safeguarding the health of local people every step of the way. This important social institution and intangible asset has been pivotal to provision of comprehensive and equal healthcare for all. It includes outpatient, inpatient, emergency, and medication services needed for diseases, accidents, and childbirth. Also covered are chronic diseases, rare diseases, cancer, major illnesses, home healthcare, and innovative medical technologies. The populace is no longer impoverished by illness or made ill by poverty.

Combined, population aging and advances in medical technology have pushed healthcare costs higher by the year. Given limited resources available to NHI, the National Health Insurance Administration (NHIA) is proactive to promote the Family Physician Program that integrates related systems and platforms for provision of continuous, comprehensive services throughout the entire healthcare process. NHI services are thus extended beyond medical treatment to healthcare, as well as connected to home-based medical care, acute care at home, and long-term care. The aim is to vertically integrate all levels of healthcare teams and horizontally combine related services, thereby maximizing the use of medical resources.

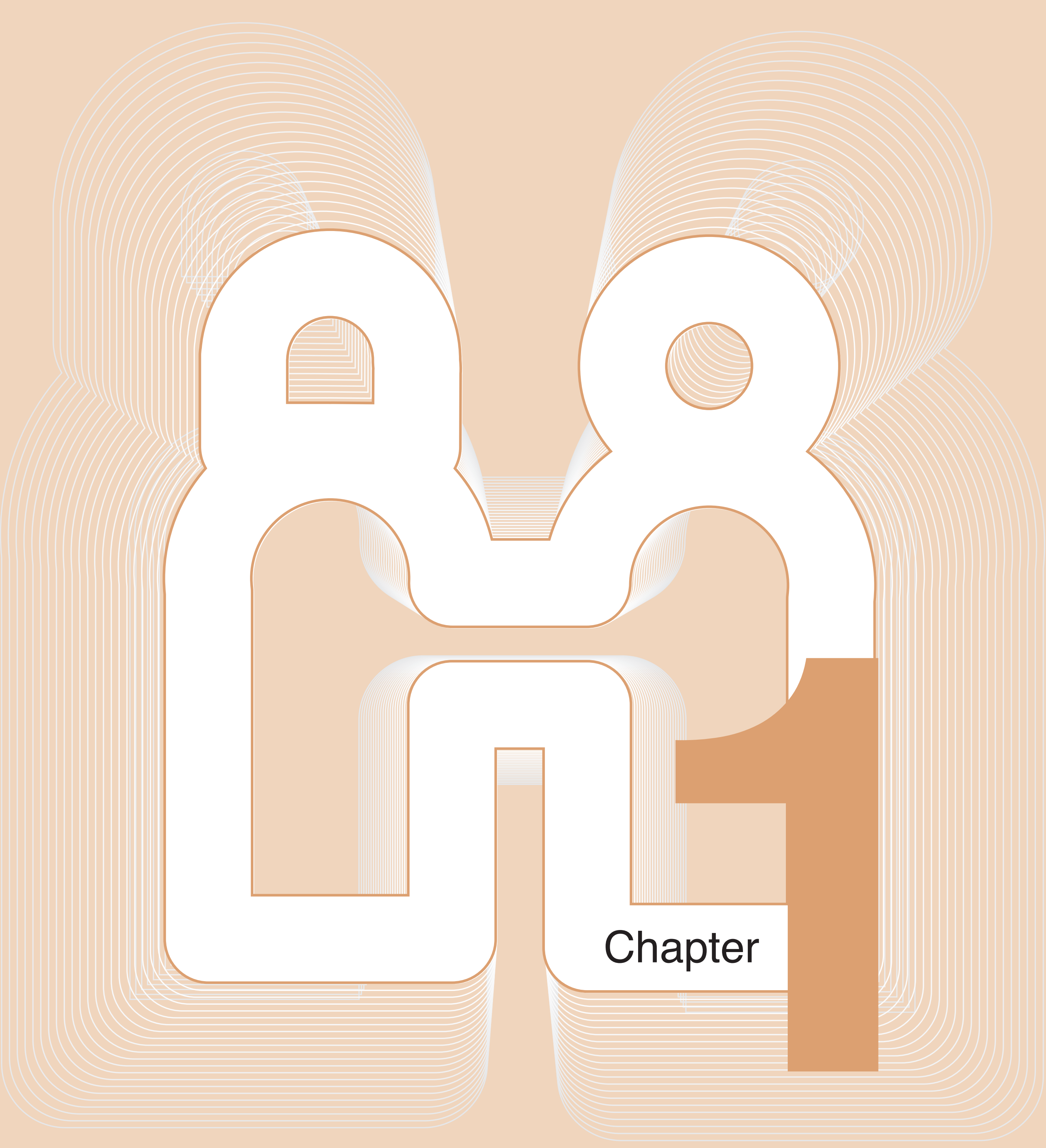
In order to provide empirically supported medical services while safeguarding patient rights, the NHIA signed a partnership agreement for health technology assessment with the U.K.’s National Institute for Health and Care Excellence (NICE) earlier this year. Through the exchange of knowledge and experience, this partnership aims to gain insights into the efficacy and benefits of new drugs, thus accelerating the decision-making process for their inclusion in the NHI drug coverage list and making Taiwan’s health technology assessment more effective.

Meanwhile, the NHIA has been avid to push the digital transformation of healthcare. Of digitally transformed NHI services, telemedicine is proactively promoted to better serve residents in remote areas. The overall objective is to enhance the accessibility, affordability, and fairness of healthcare for all. In the highlight is ongoing work to further improve the “My Health Bank” app and virtual NHI card. A software development kit (SDK) is now available for the aforesaid app. Special attention is also given to strengthening the cybersecurity system and guarding personal data via transparent governance, as well as reviewing and revising regulations that govern NHI data use to foster innovation. In terms of policy drafting and implementation, priority is given to keeping up our dialogue and communication with other government agencies, the medical community, and the general public.

Agility and resilience hold the key to the future of healthcare. Agility allows for a rapid response to challenges, while resilience enables us to overcome crises. To establish a healthcare system that embodies both agility and resilience, we need to draw on smart technology and build an ecosystem of digital health and digital healthcare, that is, a win-win medical environment for both care providers and recipients. As such, the NHIA is set to keep striving for the goal of health for all that benefits NHI, the insured, and medical care providers alike.

Chung-liang Shih, MD, DrPH

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　承先啓後

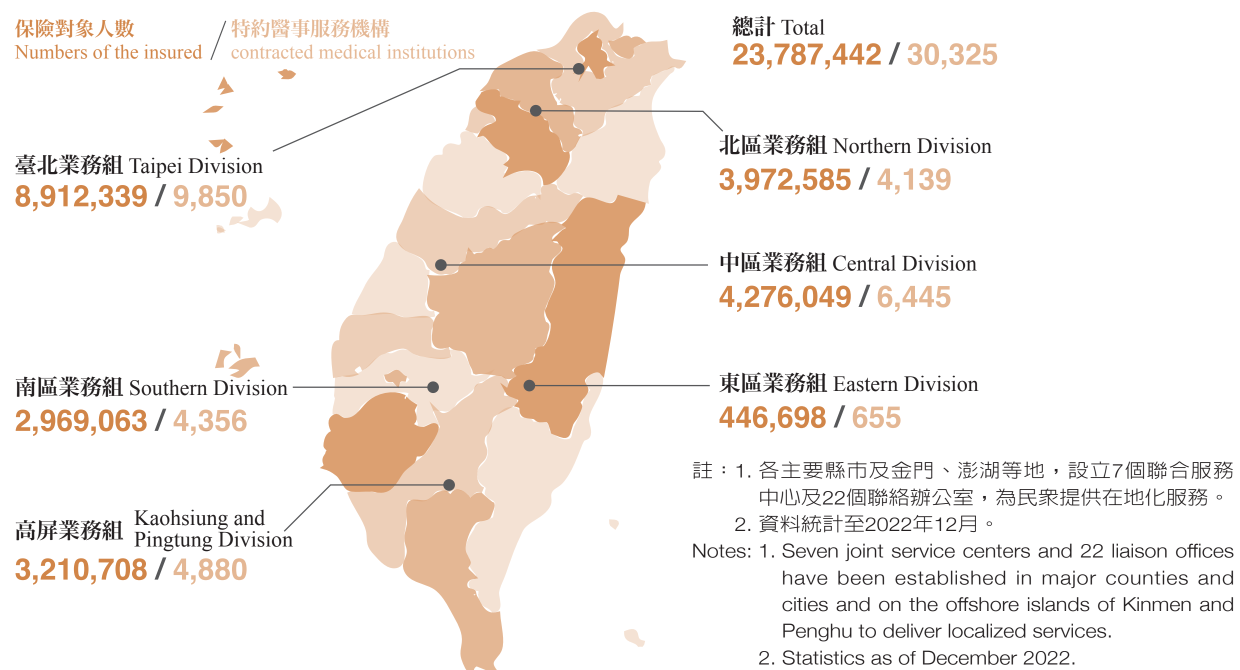
健保署前身為「行政院衛生署中央健康保險局」的金融保險事業機構，於1995年整併當時僅約59%國民可參加之勞保、農保、公保三大職業醫療保險體系，秉持永續發展、關懷弱勢的原則，擴展至全民納保的完整社會保險制度，期間歷經2010年改制行政機關及2013年政府組織整併，最終成就現行的全民健康保險公辦公營、單一保險人模式的組織體系。

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2022年12月31日，在職員工計有3,059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



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2022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 2022.

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, 2022, the NHIA had 3,059 employees.

圖1-1　中央健康保險署組織架構圖

- 衛生福利部
  - 綜合規劃司
  - 社會保險司
  - 社會救助及社工司
  - 護理及健康照護司
  - 保護服務司
  - 醫事司
  - 心理健康司
  - 中醫藥司
  - 長期照顧司
  - 口腔健康司
  - 秘書處
  - 人事處
  - 政風處
  - 會計處
  - 統計處
  - 資訊處
  - 法規會
  - 附屬醫療及社會福利機構管理會
  - 衛生福利人員訓練中心
  - 國民年金監理會
  - 全民健康保險會
  - 全民健康保險爭議審議會
  - 國際合作組
  - 疾病管制署
  - 食品藥物管理署
  - 中央健康保險署
    - 企劃組
    - 承保組
    - 財務組
    - 醫務管理組
    - 醫審及藥材組
    - 資訊組
    - 秘書室
    - 人事室
    - 主計室
    - 政風室
    - 臺北業務組
    - 北區業務組
    - 中區業務組
    - 南區業務組
    - 高屏業務組
    - 東區業務組
  - 國民健康署
  - 社會及家庭署
  - 國民年金局（註）
  - 國家中醫藥研究所

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

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

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

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

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

National Health Insurance 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).

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。

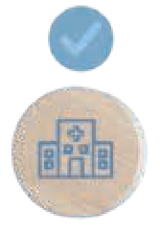
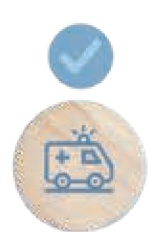
二代健保施行後，為全面落實平等醫療服務及就醫之權利，矯正機關之受刑人亦納入健保納保範圍內；本國人久居海外返國重新設籍欲參加健保時，必須有在2年內參加健保的紀錄，或是在臺灣設籍滿6個月才能加入健保；外籍人士也必須在臺灣地區領有居留證明文件且連續居留滿6個月始可加入健保，以符合社會公平正義之期待。

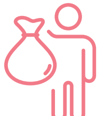
截至2022年12月底止，參加全民健保的總人數有23,787,442人（表2-2），投保單位有937,605家。

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。

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。



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 Taiwanese 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 2022, NHI beneficiaries numbered 23,787,442 (Table 2-2) and group insurance applicants, 937,605.

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.

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,

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. Veterans' Unemployed spouse 2. Veterans' Unemployed lineal blood ascendants 3. Veterans' 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 Administration office of the village, township, municipality, 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 Beneficiaries 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 Insureds	14,444,902	3,577,629	1,929,257	97,330	282,652	3,455,672	23,787,442
占總納保人數百分比 Percentage	60.72%	15.04%	8.11%	0.41%	1.19%	14.53%	100%

資料時間：2022年12月31日
As of December 31, 2022

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，每年協議訂定醫療給付費用總額，完成各年度保險費費率審議，報衛生福利部轉報行政院核定。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）。

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.

In 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2023年1月1日起公告為0.57人。
6. 第4類及第5類平均保險費：2023年1月1日起調整為2,063元（調整前為1,839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: 0.57 from January 1, 2023.
6. Average premium for Categories 4-5 insureds: Fully subsidized by the government, the premium was raised to NT$2,063 (from NT$1,839) from January 1, 2023.
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

<table>
<tr><th colspan="3" rowspan="2">保險對象類別
Classification of the Insured</th><th colspan="3">負擔比率 Contribution Ratios (%)</th></tr>
<tr><th>被保險人
The Insured</th><th>投保單位
Group Insurance Applicant</th><th>政府
The Government</th></tr>
<tr><td rowspan="7">第一類
Category 1</td><td>公務人員
Civil servants</td><td>本人及眷屬
Insured and dependents</td><td>30</td><td>70</td><td>0</td></tr>
<tr><td>公職人員、志願役軍人
Public office holders, volunteer military personnel</td><td>本人及眷屬
Insured and dependents</td><td>30</td><td>70</td><td>0</td></tr>
<tr><td>私立學校教職員
Private school teachers and staffers</td><td>本人及眷屬
Insured and dependents</td><td>30</td><td>35</td><td>35</td></tr>
<tr><td>公、民營事業機構等有一定雇主的受僱者
Employees of public/private enterprises and organizations</td><td>本人及眷屬
Insured and dependents</td><td>30</td><td>60</td><td>10</td></tr>
<tr><td>雇主
Employers</td><td>本人及眷屬
Insured and dependents</td><td>100</td><td>0</td><td>0</td></tr>
<tr><td>自營業主
The self-employed</td><td>本人及眷屬
Insured and dependents</td><td>100</td><td>0</td><td>0</td></tr>
<tr><td>專門職業及技術人員自行執業者
Independent professionals and technical specialists</td><td>本人及眷屬
Insured and dependents</td><td>100</td><td>0</td><td>0</td></tr>
<tr><td rowspan="2">第二類
Category 2</td><td>職業工會會員
Occupational union members</td><td>本人及眷屬
Insured and dependents</td><td>60</td><td>0</td><td>40</td></tr>
<tr><td>外僱船員
Foreign crew members</td><td>本人及眷屬
Insured and dependents</td><td>60</td><td>0</td><td>40</td></tr>
<tr><td>第三類
Category 3</td><td>農民、漁民
Members of farmers' and fishermen's associations</td><td>本人及眷屬
Insured and dependents</td><td>30</td><td>0</td><td>70</td></tr>
<tr><td rowspan="4">第四類
Category 4</td><td>義務役軍人
Military conscripts</td><td>本人
Insured</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td>軍校軍費生、在卹遺眷
Military academy students who receive grants from the government, dependents of military personnel on pensions</td><td>本人
Insured</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td>替代役役男
Substitute service draftees</td><td>本人
Insured</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td>矯正機關收容人
Inmates in correctional facilities</td><td>本人
Insured</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td>第五類
Category 5</td><td>低收入戶
Low-income households</td><td>家戶成員
Household members</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td rowspan="3">第六類
Category 6</td><td rowspan="2">榮民、榮民遺眷家戶代表
Veterans, household representatives of survivors of veterans</td><td>本人
Insured</td><td>0</td><td>0</td><td>100</td></tr>
<tr><td>眷屬
Dependents</td><td>30</td><td>0</td><td>70</td></tr>
<tr><td>地區人口
Other individuals</td><td>本人及眷屬
Insured and dependents</td><td>60</td><td>0</td><td>40</td></tr>
</table>

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2023年1月1日起共有50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2023年1月1日起為26,400元。

表2-5　2023年投保金額分級表

Table 2-5 2023 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	26,400	26,400以下
	2	27,600	26,401~27,600
	3	28,800	27,601~28,800
第二組級距 1500元 Bracket 2 NT$1,500	4	30,300	28,801~30,300
	5	31,800	30,301~31,800
	6	33,300	31,801~33,300
	7	34,800	33,301~34,800
	8	36,300	34,801~36,300
第三組級距 1900元 Bracket 3 NT$1,900	9	38,200	36,301~38,200
	10	40,100	38,201~40,100
	11	42,000	40,101~42,000
	12	43,900	42,001~43,900
	13	45,800	43,901~45,800
第四組級距 2400元 Bracket 4 NT$2,400	14	48,200	45,801~48,200
	15	50,600	48,201~50,600
	16	53,000	50,601~53,000
	17	55,400	53,001~55,400
	18	57,800	55,401~57,800
第五組級距 3000元 Bracket 5 NT$3,000	19	60,800	57,801~60,800
	20	63,800	60,801~63,800
	21	66,800	63,801~66,800
	22	69,800	66,801~69,800
	23	72,800	69,801~72,800
第六組級距 3700元 Bracket 6 NT$3,700	24	76,500	72,801~76,500
	25	80,200	76,501~80,200
	26	83,900	80,201~83,900
	27	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 January 1, 2023 has 50 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, 2023, 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$26,400.

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	28	92,100	87,601~92,100
	29	96,600	92,101~96,600
	30	101,100	96,601~101,100
	31	105,600	101,101~105,600
	32	110,100	105,601~110,100
第八組級距 5400元 Bracket 8 NT$5,400	33	115,500	110,101~115,500
	34	120,900	115,501~120,900
	35	126,300	120,901~126,300
	36	131,700	126,301~131,700
	37	137,100	131,701~137,100
	38	142,500	137,101~142,500
	39	147,900	142,501~147,900
	40	150,000	147,901~150,000
第九組級距 6400元 Bracket 9 NT$6,400	41	156,400	150,001~156,400
	42	162,800	156,401~162,800
	43	169,200	162,801~169,200
	44	175,600	169,201~175,600
	45	182,000	175,601~182,000
第十組級距 7500元 Bracket 10 NT$7,500	46	189,500	182,001~189,500
	47	197,000	189,501~197,000
	48	204,500	197,001~204,500
	49	212,000	204,501~212,000
	50	219,500	212,001以上

註：2023年1月1日生效。
Note: Effective from January 1, 2023.

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；2022年全年補充保險費計收約730.9億元，占同年保險費收入約7.70%。

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2022年12月累計收支結餘為1,049億元（表2-6）。

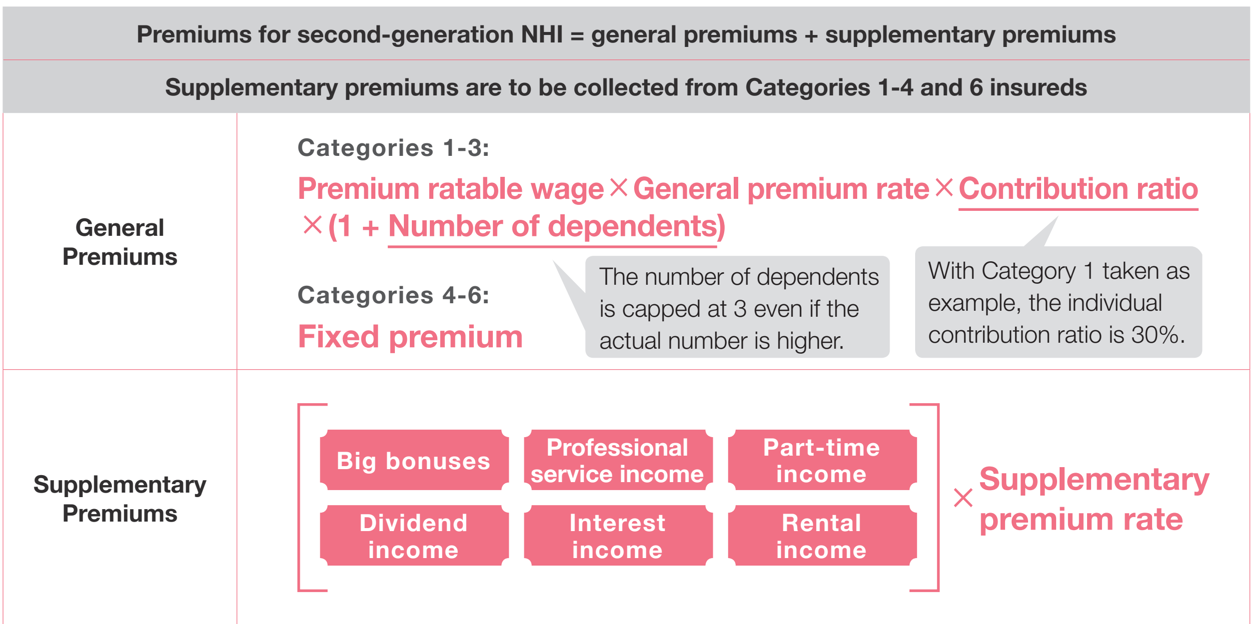
圖2-1　二代健保保險費示意圖

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, parttime 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 2022, NHI supplementary premiums amounted to around NT$73.09 billion, accounting for 7.70% of all premium income for the year.

Chart 2-1 Premiums for Second-Generation NHI

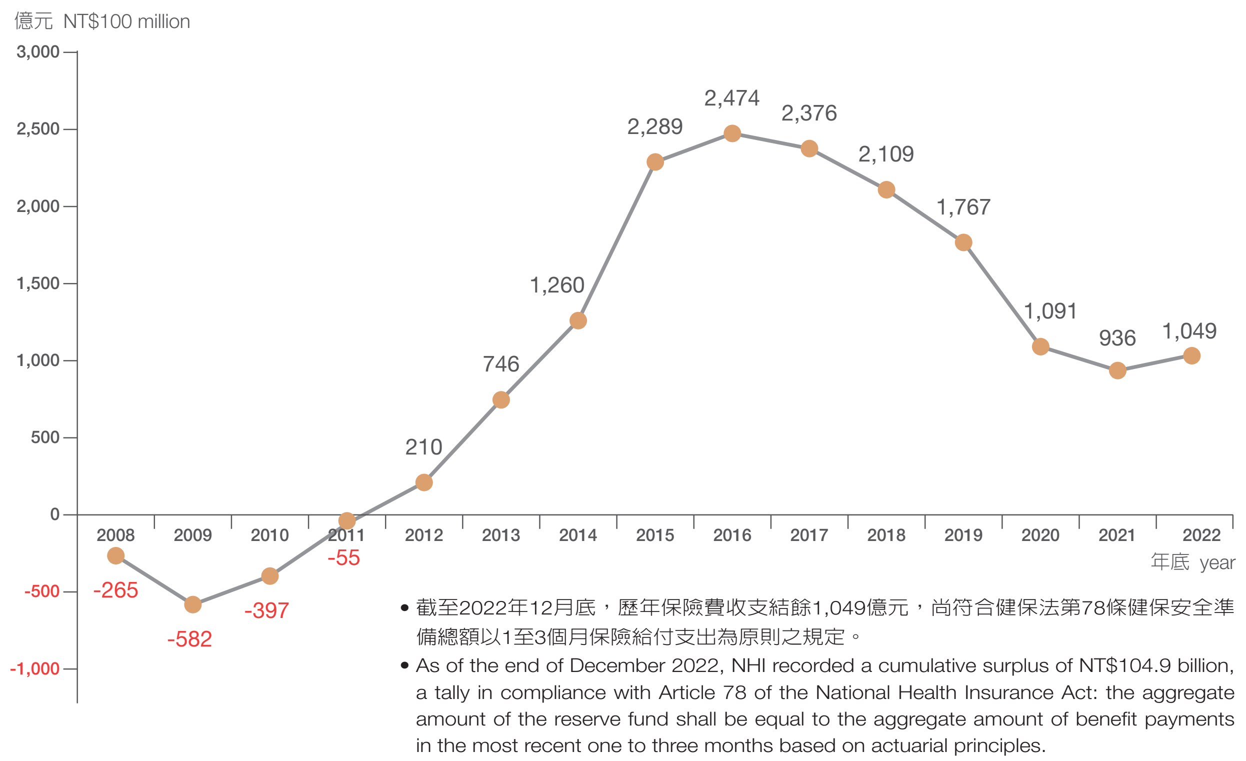


Premiums for second-generation NHI = general premiums + supplementary premiums	
Supplementary premiums are to be collected from Categories 1-4 and 6 insureds	
General Premiums	Categories 1-3: Premium ratable wage × General premium rate × Contribution ratio × (1 + Number of dependents) Categories 4-6: Fixed premium 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%.
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. Parttime 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



- 截至2022年12月底，歷年保險費收支結餘1,049億元，尚符合健保法第78條健保安全準備總額以1至3個月保險給付支出為原則之規定。
- As of the end of December 2022, NHI recorded a cumulative surplus of NT$104.9 billion, a tally in compliance with Article 78 of the National Health Insurance Act: the aggregate amount of the reserve fund shall be equal to the aggregate amount of benefit payments in the most recent one to three months based on actuarial principles.

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%.

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 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 2022, NHI recorded a cumulative surplus of NT$104.9 billion (Table 2-6).

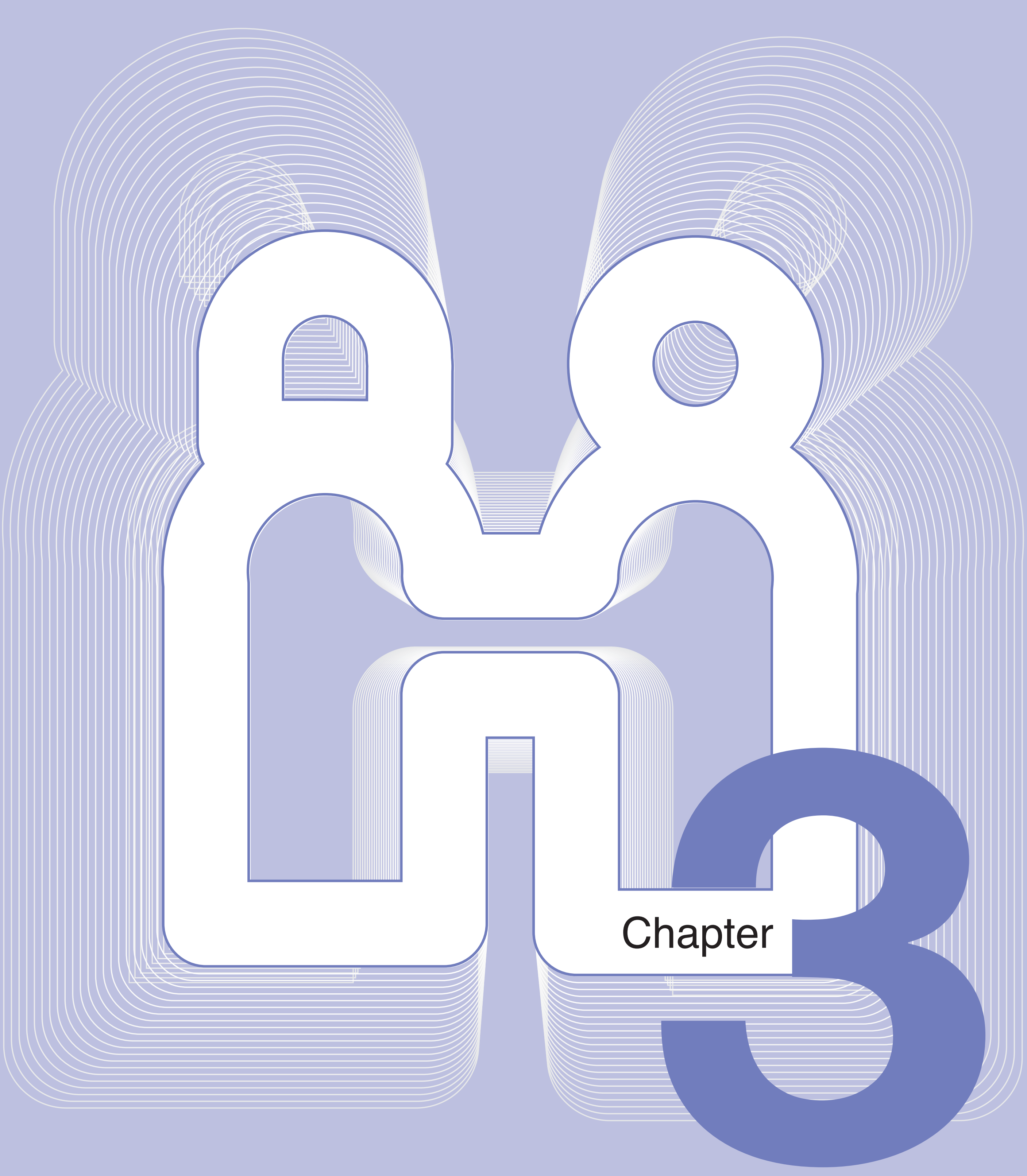
表2-6　最近5年全民健康保險財務收支狀況（權責基礎）

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 (%)		
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	13.40	7,274	4.60	-155	936
2022	7,603	6.81	7,491	2.98	113	1,049
1995/3~ 2022/12	124,398	-	123,349	-	-	1,049

說明：1. 資料截至2022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。
4. 部分資料因尾數四捨五入關係，致總數與細數之間，容有未能完全吻合情況。

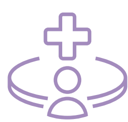
Notes: 1. Statistics as of December 2022.
2. NHI revenues = premiums + overdue charges + net investment income + contributions from public welfare lottery net revenues and the tobacco health and welfare surcharge + other net revenues – provisions for bad debts – interest expenses.
3. NHI expenditures = reimbursements of medical expenses+ other insurance expenses.
4. Discrepancies between totals and accumulations of individual numbers caused by rounding.



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前一季支付國內特約醫院及診所之平均費用為最高上限。

截至2022年12月底止，全民健保特約醫療院所合計達21,860家，占全國所有醫療院所總數92.04%（表3-1）；另有特約藥局7,184家、居家護理機構744家、精神復健機構250家、助產機構16家、醫事檢驗所217家、物理治療所32家、醫事放射所8家、職能治療所2家及居家呼吸照護所12家，保險對象可自由選擇醫療院所接受醫療照護服務。

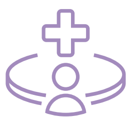
表3-1　全民健保特約醫療院所數

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	23,751	470	12,138	4	4,146	1	6,992
特約醫療院所數 Contracted Medical Institutions	21,860	470	10,665	4	3,881	1	6,839
特約率 Percentage of Contracted Institutions	92.04%	100%	87.86%	100%	93.61%	100%	97.81%

資料時間：2022年12月31日。
Data time: December 31, 2022.



Comprehensive Benefits and Convenient Access

Scope of Benefits

In case of illness, accident, or childbirth, insureds can use their NHI cards to receive healthcare at contracted medical institutions, including hospitals, clinics, pharmacies, and medical testing laboratories.

Currently NHI offers the following healthcare services: outpatient care, hospitalization, traditional Chinese medicine, dentistry, childbirth, rehabilitation, home care, and chronic psychiatric rehabilitation. The scope of medical payments under NHI includes diagnosis and treatment, examination, testing, surgery, anesthesia, drugs, materials, therapy, nursing, and insured beds. It's no exaggeration to say that all necessary diagnostic and treatment services are within the scope of 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 people are overseas and encounter emergency illness, injury, or 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. Nevertheless, the reimbursed expenses may not exceed the average expenses paid to domestic contracted hospitals and clinics in the preceding quarter.

As of the end of December 2022, there were a total of 21,860 NHI contracted hospitals and clinics, which accounted for 92.04% of all hospitals and clinics nationwide (Table 3-1). There were also 7,184 contracted pharmacies, 744 home care institutions, 250 psychiatric rehabilitation institutions, 16 midwifery institutions, 217 medical testing institutions, 32 physical therapy clinics, 8 medical radiological test institutions, 2 occupational therapy clinics, and 12 home respiratory care institutions. Insureds can thus freely choose the hospital or clinic at which they wish to receive healthcare services.

In 2022, the average number of per capita outpatient visits was 14.27, the average number of hospitalizations per 100 persons was 13.2, and the average number of days of hospitalization per capita was 1.24 days.

Adjust Copayments, Enforce the User-Pays Principle

NHI copayments are designed to be an important link in the social insurance system. They are also intended to stop insureds from thinking 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.

The NHIA is keen to encourage people to seek care at clinics when suffering from minor illnesses. Only when there is need for further examination or treatment should they secure a referral to a larger

2022年平均每人每年門診就醫次數14.27次，平均每百人住院次數13.2次，全國每人每年平均住院日數1.24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－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。2023年7月起，調整藥品部分負擔及急診部分負擔；門診藥品部分負擔調高醫學中心及區域醫院負擔上限，另醫院開立之慢性病連續處方箋第一次調劑比照一般藥品收取部分負擔，第二次以後調劑維持免收，為推動分級醫療及保障弱勢，本次基層診所、中低收入和身心障礙者均不調整。急診部分，為實務作業順暢並減少爭議，取消依檢傷分類計收規定，僅依就醫院所層級別收取部分負擔，將大型醫院資源保留給急重症病人。門診及住院部分負擔如表3-2至表3-4。

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10%調降為5%，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。

institution such as a regional hospital or medical center. On July 15, 2005, the NHIA thus introduced a system under which patients' copayments stay low when they comply with referral procedures while adjusting basic outpatient copayments accordingly at the same time. As such, the basic Western medicine outpatient copayment is calculated on the basis of either “no referral” or “referral.” 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 incur a fixed 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 need to undergo 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, a copayment of NT$50 must be paid for each session. Copayments are waived, however, in case of major illness/injury or childbirth, care in mountainous regions or on offshore islands, and other cases meeting NHIA requirements.

In June 2016, the NHIA started to promote a hierarchical referral system that encourages people to first seek care at a primary care hospital or clinic when they are ill and, when necessary, obtain a referral to an appropriate specialist hospital or clinic. This will strengthen large hospitals' focus on critical care and medical research, while allowing primary care hospitals and clinics to 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: the copayment at a medical center or regional hospital with a referral was reduced to NT$40 and the copayment at medical centers without a referral was raised to NT$60. Since July 2023, the copayment for OPD medication and emergency care will be increased, The copayment for outpatient medication will be increased, setting a higher limit for medical centers and regional hospitals. Additionally, for the first dispensing of chronic disease prescriptions issued by hospitals, copayments will be charged as for general medications. From the second dispensing onwards, copayments will be waived. In order to promote tiered medical care and protect vulnerable populations, there will be no adjustments for primary clinics, middle and low-income individuls and persons with disabilities.

Regarding the emergency department copayments, in order to streamline operations and reduce disputes, copayments will be based on the level of the treating hospital, with the aim of reserving resources in large hospitals for critically ill patients. The copayments for outpatient and inpatient services are detailed in Tables 3-2 to 3-4.

In addition, the copayments of patients seeking care in areas lacking medical resources are given a 20% discount; their home care copayment rate is also slashed to 5% from 10%. Such measures certainly benefit areas with shortages of medical resources and people who cannot easily travel to other places for medical attention.

Family Doctors and Community Pharmacies

To ensure that people can receive continuous, comprehensive healthcare nearby, the "NHI Family Doctor Plan" introduced in March 2003 allows five or more contracted Western medicine clinics in the same area to join a community hospital to form a community healthcare group. As long as people take physicians at a primary care clinic near their home as a family doctor, they can easily obtain first-line healthcare. Family doctors can provide

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. 持轉診單就醫後一個月內未逾四次之回診、門診手術後、急診手術後、生產出院後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. Outpatients' not more than 4 follow-up visits within one month of seeking medical attention with a referral and their first follow-up visit after outpatient or emergency surgery, within 6 weeks of hospital discharge after giving birth, or within 30 days after hospital discharge shall be considered to have a referral, and hospitals shall provide patients with proof of need for a follow-up.
3. This copayment schedule took effect on April 15, 2017.

表3-3　全民健保藥品部分負擔

Table 3-3　Copayment Rates for medication

藥品費用 **Medication fee**	應自行負擔費用 **Copayment**	
	西醫基層醫療單位/ 地區醫院/中醫 **Clinic/District Hospital/** **Traditional Chinese Medicine**	區域醫院/醫學中心 **Medical Center/Regional Hospital**
100元以下　Under NTD$100	0元　NTD$0	低收入戶/中低收入者/身心障礙者(註1) 0元　NTD$0 Low-income household[1]/near-poor household/Persons with disabilities 10元　NTD$10
101-200元　NTD$ 101-200	20元　NTD$20	20元　NTD$20
201-300元　NTD$201-300	40元　NTD$40	40元　NTD$40
301-400元　NTD$ 301-400	60元　NTD$60	60元　NTD$60
401-500元　NTD$401-500	80元　NTD$80	80元　NTD$80

<table>
<tr><th rowspan="2">藥品費用
Medication fee</th><th colspan="3">應自行負擔費用 Copayment</th></tr>
<tr><th>西醫基層醫療單位/
地區醫院/中醫
Clinic/District Hospital/
Traditional Chinese Medicine</th><th colspan="2">區域醫院/醫學中心
Medical Center/Regional Hospital</th></tr>
<tr><td>501-600元 NTD$501-600</td><td>100元 NTD$100</td><td colspan="2">100元 NTD$100</td></tr>
<tr><td>601-700元 NTD$601-700</td><td>120元 NTD$120</td><td colspan="2">120元 NTD$120</td></tr>
<tr><td>701-800元 NTD$701-800</td><td>140元 NTD$140</td><td colspan="2">140元 NTD$140</td></tr>
<tr><td>801-900元 NTD$801-900</td><td>160元 NTD$160</td><td colspan="2">160元 NTD$160</td></tr>
<tr><td>901-1,000元 NTD$901-1,000</td><td>180元 NTD$180</td><td colspan="2">180元 NTD$180</td></tr>
<tr><td>1,001-1,100元 NTD$1,001-1,100</td><td rowspan="6">200元 NTD$200</td><td>200元 NTD$200</td><td rowspan="6">低收入戶(註2)/
中低收入者/身心障礙者
200元
Low-income household[2]/near-poor household/Persons with disabilities
NTD$200</td></tr>
<tr><td>1,101-1,200元 NTD$1,101-1,200</td><td>220元 NTD$220</td></tr>
<tr><td>1,201-1,300元 NTD$1,201-1,300</td><td>240元 NTD$240</td></tr>
<tr><td>1,301-1,400元 NTD$1,301-1,400</td><td>260元 NTD$260</td></tr>
<tr><td>1,401-1,500元 NTD$1,401-1,500</td><td>280元 NTD$280</td></tr>
<tr><td>1,501元以上 More than NTD$1,501</td><td>300元 NTD$300</td></tr>
</table>

（一）保險對象持醫院開立之慢性病連續處方箋調劑（開藥二十八天以上），第一次調劑以當次調劑慢性病藥品費用與一般藥品費用併計應自行負擔之門診藥品費用。

（二）下列情形之一者，免計應自行負擔之門診藥品費用：

1. 接受牙醫醫療服務。
2. 接受全民健康保險醫療服務給付項目及支付標準所定論病例計酬項目服務。
3. 低收入戶、中低收入者及身心障礙者持慢性病連續處方箋調劑（開藥二十八天以上）。
4. 持西醫基層醫療單位及中醫門診開立之慢性病連續處方箋調劑（開藥二十八天以上）。
5. 持醫院開立之慢性病連續處方箋第二次及第三次調劑（開藥二十八天以上）。

註：1.「低收入戶」指合於社會救助法規定之低收入戶成員；「中低收入者」指符合社會救助法規定之中低收入戶及符合老人參加全民健康保險無力負擔費用補助辦法規定之年滿七十歲中低收入老人；「身心障礙者」指領有社政主管機關核發之身心障礙證明者。
2. 低收入戶應自行負擔之費用，依法由中央社政主管機關補助。
3. 其他保險對象門診應自行負擔之費用，依現行規定辦理。

1. For insured individuals who obtain chronic disease prescriptions from hospitals with a duration of 28 days or more, the outpatient medication expenses that need to be borne by themselves shall include the medication expenses for chronic disease and general medications incurred during the first dispensing.
2. The following situations are exempted from calculating the outpatient medication expenses that need to be borne by the insured individuals:
   a) Receiving dental services.
   b) Receiving services covered by the National Health Insurance medical service payment items and payment standards for specific cases.
   c) Low-income households, middle and low-income individuals, and persons with disabilities obtaining chronic disease prescriptions with a duration of 28 days or more.
   d) Obtaining chronic disease prescriptions from primary Western medicine clinics and traditional Chinese medicine clinics with a duration of 28 days or more.
   e) Second and third dispensing of chronic disease prescriptions from hospitals with a duration of 28 days or more.

Notes: 1."Low-income households" refers to members who meet the criteria of low-income households as defined by social assistance regulations. "Middle and low-income individuals" refers to those who qualify as middle and low-income households under social assistance regulations and elderly individuals over the age of 70 who qualify for fee subsidies under the National Health Insurance for the Elderly who are unable to afford the costs. "Persons with disabilities" refers to individuals who hold a disability certificate issued by the competent social welfare authority.
2. The expenses that low-income households need to bear shall be subsidized by the central competent social welfare authority according to the law.
3. Outpatient expenses for other insured individuals shall be borne by themselves according to current regulations.

表3-4　全民健保住院部分負擔

Table 3-4 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2023年以同一疾病每次住院上限為48,000元，全年累計住院上限為80,000元。

Note: In accordance with the Ministry of Health and Welfare's announcement, the copayment for each hospitalization for the same condition was capped at NT$48,000 in 2023; the annual limit of hospitalization copayments was NT$80,000.

未來將以家庭醫師計畫為基礎，透過4大面向打造「大家醫計畫」，包括：提升服務涵蓋率、數位化追蹤管理、支付制度調整、精進醫療品質，建構家醫大平台，落實全人全程健康照護理念。

截至2022年12月底，已有609個社區醫療群在運作，參與之基層診所5,678家，參與率為53.1%，參加醫師數7,833位，參與率為46%；透過社區醫療群受益者超過600萬餘人。

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。

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-Performance, P4P）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。

professional preventive care counseling, establish comprehensive medical data on their patients, and provide 24-hour healthcare service hotlines. If a patient's condition requires further examination, surgery, or hospitalization, a family doctor can give a referral, thereby reducing the time and expense spent on seeking a doctor.In the days ahead, the Family Physician Program will be expanded mainly on the following fronts: expanding service coverage, digitizing tracking and management, adjusting the payment system, and enhancing healthcare quality. This will establish a comprehensive platform for family medicine, thereby achieving the goal of holistic and lifelong healthcare for all individuals.

As of the end of December 2022, a total of 609 community healthcare groups had been up and running. They comprised 5,678 primary care clinics and 7,833 physicians, translating into participation rates of 53.1% and 46% respectively. More than six million people benefitted from these community healthcare groups.

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 counseling services. Pharmacies not only help ensure medication safety but also make medication use knowledge accessible to the public.

Diversified Payments

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 payment system plays an important role in achieving an effective, efficient, and equitable NHI system.

After the NHI system was initiated, it sought to quickly integrate the existing civil service, labor, and farmers' insurance systems. The fee-for-service approach was adopted as the major payment system. With the government employee and labor insurance fee schedule as the basis, revisions were made in accordance with the recommendations of medical groups alongside adjustments to the scope of insurance payments. However, this system tended to foster the unchecked growth of medical expenses and thus have a negative impact on healthcare quality.

Accordingly, the NHIA has taken its lead from leading countries in designing different payment methods based on the characteristics of different types of medical care. For instance, the NHIA has implemented the global budget payment system across the board since July 2002 while simultaneously employing 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 mountainous regions and on offshore islands has enhanced integration of medical service systems. Under the P4P plan,

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，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3-5。

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。

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

年度醫療給付費用總額，由主管機關於年度開始6個月前擬訂其範圍，經諮詢健保會後，報行政院核定 The competent authority determines the global budget for the year six months before the start of the year, and the global budget is approved by the Executive Yuan after consultation with the National Health Insurance Committee	健保會於年度開始3個月前，在行政院核定總額範圍內，協議訂定醫療給付總額及其分配方式 The National Health Insurance Committee determines the global budget within the scope approved by the Executive Yuan and its allocation through negotiations within three months before the start of the year	保險人於健保會協議訂定醫療給付總額後1個月，將保險費率提請審議 The NHIA submits the premium rate for review one month after the National Health Insurance Committee has set the global budget	健保會應於年度開始1個月前依協議訂定之醫療給付總額，完成該年度應計之收支平衡費率之審議 The National Health Insurance Committee must complete review of the premium rate needed to balance accrued revenues and expenditures for the year in accordance with the global budget it has set within one month before the start of the year	費率公告實施 Announcement and implementation of the premium rate
年度開始6個月前 Six months before the fiscal year begins	年度開始3個月前 Three months before the fiscal year begins	年度開始2個月前 Two months before the fiscal year begins	年度開始1個月前 One month before the fiscal year begins	不能於期限內完成審議時，由主管機關逕行報行政院核定後公告 When review cannot be completed within the allotted time, the competent authority shall directly announce the premium rate after reporting it to the Executive Yuan for approval

hospitals and clinics get paid based on their care quality and outcomes. To further enhance patient health and medical efficiency, the Taiwan Diagnosis Related Groups (Tw-DRGs) program was launched on January 1, 2010. The second stage of this program went into effect on July 1, 2014.

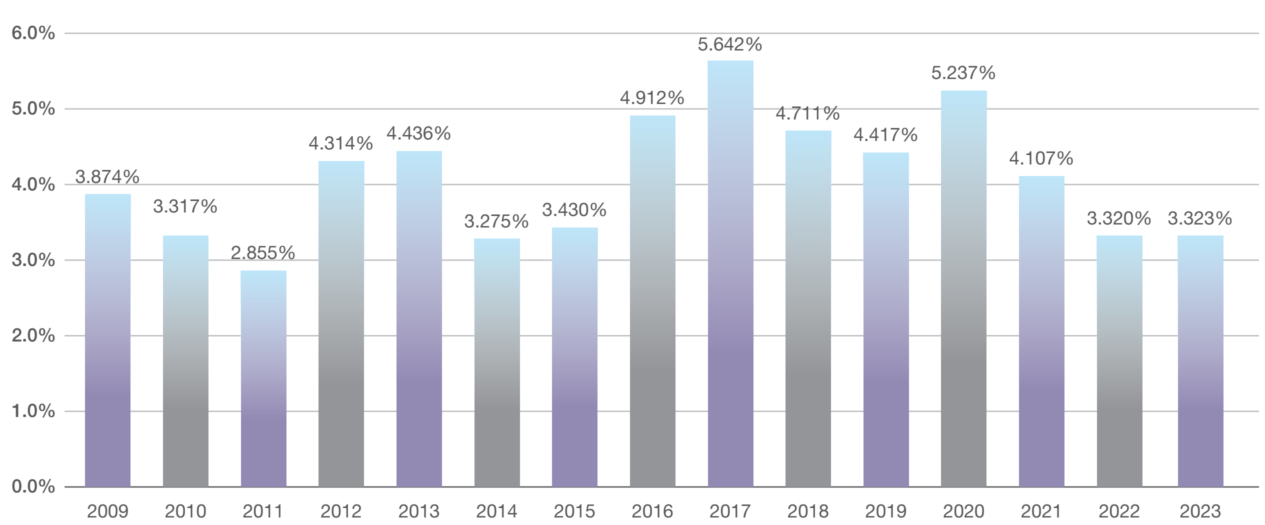
Global Budget Payment System

The NHIA started to phase in global budget payments for dentistry, traditional Chinese medicine, Western medicine primary care, and hospitals in 1998 before implementing the system across the board in 2002 in a bid to deliver efficient, high-quality medical care by drawing on NHI's limited resources. NHI's global budget drafting procedures are shown in Chart 3-1, the growth rates of negotiated total budgets over the years are shown in Chart 3-2, and the growth rates of such negotiated totals by sector after 2009 are shown in Table 3-5.

To keep intact the quality and scope of care available at medical institutions under the global budget payment system, the NHIA has also implemented quality assurance programs for global budget sectors when negotiating global medical expense budgets. These quality assurance programs include medical care quality satisfaction surveys, mechanisms for handling complaints and violation reports, 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. To ensure disclosure transparency, the NHIA has also posted medical care quality information on its website for the reference of hospitals and clinics in further improving healthcare quality.

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.

表3-5　全民健保歷年各總額部門醫療費用協定成長率

Table 3-5 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	2023
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	3.323
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	2.588
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	4.344
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	3.008
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	3.663

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2022年12月，支付標準共計有4,785項診療項目，經統計2004年至2022年12月，共計114次公告調整支付標準，另統計自健保開辦迄今，本署已陸續新增及調整支付點數，共計3,152項。

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16.14億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%。2021年投入約15億元保障區域級以上醫院加護病床之住院護理費以1點1元支應。2022年投入約30億元調升住院首日護理費支付點數30%，並保障區域級（含）以上醫院加護病床、地區醫院急性一般及經濟病床（含精神）之住院護理費以1點1元支應。2022年起編列3億元辦理住院整合照護服務試辦計畫。

Revision of the Fee Schedule

Since the inception of NHI, the NHIA has continually added diagnostic and treatment items that reflect advances in medical technologies and meet clinical needs, thereby fostering balanced development of medical care and giving local people access to the latest medical technologies. As of December 2022, the fee schedule covered a total of 4,785 diagnostic and treatment items after a cumulative 114 adjustments since 2004. Separately, changes have been made to payment points for a total of 3,152 diagnostic and treatment items since the launch of NHI.

To encourage hospitals to prioritize and hire more nursing personnel, the NHIA initiated the NHI Hospital Nursing Care Quality Improvement Program in 2009. As of 2014, this program had allocated NT$9.165 billion to encourage hospitals to hire more nursing staff and to improve nurse retention by increasing pay for night shifts and subsidizing overtime pay. In 2015, an additional NT$2 billion was set aside for adjusting hospital nursing fee rates. These measures have increased payment points and eased the burden on nursing personnel through linkage of payments and the nurse-patient ratio. The NHIA has used budgetary funds to adjust nursing fee rates on an annual basis. In the highlight is the provision of NT$1.8 billion in 2016 to adjust nursing fees for all types of patients, NT$198 million in 2017 to adjust hospital nursing fees at district hospitals, NT$372 million to improve critical nursing care quality and NT$614 million to adjust nurse-patient ratio-based fee standards in 2018, and NT$475 million in 2019 to increase hospital nursing fees for acute beds and economy beds (both include psychiatric beds). In 2020, approximately NT$1.614 billion was provided to increase nursing fees for various types of beds (apart from chronic beds), and nursing fees for isolation beds were increased by 27.65%. In 2021, around NT$1.5 billion was earmarked to support the nursing fees for intensive care unit beds in hospitals at the regional level and above, at a rate of NT$1 per point. In 2022, some NT$3 billion was set aside to sustain a 30% increase in the payment for the first day of hospital nursing fees and ensure that the nursing fees for intensive care unit beds in regional and higher-level hospitals, as well as acute general and economical beds (including psychiatric beds) in district hospitals, are covered at NT$1 per point. In 2022, another NT$300 million was allocated for the implementation of a pilot program for integrated care services during hospitalization.

As part of the push for tiered healthcare, the NHIA drew from increased funds from the “Medical consumer price index” in the hospital global budget to adjust payment points for acute/severe disease items (totaling NT$6 billion) and service items in remote areas and district hospitals (totaling NT$2.2 billion) in 2017. Beginning October 1, 2017, the payment points for 167 diagnostic and treatment items were increased, the markup method for children in 1,513 surgical items was relaxed, and general principles for surgery, markup time for emergency care on weekends and holidays, and pediatricians' markup were relaxed. In addition, payment points for 49 primary care diagnostic and treatment items at district hospitals and in remote areas were increased. The NHIA subsequently introduced the “additional weekend and holiday outpatient consultation fee at district hospitals” in 2018 and the “10% nighttime markup on outpatient consultation fees at district hospitals” in 2020. In 2021, the global budget for hospitals was increased on the basis of the “medical care services cost index change rate,” which increased emergency care fees and payment points for 400 critical diagnostic and treatment items. In 2022, the budget meant to “enhance the fees for intensive care services and promote structural

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。2022年以一般服務「提升重症照護費用，促進區域級（含）以上醫院門住診結構改變」預算用於提升重症照護費用，保障區域級（含）以上醫院加護病床之住院診察費及病房費採固定點值，及提升住院照護品質。

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2023年累計編列57.0億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項診療項目及2022年起開放「輸卵管剝離術」等3項診療項目及2023年起開放「頸動脈聲圖檢查」1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。

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。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，考量糖尿病及初期慢性腎臟病具多項共同風險因子，照護族群多有重疊或具因果關係，2022年3月1日起整併初期慢性腎臟病方案為「糖尿病及初期慢性腎臟病照護整合方案」，鼓勵院所組成跨疾病之整合性照護團隊提供服務；近年各方案之照護率如表3-6。

changes in outpatient and inpatient services in regional-level and higher hospitals" was used in increasing fees for intensive care services, ensuring fixed-point values for the inpatient examination fees and ward charges of intensive care beds at regional-level and higher hospitals, and enhancing the quality of inpatient care.

To boost the service capabilities of primary care clinics and increase their service scope, the NHIA provided NT$5.70 billion for expansion-schedule primary care items between 2017 and 2023. These included 25 items (including influenza A virus antigen test) in 2017, 9 items (including vaginal ultrasonography) in 2018, 11 items (including Lymphocyte surface marker for infectious disease detection) in 2019, 17 items (including activated partial thromboplastin time) in 2020, 5 items (including non-stress test) in 2021, 3 items (including salpingolysis with microscopic) in 2022, and 1 item (carotid phonoangiography) in 2023.

Pay-for-Performance Plans

NHI's pay-for-performance plans rely on adjustment of hospital and clinic medical expense payments to provide appropriate incentives for inducing medical care providers to offer comprehensive care. Healthcare quality and effectiveness are also taken as a basis for payments. Since October 2001, the NHIA has phased in pay-for-performance plans for cervical cancer, breast cancer, tuberculosis, diabetes, and asthma.

The cervical cancer 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 implemented in January 2010: for schizophrenia and for persons with HBV and HCV. In January 2011, another plan was introduced for early chronic kidney disease. This was followed by the inclusion of a pay-for-performance plan for chronic kidney disease in 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 from the Ministry of Health and Welfare's Medical Development Fund. A pay-for-performance plan for treatment of development retardation was added in October of the same year, followed by that for chronic obstructive pulmonary disease in 2017. In 2019, the NHIA launched the program on improving hospital medication safety and quality.

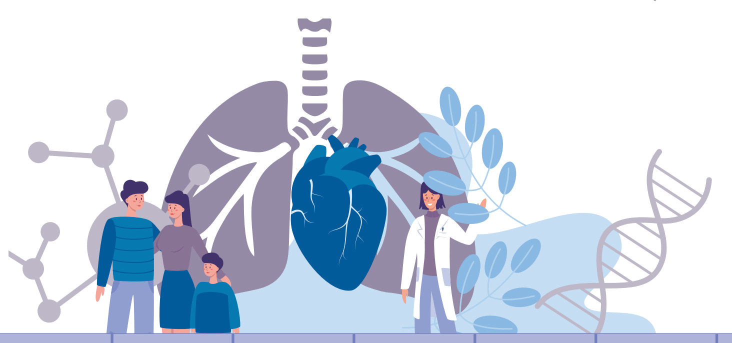
Patients enrolling in the hypertension plan commonly also suffer from concomitant diabetes and chronic kidney disease. Since 2013, these conditions have been removed from the list of independent items and included in other pay-for-performance plans instead to consolidate care. Implementation of the diabetes pay-for-performance plan has yielded favorable results, and the plan was included in fee schedules and implemented on a full scale in October 2012. Taking into consideration the multiple common risk factors between diabetes and early-stage chronic kidney disease, the care groups often overlap or have a causal relationship. Beginning March 1, 2022, the "Diabetes and Early-stage Chronic Kidney Disease Integrated Care Program" was implemented to encourage healthcare institutions to form interdisciplinary care teams to provide services. The care rates of each plan in recent years are shown in Table 3-6.

表3-6　全民健保醫療給付改善方案照護率

Table 3-6 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 of 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						
糖尿病合併初期慢性腎臟病 **Diabetes combined with early-stage chronic kidney disease**							

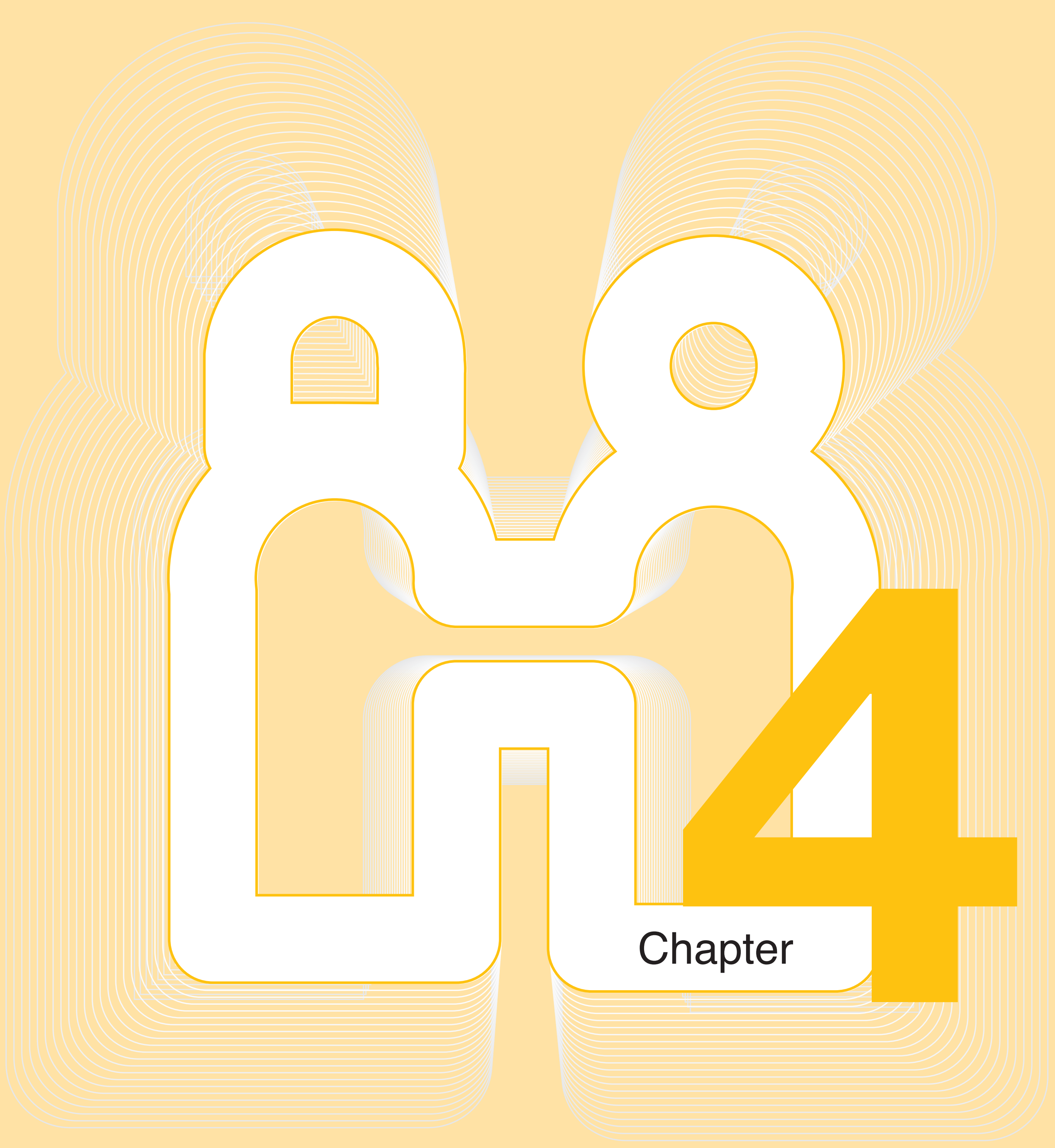
註：高血壓方案自2006年起於西醫基層開始試辦，2007年則擴大至醫院，其照護率因涵蓋基層診所及醫院，呈現照護率下降情形，又因病人常合併多重疾病，例如糖尿病、慢性腎臟病等，故未再以疾病別單獨另列計畫追蹤，自2013年起停止試辦。慢性阻塞性肺病自2017年4月實施，糖尿病合併初期慢性腎臟病照護自2022年3月起推動。



單位：% Unit: %

2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
39.3	37.5	41.9	36.0	28.2	29.5	35.1	35.6	38.3	41.1	38.6
33.9	35.1	41.9	41.1	43.4	47.9	51.3	55.4	58.0	59.9	60.3
-	-	-	-	-	-	-	-	-	-	-
13.4	13.1	10.9	10.6	9.7	8.2	7.7	7.3	7.1	7.0	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	59.3
26.1	30.6	37.2	32.6	35.3	36.6	39.9	41.5	41.5	42.4	43.6
26.4	32.1	26.7	38.5	42.1	41.8	30.0	30.9	33.5	34.2	33.1
金支應 Medical Development Fund			29.3	29.5	32.3	33.4	33.3	34.0	29.9	21.3
				15.3	14.9	13.2	11.5	11.0	13.2	7.3
					24.3	38.5	35.4	40.3	45.6	48.3
										10.9

Note: The hypertension plan was first implemented on a trial basis at the primary care level in 2006, and was expanded to include hospitals in 2007. Because of the plan's coverage of both primary care clinics and hospitals, the care rate displays a decreasing trend. As hypertension is commonly accompanied by diabetes and chronic kidney disease among others, trial implementation of the hypertension plan was ended in 2013 and tracking of hypertension cases under an individual plan was discontinued. The chronic obstructive pulmonary disease plan was implemented in April 2017, and the plan for diabetes combined with early-stage chronic kidney disease was introduced in March 2022.


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。

全民健康保險醫療費用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，啓動相關措施，避免醫療資源浪費。

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. An average of approximately 356 million outpatient reimbursement claims are made every year, and roughly 970,000 such claims are made every day. That some 3.28 million inpatient care claims are made every year works out to roughly 9,000 such claims every day. Based on manpower and administrative cost considerations, two types of medical care review can be employed: procedural review and professional review. Computer technology and data analytics are used extensively in these review processes, and the 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 review. 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 discard rate found in random sampling review is used to infer the discard rate in the entire case population. Because purposive sampling review focuses on all cases with certain characteristics, their results are not used for inferential purposes.

Directions of National Health Insurance Claims Review are adopted 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. Since 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 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 NHI database. Thanks to digitization, the NHIA can quickly and efficiently review reimbursement claim data from hospitals and clinics, and can discover any abnormalities. In addition, analysis of the NHIA's vast amounts of accumulated data can assist the drafting of policies, and facilitate the initiation of preventive measures against the waste of medical resources.

Automated Review System

The NHIA has established automated review procedures that focus on payment regulations such as NHI medical care payment items and fee schedules, and specific no-payment rules (such as age, gender, and specialist physician restrictions). Computer programs are used to check medical orders, and can directly weed out medical order items not eligible for payment. This approach has

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等給付規定，明確規範不給付醫令項目（例如年齡限制、性別限制、專科醫師限制等），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。
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。
   (1) 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。

been gradually enhancing the accuracy 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. To date the NHIA has taken the following measures:

1. Statistical analysis is employed to detect irregularities in patient care, diagnosis and treatment patterns at hospitals and clinics, and in 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 individual cases to 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, thus 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 following five areas: outpatient care, inpatient care, medication, specific diagnosis and treatment, and specific case lists.

Assisted Professional Review

While the NHIA has been promoting computerized review processes since 2014, priority is given to strengthening the capacity of the “Intelligent Peer Review Learning System (IPL) for information integration. 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 perform review with efficiency and precision.

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 their identities, the NHIA initiated a named double professional review program on a trial basis for reviews within the scope of hospitals' global budgets in October 2016. The NHIA hopes that named reviews will reduce differences between professional opinions and enhance the rationality of curtailing medical expenses. This program has the following features:

1. Double professional review: Such review may be adopted to ensure that all medical specialties comply with specific conditions. The physician performing the second review may refer to the opinions of the first reviewing physician, but the results obtained by the second reviewing physician shall generally form the basis for

(2) 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10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啟動每年一次之藥價調整，讓藥費維持於穩定及合理範圍。

rejection of claims. Still, 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. After relevant units express willingness to provide a list of names, such lists will undergo evaluation before the districts and departments eligible for 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. Clinical physicians can then consult the list of expert group members who have allowed their names to be disclosed. The agreement rate now stands at around 60%.

Disclosure of Medical Quality Information

Established in 2005, the NHIA’s healthcare quality information disclosure platform is intended 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 for the reference of healthcare choices. In the highlight are professional healthcare quality reports, healthcare quality indicators for each contracted hospital and clinic, service indicators, and indicators for specific illnesses. Such information can give members of the public a better understanding of the state of healthcare quality in Taiwan.

Furthermore, the NHIA’s website also offers other basic information of contracted medical institutions, such as service items, medical departments, fixed visit hours, insured bed ratios, and registration fees, as well as information on medical institutions that have violated applicable regulations.

Reasonable Drug Price Adjustments

Under the current drug payment system, medical institutions are supposed to make reimbursement claims to the NHIA in accordance with drug dispensing items and fee schedules. Next, the NHIA will obtain the actual transaction prices through periodic drug price surveys so as to adjust the drug payment prices to make them closer to the market prices of the drugs.

Beginning 1999, the NHIA's reduction in drug prices on the basis of survey results has reduced drug pricing differences and eased the growth in medication expenditures. The money saved from reductions in drug prices can be used to accelerate the entry of new drugs and approval of payment, expand the scope of drug payments, and adjust items with low fee rates. This has allowed people in Taiwan to obtain drugs concurrently with the world's leading nations, while also improving healthcare quality and achieving tangible improvements in people's health.

To maintain control over NHI drug costs as a whole, the NHIA implemented the “NHI Drug Expenditure Allocation Ratio Target System” on a trial basis on January 1, 2013. This system presets target values for annual drug expenditures and ties them to actual drug expenditures each year. When the said target values are exceeded, the system

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。2021年10月起開放醫師不限科別都能開立C肝全口服新藥。2017年至2022年已投入約358.51億元預算用於給付C型肝炎用藥之治療，近6年來約有14.7萬人受惠。為達到2025年臺灣消除C肝的願景，持續編列充足治療經費，2023年預算共45.32億元，約可讓3.2萬人接受治療。

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。

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，腦脊髓液分流系統於2015年6月1日收載為民眾自付差額特材，考量具有臨床需要性，經評估後先將其中市占率最高的調控式腦室腹腔引流系統—流速控制型或可調適壓力閥（不具抗虹吸功能）類別，於2022年11月納為全額給付。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。

automatically activates an annual adjustment of drug prices, thereby ensuring that they stay within a stable, reasonable range.

Payment for New Oral HCV Medications

Treatment of hepatitis C used to require weekly injection of pegylated interferon, combined with daily oral ribavirin for six months to one year. But now direct-acting antiviral agents for hepatitis C can increase the odds of a cure, reduce side effects, and shorten the treatment process. NHI has covered these drugs since January 2017, and a special fund has been allocated out of the total health insurance medical expenses specifically for hepatitis C treatment. Beginning in October 2021, physicians can prescribe all oral new drugs for liver C regardless of discipline. From 2017 to 2022, NT$35.851 billion went toward provision of hepatitis C drugs. Some 147,000 people benefitted during this six-year period. To achieve Taiwan's vision of eradicating hepatitis C by 2025, the NHIA is set to persist with adequate funding on this front. As such, NT$4.532 billion was appropriated for 2023, thanks to which about 32,000 people would be able to receive treatment.

Medical Devices Covered via Balance Billing

More and more new medical devices have come into use thanks to the industry’s rapid development. Aware that people’s medical needs are changing with the times, the NHIA is gradually covering new medical devices as NHI special materials (medical devices covered by 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. To give the public access to appropriate, effective new medical devices, the NHIA has added nine categories for coverage via balance billing since 1995. They are 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 any balance billing special materials, 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 were included for coverage as a balance billing special material on August 1, 2017. Thanks to their ubiquity in clinical applications, the NHIA decided to provide full coverage in December 2018. Furthermore, the cerebrospinal fluid (CSF) shunt system was included as a balance billing special material on June 1, 2015. As clinical demand grew, the NHIA decided to offer full coverage for the adjustable shunt system—the variety enjoying the highest market share—either of the flow-regulated type or with a programmable valve (without anti-siphonage capability) in November 2022. In 2020, the NHIA started to reform the balance billing system for special materials by setting reasonable ratios of differential expenses to NHI payment for items according to empirical support of their clinical effectiveness. While taking NHI finances into consideration, the NHIA hopes to have more new medical devices covered via balance billing, thereby giving people greater access to innovative medical devices.

In order to protect the public's rights and interests, the NHIA was joined by pertinent associations and

表4-1　民眾關心之自付差額特材一覽表

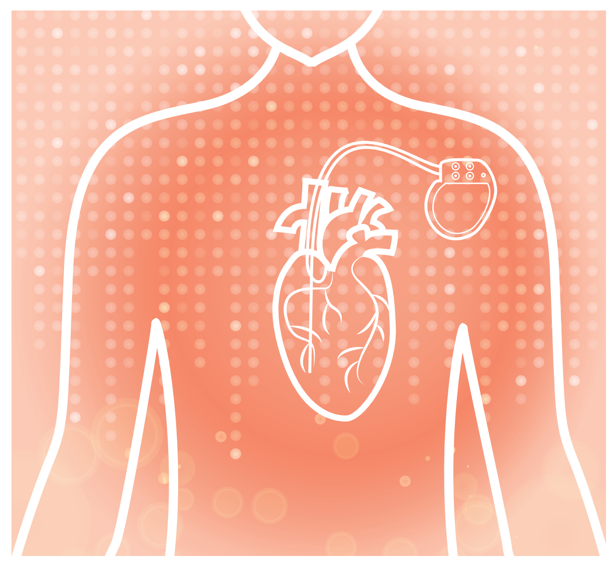
Table 4-1 Special Medical Devices Covered via Balance Billing

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 Valve	2014/06/01
腦脊髓液分流系統 Cerebral Spinal fluid shunt System	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

醫療科技評估提升健保給付效益

隨著醫療科技日新月異，新藥及新醫材不斷推陳出新，2022年健保支出藥品費用約2,300億點，特材費用約350億點，在健保資源有限的情況下，如何決定新醫療科技的臨床經濟效益納入健保給付，需要一個良好的評估工具。

健保署為精進健保給付效益之管理，並與國際接軌，自2008年起導入醫療科技評估管理（Health Technology Management, HTM）中之醫療科技評估（Health Technology Assessment, HTA），就新藥物進行人體健康、醫療倫理、醫療成本效益及健保財務等面向評估，以輔助新藥物納入健保收載之決策，並於2020年起循環式管理，透過前瞻式評估（Horizon Scanning, HS）瞭解新藥物上市到健保決定收載前之臨床使用情形與需求，並蒐集真實世界實證資料（Real World Data），對於健保已收載品項就臨床療效、成本效益、安全性及財務影響等面項進行醫療科技再評估（Health Technology Reassessment, HTR），透過從健保給付前至給付後之成本效益循環式管理，使健保資源有效合理配置，進而提升健保給付效益。

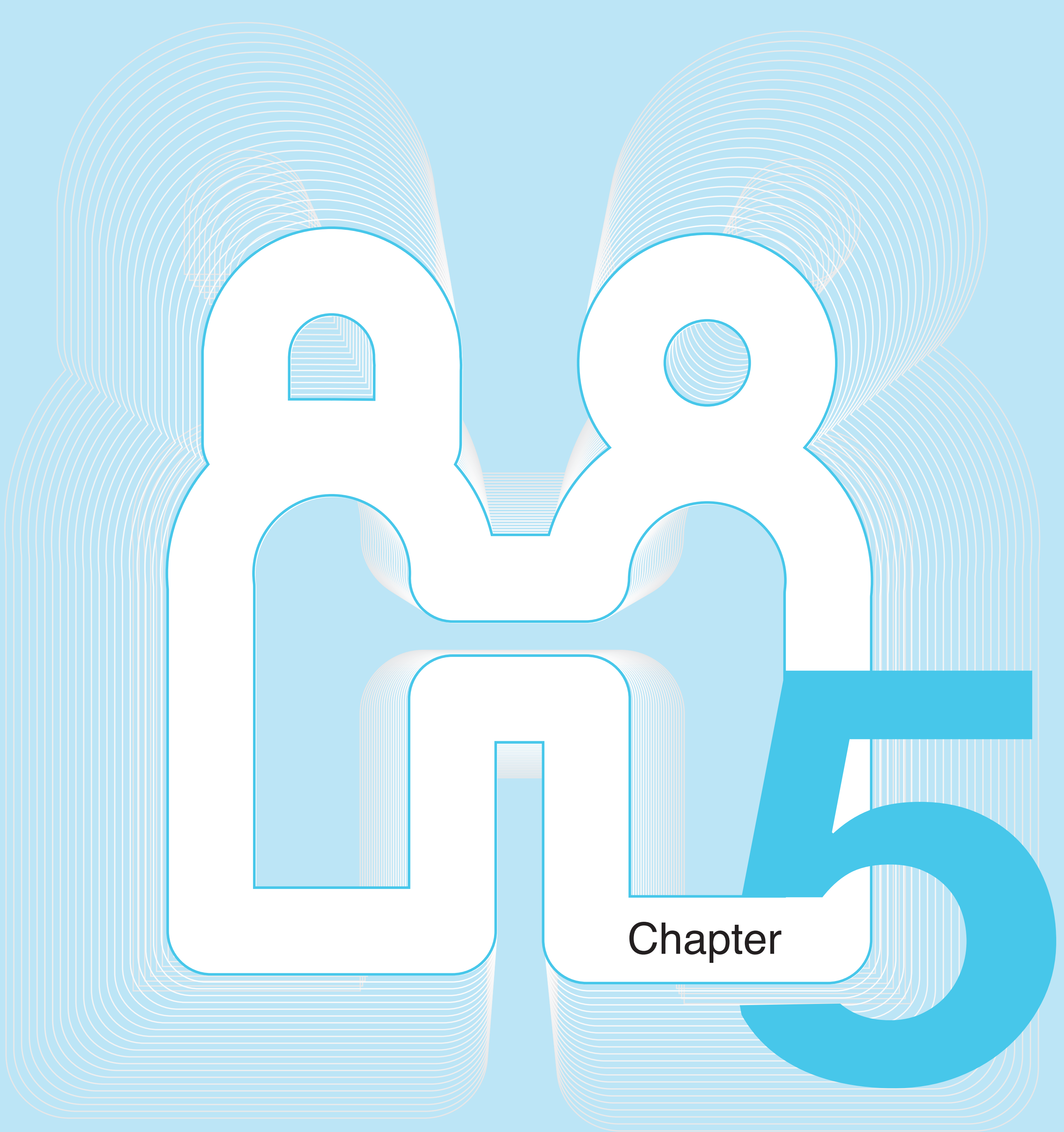


societies for a review of special materials (with the exception of prosthesis) covered via balance billing prior to December 31, 2019. Based on their classification by function and material, an easy-to-use explanatory document is compiled for the public's reference. Also provided are what experts believed to be the reasonable extreme prices for different categories. Beginning August 24, 2020, devices in these categories were put under management in keeping with the spirit of professional autonomy. Meanwhile, the Medical Care Act stipulates that hospitals and clinics must give the public full access to pertinent information before any surgery or other treatment. Also, hospitals and clinics must place the names and item codes of special materials covered via balance billing, 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 at other easily visible locations. Furthermore, the NHIA also lists price and function information for special materials covered via balance billing and other fully covered special materials on its website. People can visit 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.

Raise NHI Payment Efficiency via Health Technology Assessment

Given the rapid advances in medical technologies, new drugs and medical devices are constantly emerging. In 2022, some 230 billion NHI points and 35 billion points were spent on drugs and special materials respectively. In light of NHI's limited resources, it is crucial to have a robust assessment tool to determine the clinical and economic benefits of new medical technologies for NHI coverage.

To better manage NHI payment and align with international standards, the NHIA ushered in health technology assessment (HTA), a key component of health technology management (HTM) in 2008. HTA evaluates new drugs from various aspects, including human health, medical ethics, cost-effectiveness, and financial impact on NHI. It assists in the decision-making process regarding the inclusion of new drugs for NHI coverage. Under the cyclical management approach adopted in 2020, horizon scanning (HS) is used to understand the clinical usage and demand of new drugs before their inclusion in NHI coverage. Real-world data is collected, and health technology reassessment (HTR) is conducted for NHI-covered items to reassess their clinical efficacy, cost-effectiveness, safety, and financial impact. Through this cyclical management approach, from pre-coverage assessment to post-coverage evaluation of cost-effectiveness, the efficient and rational allocation of NHI resources is achieved, ultimately enhancing the effectiveness of NHI coverage.


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」，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。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，強化用藥安全環境。

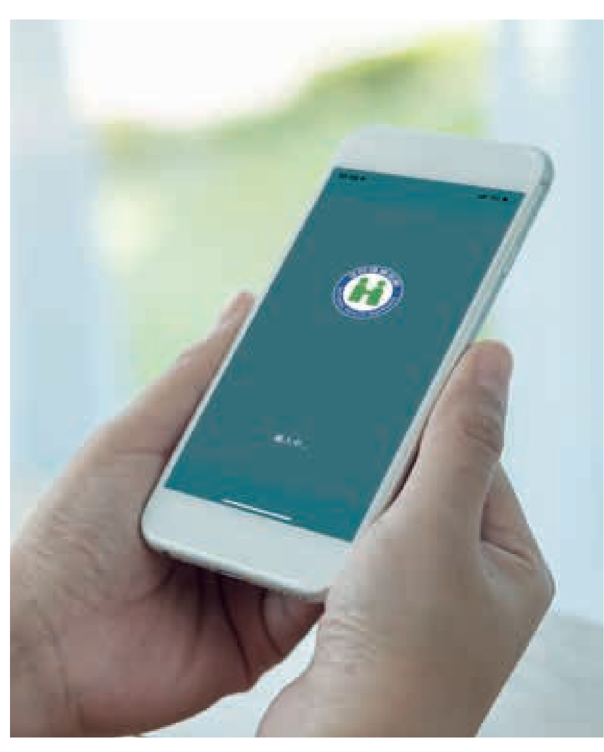
基於前述推動基礎，健保署參考使用者回饋意見及臨床實務需求，自2015年起擴大發展「健保醫療資訊雲端查詢系統」，增建中醫用藥紀錄、檢查檢驗紀錄、檢查檢驗結果（含醫療影像、國民健康署成人預防保健及四癌篩檢結果）、手術明細紀錄、牙科處置及手術紀錄、過敏藥物紀錄、特定管制藥品用藥紀錄、特定凝血因子用藥紀錄、復健醫療紀錄、出院病歷摘要及疾病管制署預防接種紀錄等共12類主題式資料，以及設置專區呈現B、C型肝炎就醫資訊、特殊給付限制就醫資料等。並發展提示功能、友善查詢介面及主動提醒機制，以縮短使用及閱讀所需時間，並有助於醫師、藥師（藥劑生）及特定醫事人員臨床處置專業判斷，提供病人更好的照護品質。

Health Technology and Value-Added Services

NHI MediCloud System for Sharing Information Anytime, Anywhere

NHI has accumulated over 20 years of health insurance reimbursement claim data, which may well form Taiwan's largest database. With big data coming under the spotlight in recent years, the NHIA has begun to gradually compile data from various fields, and makes use of cloud technology to provide doctors with 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," allowing contracted medical institutions to immediately access patients' medication records of the previous six months for diagnostic or treatment purposes. Such information can be of great value to doctors in making out prescriptions or to pharmacy personnel in providing medication counseling to patients, thereby enhancing healthcare quality and reducing the redundant consumption of medical resources. By integrating information from the NHI PharmaCloud System with in-hospital information systems, contracted medical institutions gradually established their own dedicated in-hospital medication management mechanisms, thereby enhancing medication safety.

Based on the NHI PharmaCloud System, starting in 2015, the NHIA developed the expanded "NHI MediCloud System" after referring to users' feedback and clinical needs. The "NHI MediCloud System" incorporated 12 types of thematic data, including medication records, Chinese medicine use records, examination and test records and results (including medical care imaging as well as 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, records on use of specific controlled drugs, records on use of drugs for specific coagulation factors, rehabilitation records, hospital discharge summaries, and Taiwan Centers for Disease Control's vaccination records. Additionally, the system incorporated special sections meant for medical records regarding Hepatitis B and C as well as special payment restrictions. NHIA also offers a prompt function, a user-friendly query interface, and active reminder mechanisms to shorten users' reading time, therefore helping physicians, pharmacists, and other medical professionals to make clinical treatment judgments and to provide better quality care to patients by using this system.



雲端加值服務　健康存摺運用

為控制不必要的檢驗檢查及用藥，健保署自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，運用視覺化資訊圖表，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，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年截至2022年12月31日止，健康存摺使用人數約1,090萬人，使用人次已達3億642萬人次。約9成使用者認同透過健康存摺可了解個人就醫情形，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。

(1) 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，可透過大數據分析了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

Value-Added Cloud Services: My Health Bank

The NHIA has encouraged hospitals and clinics to upload patients' testing and examination results since 2015 in a bid to curb unnecessary tests, examinations, and medications. Beginning January 2018, after patients have undergone CT, MRI, ultrasound, gastroscopy, colonoscopy, and x-ray examinations 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. Meanwhile, 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 service—My Health Bank—enables people who have registered their NHI cards to log into the system and make queries therein. Drawing on easy-to-understand charts and tables, My Health Bank allows users to quickly view and understand their most recent healthcare records, testing and examination results, and preventive care data, thereby helping them monitor health status and perform health management. Members of the public can also download My Health Bank data for other applications or use a mobile device to log into the app and access their personal healthcare data for the reference of physicians during visits. In turn, this goes a long way toward improving the information asymmetry between doctors and patients and enhancing medical care safety and effectiveness.

My Health Bank's user base has increased steadily since its introduction in 2014. As of December 31, 2022, it had accumulated approximately 10.9 million users, and had been used more than 306.42 million times. Roughly 90% of users agree that My Health Bank can help them understand their healthcare situation and monitor their state of health. As such, it is fair to say that My Health Bank can significantly promote better health self-management among the public.

Apply AI to Enhance Precision of NHI Review

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 draws on big data analysis to actively provide prompts indicating various review focal points in the professional review system. Take medical expense cases as an example. The system will automatically indicate whether a contracted medical institution is a target for randomly conducted irregularity screening and the reason for such screening, the medical institution's various medical utilization statistics, and its record of medical expense reductions. Take cases involving prior review as another example. The system will automatically single out cases in which immunotherapy drugs for cancer cannot be used in combination with targeted drugs or immunotherapy drugs cannot be used to treat rheumatoid arthritis, as well as other information such as rheumatic disease medication history and test results. Such information can help reviewing physicians quickly grasp focal

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。

(2) 特約醫事服務機構申報後的送審影像重複或相似度偵測：

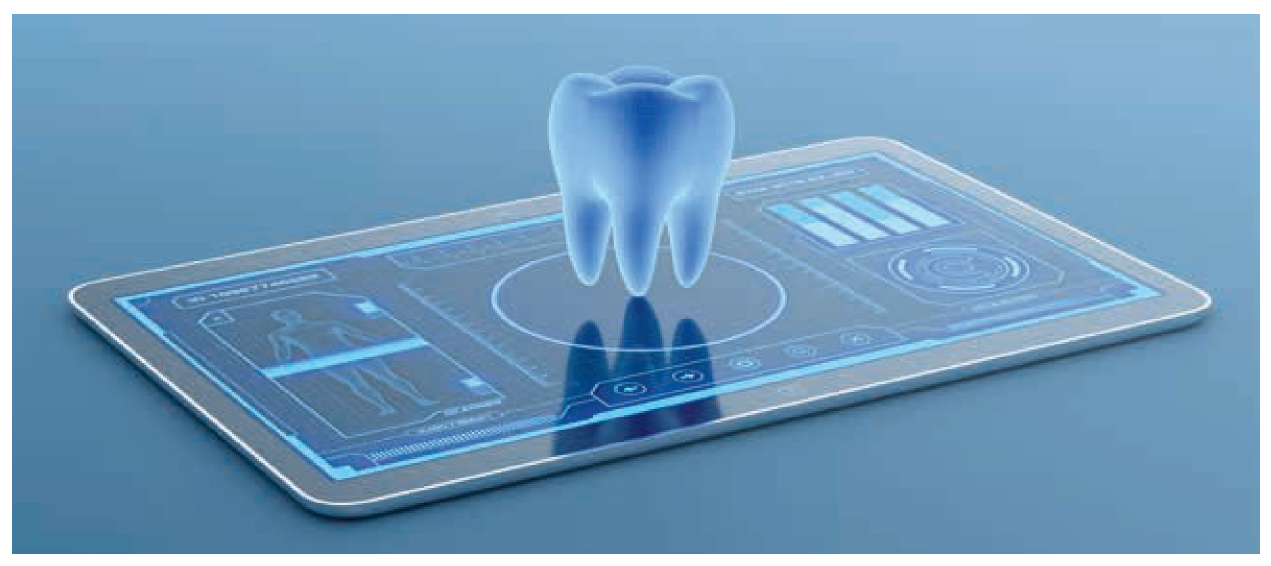
運用AI技術自行開發重複醫療影像偵測、牙科影像及白內障影像相似度偵測等審查輔助工具，能將影像自動分群，在5秒內完成1千張影像重複偵測、6分鐘完成1千對牙科及白內障影像相似度偵測，輔助審查醫師快速判讀是否有不同個案送審重複及相似度高的影像之異常情事。

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。

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；建立個人病歷附件歸戶平台，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



points while simplifying manual operations such as going through patient records and checking payment regulations.

2. AI-Assisted Precision Review

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

(1) Monitoring of the quality of images and reports uploaded by contracted medical institutions before filing a claim:

Contracted medical institutions are encouraged to promptly upload data such as medical images, text examination reports, and test results. For its part, the NHIA has established an upload quality monitoring system specifically for text reports on CT and MRI examinations and hepatitis C and kidney function test results. 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 data is consistent with the corresponding care order item, whether text imaging reports contain discoveries or conclusions, and whether any test values are null. 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 repetition or similarity of images uploaded by contracted medical institutions after filing a claim:

The NHIA draws on AI technology to develop supplementary tools for detecting repetition of medical images and similarity of dental and cataract images. Capable of grouping images automatically, these tools can undertake repetition detection of 1,000 images in five seconds, and can complete comparison of 1,000 pairs of dental or cataract images for similarity in six minutes. As such, they can greatly help reviewing physicians quickly determine whether cases have been sent repeatedly for review and whether there are any images with an abnormally high degree of similarity.

Enhance Efficiency via Electronic Claims

Since the introduction of NHI, the NHIA has encouraged contracted medical institutions to use the Internet, media, or the NHI VPN to report reimbursement claims. Statistics show that contracted medical institutions now file close to 100% of such claims electronically.

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 filing expense claims.

In September 2006, the NHIA established an online professional review system, thus ushering in an online environment for the professional review of medical expense claims (including texts and images). The NHIA's "Picture-Archiving and Communication System" (PACS) was adopted for transmitting image files for cases submitted for review. Meanwhile, a platform for consolidating individual patient records

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。

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。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。

and attached files was set up to create a premium working environment for reviewing physicians. In 2017, the NHIA completed a centralized medical image and associated e-file management system while enhancing its data processing capability for pre-review and medical expense sampling review cases. Professional reviews 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 to the NHIA's internal medical payment system. As such, review procedures as a whole have been more fully automated, 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, the NHIA's IC Card Data Center (IDC) has been designated as the single entry point for all claims reporting by contracted medical institutions. To meet their operating needs, the NHIA has also made it a point to provide contracted medical institutions with more readily accessible electronic reporting services.

Accelerate Digital Management of NHI Cards

Smart NHI cards were formally introduced on January 1, 2004 in an effort to make people's access to medical care more convenient. These IC cards integrate the medical records and information originally contained in paper NHI cards, children's health booklets, maternal health booklets, and catastrophic illness certificates; 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. Although it takes approximately 2-3 days for data 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.

Hospitals and clinics are required to record people's care records on their NHI cards and transmit this information to the NHIA within 24 hours. In turn, the NHIA can readily compile statistics on daily outpatient visits and inpatient person-times, and promptly detect, track, and correct any irregular medical actions. Furthermore, data on organ donation, hospice and palliative care wishes, and advance medical decisions can also be recorded on NHI cards.

Multiple Mechanisms for Ensuring Information Security

NHI cards can not only help 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.

NHI 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 further strengthen NHI card and health insurance data security, the NHIA established an information security task force in August 2003 to bear responsibility for relevant tasks and promote certification. In addition, the NHIA has established an information security management system (ISMS). The NHIA's information security measures also include

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，系統視窗即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2022年12月為止，TOCC提示之總查詢次數已高達近20.8億人次。

隨著疫情變化，TOCC提示已陸續退場（參考圖5-2），惟考量醫師診療COVID-19確診者及照護長新冠個案需要，健保署運用數位科技整合跨部會資料，於雲端系統提供病人COVID-19相關檢驗結果、口服抗病毒藥物領用情形及藥品交互作用查詢、臺灣清冠一號領用情形等，提供醫事人員充分參考資訊，讓病患得到適切的診療照護。

2. 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。

依嚴重特殊傳染性肺炎中央流行疫情指揮中心111年4月25日肺中指字第1113800165號函，因應COVID-19社區流行疫情，為減輕大規模疫情期間基層院所及公衛端負荷，爰自111年4月25日起停止辦理本項作業。

3. 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，配合嚴重特殊傳染性肺炎中央流行疫情指揮中心（下稱指揮中心）防疫政策，健保署公告「因應COVID-19疫情全民健康保險特約醫事服務機構提供保險對象視訊診療作業須知」，實施期間至指揮中心解散日止。2020年2月起，居家隔離、居家檢疫、自主健康管理保險對象或居家照護之確診病例，持續依指揮中心政策提供視訊診療服務，另考

the establishment of a single network entry point, in-depth defense mechanisms, and various detection and defense mechanisms (such as SOC, firewalls, e-mail filters, intrusion detection, application system firewalls, anti-virus/anti-spyware software, and advanced continuous threat and attack prevention measures). Meanwhile, there is constant network and e-mail security monitoring, and personal information fields in databases are stored in encrypted form, thereby ensuring the NHIA's overall information security.

Apply NHI Cloud Technologies to Tackle Pandemic

As the COVID-19 pandemic ravaged the world in 2020, Taiwan's NHI system played a key role in epidemic prevention. The NHI database and cloud system established over the years proved an effective tool not only in containing the pandemic but also in allowing medical institutions to exchange all necessary information during this critical period of time. To be sure, the NHIA took various epidemic control measures in accordance with the Communicable Disease Control Act and the Special Act for Prevention, Relief and Revitalization Measures for Severe Pneumonia with Novel Pathogens. The ultimate goal is to maximize the benefits of public health and safety while keeping intrusion of privacy to a minimum.

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

Following the outbreak of the COVID-19 pandemic worldwide in early 2020, the NHIA cooperated with the Central Epidemic Command Center and had its VPN and NHI MediCloud System—already widely used across medical institutions—incorporate prompts with regard to people's history of travel to Wuhan and listed contacts with confirmed cases. When a patient's NHI card was inserted into a reader, the cloud system would immediately display a window reminding hospitals and clinics to pay attention to the patient's condition. Subsequently, in line with general epidemic prevention efforts, the NHIA gradually expanded this system to encompass individuals' history of travel to all countries, high-risk occupation and cluster history, notices of referral for specimen collection and testing, as well as prescriptions of anti-influenza drugs within the past

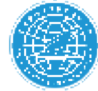
圖5-1　跨部會資料整合　全民防疫守門人

Chart 5-1 Cross-agency data integration for epidemic prevention

疾管署
Centers for Disease Control

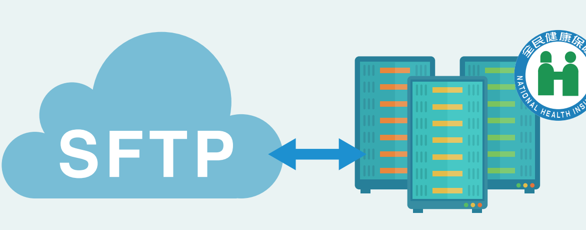
移民署
National Immigration Agency

衛福部
Ministry of Health and Welfare



民航局
Civil Aeronautics Administration

退輔會
Veterans Affairs Council



跨部會資料整合
Cross-agency and integration of resources

- 旅遊史、接觸史
  Travel history, contact history
- 職業及群聚史
  occupation and cluster
- 轉診採檢對象提示
  notice for referral specimen collection
- 流感抗病毒藥劑使用情形
  usage of antiflu drugs

開放非特約院所查詢
open for non-contracted medical institutions

- 健保特約醫事機構
  NHI contracted medical institutions
- 非健保特約醫事機構
  non-NHI contracted medical institutions
- 長照機構
  long-term care institutions
- 公務機關
  government agencies

多元查詢管道
multiple inquiry methods

- 網頁、API 即時查詢（現場掛號、陪病者）
  website, application programming interface (walk in registration, individuals accompanying the patient)
- 批次下載（預約掛號）
  batch-download (pre-registration)

消防署
National Fire Agency

矯正署
Agency of Corrections

檢察署
Prosecutors Office

10 days. Data from the Ministry of Health and Welfare, National Immigration Agency, MOI, Civil Aeronautics Administration, MOTC, and Veterans Affairs Council among others (Chart 5-1) was integrated and made accessible to medical institutions (including both contracted and non-contracted ones), long-term care institutions, administrative agencies (the National Fire Agency, MOI, Agency of Corrections, MOJ, and local prosecutor's offices) (Chart 5-2). This information can be queried online (with/without NHI card), downloaded in batches, or viewed via an API interface. The NHIA's efforts have reduced risk of COVID-19 spreading, eased the infection risk and stress of medical personnel and other vital workers, and effectively curbed spread of the disease and prevented infection clusters. According to statistics for the period from February 2020 to December 2022, a total of 2.8 billion queries of TOCC notices were made during this period.

As the pandemic receded, TOCC prompts alerts have gradually been phased out (see Chart 5-2). However, considering the needs of physicians treating confirmed cases and caring for long COVID patients, the NHIA utilizes digital technology to integrate data from all related government agencies and provide such patient information as COVID-19 test results, oral antiviral medication usage, drug interactions, and use of Taiwan's NRICM101 medication in NHI MediCloud System. Such comprehensive information serves as a valuable reference for healthcare professionals, ensuring that patients receive appropriate diagnosis and care.

2. 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 capabilities within the community and enhance pandemic containment efforts, the NHIA collaborated with Taiwan CDC to incorporate a list of "designated community institutions for specimen collection" into the NHI electronic referral platform. This measure aims to prevent suspected cases from gathering at large hospitals for specimen collection, reduce overcrowding in emergency departments, and minimize the risk of infections within hospitals, thereby preserving overall medical capacity. Additionally, the NHIA utilizes the NHI MediCloud System to present prompts on cases yet to undergo referral specimen collection, thereby facilitating seamless referral and triage processes for patients seeking medical attention.

According to the CECC policy, in response to the COVID-19 community pandemic, in order to reduce the load on grassroots institutions and public health facilitiesduring the large-scale pandemic, this operation has been suspended since April25, 2022.

3. Using NHI payments for telemedicine to meet the medical needs of persons undergoing home isolation, home quarantine, or self-health management

In accordance with CECC's epidemic prevention policy, the NHIA implemented the Guidelines for Telemedicine Operations by NHI Contracted Healthcare Service Institutions in Response to the COVID-19 Pandemic that would be in effect until CECC's disbanding. Beginning February 2020, telemedicine services were kept available for people under home quarantine, home isolation, or self-health management and COVID patients undergoing home care. With the digital divide taken into account, however, telephone consultations were offered as an alternative under special circumstances such as absence of internet access or videoconferencing devices or inability to use teleconferencing software in isolated areas. As of December 31, 2022, local

圖5-2　雲端系統TOCC等防疫資訊提示視窗示意圖

居家隔離個案，請通知當地衛生局！

※接觸日期：111/07/29

接觸史(C)
(2022年10月起取消)

病人如有「 發燒或有呼吸道症狀、嗅覺、味覺異常或不明原因之腹瀉 」等症狀， 請注意：
如符合通報條件，應進行法定傳染病通報採檢！不符合上述條件，醫師仍認為需進行 SARS-CoV-2檢驗 ，請進行採檢！
(參考資料請按我：法定傳染病通報定義、口服抗病毒藥物適用條件)

關 閉

COVID-19防疫規範及疫情相關問題請洽防疫專線1922。

居家檢疫個案，請通知當地衛生局！

【旅遊史參考】
111/07/29由美國入境。

國外旅遊史(T)
(2022年10月起取消)

病人如有「 發燒或有呼吸道症狀、嗅覺、味覺異常或不明原因之腹瀉 」等症狀， 請注意：
如符合通報條件，應進行法定傳染病通報採檢！不符合上述條件，醫師仍認為需進行 SARS-CoV-2檢驗 ，請進行採檢！
(參考資料請按我：法定傳染病通報定義、口服抗病毒藥物適用條件)

關 閉

COVID-19防疫規範及疫情相關問題請洽防疫專線1922。

※查無此身分證號之旅遊史或接觸史資料！

特定職業別(O)及
是否群聚(C)註記
(2022年5月起取消)

此個案為住宿型照護機構工作人員。

請院所加強疑似病例之
通報採檢(固定顯示)
(2023年3月底取消)

病人如有「 發燒或有呼吸道症狀、嗅覺、味覺異常或不明原因之腹瀉 」等症狀， 請注意：
如符合通報條件，應進行法定傳染病通報採檢！不符合上述條件，醫師仍認為需進行 SARS-CoV-2檢驗 ，請進行採檢！
(參考資料請按我：法定傳染病通報定義、口服抗病毒藥物適用條件)

個案COVID-19疫苗
接種紀錄

此個案已於110/06/23(Moderna)、110/07/27(Moderna)、111/02/12(Moderna) 、111/09/26(bModerna_BA1)接種新冠肺炎疫苗

此個案曾於111/10/28開立流感抗病毒藥劑(Tamiflu)，如症狀未改善，應評估COVID-19感染可能，加強通報採檢。

個案10日內曾被開立公費
流感抗病毒藥劑情形

關 閉

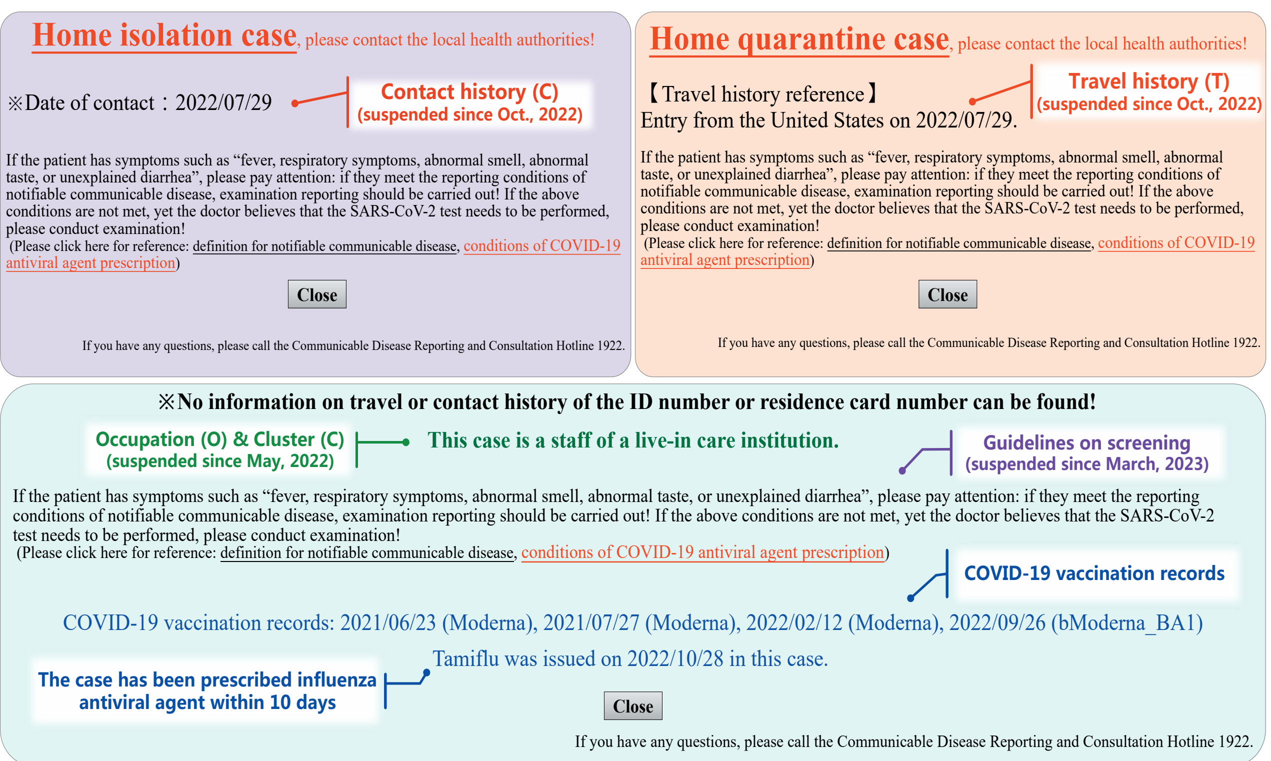
COVID-19防疫規範及疫情相關問題請洽防疫專線1922。

量數位落差，偏遠地區網路傳輸問題、無視訊設備或不會使用視訊軟體等特殊情形無法視訊時，個案得採行電話診療。截至2022年12月31日衛生局指定之通訊診療醫療機構計13,070家，其中醫院431家、診所12,639家；累計接受視訊診療民眾計6,513,203人、12,581,474人次。

4. 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。

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



health bureaus had designated 13,070 medical institutions—431 hospitals and 12,639 clinics—to provide telemedicine services; a total of 6,513,203 people attended a cumulative 12,581,474 telemedicine sessions.

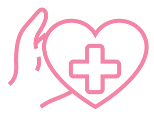
4. Use of NHI cards in support of the name-based mask distribution system

Under the name-based mask distribution system, the general public could utilize their NHI card for verification purposes when purchasing face masks. Initially, the NHIA introduced purchase method 1.0 (physical channels), enabling mask purchases from pharmacies and local health stations. Subsequently, the NHIA expanded the system to include method 2.0 (online channels), where individuals could log into the eMask pre-order system using their NHI card or natural person certificate. Additionally, they could also order masks through the My Health Bank app after completing identity and cellphone authentication. To enhance convenience for the public, the NHIA also collaborated with convenience stores across Taiwan to promote purchase method 3.0—pre-ordering masks from convenience stores. As such, people could directly order masks by inserting their NHI card into a convenience store service kiosk. The utilization of NHI cards in supporting face mask sales through the name-based mask distribution system not only enabled Taiwan CDC and the Food and Drug Administration to fairly distribute a key resource for epidemic prevention but also helped ensure comprehensive protection for the public during the pandemic.

Chapter 6

照顧弱勢 守護偏鄉

Care for the Disadvantaged, Watch over Isolated Areas



照顧弱勢　守護偏鄉

對經濟弱勢民眾的補助措施

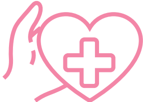
全民健保採強制納保，社會上難免有一部分繳不起保險費的低收入戶及經濟邊緣人口，如何貫徹全民納保政策，有賴多項協助措施，以確保社會安全網的穩固，更彰顯自助互助的精神。為了照顧癌症、洗腎、血友病、精神病等重大傷病患者，以及經濟困難弱勢民眾的就醫權益，健保署提出多項協助繳納保險費的措施。另外，對於罕見疾病、重症患者及偏遠地區民眾，亦提供醫療及經濟上的協助。現行的協助措施包括保險費補助、紓困貸款及分期繳納等，執行成果請見表6-1。

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	2021.1~12	363.3萬人 3.633 million persons	316.2億元 NT$31.62 billion
		2022.1~12	365.3萬人 3.653 million persons	322.7億元 NT$32.27 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	2021.1~12	1,747件 1,747 cases	1.51億元 NT$151 million
		2022.1~12	1,525件 1,525 cases	1.41億元 NT$141 million
分期繳納 Installment payment plans	欠繳保險費無力一次償還者 Persons who are unable to immediately repay owed premiums	2021.1~12	70,315件 70,315 cases	23.39億元 NT$2.339 billion
		2022.1~12	71,984件 71,984 cases	21.94億元 NT$2.194 billion
愛心轉介 Referral to charities	無力繳納健保費者 Persons who are unable to pay premiums	2021.1~12	4,391件 4,391 cases	2,683萬元 NT$26.83 million
		2022.1~12	4,734件 4,734 cases	3,632萬元 NT$36.32 million

資料時間：2021年1月1日～2022年12月31日。
Data period: From January 1, 2021 to December 31, 2022.



Care for the Disadvantaged, Watch over Isolated Areas

Subsidies for the Economically Disadvantaged

Against NHI's mandatory health insurance enrollment, some low-income households and people living on the margins of society understandably could not afford to pay their premiums. To faithfully implement the government's blanket enrollment policy, the NHIA has taken a number of assistance measures to strengthen the social welfare net and realize the spirit of mutual help. In addition, the NHIA has also introduced several premium payment assistance measures to help care for patients suffering from cancer, hemophilia, or severe mental illness or receiving dialysis, as well as underprivileged persons in need of medical attention against economic difficulties. Likewise, medical and economic assistance is offered to persons with rare or critical illnesses and those living in isolated areas. Such assistance measures include premium subsidies, relief loans, and installment payment plans. Refer to 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 unemployed indigenous citizens who are under the age of 20 or over the age of 55. A total of NT$31.62 billion in such subsidies was provided to 3.633 million people in 2021, followed by a total outlay of NT$32.27 billion that benefitted 3.653 million people in 2022.

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，2021年全年補助人數約363.3萬人，補助金額約316.2億元。2022年全年補助人數約365.3萬人，補助金額約322.7億元。

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。2021年全年共核貸1,747件，金額1.51億元。2022年全年共核貸1,525件，金額1.41億元。

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，2021年全年辦理分期繳納共7萬件，合計23.39億元。2022年全年辦理分期繳納共7.2萬件，合計21.94億元。

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。2021年全年轉介成功個案計4,391件，補助金額共2,683萬餘元。2022年全年轉介成功個案計4,734件，補助金額共3,632萬餘元。

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。

Relief Fund Loans

To protect people's right to healthcare, the NHIA provides interest-free loans to members of the public who are suffering from economic difficulties so that they can pay their premiums and cover unpaid copayments for medical care. A total of NT$151 million went toward such loans granted to 1,747 cases in 2021, and NT$141 million was lent to 1,525 cases the following year.

Installment Payment

When it comes to people not eligible for relief loans, the NHIA offers installment payment plans to persons who owe premiums totaling more than NT$2,000 but, due to economic hardship, cannot repay this debt in one go. Installment payment plans for a total of NT$2.339 billion were provided in more than 70,000 cases during 2021, followed by NT$2.194 billion in nearly 72,000 cases in 2022.

Referral to Charitable Groups for Premium Subsidies

With regard to persons who are unable to pay their premiums, the NHIA also provides referral to charitable groups, companies, and individuals for premium assistance. Such referrals were made in 4,391 cases involving total subsidies of NT$26.83 million in 2021, and NT$36.32 million in 4,734 cases in 2022.

Protect the Right to Healthcare of the Underprivileged

The NHIA is proactive to uphold the universal value of equal access to healthcare and fulfill President Tsai Ing-wen's campaign promise that all individuals who meet NHI's eligibility requirements are entitled to use their NHI cards for healthcare services. As such, the NHIA implemented the "decoupling of the right to healthcare from unpaid NHI premiums and fees" on June 7, 2016. The unblocking of all NHI cards is key to upholding the equality of healthcare rights for all citizens. As long as individuals have completed their subscription procedures, they can be assured of access to NHI-covered healthcare. The unblocking of all NHI cards represents a significant milestone in safeguarding the right to healthcare, ensuring that beneficiaries will not have their cards blocked due to unpaid premiums or fees. The abolition of the card blocking system has alleviated the concerns of underprivileged individuals who previously feared being denied essential care due to outstanding payments. This accomplishment further demonstrates the government's commitment to caring for the underprivileged and protecting the healthcare rights of all citizens.

The NHIA implements multiple measures to support underprivileged individuals, thus establishing a healthcare safety net for citizens experiencing economic hardships. By eliminating barriers to NHI coverage, the NHIA ensures that individuals facing financial difficulties can access necessary medical care whenever needed. Furthermore, the NHIA provides assistance to these individuals by offering support in NHI enrollment, premium relief, referrals to aid programs, and flexible installment payment plans.

Vie for Public Welfare Lottery Feedback Funds to Help the Disadvantaged

To ensure healthcare access for underprivileged groups and safeguard their right to healthcare, the NHIA implements various assistance measures, including installment payment plans, relief loans, and referrals to charitable programs. Since 2008, the NHIA has also utilized contributions from public

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2022年12月底，累計補助金額已達48.27億元，累計補助人數達25萬5,897人（表6-2）。

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，門診基本部分負擔和藥品部分負擔費用均按診所層級，較一般民眾為低。

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

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	人數 Persons	金額（新臺幣） Amount (NT$)
2021	協助弱勢青年及貧戶家庭脫離健保欠費困境計畫 Plan to help underprivileged youths and low-income households obtain relief from unpaid NHI premiums and fees	13,021	2.15億元 NT$215 million
2022	協助中度以上身心障礙者及貧戶家庭脫離健保欠費困境計畫 Plan to help persons with moderate or more severe physical or mental disabilities and low-income households obtain relief from unpaid NHI premiums and fees	5,543	1.75億元 NT$175 million
2008/1~2022/12 Total		255,897	48.27億元 NT$4.827 billion

註：資料時間截至2022年12月底。
Note: The data period ended in December 2022.

welfare lotteries to alleviate the medical financial burdens of eligible underprivileged individuals. Proactively identifying qualified beneficiaries, the NHIA notifies them about available assistance for paying NHI premiums and fees. As of the end of December 2022, a cumulative NT$4.827 billion in subsidies had been disbursed to support 255,897 individuals (Table 6-2).

Ease Copayment Burden on Specific Patients

Persons who have received a disability certificate need only pay a clinic-level outpatient copayment when seeking care at any level of hospital or clinic. This copayment is lower than that paid by the general public.

For patients with conditions such as cancer, chronic mental illness, dialysis needs, rare diseases, or congenital disorders who possess a major illness/injury certificate, there is no requirement for copayment when they are seeking medical care specifically related to these conditions. In an effort to safeguard the rights of patients with rare diseases, the NHI covers the costs of all medications necessary for the treatment of rare disorders, as designated by the Ministry of Health and Welfare, through a dedicated budget. This initiative has substantially alleviated the financial burden on individuals with rare diseases.

Care for the Medically Vulnerable

Persons with disabilities

Initiated in 2002, the NHIA's "Dental Outpatient Global Budget Special Medical Service Plan" provides services under a medical service markup payment system. Dentists are encouraged to serve patients with congenital cleft lip and palate and other specific disabilities.

In 2006, the NHIA introduced deregulations that allow local dentist associations or groups to establish dental teams catering specifically to institutions providing care for individuals with disabilities. These dental teams are authorized to offer regular services, including roving dental care, to psychiatric hospitals lacking dental departments and special education schools for individuals with special needs. Since July 1, 2011, dentists from these teams have been providing in-home dental services to individuals with designated disabilities who meet the criteria for residential care. On January 1, 2013, the dental teams expanded their services to include bedridden patients at institutions dedicated to the care of individuals with disabilities. From January 1, 2014, these teams began providing dental care at government-registered institutions catering to children with developmental delays. The scope of their services was further extended to include bedridden individuals at elderly care facilities under the Ministry of Health and Welfare from January 1, 2015. Following the launch of services to persons suffering from severe loss of major organ functions on January 1, 2016, dental care has been made

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2022年12月底，重大傷病證明有效領證數約有101.2萬餘張（人數為94萬8千餘人，約占總保險對象的3.9%），而2022年全年重大傷病醫療費用約2,417億餘元（占全年總醫療支出的27.8%），健保藥品費用中，每年約有805億元（近3.4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2022年12月衛生福利部公告的罕見疾病種類有242項，截至2022年12月底止，重大傷病罕見疾病項目領證數共12,957張。經統計2022年罕見疾病之藥品費用約為62.3億元。

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。

available to individuals preparing for hospital discharge and general nursing homes selected by the Ministry of Health and Welfare's Department of Nursing and Health Care. Furthermore, dental services have been extended to individuals with moderate functional disabilities caused by brain and spine injuries since January 1, 2021.

Persons with catastrophic illnesses and injuries

The NHIA currently recognizes 30 types of catastrophic illnesses and injuries, including cancer, chronic mental illness, conditions requiring dialysis, and congenital disorders. These illnesses often incur substantial medical expenses that pose significant financial challenges. To alleviate the burden on the insureds, the NHIA has implemented a policy of waiving copayments for the treatment of these catastrophic illnesses and injuries for all those who possess a major illness/injury certificate.

As of the end of December 2022, more than 1.012 million valid major illness/injury certificates had been issued (to more than 948,000 persons, who accounted for roughly 3.9% of all insureds). Total medical expenditures for catastrophic illnesses and injuries exceeded NT$241.7 billion in 2022 (accounting for 27.8% of all NHI medical expenditures for the year). Of the annual expenses for NHI-covered drugs, about NT$80.5 billion (nearly 34%) is spent on those meant for catastrophic illnesses and injuries each year. It is clear that catastrophic illnesses and injuries account for a very large share of medical expenses, and NHI has consequently been a godsend for patients with these conditions.

Persons with rare diseases

Since rare diseases are considered catastrophic illnesses and injuries, copayments are waived when patients seek treatment. As of December 2022, the Ministry of Health and Welfare had recognized 242 rare diseases, and 12,957 major illness/injury certificates had been issued for rare diseases accordingly. NHI’s drug expenditures for rare diseases totaled NT$6.23 billion in 2022.

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 while easing their healthcare burden.

Persons with multiple chronic conditions

Individuals with multiple chronic conditions represent the highest utilization of healthcare resources in Taiwan's healthcare system. With the country's aging population, the prevalence of multiple chronic conditions has been steadily rising, making the care of these individuals a crucial concern. To ensure that people with multiple chronic conditions receive comprehensive and coordinated care services, while also minimizing the risks associated with redundant or incorrect medications or treatments, the NHIA introduced the “Patient-Centered Integrated Care Program” across local hospitals on December 1, 2009.

Since its implementation, the program has demonstrated remarkable effectiveness, as evidenced by a steady decline in the average number of medical visits among program participants over the years. In December 2022, a total of 130 hospitals participated in the program.

Provide care in medically underserved isolated areas

According to Article 43 of the *National Health Insurance Act* and Article 60 of its enforcement

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。2022年12月參與照護，提供整合服務之醫院共130家。

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昇計畫（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，當地民眾對計畫平均滿意度為94%。

醫療資源不足地區改善方案

2023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。2022年共有628家特約院所至醫療資源不足地區巡迴，服務民眾達69.8萬餘人次。

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， 2022年計有93家醫院參與。

全民健保遠距醫療給付計畫

由在地醫師與遠距醫師以視訊方式，共同診察病人、給予診療建議，由在地醫師開立醫囑，提供民眾迫切需要的專科門診遠距會診（限眼科、耳鼻喉科、皮膚科、心臟內科、胃腸科、神經內科、胸腔科）或急診遠距會診（不限科別），提升偏鄉地區專科門診可近性。111年專科門診遠距會診服務人次計6,305人次，急診遠距會診服務人次計85人次。

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 mountain areas and offshore islands

Due to their geographical challenges and limited transportation options, mountain areas and offshore islands often face difficulties in accessing adequate healthcare services. In response, the NHIA has proactively sought cooperation with hospitals and clinics that have the necessary resources to dispatch medical personnel to these underserved areas. In November 1999, the NHIA launched the Integrated Delivery System (IDS) program for mountain areas and offshore islands. This program encourages large hospitals to offer specialized medical services, emergency care, and overnight care either at fixed locations or through mobile services, ensuring that residents in these areas receive the necessary healthcare support.

Currently, there are 50 mountain or outlying townships in the country, where a total of 26 contracted hospitals and clinics are undertaking 30 projects to serve over 480,000 people. In these areas, the average rate of satisfaction with the IDS program comes in at 94%.

Improvement Project for Regions Deficient in Medical Resources

The NHIA allocated NT$869 million for the 2023 Improvement Project for Regions Deficient in Medical Resources. Dentists and Chinese and Western medicine physicians are encouraged to demonstrate their commitment to serving local communities by starting their practices in areas that lack sufficient medical resources or providing healthcare services on a rotating basis. In 2022, a total of 628 contracted hospitals and clinics conducted rotating services, benefiting over 698,000 individuals in medically underserved areas.

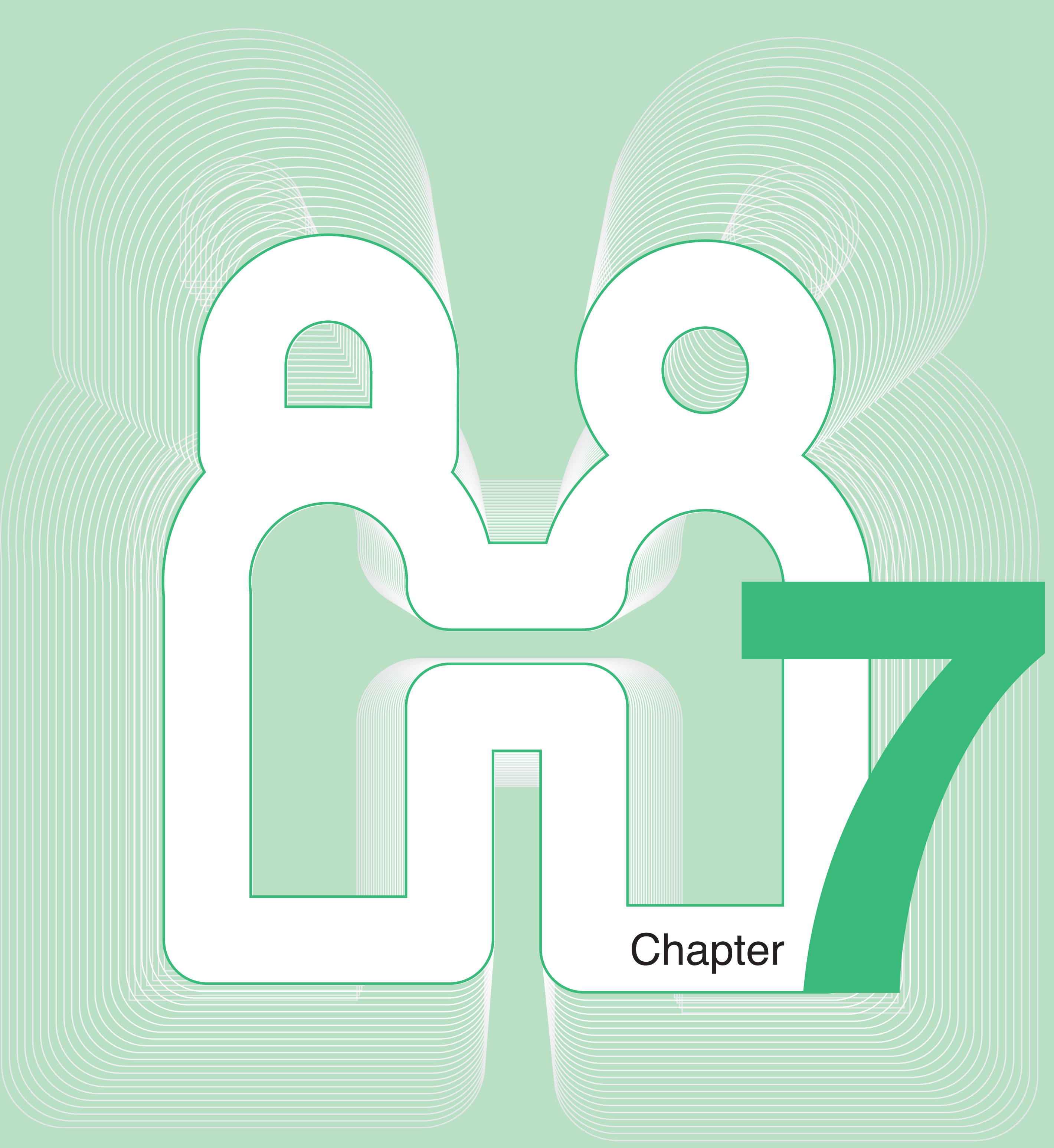
Service Improvement Program for Medically Underserved Areas

To enhance access to medical services and community preventive care for individuals residing in medically underserved areas such as offshore islands and mountain regions, the NHIA launched the "Service Improvement Program for Medically Underserved Areas" in 2012. This program utilizes dedicated funding and a guaranteed point value delivery approach to incentivize hospitals located in underserved areas or nearby regions to provide round-the-clock emergency care services, as well as outpatient and inpatient services in internal medicine, surgery, gynecology/obstetrics, and pediatrics. In 2022, a total of 93 hospitals participated in this program.

Medicare Telemedicine Benefit Plan

Local physicians and remote physicians will jointly examine patients and give diagnosis and treatment suggestions via video consultation for certain specialties (limited to ophthalmology, otolaryngology, dermatology, cardiology, gastroenterology, neurology, chest cavity) or emergency teleconsultation, to improve the accessibility of specialized outpatient clinics in rural areas.

In 2011, there were 6,305 person-times of remote specialists consultation services, and 85 person-times of remote emergency consultation services.



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，2022年再次獲得APEC衛生工作小組（HWG）補助，辦理APEC Conference on Digital Healthcare Innovation-COVID-19 Response by Health Information Utilization研討會，美國、日本、韓國、澳大利亞、泰國、菲律賓、印尼等經濟體官員及專家來臺及同時以線上方式就數位技術及資料在COVID-19之應用進行研討與分享。2023年9月繼續辦理APEC衛生工作小組（HWG）補助之國際研討會APEC Workshop on Public-Private Collaboration in Supporting of Containing Measures During and Beyond Pandemic。

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

Public Satisfaction and International Recognition

Internationally Acclaimed NHI Achievements

Taiwan's NHI adopts a single-payer system that not only can pool and integrate resources but is also widely applicable. In comparison with the healthcare systems of other countries, NHI features lower administrative expenditures as well as 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 for the purpose of learning more about NHI. Even during the COVID-19 pandemic, the NHIA made it a point to stay in contact with counterparts in other countries via videoconferencing.

A key component of the UN's sustainable development goals, universal health coverage aims to ensure that each individual has access to basic medical care. NHI was initiated in 1995 precisely with the aim of allowing all citizens to enjoy an equal right to medical care and providing the public with an accessible, low-cost medical environment. According to the 2021 Health Care Index of internationally renowned CEOWORLD magazine, Taiwan has the second-best healthcare system out of 89 countries. In addition, the Health Care Index of Numbeo, a leading global database, ranked Taiwan first among 95 countries in 2022, further attesting to the premium quality of Taiwan's healthcare system.

As the COVID-19 pandemic ravaged the world in 2020, Taiwan's outstanding success in containing the spread of the virus received extensive international recognition. On July 21, 2020, The BMJ published a blog post entitled “What we can learn from Taiwan's response to the COVID-19 epidemic.” In the highlight are two key information technologies the NHIA adopted for pandemic preparedness and control: NHI cards that allow hospitals and clinics to upload patients' medical information in real time and the NHI MediCloud System that provides doctors with the medical records and information of people seeking care for their reference in diagnoses and prescriptions. This article helps other countries understand how Taiwan made use of medical information technology and well-rounded public health infrastructure in conjunction with forward-looking plans to effectively contain the spread of COVID-19 in Taiwan.

The Asia-Pacific Economic Cooperation (APEC) forum is a leading international organization in which Taiwan is a member and health stands out as a key area for its involvement. In 2019, the NHIA secured a subsidy from APEC to host its international conference on sharing medical information. This was followed by funding from APEC's Health Working Group (HWG) in 2022 for the NHIA's hosting “APEC Conference on Digital Healthcare Innovation—COVID-19 Response by Health Information Utilization.” Both physically and virtually, officials and specialists from member economies—the U.S., Japan, Korea, Australia, Thailand, the Philippines, and Indonesia—discussed and shared insights on applying digital technology and information to combat COVID-19. Also with a subsidy from APEC's HWG, the NHIA is scheduled to hold its Workshop on Public-Private Collaboration in Supporting of Containing Measures During and Beyond Pandemic in September 2023.

In keeping with the government's New Southbound Policy, the NHIA has long engaged in intensive bilateral exchanges with the Philippines, Thailand, and Vietnam. These have yielded impressive results. While the COVID-19 pandemic made in-person

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。

全民健保　民眾滿意

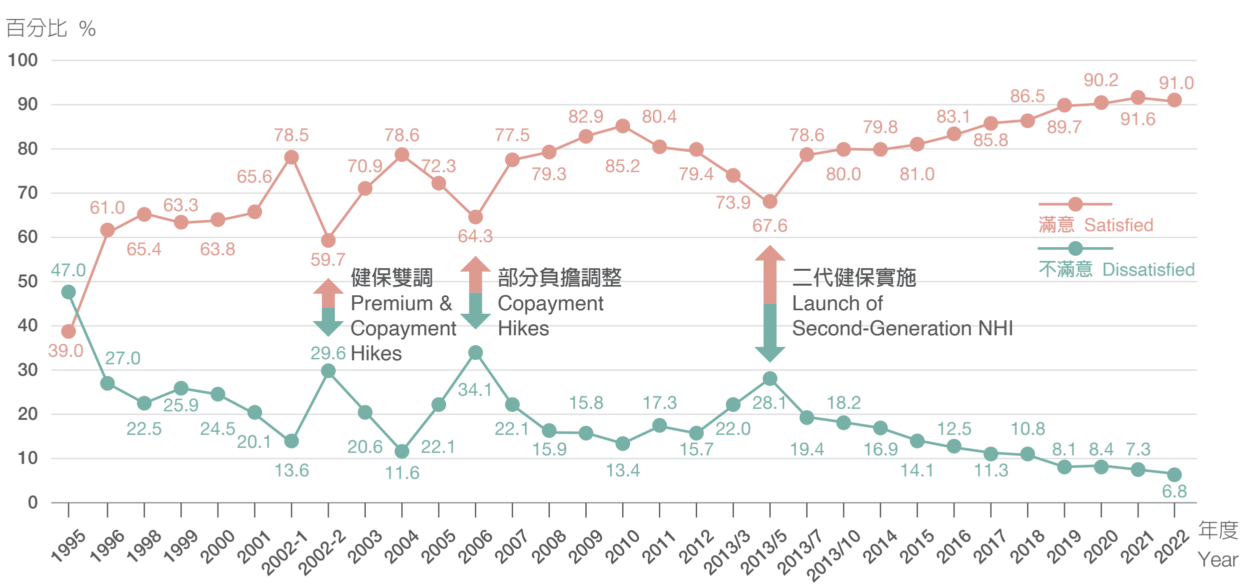
全民健保實施曾面臨諸多困難，從一開始的滿意度不到4成，到目前持續成長至8成以上，顯見民眾十分肯定健保。其中雖曾因2002年度保險費率及部分負擔調整，以及2005年度開始進行多元微調，導致民眾對全民健保的滿意度稍有下降，但隨後即快速回升至7成以上。2013年1月起二代健保實施，針對所得收入高者加收補充保險費，滿意度曾一度下滑後隨即回穩至8成左右，自2020年起民眾對健保的滿意度連續三年超過9成（圖7-1），我國因有全民健保，對經濟弱勢民眾的健康照護更能提供完善的醫療保障。

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4.24%，醫療費用卻高達健保總醫療支出的27.83%。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5.8倍到82.0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。

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. Second-Generation NHI was implemented in 2013.

contact all but impossible in 2020, the NHIA resorted to videoconferencing for staying in contact with medical and health agencies in countries covered by the New Southbound Policy. With assistance from diplomatic personnel, the NHIA organized videoconferences with Thailand's National Health Security Office (NHSO) and Philippine Health Insurance Corp. (PhilHealth) respectively to share and exchange experiences on how health insurance systems should respond to the COVID-19 pandemic.

High Satisfaction with NHI

NHI has endured quite a few difficulties since its inception. Over time, however, NHI has come to enjoy a high level of public satisfaction, with an over 80% approval rate in comparison with a low of less than 40% in the early days. Indeed, public satisfaction with NHI sustained a slight decrease due to increases in the premium rate and copayments in 2002 and some further finetuning of the system in 2005. But a rebound to over 70% soon followed. Likewise, another slip following Second-Generation NHI's imposition of supplementary premiums on high-income households in January 2013 was soon followed by a recovery to around 80%. For three straight years (2020-2022), public satisfaction with NHI stayed above 90% (Chart 7-1). Thanks to NHI, Taiwan is able to provide comprehensive medical protection to even the economically underprivileged.

Maximize the Power of Mutual Assistance

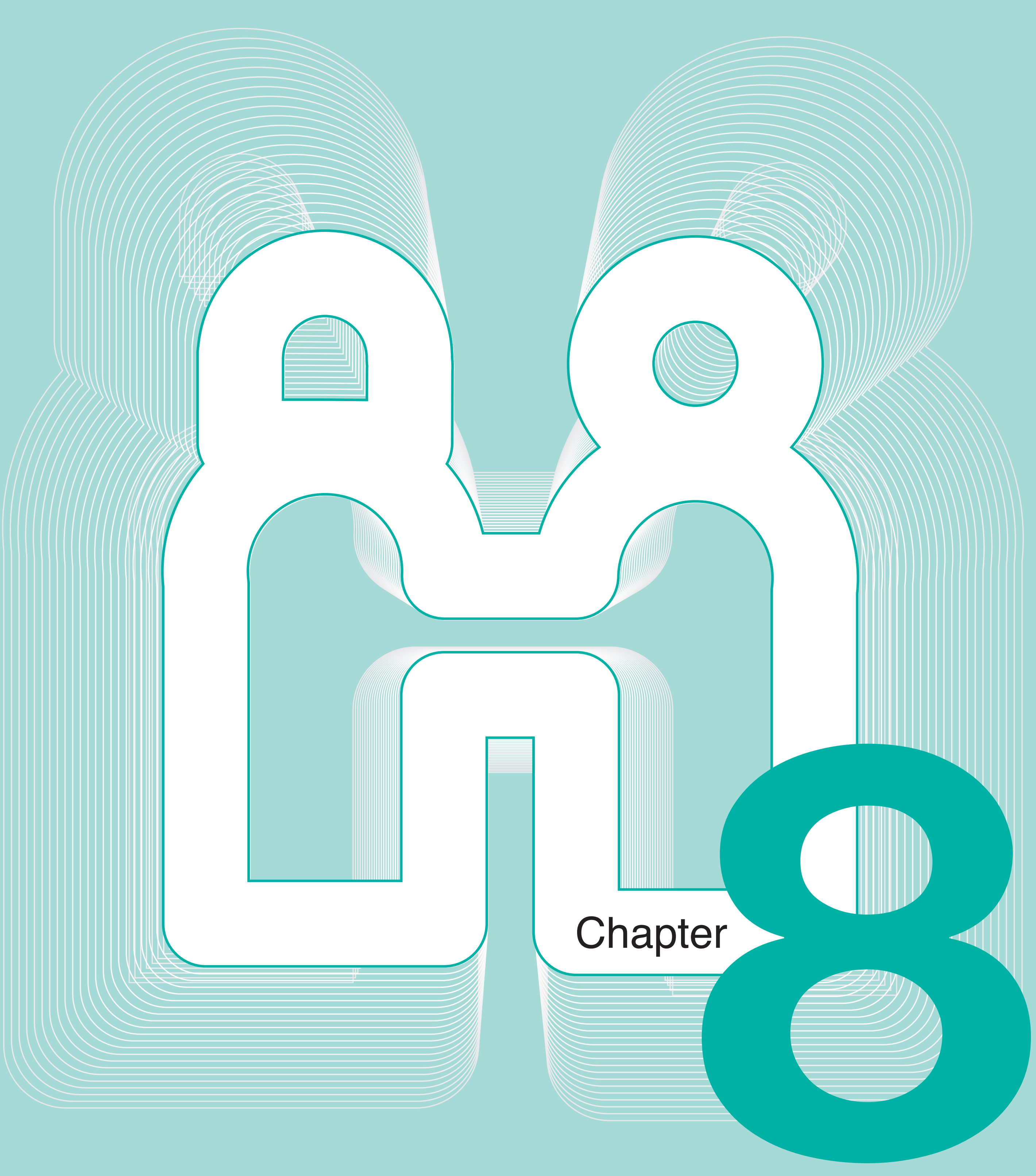
NHI's core value lies in drawing from a social insurance mechanism in which the financial risk of illness is dispersed among insureds through mutual assistance. For instance, although persons with catastrophic illnesses and injuries account for only 4.24% of all patients, they also account for as much as 27.83% of all NHI medical outlay. In particular, such catastrophic illnesses as cancer, conditions requiring dialysis, and hemophilia incur medical expenses 5.8-82.0 times the average spending. This clearly attests to NHI's playing the crucial role of mutual assistance in social insurance, thereby 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	36,642	1.0
每一重大傷病患者 Each catastrophic illness patient	240,238	6.6
每一癌症患者 Each cancer patient	212,734	5.8
每一罕病患者 Each rare disease patient	732,292	20.0
每一洗腎患者 Each dialysis patient	649,865	17.7
每一呼吸器患者 Each ventilator patient	829,639	22.6
每一血友病患者 Each hemophilia patient	3,004,477	82.0

註：以2022年重大傷病年度統計資料為例。
Note: Based on 2022 statistics for catastrophic illnesses and injuries.


Chapter
8

跨步精進 展望未來
Progress and Prospects

跨步精進　展望未來

我國全民健保落實WHO Universal Health Coverage之重要社會制度，走過從前、邁向未來，在人口高齡化及醫療資源有限情形下，為健保永續發展，將以「體系、財務、科技、法治、社會溝通」五大面向，以發展全人照護、力推數位醫療，推動各項革新措施，並規劃遠景藍圖：

以人為本　建構全人全程照護體系

健保署推動人本健康，賦能民眾健康管理，以家庭醫師為平台，向前延伸居家醫療整合照護計畫、代謝症候群防治計畫等政策，透過健康存摺獲得個人化的整合性照護，提供相關衛教，提升民眾自我照護的能力，落實初期照護精神。向後銜接病人出院後持續性照護，推動出院準備服務、急性後期照護，銜接居家安寧及長照服務，解決高齡化社會引發的醫療需求問題，公私協力提供全人全程的健康照護。

醫療科技評估　落實公平負擔

健保署與國際接軌，導入醫療科技評估（HTA），並與英國國家健康暨照護卓越研究院（National Institute for Health and Care Excellence, NICE）簽訂合作協定，就新藥物進行人體健康、醫療倫理、醫療成本效益及健保財務等面向評估，以輔助新藥物納入健保收載之決策，與國家生技產業政策結合，以發揮綜效。並持續進行前瞻式評估及蒐集實證資料，作為健保持續給付、調整給付條件或取消給付之依據，透過成本效益循環式管理，使資源合理有效應用，讓醫療資源配置達到最大效率，使民眾得到更有效果及效率的照護。

Progress and Prospects

NHI is an important social institution in keeping with the WHO's push for universal health coverage. As we reflect on the past and move towards the future, the challenges posed by an aging population and limited healthcare resources make ensuring NHI sustainability all the more crucial. Efforts will be made on five key fronts: system enhancement, financial stability, technological advancements, legal governance, and social communication. Developing holistic care, promoting digital healthcare, and undertaking reforms will help attain our vision for the future.

Create a Human-Centric Continuous Holistic Care System

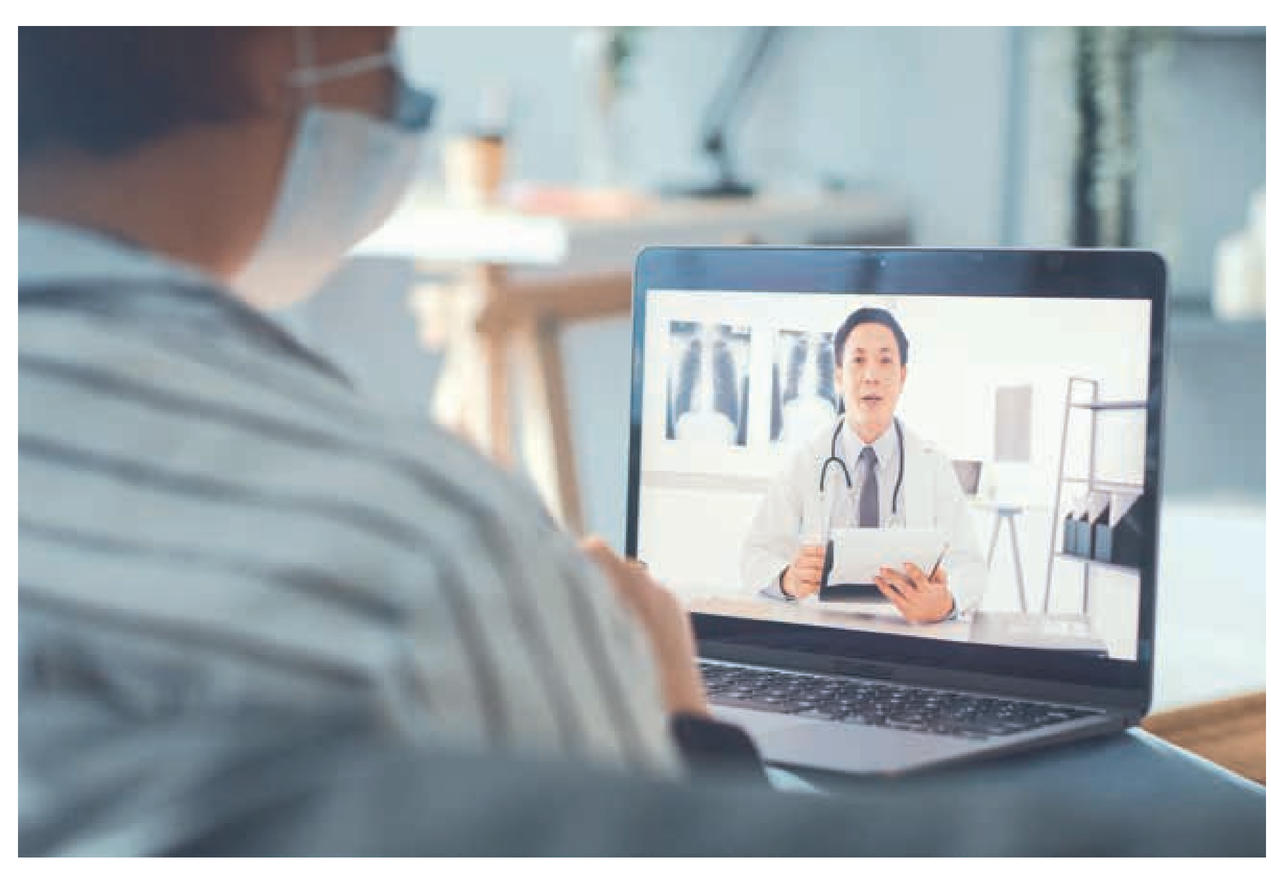
The NHIA promotes human-centric healthcare and empowers individuals to manage their health. It draws on family physicians as the platform to undertake integrated home care and metabolic syndrome prevention and treatment among other programs. In keeping with the spirit of primary care, My Health Bank acts as the foundation for delivering personalized integrated care and health education and enhancing the public's self-care capability. Equal emphasis is placed on offering continuous care for patients after hospital discharge. High on the list are discharge preparation services and post-acute care for seamless integration with home hospice and long-term care services. To effectively meet healthcare needs in our aging society, public-private collaboration is set to prove crucial in the provision of continuous holistic healthcare services.

健保數位升級　推動醫療轉型

健保署加速數位醫療服務轉型發展，串接遠距及視訊診療、電子處方箋及虛擬健保卡等作業流程，透過全民健保行動快易通｜健康存摺App介接行動支付，完善智慧化就醫模式，並利用健康存摺SDK（Software Development Kit）開放結合產業，在民眾的授權使用下，體驗更完整的數位照護。同時，配合「通訊診察治療辦法」，共同推動通訊診療納入健保給付政策，逐步擴大推廣遠距醫療服務範圍及虛擬健保卡使用情境，強化電子處方箋推廣至多元應用場域，並完備介接行動支付，以提供民眾多元化的選擇。

完備資料治理機制　健保永續發展

健保署以民眾為中心，未來持續完善健保資料管理機制及法制規範，保障個人資訊隱私，提升資訊安全及創造資料運用價值，並導入創新科技，透過客服中心、全球資訊網、FB、LINE@等服務管道，提升為民服務品質，強化與各部會、醫界及民眾溝通，透過多元管道宣導珍惜醫療資源，促進醫療服務效率，使健保效益極大化，共創健保永續發展。



Attain Equitable Responsibility via Health Technology Assessment

In compliance with international standards, the NHIA has ushered in health technology assessment (HTA) to evaluate new drugs in terms of human health, medical ethics, cost-effectiveness, and the financial impact on NHI. For the same cause, the NHIA has signed a partnership agreement with the National Institute for Health and Care Excellence (NICE). Maximal synergies become possible as this assessment can serve not only as a supportive decision-making tool for NHI's inclusion of new drugs for coverage but also as a contributing component of the country's biotechnology policy. Furthermore, proactive evaluation and evidence collection are conducted continuously to serve as a basis for sustainable insurance coverage, adjustment of reimbursement conditions, or discontinuation of reimbursement. Through cyclic cost-effectiveness management, resources are applied rationally and effectively, thereby optimizing the allocation of healthcare resources to achieve maximum efficiency and provide the public with more effective and efficient care.

Promote NHI Digitization and Healthcare Transformation

The NHIA is accelerating the transformation and development of digital healthcare services by integrating processes such as telemedicine and video consultations, electronic prescriptions, and the virtual NHI card. The "My Health Bank" app also doubles as an interface for mobile payments to help promote a truly intelligent mode of seeking medical attention. Meanwhile, a software development kit (SDK) is now available for further expanding My Health Bank's applications. With the authorization of citizens, these initiatives promise to provide them with better-rounded digital care. Meanwhile, in accordance with the Rules for Medical Diagnosis and Treatment by Telecommunications, efforts are being made to promote the inclusion of telemedicine in NHI coverage, expand the scope of telemedicine and applicable scenarios for the virtual NHI card, broaden applications of electronic prescriptions, and attain ubiquity of mobile payments.

Refine Data Governance Mechanisms for NHI Sustainability

Always placing people at the center, the NHIA will continue to improve the mechanisms and legal regulations for managing NHI data, protect personal information and enhance information security, and create value from data utilization. Innovative technologies will be introduced to enhance the quality of services to the public through such channels as its customer service center and website, Facebook, and Line@. The NHIA will also strengthen communication with various government agencies, the medical community, and the general public to promote awareness of the importance to treasure healthcare resources, enhance efficiency in healthcare services, and maximize NHI benefits, thereby ensuring NHI's sustainable development.

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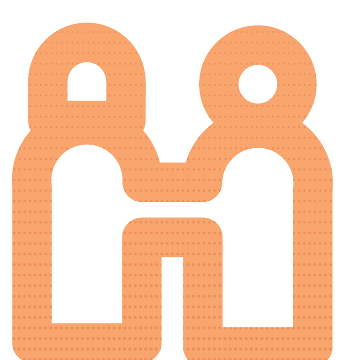

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