全民健康保險年報

National Health Insurance

2025 — 2026

Annual Report

為提供保險醫療服務
增進全體國民健康

- 提升品質
- 關懷弱勢
- 健保永續
- 國際標竿

全民健康保險年報

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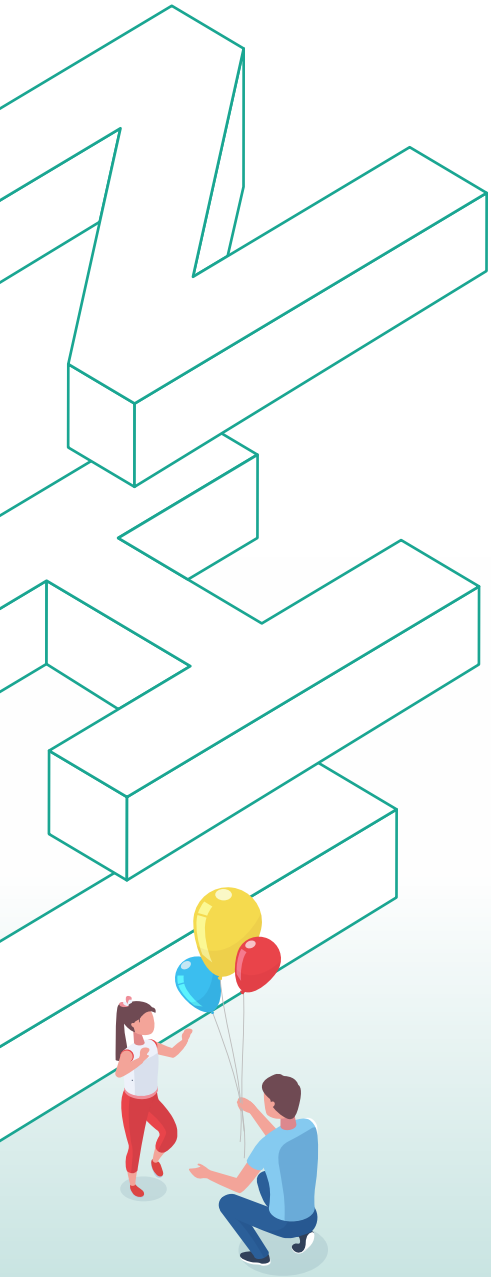


署長的話

Message from the Director General

NUMBEO網站公布2025年全球醫療照護指數，臺灣以86.5分蟬聯世界第一，連續七年居冠。這不僅是全民福祉的里程碑，更是臺灣健保制度值得驕傲的成就。三十年來，全民健保一步一腳印走到今天，展現在醫療公平、可近與滿意度上的進步，有賴前人耕耘、醫界堅守崗位，以及全民的信任與支持。

面對人口老化、醫療利用增加、醫事人力流動、新藥引進及新科技發展快速等挑戰，健保署積極推動「大家醫計畫」，透過強化自我健康照護、預防保健、社區整合照護與長照銜接，逐步打造以人為本的韌性醫療體系，落實全人照護。

我國慢性病患者約850萬人，從源頭著手控制三高、改善生活型態，並推動慢性病888計畫，將健康促進的概念融入健保。再者，癌症已連續43年位居臺灣十大死因之首，健保推動百億癌症新藥基金，減輕癌友與其家庭的負擔，治療指引接軌國際建立評估機制並加速新藥及新醫材收載，兼顧病人權益與財務永續。

全民健保的永續，包含財務永續及人力永續。財源部分，需仰賴多元財務挹注，並將健保資源有效分配。人力部分，需仰賴在第一線辛勤付出的醫護同仁，透過支付制度的調整，跨部司署共同合作改善醫護人員工作環境，醫事人員是穩固醫療系統之根基，唯有財務永續、人力永續，才能有健保永續。

為加速醫療資訊革新接軌國際，未來將投入次世代數位醫療平台，創造智慧安全的就醫環境，同時強化資料保護，提升資料利用的透明度與信任度，為健康政策與公共利益創造更多價值。

健保將持續打造公平、智慧與韌性的健保體系，讓醫療走入生活。透過不斷改革精進，打造「健康台灣」，布局健保永續未來。

衛生福利部中央健康保險署　署長

陳亮妤

Taiwan retained its top ranking for the seventh year in the Health Care Index 2025 issued by the international NUMBEO website, with a score of 86.5. This achievement is not only a milestone for the well-being of all citizens but also a source of pride for Taiwan's National Health Insurance system. Over the past three decades, the National Health Insurance has steadily progressed, demonstrating remarkable advances in healthcare equity, accessibility, and patient satisfaction. These accomplishments are the result of the dedication of previous generations, the unwavering commitment of medical professionals, and the trust and support of the entire population.

Facing challenges such as an aging population, increasing healthcare utilization, healthcare workforce mobility, rapid introduction of new medications, and swift technological advancements, the National Health Insurance Administration (NHIA) is actively promoting "The Grand Family Physician Plan." By strengthening self-health management, preventive care, community-based integrated care, and seamless connections to long-term care services, the NHIA is progressively building a people-centered and resilient healthcare system that delivers holistic, comprehensive care.

Taiwan has approximately 8.5 million people with chronic diseases. To address this, the NHIA tackles the issue at its source by controlling the "three highs" (hypertension, hyperglycemia, and hyperlipidemia), promoting healthier lifestyles, and implementing the 888 Program for prevention and treatment of the "three highs" which integrates the concept of health promotion into the National Health Insurance system. Furthermore, cancer has ranked as the leading cause of death among Taiwan's top ten causes for 43 consecutive years. To address this, the NHIA has established a NT$10 billion New Cancer Drug Fund to alleviate the financial burden on cancer patients and their families. Treatment guidelines are aligned with international standards, evaluation mechanisms have been established, and the process for including new drugs and medical devices has been accelerated, thereby balancing patient rights with financial sustainability.

The sustainability of National Health Insurance encompasses both financial and workforce sustainability. In terms of financing, it relies on diversified funding sources and the effective allocation of NHI resources. Regarding the workforce, it depends on the dedication and hard work of frontline medical and nursing staff. Through adjustments to the payment system and inter-ministerial and inter-agency collaboration to improve the working environment for healthcare personnel, the foundation of a stable healthcare system is strengthened. Healthcare professionals are the cornerstone of a robust medical system. Only with financial and workforce sustainability can the National Health Insurance achieve long-term sustainability.

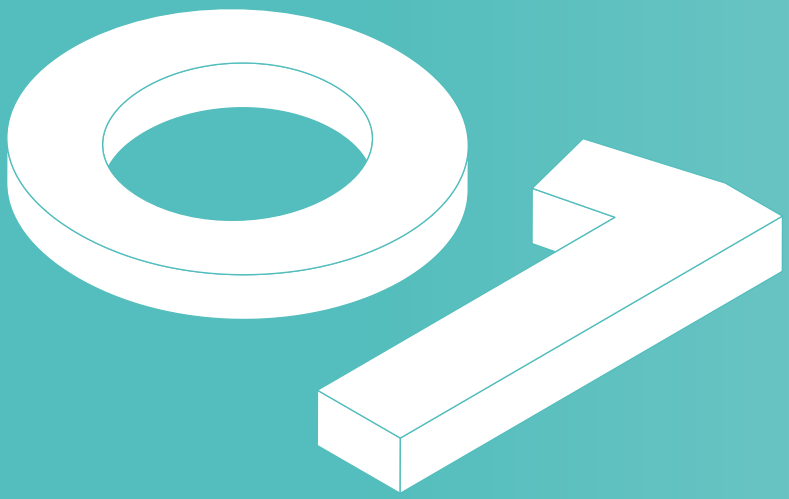
To accelerate innovation in medical information systems and align with international standards, the NHIA will invest in next-generation digital healthcare platforms to create a smart and secure healthcare environment. At the same time, data protection will be strengthened, and the transparency and trustworthiness of data utilization will be enhanced to create greater value for health policies and the public interest.

The National Health Insurance will continue to build a fair, smart, and resilient healthcare system that integrates medical care into everyday life. Through continuous reform and improvement, we aim to create a "Healthy Taiwan" and lay the foundation for a sustainable future for National Health Insurance.

Lian-Yu Chen

Lian-Yu Chen, M.D., Ph.D.
Director General
National Health Insurance Administration,
Ministry of Health and Welfare

Chapter



組織沿革　承先啟後

Organization Structure and History

組織沿革　承先啟後

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

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

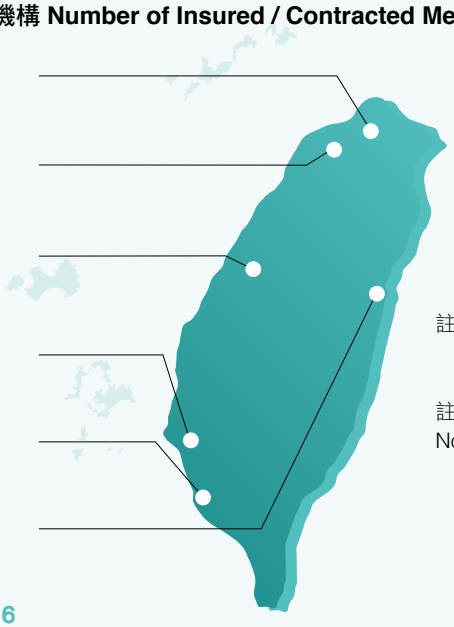
為有效推動全民健保各項服務，健保署除依業務專業性質設置專業組室，規劃各項業務措施之推動，在各地設有6個分區業務組（表1-1、圖1-1），直接辦理承保作業、保險費收繳、醫療費用審查核付及特約醫事服務機構管理等服務，同時設置22個聯絡辦公室，服務在地民眾。至2024年12月31日，在職員工計有2,980名。

表1-1　中央健康保險署各分區業務組
Table 1-1　The NHIA's Regional Divisions

• 保險對象人數 / 特約醫事服務機構 Number of Insured / Contracted Medical Institutions

- 臺北業務組 Taipei Division
  9,031,043 / 10,190
- 北區業務組 Northern Division
  4,045,971 / 4,376
- 中區業務組 Central Division
  4,287,646 / 6,632
- 南區業務組 Southern Division
  2,951,629 / 4,495
- 高屏業務組 Kaoping Division
  3,203,583 / 4,972
- 東區業務組 Eastern Division
  440,100 / 651

總計Total: 23,959,972 / 31,316



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。
註2：資料統計至2024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 2024.

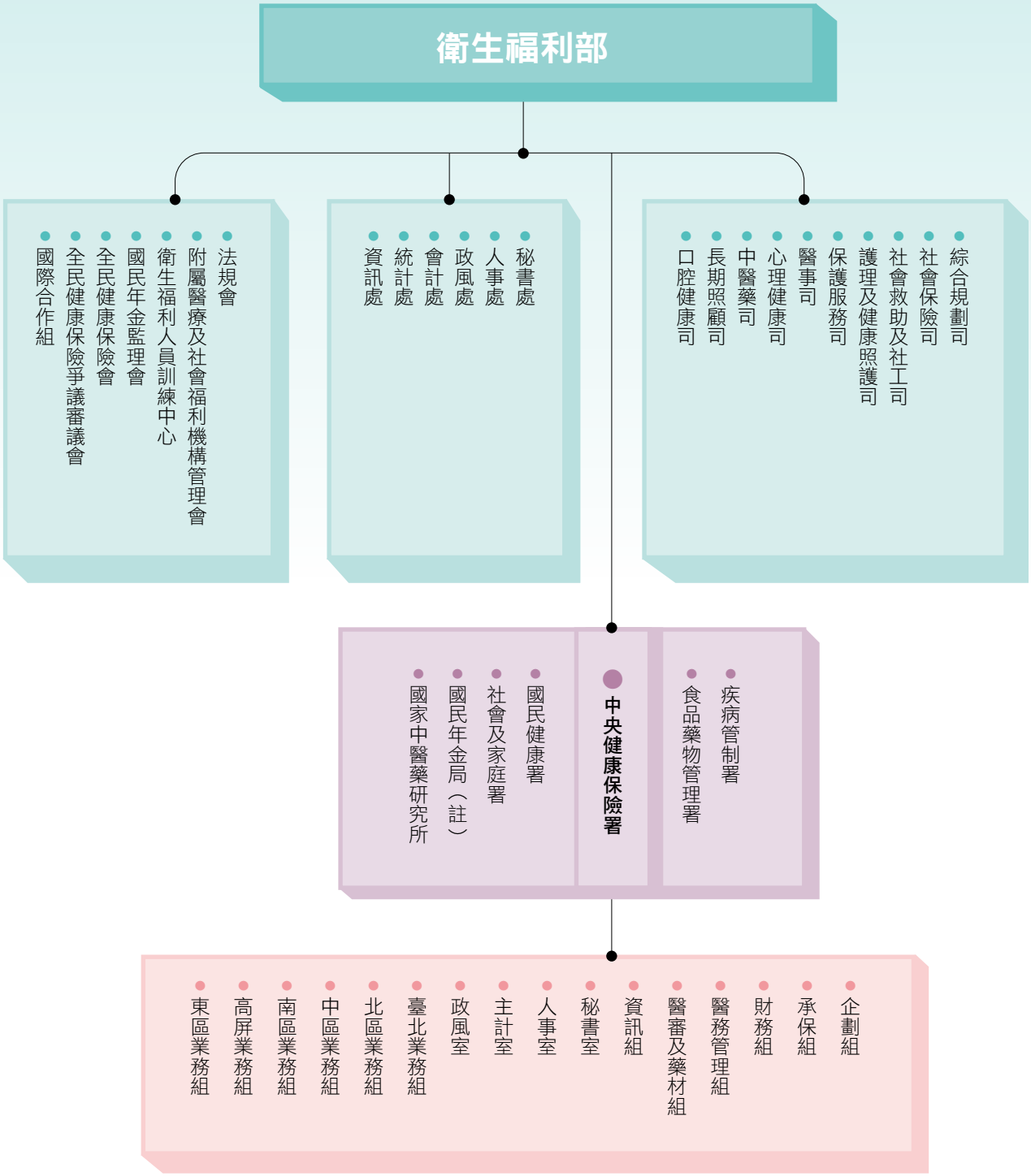
Organization Structure and History

The National Health Insurance Administration (NHIA) was formerly a finance/insurance business 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 for laborers, farmers, and government employees that covered approximately 59% of the population. As well as following the principles of sustainability and caring for the disadvantaged, this move was intended to develop a complete social insurance scheme that covers the entire population. In 2010, the NHIA was transformed as an administrative agency and consolidated in 2013. Today, it becomes the National Health Insurance (NHI) system, which is a government-run, single-payer scheme.

The Ministry of Health and Welfare (MOHW) is the competent authority of NHI, a type of government social insurance. Under the MOHW, the National Health Insurance Committee is responsible for assisting in formulating NHI policy and overseeing implementation of related affairs while the National Health Insurance Dispute Mediation Committee handles NHI disputes. As an insurer, the NHIA is responsible for NHI affairs, healthcare quality and information management, R&D, and personnel training. The central government shall budget the administrative expenses required by the NHIA.

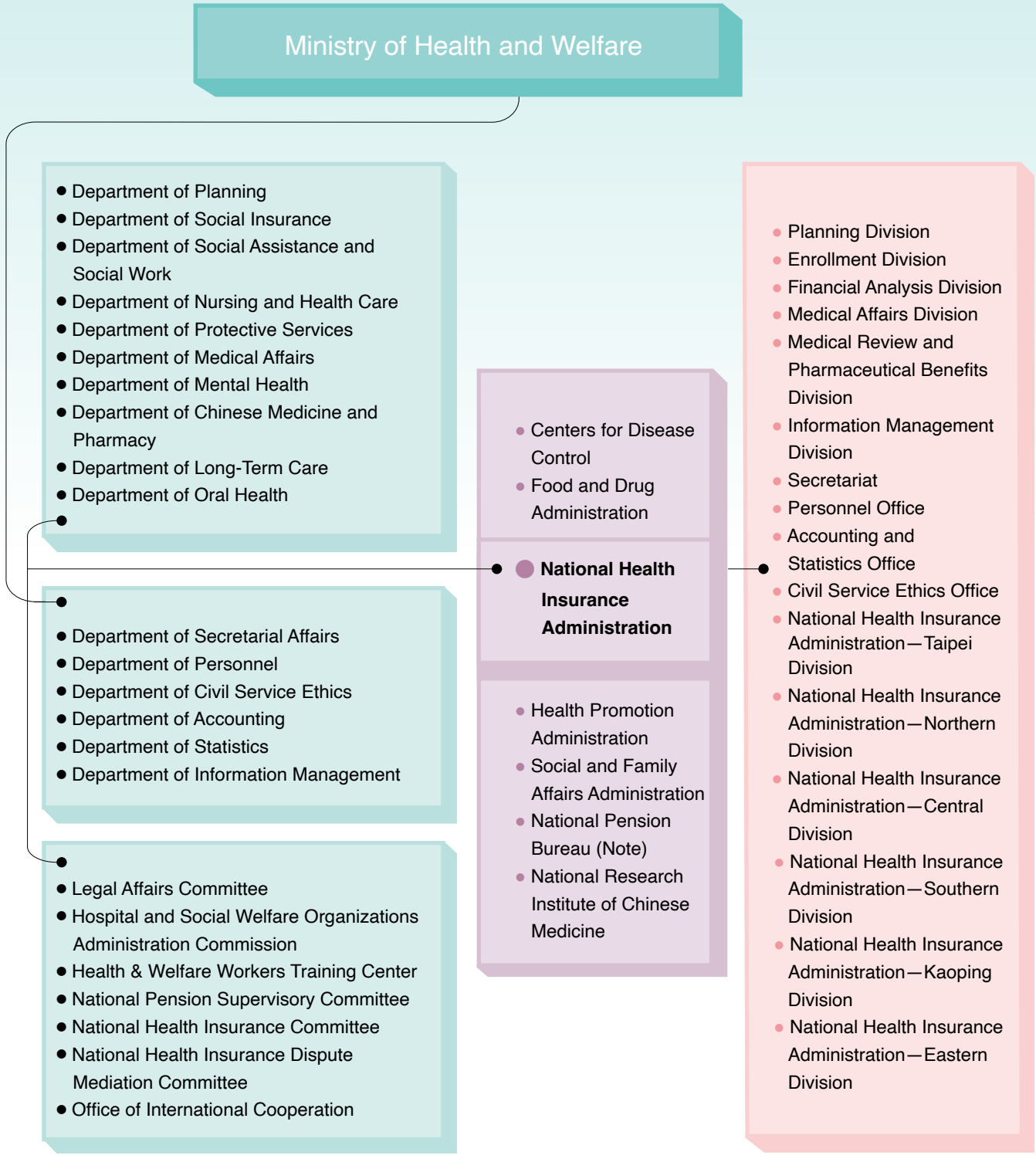
The NHIA has established various specialized departments to handle operations for the provision of NHI services. Six regional divisions (Table 1-1 and Chart 1-1) are in place to handle enrollment, premium collection, medical expense review and approval, and the management of contracted medical institutions. They are supplemented by 22 liaison offices throughout the country for the delivery of localized services. As of December 31st, 2024, the NHIA had 2,980 employees.

圖1-1　中央健康保險署組織架構圖



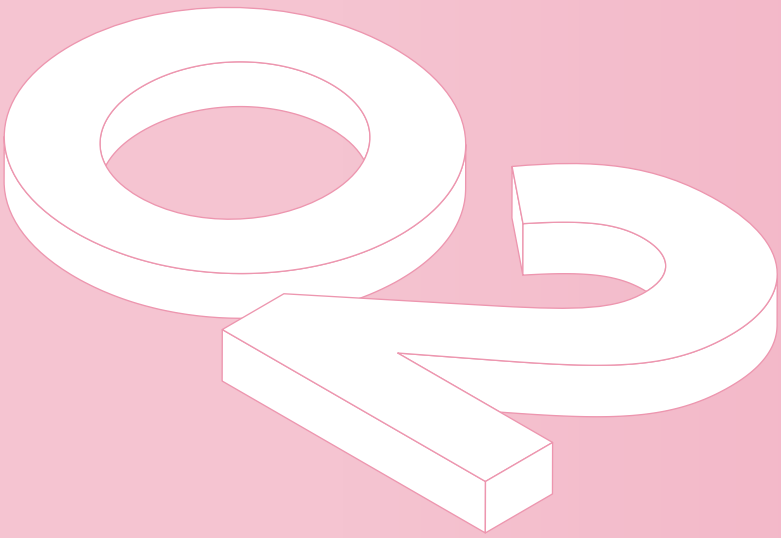
註：國民年金局暫不設置，衛生福利部組織法明定其未設立前，業務得委託相關機關（構）執行。

Chart 1-1　NHIA Organization Chart



Note: The National Pension Bureau has yet to be established. The Organization Act for the Ministry of Health and Welfare stipulates that prior to the establishment, the operations of the bureau may be handled by other government agencies (or entities).

Chapter



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2024年12月底止，參加全民健保的總人數有2,395萬9,972人（表2-2），投保單位有101萬9,735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。

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。

Universal Coverage and Financial Sustainability

Universal Healthcare Coverage, Equal Access to Medical Care

The government initiated the National Health Insurance (NHI) scheme to provide the entire population with health security via a self-help and a mutual assistance system. As such, NHI coverage was extended to dependents, veterans, and the unemployed—people in the non-working population (including women, students, children, and the elderly—who were not covered prior to its inception. All 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, who have had a registered domicile in Taiwan for six months or more, and all newborns in the Taiwan area to participate in NHI. The insured are classified into six categories (Table 2-1), based on which insurance premiums are calculated.

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

To further promote equal right to medical care, second-generation NHI included inmates in correctional facilities 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 possess an Alien Resident Certificate (ARC) and have resided in Taiwan for at least six consecutive months, so as to respond to public expectations of social fairness and justice.

As of the end of December 2024, NHI participants numbered 23,959,972 (Table 2-2) and group insurance applicants, 1,019,735.

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 small amount is supplemented by premium overdue charges and contributions from the Public Welfare Lottery surplus and the tobacco health and welfare surcharge.

Social and demographic changes, however, have led to NHI expenditure growing far faster than premium income. In addition to broadening sources of income and conserving funds, the NHIA increased the premium rate in 2002, 2010, and 2021. In keeping with the spirit of the ability to pay, the NHI 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 the highest premiums are collected. Measures also phased

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 the Insured		投保單位 Group Insurance Applicants
	本人 Insured Person	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 faculty / staff		
	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, 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 Services 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 the Insured		投保單位 Group Insurance Applicants
	本人 Insured Person	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	
	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 person to qualify as a dependent or a member of Category 6.
　　2. From January 1st, 2013, inmates in correctional facilities were included as Category 4 beneficiaries in the NHI system.

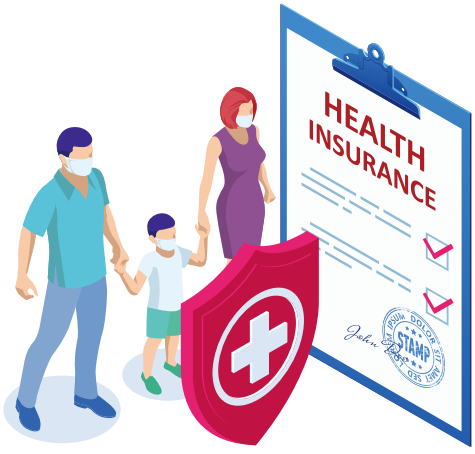


表2-2 全民健保各類保險對象人數
Table 2-2 Number of NHI Enrollees by Category

	第1類 Category 1	第2類 Category 2	第3類 Category 3	第4類 Category 4	第5類 Category 5	第6類 Category 6	總計 Total
人數 Number of Enrollees	14,738,165	3,419,965	1,782,750	101,632	256,914	3,660,546	23,959,972
占總納保人數百分比 Percentage	61.51%	14.27%	7.44%	0.42%	1.07%	15.28%	100%

資料時間：2024年12月31日
Dated: As of December 31st, 2024

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）。

in over the years to calculate the premiums for military personnel, civil servants, and teachers according to their total compensations rather than basic salaries. Supplementary premiums from six types of income hitherto not included in premium calculations are collected, and a lower limit for government contribution is also set. All these measures have been adopted to stabilize NHI finances and ensure that NHI is structurally sound to continue to operate.

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 to become the National Health Insurance Committee. Comprising the insured, employers, insurance medical service providers, experts and scholars, impartial persons, and representatives of related agencies, the committee is entrusted to review the premium rate based on the negotiated total of medical benefit payments each year. The review outcome is then presented first to the Ministry of Health and Welfare (MOHW) and then to the Executive Yuan for approval. The aim is 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 maintained at 4.25%. For NHI financial 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 lowered to 4.91% from January 2013. Taking effect in January 2016, NHI's general and supplementary premium rates were further reduced 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 1st, 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 is calculated as the insured's premium ratable wage multiplied by the general premium rate. The premium of Categories 4-6 insured is calculated according to the average premium paid by those classified in categories 1 to 3 (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 Recipients	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2024年1月1日起公告為0.56人。
6.第4類及第5類平均保險費：2025年1月1日起調整為2,237元（調整前為2,160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 1st, 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: 0.56 from January 1st, 2024
6. Average premium for Categories 4-5 insured persons: Fully subsidized by the government, the premium was raised to NT$2,237 (from NT$2,160) from January 1st, 2025.
7. Average premium for Category 6 insured persons: Raised to NT$1,377 (from NT$1,249) from January 1st, 2021. With the government contributing 40%, each insured shall pay 60%, or NT$826 (up from NT$749 previously).

表2-4　全民健保保險費負擔比率
Table 2-4　NHI Premium Contribution Ratios

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

投保金額之訂定

第1類至第3類被保險人之投保金額，由衛生福利部擬訂分級表，報請行政院核定，自2025年1月1日起共有59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2025年1月1日起為2萬8,590元。

表2-5　2025年投保金額分級表
Table 2-5　2025 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1,200元 Bracket 1 NT$1,200	1	28,590	28,590以下 Less than 28,590
	2	28,800	28,591~28,800
第二組級距1,500元 Bracket 2 NT$1,500	3	30,300	28,801~30,300
	4	31,800	30,301~31,800
	5	33,300	31,801~33,300
	6	34,800	33,301~34,800
	7	36,300	34,801~36,300
第三組級距1,900元 Bracket 3 NT$1,900	8	38,200	36,301~38,200
	9	40,100	38,201~40,100
	10	42,000	40,101~42,000
	11	43,900	42,001~43,900
	12	45,800	43,901~45,800
第四組級距2,400元 Bracket 4 NT$2,400	13	48,200	45,801~48,200
	14	50,600	48,201~50,600
	15	53,000	50,601~53,000
	16	55,400	53,001~55,400
	17	57,800	55,401~57,800
第五組級距3,000元 Bracket 5 NT$3,000	18	60,800	57,801~60,800
	19	63,800	60,801~63,800
	20	66,800	63,801~66,800
	21	69,800	66,801~69,800
	22	72,800	69,801~72,800
第六組級距3,700元 Bracket 6 NT$3,700	23	76,500	72,801~76,500
	24	80,200	76,501~80,200
	25	83,900	80,201~83,900
	26	87,600	83,901~87,600
第七組級距4,500元 Bracket 7 NT$4,500	27	92,100	87,601~92,100
	28	96,600	92,101~96,600
	29	101,100	96,601~101,100
	30	105,600	101,101~105,600
	31	110,100	105,601~110,100

Set Payroll Brackets for Calculating Premiums

When it comes to the premium ratable wages of Categories 1-3 insured, 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 1st, 2025 has 59 brackets (Table 2-5). The premium ratable wages of Category 1 insured refer to the payroll of employees, based on which group insurance applicants (employers) pay premiums according to the corresponding bracket in the aforementioned table. Beginning on January 1st,

組別級距 Bracket	投保等級 Income Tier	月投保金額（元） Monthly Premium Ratable Wage (NT$)	實際薪資月額（元） Actual Monthly Wage (NT$)
第八組級距5,400元 Bracket 8 NT$5,400	32	115,500	110,101~115,500
	33	120,900	115,501~120,900
	34	126,300	120,901~126,300
	35	131,700	126,301~131,700
	36	137,100	131,701~137,100
	37	142,500	137,101~142,500
	38	147,900	142,501~147,900
	39	150,000	147,901~150,000
第九組級距6,400元 Bracket 9 NT$6,400	40	156,400	150,001~156,400
	41	162,800	156,401~162,800
	42	169,200	162,801~169,200
	43	175,600	169,201~175,600
	44	182,000	175,601~182,000
第十組級距7,500元 Bracket 10 NT$7,500	45	189,500	182,001~189,500
	46	197,000	189,501~197,000
	47	204,500	197,001~204,500
	48	212,000	204,501~212,000
	49	219,500	212,001~219,500
第十一組級距8,700元 Bracket 11 NT$8,700	50	228,200	219,501~228,200
	51	236,900	228,201~236,900
	52	245,600	236,901~245,600
	53	254,300	245,601~254,300
	54	263,000	254,301~263,000
第十二組級距10,000元 Bracket 12 NT$10,000	55	273,000	263,001~273,000
	56	283,000	273,001~283,000
	57	293,000	283,001~293,000
	58	303,000	293,001~303,000
	59	313,000	303,001以上 Above 303,001

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；2024年全年補充保險費計收約715億元，占同年保險費收入約8.9%。

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。

圖2-1　二代健保保險費示意圖

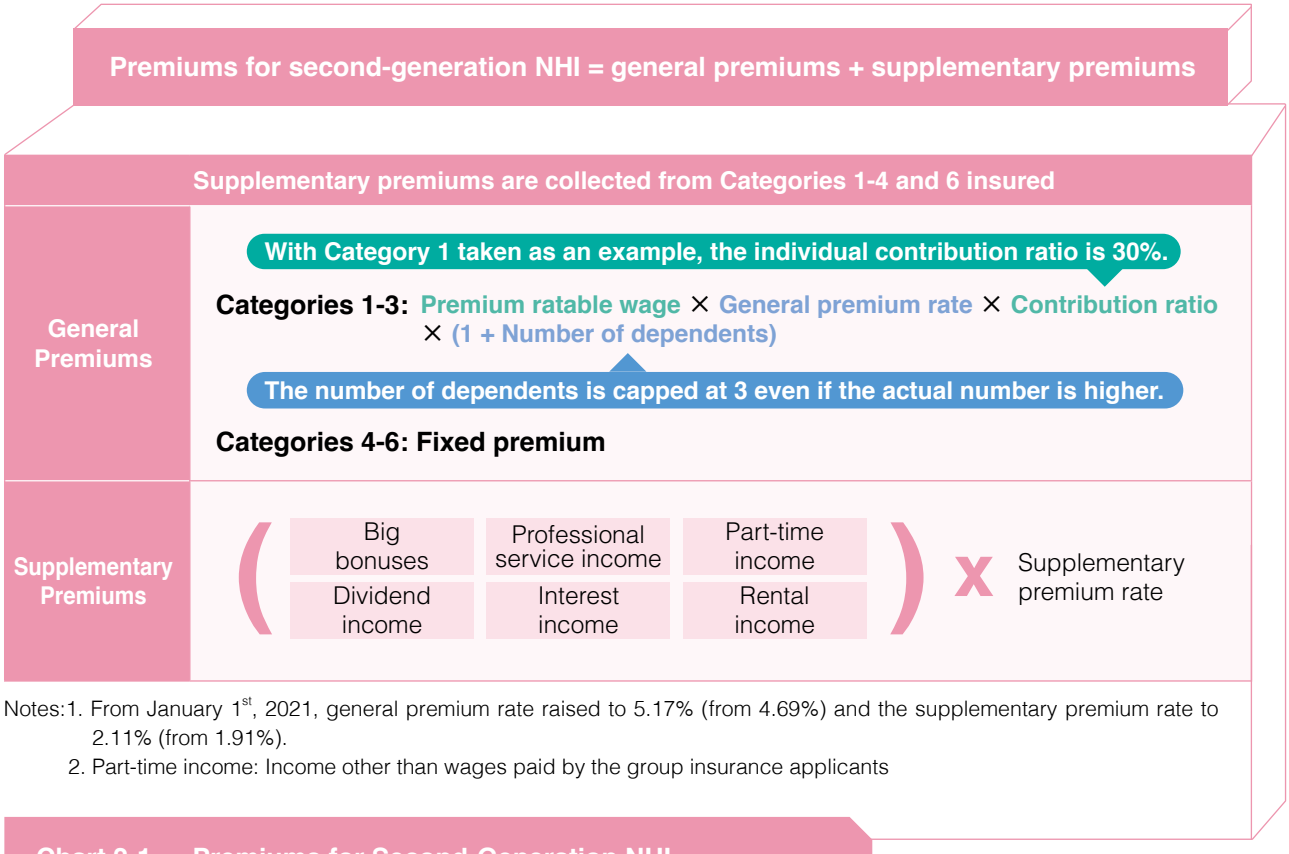
健保財務收支情形

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2024年12月累計收支結餘為1,622億元（表2-6）。

2025, the minimum premium ratable wage for Category 2 insured with no particular employers and the premium ratable wage for Category 3 insured—farmers and fishermen—are both NT$28,590.

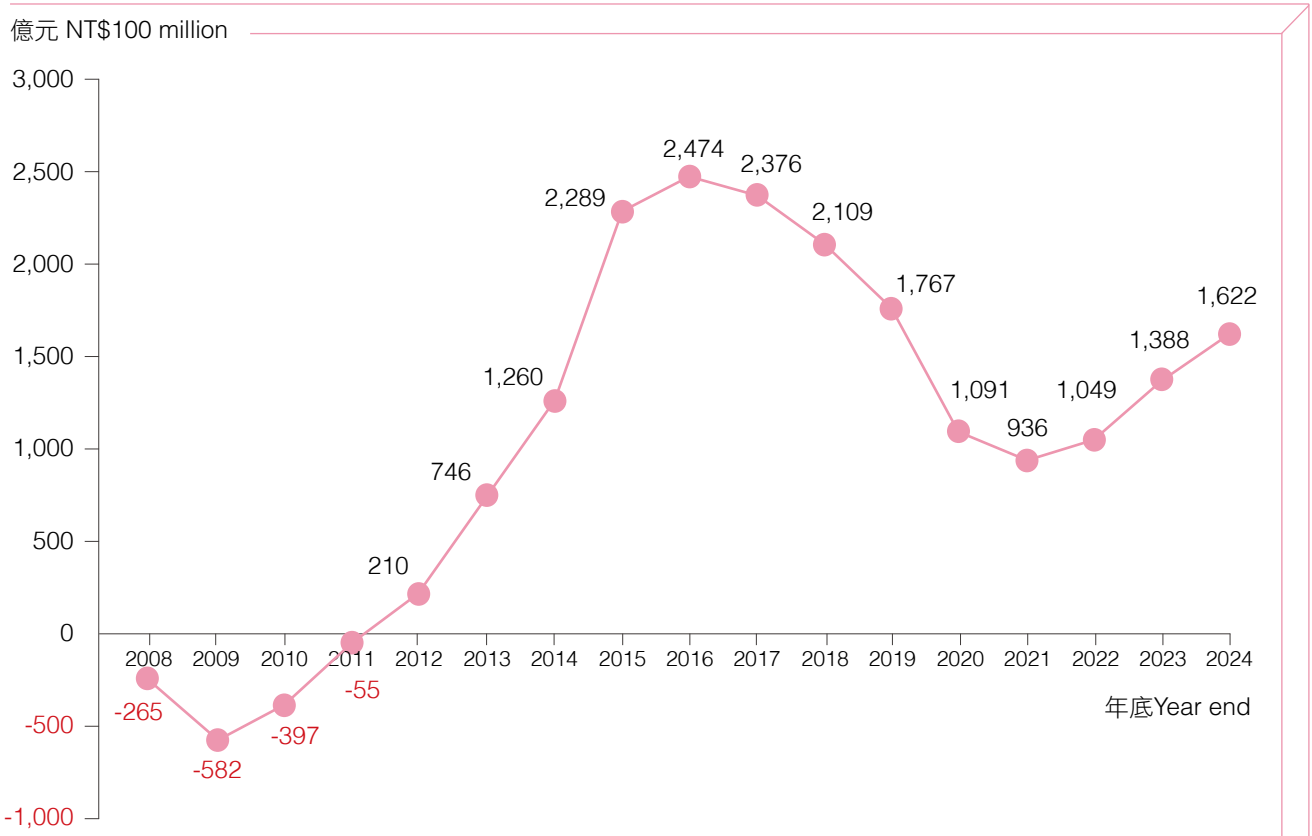
Calculation of Supplementary Premiums

Second-generation NHI added supplementary premiums to general premiums that are collected on the basis of premium ratable wages. Hitherto uncovered items—big bonuses, part-time income, professional service income, dividend income, interest income, and rental income—are now included for calculating supplementary premiums. It is hoped that the 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 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 2024, NHI supplementary premiums amounted to around NT$71.50 billion, accounting for 8.9% of all premium income for the year.



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

Chart 2-1　Premiums for Second-Generation NHI



- 截至2024年12月底，歷年保險費收支結餘1,622億元，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 2024, NHI recorded a cumulative surplus of NT$162.2 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.

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

財務改革措施 Fiscal Reforms

2010年4月
- 費率由4.55%調整至5.17%

April 2010
- Premium rate 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
- General premium rate 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
- General premium rate reduced to 4.69% from 4.91%.
- Supplementary premium rate 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
- General premium rate raised to 5.17% from 4.69%.
- Supplementary premium rate raised to 2.11% from 1.91%.

Balance of 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) occurred when its second generation version was launched in January 2013. An expanded income base, thanks to the addition of supplementary premiums and higher ratios of government contribution, helped ease NHI's financial burden. Medical expenditures, however, continued to increase far faster than premium income. Given a steadily widening deficit from 2017, the NHI premium rate was again raised from January 2021. As of December 2024, NHI recorded a cumulative surplus of NT$162.2 billion (Table 2-6).

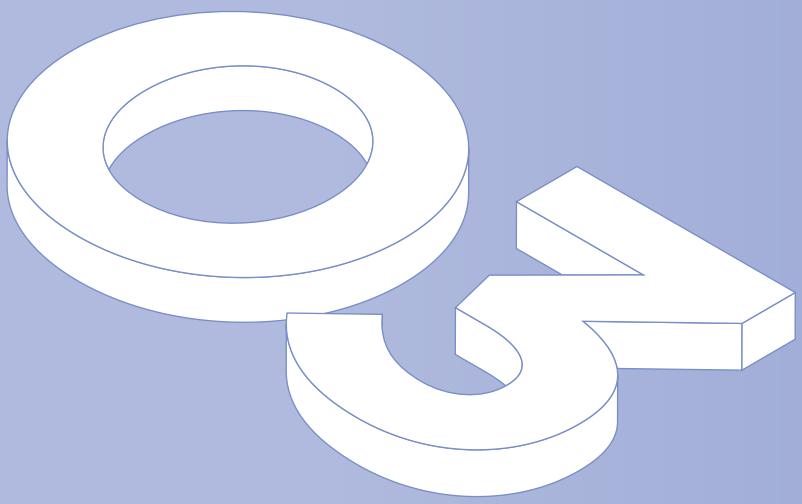
表2-6　最近5年全民健康保險財務收支狀況（權責基礎）
Table 2-6　NHI Revenues and Expenditures of the Past Five Years (Accrual Basis)

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 (%)		
2020	6,278	0.87	6,954	5.91	-676	1,091
2021	7,119	13.39	7,274	4.60	-155	936
2022	7,603	6.81	7,491	2.98	113	1,049
2023	8,110	6.66	7,771	3.74	339	1,388
2024	8,344	2.89	8,110	4.37	234	1,622
1995/3~2024/12	140,852	-	139,231	-	-	1,622

註：1.資料截至2024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 2024.
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



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2024年12月底止，全民健保特約醫療院所合計達2萬2,352家，占全國所有醫療院所總數91.01%（表3-1）；另有特約藥局7,649家、居家護理機構741家、精神復健機構284家、助產機構16家、醫事檢驗所211家、物理治療所29家、醫事放射所9家、職能治療所8家及居家呼吸照護所17家，保險對象可自由選擇醫療院所接受醫療照護服務。

2024年平均每人每年門診就醫次數16.4次，平均每百人住院次數14.8次，全國每人每年平均住院日數1.33日。

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	24,561	459	12,667	4	4,299	1	7,131
特約醫療院所數 Contracted Medical Institutions	22,352	459	10,901	4	4,024	1	6,963
特約率 Percentage of Contracted Institutions	91.01%	100%	86.06%	100%	93.60%	100%	97.64%

資料時間：2024年12月31日。
Data time: December 31st, 2024

Comprehensive Benefits and Convenient Access

Scope of Benefits

In case of illness, accident, or childbirth, the insured can receive healthcare at contracted medical institutions with their NHI cards, including hospitals, clinics, pharmacies, and medical laboratories.

Currently, the NHI offers the following healthcare services: outpatient care, hospitalization, Traditional Chinese Medicine (TCM), 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, medial devices, therapy, nursing, and insured beds. It can be said 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 an emergency illness, injury, or childbirth, and require immediate care at a local medical institution, they can apply for reimbursement of their self-paid overseas medical expenses within 6 months of the date of emergency care, outpatient treatment, or hospital discharge. 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 2024, there were a total of 22,352 NHI contracted hospitals and clinics, accounting for 91.01% of all hospitals and clinics nationwide (Table 3-1). There were also 7,649 contracted pharmacies, 741 home care institutions, 284 psychiatric rehabilitation institutions, 16 midwifery institutions, 211 medical testing institutions, 29 physical therapy clinics, 9 medical radiological test institutions, 8 occupational therapy clinics, and 17 home respiratory care institutions. The insured can freely choose the hospital or clinic at which they wish to receive healthcare services.

In 2024, the average number of per capita outpatient visits was 16.4, the average number of hospitalizations per 100 persons was 14.8, and the average number of days of hospitalization per capita was 1.33 days.

大家醫計畫　落實整合照護

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。

未來將以家庭醫師計畫為基礎，透過四大面向打造「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。

自2024年起家醫計畫著重加強參與醫師糖尿病及初期慢性腎臟病的疾病管理照護能力。截至2024年12月底，已有522個社區醫療群在運作，參與之基層診所5,544家，參與率為51.6%，參加醫師數7,949位，參與率為44.7%；透過社區醫療群受益者近627萬人。

自2024年8月27日起推動「全民健康保險地區醫院全人全社區照護計畫」，藉由整合醫院的醫療及人力資源，使三高病人（高血壓、高血糖、高血脂）於最常就醫之醫院獲得完善且整合性之醫療照護（含預防保健、癌症篩檢、疫苗接種、疾病治療、相關檢驗（查）、24小時諮詢及生活習慣諮商），以延緩慢性疾病重症之發生。2024年計127家地區醫院、471位醫師參與，已收案4萬5,655人。

居家整合照護計畫與健保遠距醫療提升就醫可近性

全民健保自1995年開辦起，陸續推動行動不便患者一般居家照護、慢性精神病患居家治療、呼吸器依賴患者居家照護、末期病患安寧療護等多項居家醫療照護。為改善不同類型居家醫療照護片段式之服務模式，自2016年2月起健保署將一般居家照護、呼吸居家照護、安寧居家療護等服務，整合為「居家醫療照護整合計畫」。計畫的特色為擴大照護對象、強化個案管理機制，且著重於促進社區內照護團隊之合作，包括各類醫事人員間之水平整合，及上、下游醫療院所之垂直整合，以病人為中心提供完整醫療服務。

自2019年6月起計畫擴大服務內容，納入中醫師及藥師服務，並加重居家主治醫師的責任，病患之整體照護需求，由居家主治醫師整體評估，必要時再連結中醫師、護理師、呼吸治療師等其他醫事人員服務。截至2024年12月，有3,436家醫事服務機構組成232個團隊，就近照護約8.8萬人。

為提供行動不便者之連續性照護，2024年健保署推動「在宅急症照護試辦計畫」，提供行動不便之感染急症患者住院替代服務，由醫事人員前往案家或照護機構提供民眾抗生素治療，並配合「通訊診察治療辦法」公告及虛擬健保卡推動，以視訊診療取代實地訪查，提高醫師診治病人效率，即時

Grand Family Physician Integrated Care System implements integrated care service

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

In the future, the Grand Family Physician Plan will be expanded mainly as follows: expanding service coverage, digitalized 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.

Since 2024, the Family Physician Plan has focused on strengthening participating physicians'disease management and care capabilities for diabetes and early-stage chronic kidney disease. As of the end of December 2024, a total of 522 community healthcare groups had been set up for operation. They comprised 5,544 primary care clinics and 7,949 physicians, translating into participation rates of 51.6% and 44.7% respectively. More than six million people benefit from these community healthcare groups.

Starting from August 27th, 2024, the "Holistic and Community Care Program of NHI Regional District Hospitals" was launched. By integrating hospitals' medical and human resources, patients with the three highs (hypertension, hyperglycemia, and hyperlipidemia) can receive comprehensive and integrated medical care at the hospitals they most frequently visit (including preventive health services, cancer screening, vaccination, disease treatment, related laboratory tests/examinations, 24-hour consultation, and lifestyle counseling) to delay the onset of severe chronic diseases. In 2024, a total of 127 district hospitals and 471 physicians participated, with 45,655 patients enrolled.

Home Health Care Integration Program and NHI Medicare Telemedicine Improve the Accessibility of Medical Resources

Since 1995, home health care services have been available for disabled, chronically mentally ill, ventilator-dependent, terminally ill, and hospice patients. In order to improve the fragmented service models of different types of home care, the NHIA integrated three types of services, including general home care, respiratory home care, and hospice care, as the "Home Health Care Integration Program" in February 2016. The goal of the program is to expand the types of people who receive the services, strengthen case management mechanisms and promote cooperative team

追蹤病人病情。健保署將持續推動居家醫療及在宅急症照護等服務，讓病患回歸社區生活，截至2024年12月，有746家醫事服務機構組成167個團隊，收案1,290人次。

為增進山地離島及偏僻地區民眾專科醫療可近性與照護完整性，自2020年12月29日公告「全民健康保險遠距醫療給付計畫」，以醫師對醫師（B to B）之方式提供民眾迫切需要的專科門診遠距會診或急診遠距會診（不限科別），期能充實偏遠地區在地醫療資源。另為持續提升偏遠地區民眾專科醫療可近性，自2025年8月開放遠距專科會診不限西醫專科別。此外，為便利民眾就醫及醫師查詢雲端就醫紀錄，作為診療參考，鼓勵院所協助病人綁定虛擬健保卡並透過虛擬健保卡進行遠距醫療。

衛生福利部已於2024年1月22日發布修正「通訊診察治療辦法」，並自2024年7月1日施行，依通訊診察治療辦法第21條規定，通訊診療之病人為全民健保之保險對象時，其保險給付，應依全民健康保險法及其相關法規之規定辦理。為兼顧病人安全與就醫便利性，健保署規劃由低風險及風險可控之就醫模式逐步以專款計畫納入健保給付，第一階段以偏遠地區、區域聯防及矯正機關之遠距會診為主軸，通訊診察則限衛教諮詢（如大家醫計畫、鼓勵腹膜透析計畫）；第二階段放寬在宅急症照護視病人病情使用通訊診療，另倘現行矯正機關醫療服務未能滿足收容人需求時，除配合遠距醫療放寬專科會診不限西醫專科別之外，亦得開設通訊診療門診（限皮膚科及精神科）；健保署將持續檢討遠距及通訊診療相關計畫及政策，並視執行成效研議擴大至其他實體就醫困難之族群。

care in the community. This program also calls for the horizontal integration of various types of medical personnel and the vertical integration of upstream and downstream hospitals and clinics, and seeks to provide comprehensive patient-centered medical services.

Starting from June 2019, the program has expanded its scope and started to include services provided by Chinese medicine physicians, and pharmacists. At the same time, the responsibility of home care doctors has been further emphasized. The home care doctor is responsible for evaluating a patient's overall needs for home care, and requesting services provided by other medical personnel, such as Chinese medicine physicians, nurses, and respiratory therapists, when necessary. As of December 2024, a total of 3,436 medical institutions had organized 232 teams to provide care to 88,000 persons.

To provide services for disabled patients with acute infections with alternative hospitalization, the NHIA launched a pilot program of home care for acute symptoms in 2024. Medical staff administer antibiotic treatment to patients in their homes or care facilities. In addition, with the implementation of the NHI virtual card and the announcement of regulations on telemedicine, on-site visits can be replaced by telemedicine, increasing the efficiency of medical treatment. Promotion of home health care and home care for acute symptoms will be continued by the NHIA, enabling patients to return to their community lives. As of December 2024, a total of 746 medical institutions had organized 167 teams to provide care to 1,290 persons.

A Medicare Telemedicine Benefit Plan was launched on December 29th, 2020, ensuring access to medical resources in mountainous regions, offshore islands, and remote regions. With B to B (doctors to doctors), the Plan provides services to those in urgent need of video consultations for certain specialties, as well as emergency teleconsultations (not limited to any specialty), so rural outpatient clinics are more accessible. To continuously improve the accessibility of specialized medical care for people in remote areas, starting from August 2025, specialist teleconsultations will be available without restrictions on the type of specialty. Additionally, through the NHI MediCloud System, people seeking care can also add their NHI virtual cards, which provide doctors with easy access to medical records and information for diagnosis.

The Ministry of Health and Welfare (MOHW) issued revised " Regulations of Medical Diagnosis and Treatment by Telecommunications" on January 22nd, 2024, which took effect on July 1st, 2024. According to Article 21 of the Regulations of Medical Diagnosis and Treatment by Telecommunications, for patients who are NHI beneficiaries and receive telemedicine services, their insurance benefits shall be provided in accordance with the National Health Insurance Act and its related regulations. To balance patient safety with healthcare accessibility, the National Health Insurance Administration (NHIA) plans to gradually include telemedicine in health insurance coverage through special programs, starting with low-risk and controllable medical care models. The first phase focuses on tele-expertise in remote areas, regional joint defense, and correctional institutions, with teleconsultations limited to health education counseling (such as the Grand

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3-2。

Family Physician Plan and Peritoneal Dialysis Promotion Program). The second phase will expand to allow telemedicine for patients who enrolled in the Acute Care at Home Program. Additionally, if current medical services in correctional institutions cannot meet inmates' needs, to relax the restrictions on specialist consultations to include all specialty through teleconsultations, telemedicine outpatient clinics may be established (limited to dermatology and psychiatry). The NHIA will continue to review programs and policies related to tele-expertise and teleconsultations, and consider expanding to other groups with physical access difficulties to healthcare based on implementation effectiveness.

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 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 five 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 (HPA) in 2006, and that same year a pay-for-performance plan for hypertension treated at 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 patients with early-stage chronic kidney disease. This was followed by the inclusion of a pay-for-performance plan for early-stage chronic kidney disease in the NHI fee schedule in April 2016.

In 2015, the management of the pay-for-performance program covering full-course maternal care for pregnant women returned to NHIA from the MOHW'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 to improve hospital medication safety and quality.

Patients enrolling in the hypertension plan usually 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 to consolidate care services. 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 on March 1st, 2022, the plan for "Diabetes Combined with Early-Stage Chronic Kidney Disease" was implemented to encourage healthcare institutions to form inter-disciplinary care teams to provide services. The care rates of each plan in recent years are shown in Table 3-2.

表3-2 全民健保醫療給付改善方案照護率
Table 3-2 Percentage of Patients Treated Under NHI-Pay-for-Performance Plans

方案別 Plan	2005	2006	2007	2008	2009
氣喘 Asthma	32.5	34.8	35.2	31.3	31.6
糖尿病 Diabetes	23.5	23.2	24.7	26.3	27.6
結核病 Tuberculosis	68.8	79.0	91.8	導入支付標準 Introduce fee schedule	-
乳癌 Breast cancer	12.1	13.0	13.6	14.6	14.5
高血壓 Hyper-tension	未實施 Not yet implemented	基層試辦 9.3 Trial at primary care level 9.3	6.5	3.9	2.7
思覺失調症 Schizophrenia	尚未實施 Not yet implemented				
B型C型肝炎帶原者 Hepatitis B/ Hepatitis C carrier	尚未實施 Not yet implemented				
初期慢性腎臟病 Early-stage chronic kidney disease	尚未實施 Not yet implemented				
孕產婦全程照護 Full-course maternity care	尚未實施 Not yet implemented				
早期療育 Treatment of development retardation	尚未實施 Not yet implemented				
慢性阻塞性肺病 Chronic obstructive pulmonary disease	尚未實施 Not yet implemented				
糖尿病合併初期慢性腎臟病 Diabetes combined with early -stage chronic kidney disease	尚未實施 Not yet implemented				

註：高血壓方案自2006年起於西醫基層開始試辦，2007年則擴大至醫院，其照護率因涵蓋基層診所及醫院，呈現照護率下降情形，又因病人常合併多重疾病，例如糖尿病、慢性腎臟病等，故未再以疾病別單獨另列計畫追蹤，自2013年起停止試辦。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，故糖尿病及初期慢性腎臟病之照護率將糖尿病合併初期慢性腎臟病照護人數納入列計。

單位：% Unit:%

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
47.0	45.5	39.3	37.5	41.9	36.0	28.2	29.5	35.1	35.6	38.3	41.1	38.6	38.1	36.7
29.3	31.4	33.9	35.1	41.9	41.1	43.4	47.9	51.3	55.4	58.0	59.9	60.9	62.4	64.0
-	-	-	-	-	-	-	-	-	-	-	-	-		-
14.6	13.7	13.4	13.1	10.9	10.6	9.7	8.2	7.7	7.3	7.1	7.0	7.0	6.1	5.8
2.6	2.9	1.4	註 Note											
40.7	46.9	51.2	52.2	59.1	62.0	63.9	68.2	69.2	67.3	66.4	67.1	59.3	61.6	62.1
9.8	19.4	26.1	30.6	37.2	32.6	35.3	36.6	39.9	41.5	41.5	42.4	43.6	46.4	48.1
	20.2	26.4	32.1	26.7	38.5	42.1	41.8	30.0	30.9	33.5	34.2	35.0	36.4	38.1
由衛生福利部醫療發展基金支應 Paid by MOHW's developmental fund					29.3	29.5	32.3	33.4	33.3	34.0	29.9	21.3	31.7	33.3
尚未實施 Not yet implemented						15.3	14.9	13.2	11.5	11.0	13.2	7.3	13.6	13.0
尚未實施 Not yet implemented							24.3	38.5	35.4	40.3	45.6	48.3	44.5	42.2
尚未實施 Not yet implemented												10.9	22.3	30.0

Note: The hypertension plan was first implemented on a trial basis at the primary care level in 2006, and expanded to 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 launched in March 2022. The care rate for diabetes and early-stage chronic kidney disease will include the care number of "diabetes combined with early-stage chronic kidney disease" plan.

部分負擔　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，西醫門診基本部分負擔按「未轉診」及「轉診」兩種方式計收。民眾若未經轉診直接到醫學中心、區域醫院、地區醫院就醫，就會付比較高的部分負擔。牙醫、中醫不分層級一律計收50元。此外，民眾看病時，如藥費超過一定金額，則須加收藥品部分負擔。同一療程中接受第2次以上的復健物理治療（中度一複雜、複雜項目除外）或中醫傷科治療，每次須自行繳交50元的部分負擔費用，但凡因重大傷病、分娩、山地離島地區就醫者及其他符合健保署規定者，均免收部分負擔。

2023年7月起，調整藥品部分負擔及急診部分負擔；為強化分級醫療，醫學中心及區域醫院門診藥品部分負擔調高負擔上限；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，基層診所、中低收入和身心障礙者不調整。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、急診及住院部分負擔如表3-3至表3-5。

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。

Copayment and the User-Pays Principle

NHI copayments are designed to be an important link in the social insurance system. They are also intended to stop the insured from thinking that the payment of NHI premiums entitles them to use health insurance resources without restraint. 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 institution such as a regional hospital or medical center. On July 15th, 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 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 TCM 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 TCM 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 July 2023, the copayment for OPD medication and emergency care was increased. To further tiered healthcare, a higher limit for medical centers and regional hospitals is set. Additionally, for the first dispensation of chronic disease prescriptions issued by hospitals, copayments will be charged for general medications. From the second dispensation 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 individuals and persons with disabilities. Regarding 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 3-3 to 3-5.

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 reduced from 10% to 5%. Such measures certainly benefit areas with shortages of medical resources and people who cannot easily travel to other places for medical attention.

表3-3 全民健保門診基本部分負擔與急診部分負擔
Table 3-3 NHI Copayments for Outpatient Visits and Emergencies

單位：新臺幣元
Unit: NT$

類型 Category	基本部分負擔 Basic Copayment				急診部分負擔 Copayment for Emergencies	
醫院層級 Types of Institution	西醫門診 Medicine Outpatient Care		牙醫 Dentistry	中醫 Traditional Chinese Medicine	一般民眾 General population	低收入戶 / 中低收入者 / 身心障礙者（註3-4） Low-income household / Near-poor household / Persons with disabilities (note 3-4)
	經轉診 With Referral	未經轉診 Without Referral				
醫學中心 Medical Centers	170	420	50	50	750	550
區域醫院 Regional Hospitals	100	240	50	50	400	300
地區醫院 District Hospitals	50	80	50	50	150	150
診所 Clinics	50	50	50	50	150	150

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.「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。
4.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。

Notes: 1. Regardless of the level of medical institutions, 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 with a referral with not more than 4 follow-up visits within one month of seeking medical attention and the 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.
3. "Low-income individuals" refer to those who qualify as low-income households under social assistance regulations. "Near-poor individuals" refer to those who qualify as near-poor households under social assistance regulations and elderly individuals over the age of 70 who qualify for subsidies for the elderly who are unable to bear NHI expenses. "Persons with disabilities" refer to individuals who hold a disability certificate issued by the competent social welfare authority.
4. The expenses that low-income households need to bear shall be subsidized by the central competent social welfare authority according to the law.

表3-4　全民健保藥品部分負擔
Table 3-4　Copayment rates for medication

單位：新臺幣元
Unit: NT$

藥品費用 Medication fees	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 NT$100	0元 (NT$)	0元　低收入戶 / 中低收入者 / 身心障礙者（註1） Low-income household (Note 1)/ Near-poor household/ Persons with disabilities NT$0	
		10元 (NT$)	
101 ～ 200元 (NT$)	20元 (NT$)	20元 (NT$)	
201 ～ 300元 (NT$)	40元 (NT$)	40元 (NT$)	
301 ～ 400元 (NT$)	60元 (NT$)	60元 (NT$)	
401 ～ 500元 (NT$)	80元 (NT$)	80元 (NT$)	
501 ～ 600元 (NT$)	100元 (NT$)	100元 (NT$)	
601 ～ 700元 (NT$)	120元 (NT$)	120元 (NT$)	
701 ～ 800元 (NT$)	140元 (NT$)	140元 (NT$)	
801 ～ 900元 (NT$)	160元 (NT$)	160元 (NT$)	
901 ～1,000元 (NT$)	180元 (NT$)	180元 (NT$)	
1,001 ～1,100元 (NT$)	200元 (NT$)	200元 (NT$)	200元 低收入戶（註2） / 中低收入者 / 身心障礙者 Low-income household (Note 2) / Near-poor household/ Persons with disabilities NT$200
1,101 ～1,200元 (NT$)		220元 (NT$)	
1,201 ～1,300元 (NT$)		240元 (NT$)	
1,301 ～1,400元 (NT$)		260元 (NT$)	
1,401 ～1,500元 (NT$)		280元 (NT$)	
1,501以上 More than NT$1,501		300元 (NT$)	

（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, outpatient medication expenses that need to be paid by themselves shall include the medication expenses for chronic disease and general medications incurred during the first dispensation.
2. The following situations are exempted from calculating outpatient medication expenses that need to be paid by the insured individuals:
a) Receiving dental services.
b) Receiving services covered by the NHI medical service payment items and payment standards for specific cases.
c) Low-income households, near-poor 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 medicine clinics and TCM 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" refer to members who meet the criteria of low-income households as defined by social assistance regulations. "Near-poor and low-income individuals" refer to those who qualify as near-poor and low-income households under social assistance regulations and elderly individuals over the age of 70 who qualify for subsidies for the elderly who are unable to bear NHI expenses. "Persons with disabilities" refer 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 paid by themselves according to current regulations.

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）、偏鄉地區全人整合照護執行方案、家庭醫師整合照護計畫，以增進醫療服務體系整合；並以品質與結果支付，例如論質計酬支付等。另為提升醫療服務效率，更自2010年1月1日起實施全民健保住院診斷關聯群支付制度（Taiwan Diagnosis Related Groups, Tw-DRGs），並於2014年7月1日起實施第2階段Tw-DRGs。

總額預算支付制度

健保署自1998年起陸續推動牙醫、中醫、西醫基層、醫院等部門總額支付制度，至2002年起全面採行總額預算支付制度，以有限健保資源提供有效率且高品質之醫療服務，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，近十年各總額部門醫療費用協定成長率如表3-6。

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。

表3-5　全民健保住院部分負擔
Table 3-5　Copayment Rates for Inpatient Care

病房別 Ward	部分負擔比率（%） Copayment Rates			
	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2025年以同一疾病每次住院上限為51,000元，全年累計住院上限為86,000元。
Note: In accordance with the MOHW's announcement, the copayment for each hospitalization for the same condition was capped at NT$51,000 in 2025; the annual limit of hospitalization copayments was NT$86,000.

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 fostered the unchecked growth of medical expenses and thus had 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 various 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, the Remote Area Integrated Holistic Implementation Plan and the "NHI Family Physician Plan," have enhanced integration of medical service systems. Under the P4P plan, 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 1st, 2010. The second stage of this program went into effect on July 1st, 2014.

Global Budget Payment System

The NHIA started to phase in global budget payments for dentistry, TCM, 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

年度開始6個月前
Six months before the fiscal year begins

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.

年度開始3個月前
Three months before the fiscal year begins

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，報主管機關核定

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. The global budget is then sent to competent authority for approval.

次年度開始2個月前
Two months before the fiscal year begins

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.

次年度開始1個月前
One month before the fiscal year begins

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

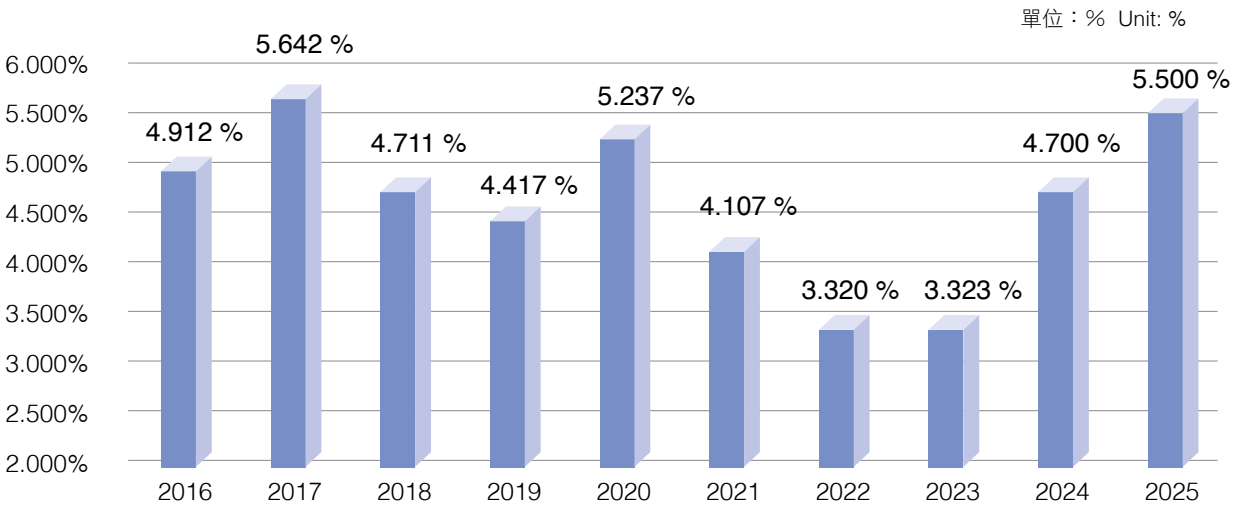
The National Health Insurance Committee must complete review of the premium rate needed to balance accrued revenues and expenditures for the year in accordance with the global budget it has set within one month before the start of the year.

費率公告實施
The premium rate is then announced and implemented.

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.

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



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.

圖3-2 近十年全民健保總額協定成長率
Chart 3-2 Growth Rate of Annual Global Budget Over the Past Ten Years

表3-6　全民健保近十年各總額部門醫療費用協定成長率
Table 3-6　Annual Negotiated Growth Rate of Global Budget Over the Past Ten Years

單位：% Unit: %

總額部門 Global Budget Sector	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
整體 Overall	4.912	5.642	4.711	4.417	5.237	4.107	3.320	3.323	4.700	5.500
牙醫門診 Outpatient Dentistry	3.463	3.246	4.001	3.433	3.876	3.055	2.756	2.588	2.436	4.679
中醫門診 Outpatient Traditional Chinese Medicine	3.927	4.066	3.699	4.429	5.393	4.306	4.208	4.344	4.221	5.274
西醫基層 Primary Care Medicine	4.274	5.157	4.053	4.067	4.401	3.552	2.744	3.008	3.757	5.500
醫院 Hospitals	5.672	6.021	4.800	4.428	5.438	4.382	3.504	3.663	4.700	5.500

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 over the past ten years are shown in Table 3-6.

To maintain 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 information 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.

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2024年12月，支付標準共計有4,872項診療項目，經統計2004年至2024年12月，共計125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3,389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，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，2025年5月1日起調升急性一般及經濟病床（含精神）之病床護理費12%至16%。

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。2023-2024年編列醫院總額專款15億元，以專款計畫方式用於區域級（含）以上醫院加護病床住院診察費及病房費、新生兒中重度住院診察費、急診觀察床病房費及護理費之支付點數差額，及地區醫院慢性呼吸照護病房論日計酬、急診診察費之額外加

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, fostering balanced development of medical care and giving local people access to the latest medical technologies. As of December 2024, the fee schedule covered a total of 4,872 diagnostic and treatment items after a cumulative 125 adjustments from 2004 to 2024. Separately, changes have been made to payment for a total of 3,389 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. In 2015, an additional NT$2 billion was set aside for adjusting hospital nursing fee. These measures have increased payment points and eased the burden on nursing personnel through linkage of payments and the nurse- to-patient ratio. The NHIA has used budgetary funds to adjust nursing fee on an annual basis: 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-to-patient ratio based fee standards in 2018, and NT$475 million in 2019 to increase hospital nursing fees for acute general beds (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 hospitals and higher level hospitals, 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 hospitals and higher-level hospitals, as well as acute general 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 skill-mixed care model during hospitalization. Starting from May 1st, 2025, nursing care fees for acute general beds (including psychiatric bed) will be increased by 12% to 16%.

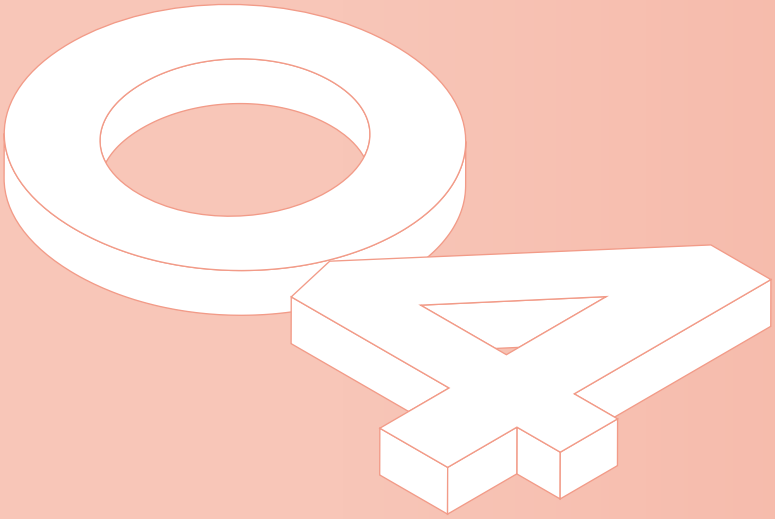
成3%-15%。2024年挹注3.38億元，用於挹注新生兒中重度住院診察費、兒童加護病房住院診察費、病房費及護理費等項目。2025年以其他預算41.56億元，用於急診相關基本診療項目（急診診察費拆分為診察費及護理費、急診觀察床診察費及護理費）、急救責任醫院加護病房基本診療項目、離島急救責任醫院急診案件醫療服務支付及急性一般（含精神）病床住院護理費支付點數。

為壯大西醫基層診所服務量能，擴大其服務範疇，自2017年起至2024年累計編列70.2億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、2021年起開放「無壓迫性試驗」等5項診療項目、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。

As part of the implement for tiered healthcare system, the NHIA drew from increased funds from the "Medical Consumer Price Index" in the hospital global budget to adjust payment 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 on October 1st, 2017, the payment for 167 diagnostic and treatment items were increased, the markup rate for children in 1,513 surgical items was relaxed, and general principles for surgery,emergency care on weekends and holidays, and pediatricians' markup rate were relaxed. In addition, payment 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 fees 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 Consumer Price Index," which increased emergency care fees and payment for 400 critical diagnostic and treatment items. In 2022, the budget was meant to "enhance the fees for intensive care services and promote structural changes in outpatient and inpatient services in regional-hospitals and higher hospitals." Such budget was used to increase fees for intensive care services, ensuring fixed-point values for the inpatient examination fees and ward charges of intensive care beds at regional hospitals and higher hospitals, and enhancing the quality of inpatient care. For 2023-2024, a special hospital budget allocation of NT$1.5 billion was designated through special funding programs for payment differentials in intensive care bed hospitalization consultation fees and ward fees at regional hospitals (and above) hospitals, neonatal moderate-to-severe hospitalization consultation fees, emergency observation bed ward fees and nursing fees, as well as an additional 3%-15% enhancement for daily payment in chronic respiratory care wards at district hospitals and emergency consultation fees. In 2024, NT$338 million was allocated for neonatal moderate-to-severe hospitalization consultation fees, pediatric ICU hospitalization consultation fees, ward fees, and nursing fees. In 2025, NT$4.156 billion from other budgets will be used for emergency-related basic medical service items (emergency consultation fees split into consultation fees and nursing fees, emergency observation bed consultation fees and nursing fees), basic medical service items for designated emergency hospital ICUs, medical service payments for emergency cases at offshore designated emergency hospitals, and payment points for acute general (including psychiatric) bed hospitalization nursing fees.

To enhance the capacity of primary care, the NHIA has allowed items previously limited to hosptials to also be claimed by western medicine primary clinics. Between 2017 and 2024, the NHIA provided NT$7.02 billion for expansion, including 25 items (such as influenza A virus antigen test) in 2017, a total of 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.

Chapter



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。一年門診申報件數約3億9千萬件，平均每日約107萬件，一年住院約353萬件，平均每日約9.7千件。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，啟動相關措施，避免醫療資源浪費。

電腦醫令自動化審查

針對全民健康保險醫療服務給付項目及支付標準、全民健康保險藥物給付項目及支付標準等給付規定，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。

Professional Review and Quality Improvement

To avoid health care overuse and ensure quality, the medical service review system is an essential mechanism. The focal points of medical service review consist of medical care items, quantities, and appropriateness. An average of approximately 390.00 million outpatient reimbursement claims are made every year, and roughly 1,070,000 such claims are made daily. Some 3.53 million inpatient care claims made annually work out to roughly 9,700 such claims every day. Based on considerations of manpower and administrative cost, two types of medical services review can be employed: procedural review and professional review. Computer technology and data analytics are used extensively in these review processes. The NHIA is striving to enhance review efficiency through the development of computerized review systems for automated review system and profile analysis.

Professional Review

Due to the huge volume of reimbursement claims, the NHIA employs a sampling approach in professional review. A sample of patient records is sent for review by medical experts. The sampling methods 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.

The Directions of National Health Insurance Claims Review were set after collecting the opinions of medical specialist associations, physicians' associations, and hospital associations, followed by discussion at advisory conferences of specialists from among the group of medical experts with relevant clinical or practical experience. Since 2017, these guidelines have been revised to rearrange more logically on the basis of the most common modes of treatment or procedures in various medical specializations. They have also been coded in parallel with medication payment regulations to facilitate computerized audits and to provide reference for reviewing physicians.

Applying Technology to Increase Review Efficiency

The NHIA has gradually promoted medical claims computerization, 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 assist the formulation 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 that are ineligible. This approach has gradually enhanced the accuracy of claims made by hospitals and clinics, improving review performance.

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。

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，公開健保「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、特定疾病類指標等資訊，期藉由品質資訊公開，激勵院所提升醫療服務品質，及增進大眾瞭解國內之醫療品質與醫療利用概況，作為就醫選擇之參考。

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。

Profile Analysis

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

The NHIA has been promoting computerized review processes since 2014, with priority given to enhancing 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.

Disclosure of Medical Quality Information

To enhance quality of medical service, the NHIA established the Medical Quality Information Disclosure Platform in 2005, which discloses "The NHI Professional Medical Service Quality Report" along with NHI medical quality indicators, specific disease indicators and other relevant information to the public. Such disclosure aims to motivate healthcare facilities to enhance their service quality. Meanwhile, with transparent insight information, the public are able to know healthcare utilization of domestic medical institutions as their reference for healthcare decision-making.

The NHIA's website also offers other basic information of contracted medical institutions, such as service items, medical departments, regular service hours, insurance bed ratios, and registration fees, as well as information on medical institutions that have violated applicable regulations.

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日起試辦至今已超過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。

Reasonable Drug Price Adjustment

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

Beginning in 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 expenditure. The money saved from reductions in drug prices is used to accelerate the entry of new drugs and approval of payment, expand the scope of drug payments, and adjust items with low fees. This allows 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 overall, the NHIA implemented the "NHI Drug Expenditure Target" on a trial basis on January 1st, 2013. This system presets target values for annual drug expenditures and ties them to actual drug expenditures each year. When the target values are exceeded, the system automatically activates an annual adjustment of drug prices, thereby ensuring the drug prices to stay within a stable, reasonable range.