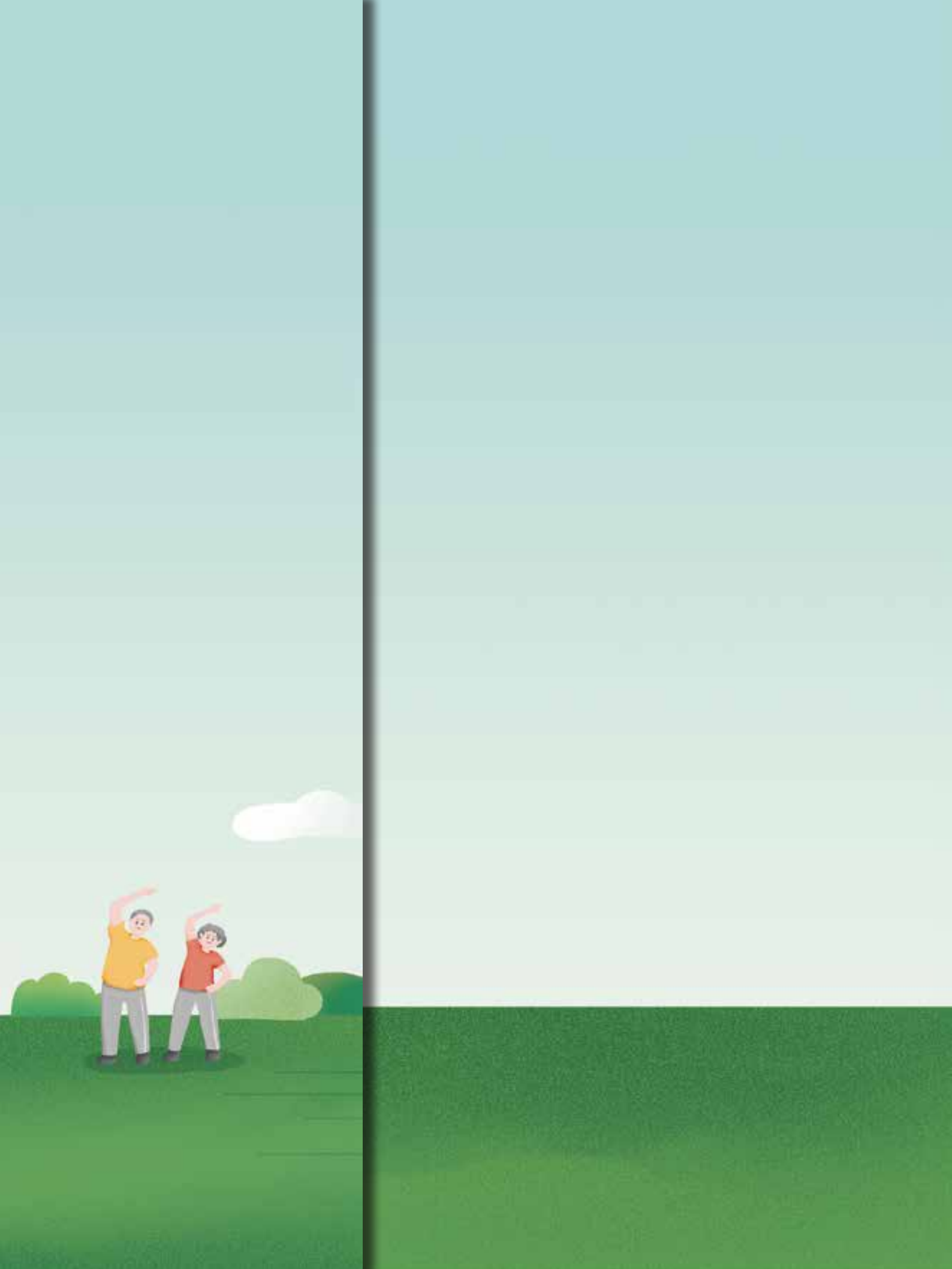




全民健康保險年報

National Health Insurance
Annual Report
2024-2025







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署長的話

Message from the Director General

全球資料庫網站NUMBEO發布2024年全球醫療照護指數(Health Care Index)，臺灣以86.0分居冠，蟬聯6年世界第1，顯見，全民健保滿足民眾就醫的可近性，具高滿意度，便宜又方便。在與有榮焉之際，我們無法忽視臺灣在慢性病照護、癌症治療、平均餘命仍低等醫療品質投資不足的問題，這正是全民健保邁向第30年的嚴肅議題，需要認真面對及因應。

健保刻正面臨四大面向的挑戰，包括醫療利用率高，資源投入低，新癌罕藥昂貴醫療支出增加，超高齡社會在宅照護需求增加，及後疫時代智慧醫療的全面翻轉。服務轉型、給付轉型及數位轉型，是目前我們提出並正在努力落實的解方。

大家醫計畫，以人為中心提供自我照顧、預防保健及醫療的整合性照護，數位化追蹤提升照護品質；擴大居家醫療範疇，推動在宅急症照護，連結長照服務實現在地老化目標；將醫療決定權交還病人，納入健保給付預立醫療諮商服務；加速新藥、新醫材的收載，推動暫時性支付，提供癌症精準醫療納入NGS檢測健保給付，並完備相關法規

保障病人隱私及獲得最適治療選擇；為實現Hospital without wall目標，啟動大規模數位轉型計畫，強化數位基礎建設，資料交換接軌國際，加速醫療資訊系統的革新，建構以人為本之價值照護。

2025年就是健保30年，是蛻變與躍起的時刻。健保署承接過去榮耀及努力的基底，要持續透過不斷創新的管理思維，以提升民眾醫療品質為依歸，實踐透過醫療政策，打造「健康臺灣」的願景而努力。

衛生福利部中央健康保險署 署長

石崇良





Taiwan retained its top ranking for the sixth year in the Health Care Index 2024 issued by international Numbeo website, with a score of 86.0. This indicates that the public is very satisfied with the accessibility, convenience and low cost of medical resources provided by the National Health Insurance (NHI) scheme. In spite of this, chronic disease care, cancer treatment, and short life expectancy, areas where quality and investments are inadequate, cannot be ignored. As NHI enters its thirtieth year, such issues need to be addressed and responded to seriously.

NHI faces four main challenges: a high rate of medical utilization, low input of resources, high expenses for new cancer and rare disease medications, an increased demand for home care for the super-aged population, and overall evolution of smart medicine in the post-pandemic era. In response, we have proposed and are now making a concerted effort to implement digital transformation, payment transformation and service transformation.

The Grand Family Physician Plan is a human-centered integrated service offering self-care, preventive health care and medical services, and digital tracking to improve care quality; it expands the coverage of home-based medical care, provides home care for acute symptoms and leverages long-term care to realize the goal of local aging. The program also gives patients the right to make medical

decisions, incorporates advance care planning into the NHI package, accelerates the inclusion of new medications and medical devices, facilitates temporary payments, includes NGS (Next Generation Sequencing) testing for cancer in the NHI package, and completes related regulations to protect patient right to privacy and most suitable treatment choice.

In order to achieve the goal of Hospital without Walls, a comprehensive digital transformation plan has been launched to enhance digital infrastructure, align exchange of information with the world, and speed up medical system reform to create a patient-centered care system.

We will be celebrating the thirtieth anniversary of NHI in 2025, a moment of metamorphosis and a leap forward. In line with its vision of Healthy Taiwan, the National Health Insurance Administration strives to improve medical quality for the public on the basis of past achievements and efforts by continuing to integrate innovative management thinking into its policies.

Chung-liang Shih, MD, DrPH

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





組織沿革 承先啟後

Organization Structure and History

01

Chapter



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。

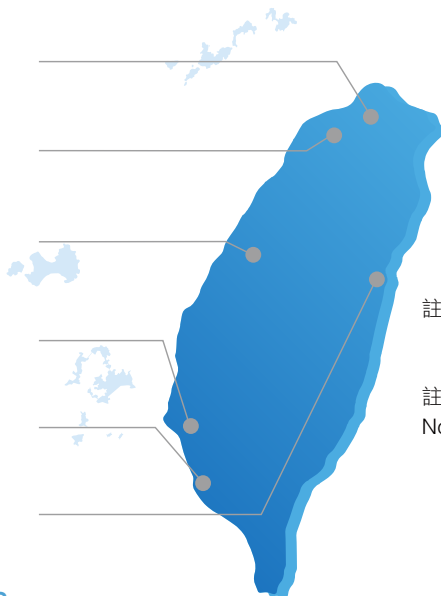
為有效推動全民健保各項服務，健保署除依業務專業性質設置專業組室，規劃各項業務措施之推動，在各地設有6個分區業務組（表1-1、圖1-1），直接辦理承保作業、保險費收繳、醫療費用審查核付及特約醫事服務機構管理等服務，同時設置22個聯絡辦公室，服務在地民眾。至2023年12月31日，在職員工計有3,013名。

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
8,989,169 / 10,030
- 北區業務組 Northern Division
3,997,089 / 4,255
- 中區業務組 Central Division
4,279,959 / 6,556
- 南區業務組 Southern Division
2,960,736 / 4,421
- 高屏業務組 Kaoping Division
3,211,885 / 4,922
- 東區業務組 Eastern Division
443,678 / 654

總計 Total: 23,882,516 / 30,838



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2023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 2023.



Organizational 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 labor, 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. 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 scheme.

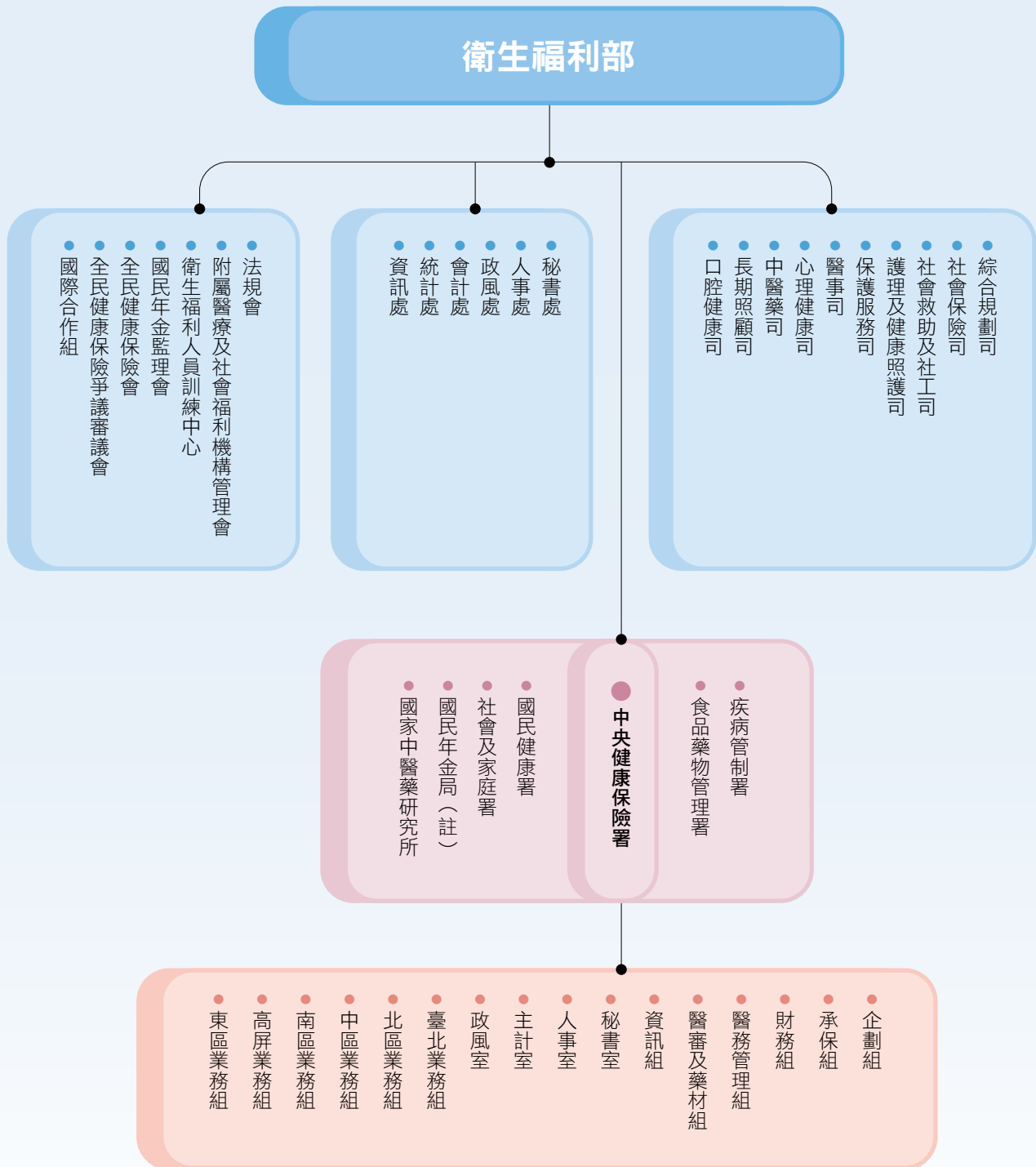
The Ministry of Health and Welfare (MOHW) is the competent authority of NHI, a type of government social insurance. Both under the

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 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 enrolment, 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 31, 2023, the NHIA had 3,013 employees.

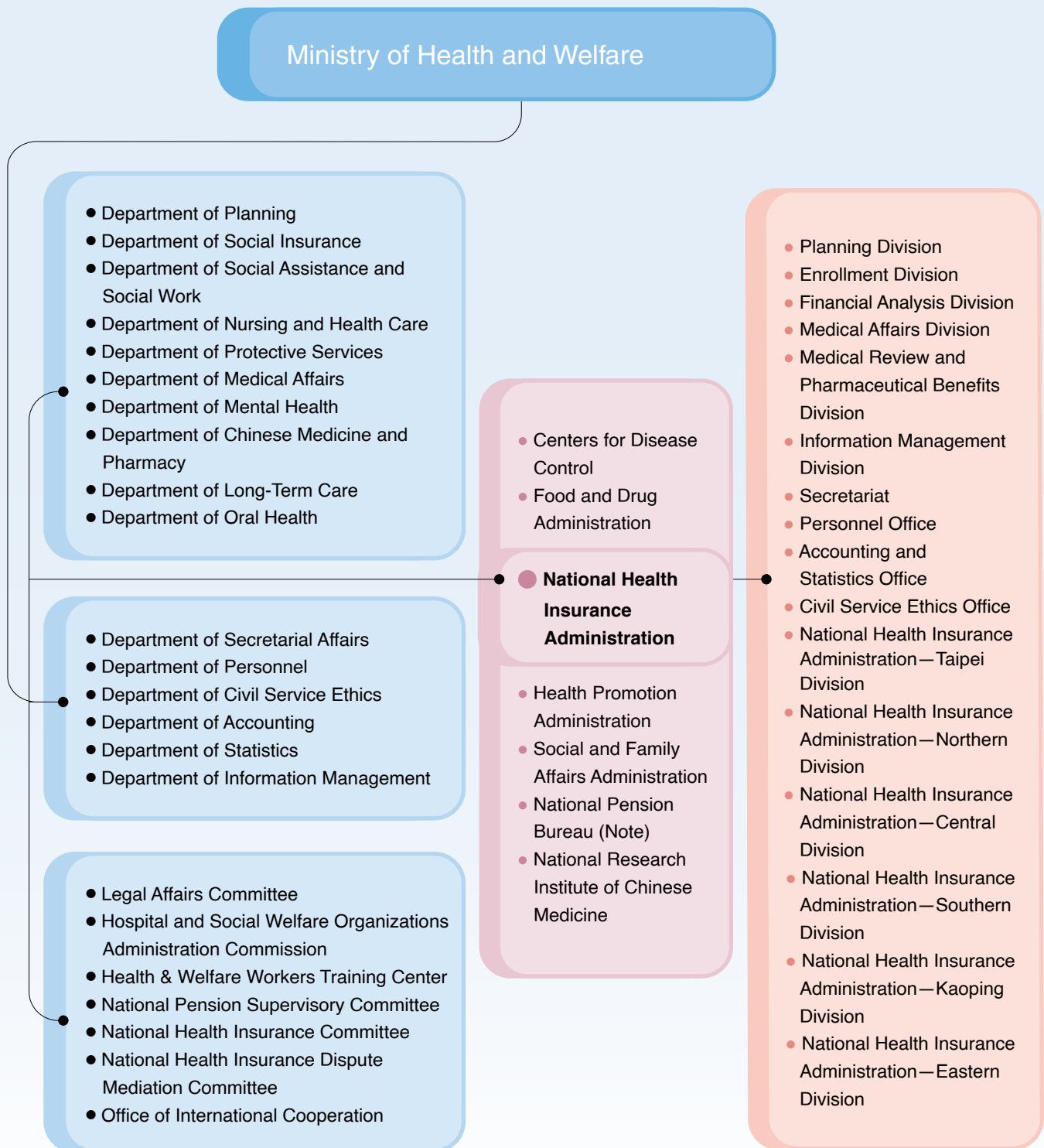


圖1-1 中央健康保險署組織架構圖



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 Organic 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).





全民有保 財務永續

Universal Coverage and
Financial Sustainability

02

Chapter



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2023年12月底止，參加全民健保的總人數有2,388萬2,516人（表2-2），投保單位有98萬340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 Coverage and Financial Sustainability

The government initiated the National Health Insurance (NHI) scheme to provide the entire population with health security via a self-help and mutual assistance system. As such, NHI coverage was extended to dependents, veterans, and the unemployed—people in the non-working population—who were not covered prior to its inception; included were women, students, children, and the elderly, etc. 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 (Taiwan) 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, 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 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, requirements warranted by public expectations of social fairness and justice.

As of the end of December 2023, NHI participants numbered 23,882,516 (Table 2-2) and group insurance applicants, 980,340.

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 and, in keeping with the spirit of the ability to pay, 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



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 Insured	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 descendants 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 / 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 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 Insured	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 1, 2013, inmates in correctional facilities were included as Category 4 beneficiaries in the NHI system.





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

	第1類 Category 1	第2類 Category 2	第3類 Category 3	第4類 Category 4	第5類 Category 5	第6類 Category 6	總計 Total
人數 Number of Enrollees	14,555,701	3,497,533	1,857,732	98,361	273,097	3,600,092	23,882,516
占總納保人數 百分比 Percentage	60.95%	14.64%	7.78%	0.41%	1.14%	15.07%	100%

資料時間：2023年12月31日
Dated: As of December 31, 2023

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）。



premiums are collected. Measures also phased in over the years include calculating the premiums for military personnel, civil servants, and teachers on the basis of their total compensations rather than basic salaries, collecting supplementary premiums from six types of income hitherto not included in premium calculations, and setting a lower limit for government contribution. All these measures have been adopted to stabilize NHI finances and ensure that NHI can continue to operate and is structurally 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 to become the National Health Insurance Committee. Comprising 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 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 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 is calculated as the insured's premium ratable wage multiplied by the general premium rate. The premium of Categories 4-6 insured are calculated according to the average actuarial premium based on the total number of Categories 1-3 beneficiaries (Table 2-3 and Table 2-4).⁵ and 6 are calculated as 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 × (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 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：2024年1月1日起調整為2,160元（調整前為2,063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: 0.56 from January 1, 2024

6. Average premium for Categories 4-5 insureds: Fully subsidized by the government, the premium was raised to NT\$2,160 (from NT\$2,063) from January 1, 2024

7. Average premium for Category 6 insureds: Raised to NT\$1,377 (from NT\$1,249) from January 1, 2021. With the government contributing 40%, each insured shall pay 60%, or NT\$826 (up from NT\$749 previously).



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

保險對象類別 Classification of 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 teachers 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2024年1月1日起為2萬7,470元。

表2-5 2024年投保金額分級表
Table 2-5 2024 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	27,470	27,470以下 Below 27,470
	2	27,600	27,471~27,600
	3	28,800	27,601~28,800
第二組級距1,500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
第三組級距1,900元 Bracket 3 NT\$1,900	8	36,300	34,801~36,300
	9	38,200	36,301~38,200
	10	40,100	38,201~40,100
	11	42,000	40,101~42,000
第四組級距2,400元 Bracket 4 NT\$2,400	12	43,900	42,001~43,900
	13	45,800	43,901~45,800
	14	48,200	45,801~48,200
	15	50,600	48,201~50,600
第五組級距3,000元 Bracket 5 NT\$3,000	16	53,000	50,601~53,000
	17	55,400	53,001~55,400
	18	57,800	55,401~57,800
	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

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 1, 2023 has 50 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

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\$)
第六組級距3,700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
第七組級距4,500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5,400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6,400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7,500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 Above 212,001

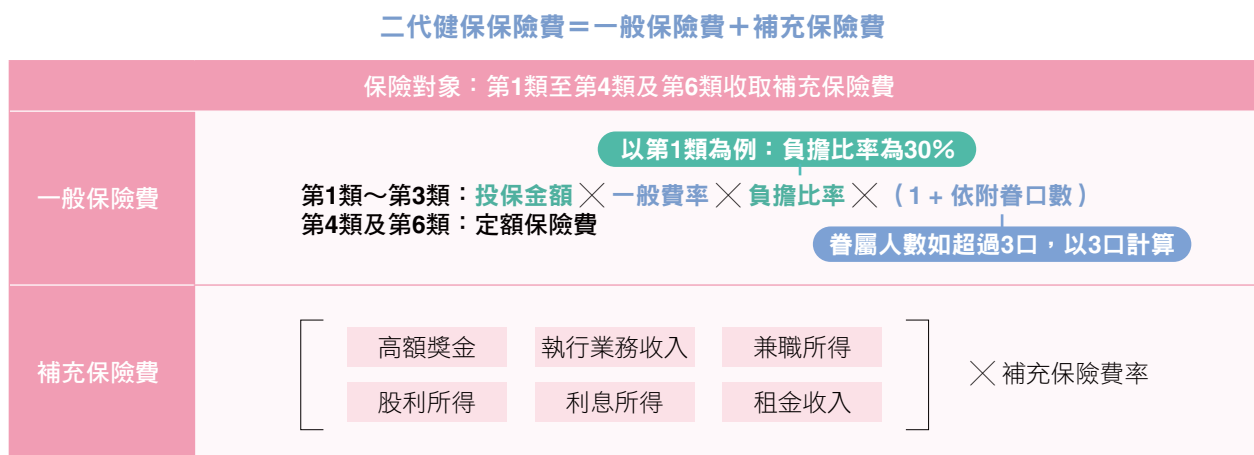


補充保險費計收

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；2023年全年補充保險費計收約718億元，占同年保險費收入約9.3%。

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。

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

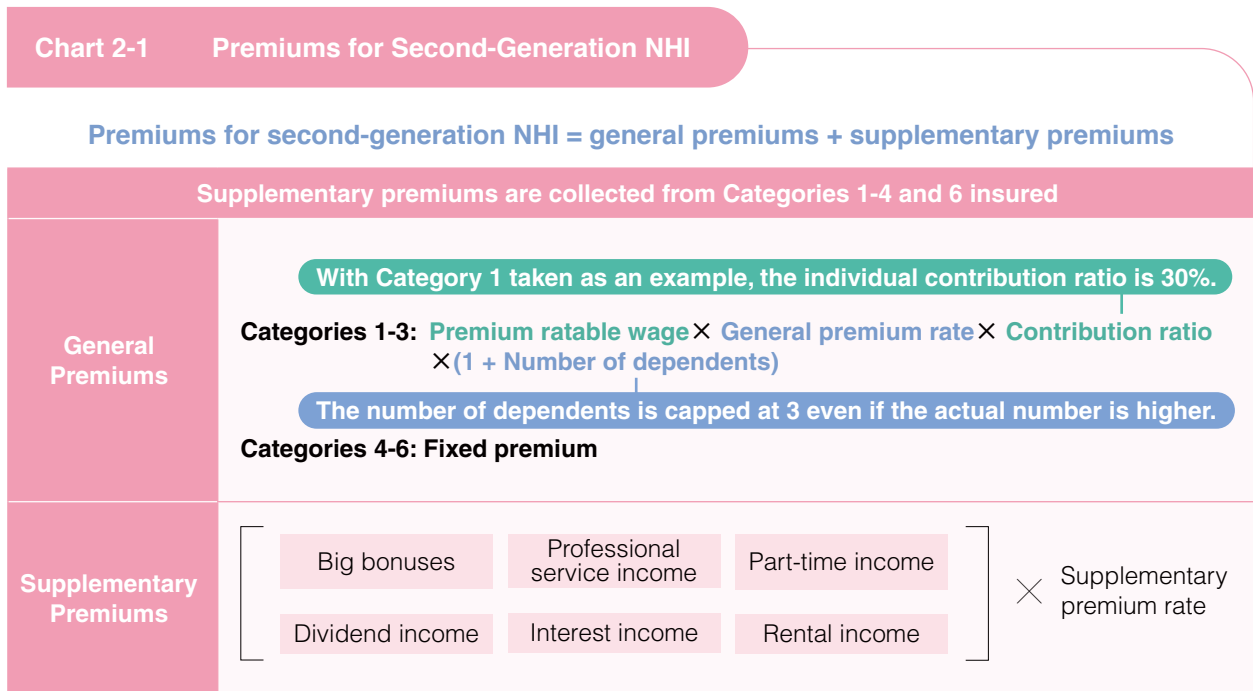
負擔比率等財源挹注，財務亦明顯改善（圖2-2），惟醫療支出成長始終高於保險費收入成長，自2017年起保險收支短絀數逐年擴大，故自2021年1月起調整保險費率，至2023年12月累計收支結餘為1,388億元（表2-6）。

according to the corresponding bracket in the aforementioned table. Beginning January 1, 2024, 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\$27,470.

Calculation of Supplementary Premiums

Second-generation NHI added supplementary premiums to general premiums that are collected on the basis of premium ratable wages. Hitherto uncovered items—big bonuses, part-time income, professional service income, dividend income, interest income, and rental income—

are now included for calculating supplementary premiums. It is hoped that expansion of NHI's premium base can move it closer toward the goal of fair contribution (Chart 2-1) by having persons with equivalent incomes pay similar premiums. Nevertheless, the insured in low-income households are exempt from 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 2023, NHI supplementary premiums amounted to around NT\$71.80 billion, accounting for 9.3% of all premium income for the year.



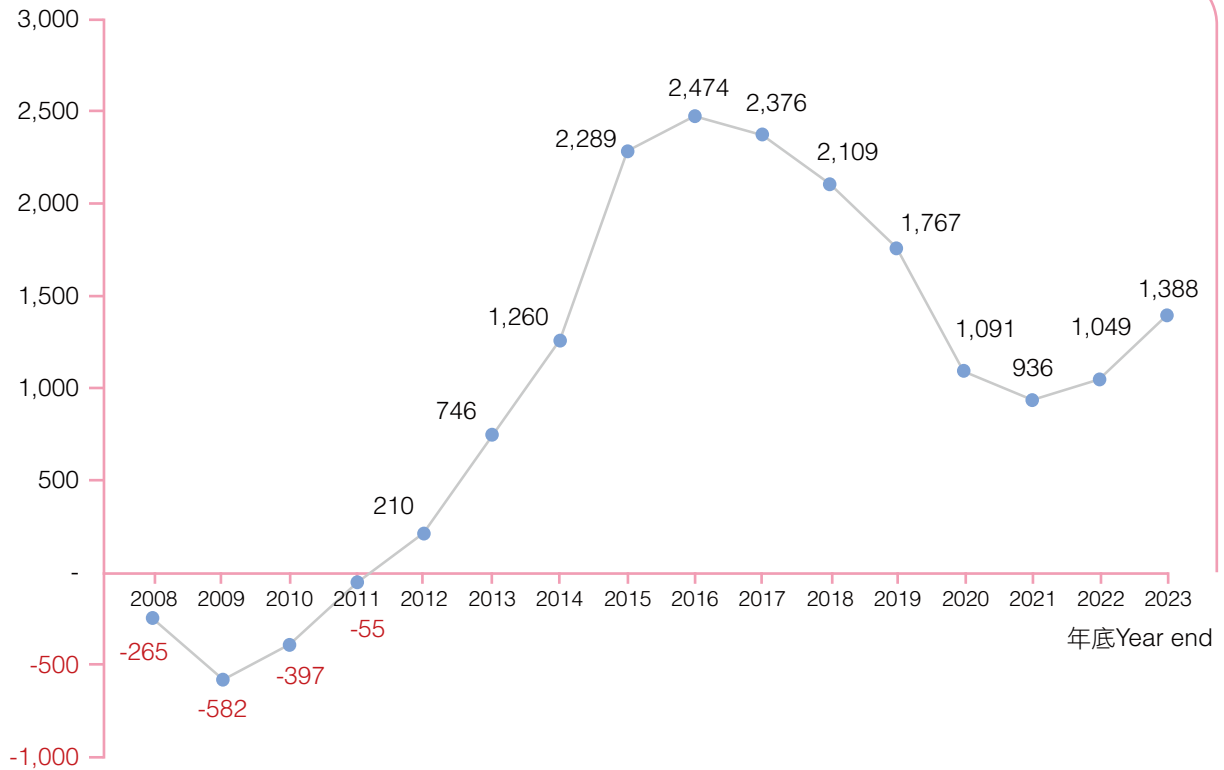
Notes: 1. From January 1, 2021, general premium rate raised to 5.17% (from 4.69%) and the supplementary premium rate to 2.11% (from 1.91%).

2. Part-time income: Income other than wages paid by the group insurance applicant.



圖2-2 二代健保實施前後財務收支累計餘絀情形
Chart 2-2 Cumulative balance before and after launch of second-generation NHI

億元 NT\$100 million



- 截至2023年12月底，歷年保險收支結餘1,388億元，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 2023, NHI recorded a cumulative surplus of NT\$138.8 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

- 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%開始收繳補充保險
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 both helped. 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 2023, NHI recorded a cumulative surplus of NT\$138.8 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(%) Growth rate (%)	金額(億元) Amount (NT\$100 million)	成長率(%) Growth rate (%)		
2019	6,224	2.69	6,566	3.77	-342	1,767
2020	6,278	0.87	6,954	5.91	-676	1,091
2021	7,119	13.39	7,274	4.60	-155	936
2022	7,603	6.81	7,491	2.98	113	1,049
2023	8,110	6.66	7,771	3.74	339	1,388
1995/3~ 2023/12	132,508	-	131,120	-	-	1,388

註：1.資料截至2023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 2023.

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.



給付完整 就醫便利

Comprehensive Benefits
and Convenient Access

03

Chapter





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2023年12月底止，全民健保特約醫療院所合計達2萬2,085家，占全國所有醫療院所總數91.58%（表3-1）；另有特約藥局7,457家、居家護理機構738家、精神復健機構272家、助產機構15家、醫事檢驗所213家、物理治療所29家、醫事放射所8家、職能治療所6家及居家呼吸照護所15家，保險對象可自由選擇醫療院所接受醫療照護服務。

2023年平均每人每年門診就醫次數16.1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	24,116	467	12,360	4	4,229	1	7,055
特約醫療院所數 Contracted Medical Institutions	22,085	467	10,759	4	3,961	1	6,893
特約率 Percentage of Contracted Institutions	91.58%	100%	87.05%	100%	93.66%	100%	97.70%

資料時間：2023年12月31日。
Data time: December 31, 2023.

Comprehensive Benefits and Convenient Access

Scope of Benefits

In case of illness, accident, or childbirth, the insured 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 (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, materials, 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 2023, there were

a total of 22,085 NHI contracted hospitals and clinics, accounting for 91.58% of all hospitals and clinics nationwide (Table 3-1). There were also 7,457 contracted pharmacies, 738 home care institutions, 272 psychiatric rehabilitation institutions, 15 midwifery institutions, 213 medical testing institutions, 29 physical therapy clinics, 8 medical radiological test institutions, 6 occupational therapy clinics, and 15 home respiratory care institutions. The insured can freely choose the hospital or clinic at which they wish to receive healthcare services.

In 2023, the average number of per capita outpatient visits was 16.1, 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.

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 Western 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



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。

截至2023年12月底，已有558個社區醫療群在運作，參與之基層診所5,590家，參與率為52.3%，參加醫師數7,807位，參與率為45.4%；透過社區醫療群受益者近600萬人。

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2023年12月，有3,315家醫事服務機構組成226個團隊，就近照護約8.5萬人。

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，減少不必要之社會性住院。

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（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），期能充實偏遠地區在地醫療資源。另為便利民眾就醫及

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 Family Physician Plan will be expanded mainly as follows: 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 2023, a total of 558 community healthcare groups had been set up and were running. They comprised 5,590 primary care clinics and 7,807 physicians, translating into participation rates of 52.3% and 45.4% respectively. More than six million people benefit from these community healthcare groups.

Home Health Care Integration Program and 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 service, 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 service, strengthen case management mechanisms and promote cooperative team 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 2023, 3,315 medical institutions had organized 226 teams to provide care to 85,000 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 and home care for acute symptoms will be continued by the NHIA, enabling patients to return to their community lives.

A Medicare Telemedicine Benefit Plan was launched in December 29, 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



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」，配合該辦法自2024年7月1日施行，將規劃推動通訊診療服務（B to C）及虛擬健保卡，第一階段優先開放以通訊方式提供衛教諮詢（如大家醫計畫、鼓勵腹膜透析計畫）；第二階段開放視訊診察（在宅急症照護計畫），領藥模式比照COVID-19疫情期間，由病人、家屬或代理人至原看診院所領藥或領取處方箋後至特約藥局領藥，或由藥師將藥品送至病人住所；第三階段再進一步搭配電子處方箋完善領藥模式，以提升醫療近便性及效率；第四階段開放一般就醫，分階段納入健保。

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。

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

for certain specialties (ophthalmology, otolaryngology, dermatology, cardiology, gastroenterology, neurology, chest cavity), as well as emergency teleconsultations, so rural outpatient clinics are more accessible. 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.

On January 22, 2024, the MOHW announced the revision of the rules of medical diagnosis and treatment by telecommunications, which will be implemented on July 1, 2024, planning to promote implementation of telemedicine (B to C) and the NHI virtual card. In the initial stage, telemedicine for health counseling (such as the Grand Family Physician Plan and Peritoneal Dialysis Encouragement Program) is offered; in the second stage, video consultations (such as home care for acute symptoms) can be accessed, with the method of collecting medicines is similar to that during the COVID-19 pandemic. The process is done by patients, their family members or their deputies receiving medication at contracted pharmacies after receiving prescriptions in medical institutions or by pharmacists sending medication to the patients' residence; as the third stage is completed by electronic prescriptions, medical services become more accessible and efficient; the fourth stage is open to general medical treatment, and the coverage of National Health Insurance is divided into stages.

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 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 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 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-



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 Included in 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 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 chronic kidney disease	尚未實施 Not yet implemented				

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。

單位：% Unit: %

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
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
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
-	-	-	-	-	-	-	-	-	-	-	-	-	
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
2.6	2.9	1.4	註										
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
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
	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
由衛生福利部醫療發展基金支應 Paid by the MOHW's					29.3	29.5	32.3	33.4	33.3	34.0	29.9	21.3	31.7
尚未實施 Not yet implemented						15.3	14.9	13.2	11.5	11.0	13.2	7.3	13.6
尚未實施 Not yet implemented							24.3	38.5	35.4	40.3	45.6	48.3	44.5
尚未實施 Not yet implemented											10.9	22.3	

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。

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 Chronic Kidney Disease" was introduced in March 2022. The care rate for diabetes and early chronic kidney disease will include the care number of diabetes combined with early chronic kidney disease.



表3-3 全民健保門診基本部分負擔
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	
	西醫門診 Western 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 (3-4)
醫院層級 Type of Institution	經轉診 With Referral	未經轉診 Without Referral				
醫學中心 Medical Center	170	420	50	50	750	550
區域醫院 Regional Hospital	100	240	50	50	400	300
地區醫院 District Hospital	50	80	50	50	150	150
診所 Clinic	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4次之回診、門診手術後、急診手術後、生產出院後6週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70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 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' with 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.
3. "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 subsidies for the elderly who are unable to bear NHI expenses. "Persons with disabilities" refers 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.



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 plan for “Diabetes combined with Early Chronic Kidney Disease” 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 3-2.

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 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 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 as 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



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 Unit: NT\$

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 NT\$100	0元(NT\$)	低收入戶／中低收入者／身心障礙者（註1）0元 Low-income household (1)/near-poor household/Persons with disabilities NT\$0
101~200元(NT\$)	20元(NT\$)	10元(NT\$)
201~300元(NT\$)	40元(NT\$)	20元(NT\$)
301~400元(NT\$)	60元(NT\$)	40元(NT\$)
401~500元(NT\$)	80元(NT\$)	60元(NT\$)
501~600元(NT\$)	100元(NT\$)	80元(NT\$)
601~700元(NT\$)	120元(NT\$)	100元(NT\$)
701~800元(NT\$)	140元(NT\$)	120元(NT\$)
801~900元(NT\$)	160元(NT\$)	140元(NT\$)
901~1,000元(NT\$)	180元(NT\$)	160元(NT\$)
1,001~1,100元(NT\$)	200元(NT\$)	200元(NT\$)
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\$)
		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 NT\$200

- (一) 保險對象持醫院開立之慢性病連續處方箋調劑（開藥28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28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28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28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70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 borne 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 borne 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, 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 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" 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 subsidies for the elderly who are unable to bear NHI expenses. "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.

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.

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 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, 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 1, 2010. The second stage of this program went into effect on July 1, 2014.

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 MOHW'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.



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

總額預算支付制度

健保署自1998年起陸續推動牙醫、中醫、西醫基層、醫院等部門總額支付制度，

至2002年起全面採行總額預算支付制度，以有限健保資源提供有效率且高品質之醫療服務，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3-2，2010年起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。

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2023年12月，支付標準共計有4,815項診療項目，經統計2004年至2023年12月，共計118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3,332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

Global Budget Payment System

The NHIA started to phase in global budget payments for dentistry, TCM, 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 2010 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.

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 2023, the fee schedule covered a total of 4,815 diagnostic and treatment items after a cumulative 118 adjustments since 2004. Separately, changes have been made to payment points for a total of 3,332 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: 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



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.

年度開始6個月前
Six 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

年度開始3個月前
Three 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2個月前
Two months 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

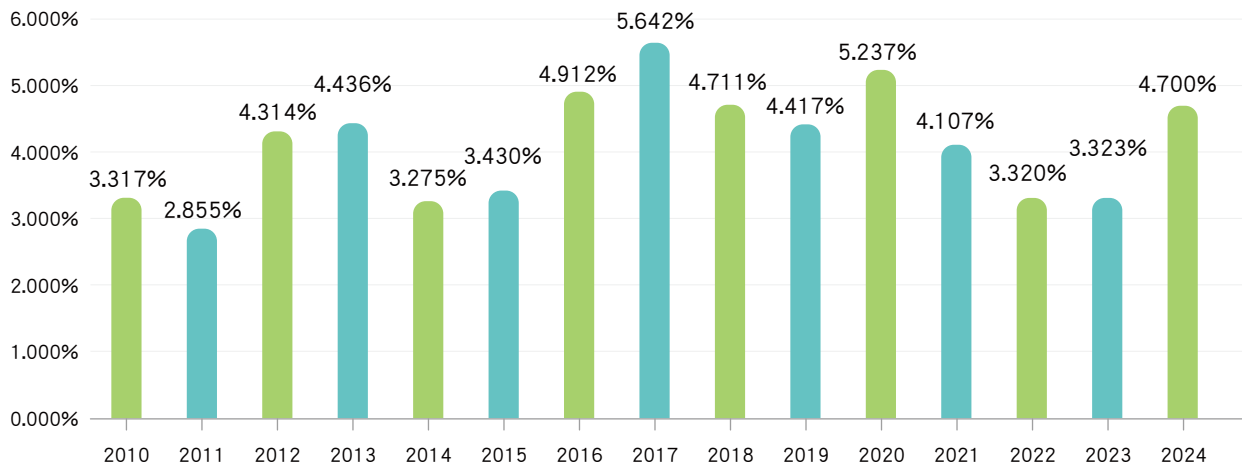
次年度開始1個月前
One month before the fiscal year begins

費率公告實施
Announcement and implementation of the premium rate

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3-2 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3-6 全民健保歷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

單位：% Unit: %

總額部門 Global Budget Sector	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
整體 Overall	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	4.70
牙醫門診 Outpatient Dentistry	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	2.436
中醫門診 Outpatient Traditional Chinese Medicine	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	4.221
西醫基層 Western Medicine Primary Care	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	3.757
醫院 Hospitals	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	4.700

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. To encourage nursing staff to retain their position, NT\$4 billion was allocated in 2024 to strengthen nursing capacity in hospital, by providing bonuses to acute wards and other wards with nursing staff on night shifts.

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



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。為鼓勵醫院護理人員留任，2024年編列40億元辦理強化住院護理照護量能方案，用於支應急性一般病床及其他病床之護理人員夜班獎勵。

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「流行性感胃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。



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 Consumer Price Index,” 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 changes in outpatient and inpatient services in regional-level and higher hospitals” 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 level and higher hospitals, and enhancing the quality of inpatient care.

To boost the service capabilities of primary care clinics and increase service scope, the NHIA provided NT\$7.02 billion for expansion-schedule primary care items between 2017 and 2024. 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.





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專業審查 提升品質

Professional Review and
Quality Improvement

04

Chapter



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3億3,875萬件，平均每日約92萬件，一年住院約312萬件，平均每日約8.5千件。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。

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

Professional Review and Quality Improvement

To avoid health care over use 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 338.75 million outpatient reimbursement claims are made every year, and roughly 920,000 such claims are made daily. Some 3.12 million inpatient care claims made annually works out to roughly 8,500 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



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。



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.

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.



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费用，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。



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.

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 1, 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 in stay within a stable, reasonable range.





The background features a network of white icons on a blue-to-orange gradient. The icons include a stethoscope, a doctor in a white coat with a stethoscope, a computer monitor displaying a heart rate, a first aid kit, and a person with a speech bubble. The icons are interconnected by a network of lines and nodes.

創新給付 數位升級

Innovative Payments and
Digital Enhancement

05

Chapter



創新給付 數位升級

新藥與新科技給付改革

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，2023年健保支出藥品費用約2,400億點，特材費用約386億點，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向進行醫療科技再評估（Health Technology Reassessment, HTR），作為健保持續給付或調整給付條件之依據，又為將醫療科技再評估機制納入常規運作，將規劃建立公開透明之作業程序。透過從健保給付前至給付後之成本效益循環式管理，增進低效益的醫療科技轉移到高效益的新醫療科技，使健保資源有效合理配置，進而提升健保給付效益。

NGS 納入健保給付

隨著分子醫學之進步，癌症治療已朝向個人化精準醫療發展，健保現已給付多項癌症標靶治療及免疫療法之生物標記檢測，如EGFR、ALL-RAS、ALK及PD-L1等檢測，而次世代基因定序（Next Generation Sequencing, NGS），是一種新開發出的高通量定序技術，能快速偵測大量基因變異，提升檢測效益。

健保署2021及2022年委託財團法人醫藥品查驗中心進行醫療科技評估（Health Technology Assessment, HTA），針對各國NGS給付現況及對健保整體財務衝擊進行研究報告，廣徵邀集各領域專家凝聚給付共識，配合「特定醫療技術檢查檢驗醫療儀器施行或使用管理辦法」於2024年落地，規劃於同年將NGS納入健保給付，針對檢測結果有對應治療藥物且效果明確之癌別優先給付，以BRCA panel、小panel（≤100個基因）、大panel（>100個基因）定額給付，並收載檢測結果，結合申報資料及臨床真實數據資料，以評估基因檢測準確性及標靶藥物之治療成效以精進給付政策，協助高風險族群精準投藥，減輕民眾財務負擔，經盤點19種癌別並訂定支付標準，於2024年5月1日上路。



Innovative Payments and Digital Enhancement

Payment Reform for New Drugs and Technologies

Raising NHI Payment Efficiency via Health Technology Assessment

Given the rapid advances in medical technologies, new drugs and medical devices are constantly emerging. In 2023, some 240 billion NHI points and 38.6 billion points were spent on drugs and special medical 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 including new medical technologies in NHI coverage.

To better manage NHI payment and align with international standards, the NHIA introduced 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. It assists in the decision-making process on 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-covered. Real-world data is collected, and health technology reassessment (HTR) is conducted for NHI coverage 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, enhancing the effectiveness of NHI coverage.

NHI Coverage Policy for NGS Testing

The advancement of molecular medicine has led to more precise and individualized treatments for cancer. NHI covers multiple biomarker tests such as EGFR, ALL-RAS, ALK and PD-L1 for targeted therapy and immuno-oncology. Next Generation Sequencing (NGS), is an innovative deep sequencing method that enables rapid examination of genetic mutation in large quantities, increasing examination efficiency.

Commissioned by the Center for Drug Evaluation, NHIA conducted Health Technology Assessment (HTA) in 2021 and 2022. A research report was conducted on the payment situation of NGS overseas and its effect on the financial aspect of health insurance, and opinions and consensus were reached among different types of professionals. Also, the Regulations Governing the Application or Use of Specific Medical Techniques, Examinations, or Medical Devices went into effect in 2024, and NGS is also be covered by the NHI by 2024. Preferential payments are given for cancers treated with medications that have evidence-based effects. The payment schemes are as follows: payment for testing BRCA panel, small panel of under 100 genes, and large panel of over 100 genes. As a result of examination, data from clinical trials and declarations will be combined to evaluate the accuracy of genetic examination and



實施暫時性支付制度

為滿足病人用藥需求，健保署致力加速新藥納入給付，包含優化核價流程與管控、精進新藥預算預估模式、建立多元風險分攤模式及強化廠商與審查專家溝通等，並於2023年6月實施暫時性支付制度。

針對衛生福利部食品藥物管理署加速核准上市，屬臨床迫切需求（unmet medical need）但臨床療效及財務具高度不確定性之新藥，以暫時性支付制度收載，並搭配風險分擔模式及建置登錄系統，期間蒐集我國臨床試驗數據、真實世界實證資料，評估其療效及成本效益，以利健保再評估是否持續給付或停止給付，運作機制與英國癌藥基金（Cancer Drugs Fund, CDF）相似。2023年已有4項新藥及2項擴增給付以暫時性支付收載，包含肺癌、膽管癌、神經母細胞瘤、白血病、NTRK基因融合腫瘤及最新細胞治療產品CAR-T。

推動暫時性支付制度後，可加速引進新藥，提升病人使用具治療潛力之新藥可近性，並可降低病人醫療成本支出，有效照顧經濟弱勢病友。

成立國家級健康政策及醫療科技評估中心

健康政策與醫療科技評估中心（Center for Health Policy and Technology Assessment, CHPTA）於2024年1月1日正式運作，協助健保進行新醫療技術、藥品及醫材給付審查，提供藥物經濟學評估及政策評估、人才培訓外，扮演與國際HTA組織間資訊交流及經驗分享之

重要角色，加速新藥收載，並擷取國際HTA組織發展經驗，奠定我國醫療科技評估之發展基礎。未來朝向設立行政法人為目標。

推動平行審查新措施

自2024年1月1日起，健保署推動平行送審新措施，廠商申請新藥查驗登記時，符合特定條件者，得同時向健保署申請建議給付，縮短等待許可證審查及健保核准給付時間，預估藥品於取得許可證後6個月內公告生效。截至2024年3月，共有3項藥品申請，1項已正式受理。

擴大新藥預算

2024年已於健保總額預算編列相關預算，包括新增新藥預算、藥品給付範圍改變預算及暫時性支付專款預算，共計60.49億元，為2023年的兩倍，未來將持續爭取預算。



effectiveness of targeted therapy, allowing those at high risk to receive precision medication and alleviating financial burdens. Since May 1, 2024, 19 types of cancer have been covered by the NHI.

Implementing the Conditional Listing System

To meet patient needs, the NHIA strives to speed up the inclusion of new drugs, including optimizing the procedure, supervising the budget for new drugs, establishing a model of risk diversification, and strengthening communication between pharmaceutical companies and review experts. The “Conditional Listing” (provisional payment) system took effect in June 2023.

The conditional listing system includes drugs of unmet medical need, but with uncertainty regarding clinical trial results and financing, that have been approved by the FDA, MOHW. Clinical trial data and real-world evidence are collected alongside the model for risk diversification and establishing a log-in system to assess efficacy and cost-effectiveness to facilitate the determination of whether drugs will be covered by the NHI; it is similar to the method used by the Cancer Drugs Fund, CDF, in the UK. The conditional listing system includes four new drugs and two new indications (lung cancer, cholangiocarcinoma, neuroblastoma, leukemia, tumor with NTRK gene fusion, and CAR-T).

The conditional listing system allows the introduction of new drugs, making them accessible to patients, reducing medical expenses and helping those with financial difficulties.

Setting up the Center for Health Policy and Technology Assessment

The Center for Health Policy and Technology Assessment started operation on January 1, 2024. In addition to assisting in new medical technology, medication and review for payment of medical materials in the NHI, offering assessments for medicine economics and policies, personal training, CHPTA has an important role in communicating with international NHA organizations and sharing experiences. CHPTA also uses the experiences of international HTA organizations as a basis for health policy and technology assessments. The goal is to set up an incorporated administrative agency.

Launch Parallel Review Methods

On January 1, 2024, the NHIA launched the parallel submission review system. When a company submits a drug licensing request, a request for NHI payment can be made at the same time, reducing waiting time between permit review and payment approval. Following receipt of the license, the drug should go into effect within six months. Three types of drug licensing have been submitted and one has been approved as of March 2024.

Expand the Budget for New Drugs

The new drug budget was allocated in global budget. In 2024, a total of NT\$6.049 billion is allocated for new drugs, change in payment for medications and provisional listing, which is double the amount allocated for 2023. Continuing efforts will be made to request more funds in the future.



規劃百億癌症新藥基金

規劃成立癌症新藥暫時性支付專款，逐年透過暫時性支付機制及專款的使用，縮短癌症新藥給付時程，讓癌友及早取得突破性的新藥，並降低癌友的經濟負擔。即刻改善癌症病友等藥的時間，現階段先以健保專款支應，後續再視財源及醫療需求情況，滾動檢討，逐步擴大至百億元規模。

國際合作與醫療科技評估人才培訓

健保署、醫藥品查驗中心和英國國家健康暨照護卓越研究院（National Institute for Health and Care Excellence, NICE）於2023年5月18日共同簽署醫療科技評估合作協定，未來將就醫療科技評估趨勢、真實世界資料應用、創新藥品基金和癌藥基金財務運作等面向，深化雙方資訊交流及人員訓練，以提升健保新藥給付評估及財務管理機制。

健保署於2023年9月13日舉辦第1屆「臺英醫療科技評估合作協議工作坊」，邀請英國NICE學者來臺，聚焦於基因治療及細胞治療等新興科技之真實世界資料收集機制與臨床療效評估方式。透過雙方資訊交流及經驗分享，有效掌握新藥療效證據及效益，加速新藥收載決策，並擷取英國NICE發展經驗，奠定我國籌劃中之行政法人醫療科技評估專責機構之發展基礎。

未來健保署與CHPTA將透過研學合作，借鏡國外標竿機構審查給付運用經驗，建構教、訓、用三合一機制，建立一套完善國內醫療科技評估人才來源及培訓制度，強化我國醫療科技評估管理實力。

醫療資訊上雲端 調閱分享無弗屆

健保醫療資訊雲端查詢系統

全民健保累積20多年的健保申報資料，隨著大數據（Big Data）分析技術提升，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。



Plan for the Funds of Cancer Drugs

The NHIA plan to establish a cancer drug fund. Through a provisional payment mechanism and designated funds, the goal is to shorten the reimbursement process for new cancer drugs with potentiality, allowing cancer patients to access breakthrough medications earlier and reducing their financial burden. Immediate improvements will be made to reduce the waiting time for drugs. Subsequently, the scale of the fund will be reviewed and expanded to NT\$100 billion based on available financial resources and medical needs.

International Cooperation and Medical Technology Assessment Personnel Training

The NHIA, Center for Drug Evaluation and the United Kingdom's National Institute for Health and Care Excellence (NICE) signed a partnership agreement on May 18, 2023. They will work collaboratively in terms of trends of medical technology, application of real-world data, funds for innovative drugs and financial operation of cancer drugs funds. By exchanging information and training personnel, the payment of NHI new drugs and the mechanism for financial management will be improved.

The first Taiwan-UK workshop was held on September 13, 2023, inviting academics from NICE to Taiwan to focus on emerging technologies such as gene therapy and cellular therapy, and real-world data collection mechanisms and clinical efficacy evaluation. The inclusion of new drugs can thus be expedited with clinical efficacy. NHIA is able to learn from the experiences of NICE and lay down the foundation for Taiwan's health technology assessment.

The NHIA will work in cooperation with CHPTA and establish a mechanism based on payment review in other countries, constructing a three-in-one Human Resource system of education, training and employment, to enhance our health technology appraised and management capabilities.

NHI MediCloud System for Sharing Information Anytime, Anywhere

The “NHI MediCloud System”

The NHIA has accumulated over 20 years of health insurance reimbursement claim data, with big data technology improvement, the NHIA began to gradually compile data from various fields, and to use cloud technology to provide doctors necessary data for clinical judgments under secure environment. 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 pharmacists 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, since 2015, the NHIA has developed the expanded “NHI MediCloud System” after



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。

2018年起雲端系統陸續發展跨院重複用藥/檢查檢驗、西藥交互作用及過敏藥、中西藥交互作用、高風險腎臟病病人非類固醇抗發炎口服藥用藥等多項主動提示功能，提醒醫師於處方時留意病人藥品使用情形，節省醫師於診間需閱讀大量資訊時間，提升醫療效率及品質，保障病人安全。為提供使用者更友善之使用介面與客製化、視覺化功能，健保署將推出健保醫療資訊雲端查詢系統2.0，除優化介面及擴充客製化功能外，並擴增醫事人員使用權限，深入基層實務運用，有助於醫師、藥師及特定醫事人員臨床處置專業判斷，提供病人更好的照護品質。

基層診所健保雲端 HIS

因應國際數位轉型，為提升醫療院所系統因應醫療政策變動敏捷度，本署規劃優先推動轉換基層醫療院所現行使用之本地端系統，階段式移轉至雲端服務，醫療模式透過雲端傳遞服務及資料交換，更利於醫療資料整合，進而提高醫療院所系統韌性。

健保署強化健保數位基礎建設的資安韌性和效能，鼓勵基層診所升級雲端系統並導入接軌國際的醫療資料交換標準（FHIR），提升資訊效能與安全。

雲端增值 精進健保快易通 App | 健康存摺運用

為避免不必要的檢驗檢查，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，鼓勵醫療院所上傳CT、MRI、超音波、胃鏡、大腸鏡及X光檢查之醫療檢查影像，其他的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增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。

referring to users' feedback and clinical needs. The "NHI MediCloud System" incorporates 12 types of thematic data, including medication records, traditional 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.

Since 2018, NHIA has gradually developed active reminders for duplicated orders, drug-drug interaction, drug allergies, and nonsteroidal anti-inflammatory drugs usage for high-risk kidney disease patients. With the technology, the NHI MediCloud System could remind the doctors to pay attention to drug prescriptions in a more active way for improving the quality and efficiency of healthcare services and ensuring the safety of patients. To offer more customized, visualized interface for users, the NHIA will launch the 2nd-generation NHI MediCloud system. In addition to optimize interfaces and expanding customized functions, more medical staff will be authorized to utilize the 2nd-generation NHI MediCloud system, therefore helping doctors, pharmacists and specific medical professionals to make clinical decisions and provide patients with better care quality.

HIS in Community Hospitals

In response to international digital transformation, the NHIA plans to transform

the current local system used by community hospitals to a cloud-based system. Using Cloud technologies, hospitals will be able to integrate medical information, improving system resilience.

By enhancing the resilience and efficacy of digital health insurance infrastructure, promoting the Cloud system at community levels, and aligning with FHIR, the NHIA increases the safety and efficacy of digital health information.

Value-Added Cloud Services: Application of My Health Bank

The NHIA has encouraged hospitals and clinics to upload patients' testing and examination results since 2015 to avoid 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 patient images and reports. As a result, when people wish to obtain a second opinion from a hospital at the same level, or receive follow-up care at a primary care hospital or clinic near their home, medical personnel need only obtain their data from the cloud, and can then view the patients' testing and examination reports. This saves patients' money and time spent waiting for hospital procedures, and also lessens the potential health risk of multiple examinations; this also realizes the hierarchical healthcare ideal of "a good hospital in the community, a good doctor nearby," boosts the quality and convenience of healthcare, and eases congestion at medical centers.

Furthermore, the NHIA's individualized cloud service—My Health Bank—enables people who have registered their NHI cards to log into



健康存摺自2014年截至2023年12月31日止，健康存摺使用人數約1,143萬人，使用人次已達3億8,324萬人次。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。

隨著行動裝置的普及化，民眾運用行動裝置紀錄個人生理量測數據（包括血壓、血糖、心率等）已成趨勢潮流，2023年健康存摺連結 Google Fit及Apple Health 將行動裝置紀錄個人生理量測數據載入健康存摺，讓民眾可以透過單一健康管理工具（健康存摺）查閱個人就醫及量測數值，便利管理個人健康；另健康存

摺提供公費癌症篩檢結果異常主動推播功能，提醒癌症篩檢結果異常個案回診接受後續診療服務，積極主動照顧民眾健康。

為弭平健康不平等，本署積極推動「全民健保行動快易通 | 健康存摺App」健康數位無障礙服務，自2023年起與身障團體進行App無障礙需求訪談，經改善功能、使用者介面及操作流程，完成無障礙功能開發，於2023年12月20日正式改版上線，新增友善就醫查詢專區、導覽列視覺化、精進報讀功能及外開視窗提醒，保障身心障礙者與其他人在平等基礎利用資訊及通信。

the system and make queries. With easy-to-understand charts and tables, My Health Bank allows users to quickly view and understand their recent healthcare records, testing and examination results, and preventive care data, helping them monitor health status and perform health management. People 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. 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, 2023, it had approximately 11.43 million users, and used more than 383.24 million times. Roughly 90% of users agree that My Health Bank can help them understand their healthcare situation and monitor their state of health. It is fair to say that My Health Bank effectively promotes better health self-management by the public.

With the popularity of mobile devices, their use in recording vital signs such as blood pressure, blood sugar and heart rate has become a trend. My Health Bank has connected with Google Fit and Apple Health to record vital signs to My Health Bank App. With a single health management tool (My Health Bank), people can search for personal medical records and vital signs to manage personal health. Moreover, My Health Bank App alerts users to abnormalities in cancer screenings so they can seek further medical attention if necessary.

To reduce inequality in health, the NHIA is actively promoting the "My Health Bank App" to cater to the needs of physically challenged individuals. Discussions on the needs of physically challenged individuals began in 2023, followed by improvements in function, user interface, and operating procedure. The updated version was launched on December 20, 2023. Physically and mentally challenged individuals can access information using the version, which features a visualized navigation bar, advanced reader function and a reminder of the external window.





健保卡資料上傳 2.0 加入就醫識別碼 精進醫療資訊串接

為提升民眾就醫便利性，自2004年1月1日起，健保IC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。

為提高健保卡就醫資料之正確性及完整性，減少紙本處方箋重複調劑、重複檢查的情形，健保署2023年9月1日實施「就醫識別碼（健保卡資料上傳格式2.0）」（以下簡稱健保卡2.0），藉由民眾就醫當下，產生一組就醫時之人、時、地特定編碼即就醫識別碼，作為各項就醫資料的唯一鍵值，以串聯就醫後各項檢查/驗結果、醫療影像、出院病歷摘要、醫療費用申報、醫療資訊雲端查詢系統及健康存摺系統等資料，並進一步推動電子處方箋，藉由就醫資訊的整合，即時管理監控異常就醫紀錄。亦訂定「健保卡資料上傳格式2.0改版獎勵」提供院所改版誘因。實施初期採申請制逐步推動，上線後因應各界使用後之回饋意見，持續精進系統功能，期使健保卡2.0運作順利。截至2023年12月31日止，於2萬8,258家特約院所中，已有2萬3,997家院所完成健保卡2.0改版作業，改版率達85%。



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。



NHI Card 2.0: Identification Code for Medical Treatment and Connection of Information in Precision Medicine

Smart NHI cards were formally introduced on January 1, 2004 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 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.

To increase the accuracy and integrity of medical records in the NHI card, reduce the possibilities of repeat prescription and examination, the NHIA implemented the identification code for medical treatment (2.0 version of the NHI card). As a person seeks medical treatment, information regarding the person, time, and place will generate an identification code for medical treatment. The code serves as reference for a range of examination records, medical imaging, discharge medical record summary, declaration of medical expenses, MediCloud, My Health Bank App and digital prescription. The abnormalities can be monitored immediately with the integration of medical records. Incentives for upgrading the NHI Card to 2.0 version were also set to encourage hospitals to upgrade the card. In the initial stage, gradual promotion was via the application system, with subsequent advancement based on later feedback on the version to ensure the smooth operation of the NHI 2.0. As of December 31, 2023, among 28,258 contracted medical institutions,

23,997 institutions have upgraded their version to the NHI card 2.0. There is an 85% upgrade rate.

Multiple Mechanisms for Ensuring Information Security

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

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





照顧弱勢 守護偏鄉

Care for the Disadvantaged and
Watch over Isolated Areas

06

Chapter



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	年度 Year	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, medium-low income 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.	2022	365.3萬人 3.653 million persons	322.7億元 NT\$32.27 billion
		2023	394.5萬人 3.945 million persons	344.6億元 NT\$34.46 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 MOHW	2022	1,525件 1,525 cases	1.41億元 NT\$141 million
		2023	1,598件 1,598 cases	1.52億元 NT\$152 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	2022	7.2萬件 72,000 cases	21.94億元 NT\$2.194 billion
		2023	7.2萬件 72,000 cases	22.20億元 NT\$2.22 billion
愛心轉介 Referral to charities	無力繳納健保費者 Persons who are unable to pay premiums	2022	4,734件 4,734 cases	3,632萬元 NT\$36.32 million
		2023	5,963件 5,963 cases	5,107萬元 NT\$51.07 million

資料時間：2022年1月1日至2023年12月31日。
Data period: January 1, 2022 to December 31, 2023

Care for the Disadvantaged and Watch over Isolated Areas

Subsidies for the Economically Disadvantaged

NHI enrollment is mandatory, however, some low-income households and people on the margins of society cannot afford to pay their premiums. To fully 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 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. Medical and economic assistance is also 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 provide premium subsidies to various underprivileged groups, including low-income households, medium-low income 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\$32.27 billion in such subsidies

was provided to 3.653 million people in 2022, followed by a total outlay of NT\$34.46 billion that benefitted 3.945 million people in 2023.

Relief Fund Loans

To protect people's right to healthcare, the NHIA provides interest-free loans to members of the public in economic difficulties so that they can pay their premiums and cover unpaid copayments. A total of NT\$141 million went toward such loans granted to 1,525 cases in 2022, and NT\$152 million was lent to 1,598 cases in 2023.

Installment Payment

For 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\$2.194 billion were provided about 72,000 cases during 2022, followed by NT\$2.22 billion in nearly 72,000 cases in 2023.

Referral to Charitable Groups for Premium Subsidies

For persons who are unable to pay their premiums, the NHIA also provides referral to charitable groups, companies, and individuals for premium subsidies. Such referrals were made in 4,734 cases involving total subsidies of NT\$36.32 million in 2022, and NT\$51.07 million in 5,963 cases in 2023.



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，2022年全年補助人數約365.3萬人，補助金額約322.7億元。2023年全年補助人數約394.5萬人，補助金額約344.6億元。

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。2022年全年共核貸1,525件，金額1.41億元。2023年全年共核貸1,598件，金額1.52億元。



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，2022年全年辦理分期繳納共7.2萬件，合計21.94億元。2023年全年辦理分期繳納共7.2萬件，合計22.2億元。

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。2022年全年轉介成功個案計4,734件，補助金額共3,632萬餘元。2023年全年轉介成功個案計5,963件，補助金額共5,107萬餘元。

保障弱勢民眾就醫權益

為落實醫療平權之普世價值，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。

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。

Protecting the Right to Healthcare of the Underprivileged

The NHIA proactively upholds the universal value of equal access to healthcare. The “decoupling of the right to healthcare from unpaid NHI premiums and fees” policy has launched on June 7, 2016. As long as individuals have completed their subscription procedures, they can enjoy access to NHI-covered healthcare. The unblocking of all NHI cards represented 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 individuals who previously feared being denied essential health care due to outstanding payments. This further demonstrates the government’s commitment to caring for the underprivileged and protecting the healthcare rights of citizens.

The NHIA implements multiple measures to support underprivileged individuals, establishing a healthcare safety net for citizens experiencing economic hardships. By eliminating barriers to NHI coverage, the NHIA ensures that individuals in 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.

Seeking 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 the Public Welfare Lottery to alleviate the medical financial burdens of eligible underprivileged individuals. Proactively identifying qualified persons, the NHIA notifies them about available assistance for paying NHI premiums and fees. As of the end of December 2023, a cumulative NT\$5.041 billion in subsidies had been disbursed to support 263,559 individuals (Table 6-2).

Easing 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. 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 MOHW, through a fund for a specified purpose. This initiative has substantially alleviated the financial burden on individuals with rare diseases.



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2023年12月底，累計補助金額已達50.41億元，累計補助人數達26萬3,559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

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 Last Two Years

年度 Year	計畫名稱 Program	人數 Persons	金額 (新臺幣) Amount (NT\$)
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 Underprivileged Youths and Low-income Households Obtain Relief from Unpaid NHI Premiums and Fees	5,543	1.75億元 NT\$175 million
2023	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	7,662	2.14億元 NT\$214 million
2008/1~2023/12 Total		263,559	50.41億元 NT\$5.041 billion

註：資料時間截至2023年12月底。 Note: The data period ends in December 2023.



Caring 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 expanded to 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 mobile health dental care, to psychiatric hospitals without dental

departments and special education schools for individuals with special needs. Since July 1, 2011, dentists from these teams have provided in-home dental services to individuals with designated disabilities who meet the criteria for home health 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 MOHW from January 1, 2015. Further services to persons suffering from severe loss of major organ functions on January 1, 2016, as of January 1, 2020, dental care has been made available to individuals preparing for hospital discharge and general nursing homes selected by the MOHW'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 financial challenges. To alleviate the burden on the insured, 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.



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2023年12月底，重大傷病證明有效領證數約有104萬餘張（人數為97萬2千餘人，約占總保險對象的4.1%），而2023年全年重大傷病醫療費用約2,524億餘元（占全年

總醫療支出的27.9%），健保藥品費用中，每年約有840億元（約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2023年12月衛生福利部公告的罕見疾病種類有244項，截至2023年12月底止，重大傷病罕見疾病項目領證數共1萬6,434張。經統計2023年罕見疾病之藥品費用約為80.6億元。

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

多重慢性病患者

多重慢性病患乃是我國醫療照護系統中最重要資源使用者，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。2023年12月參與照護，提供整合服務之醫院共135家。



As of the end of December 2023, more than 1.04 million valid major illness/injury certificates had been issued (to more than 972,000 persons, who accounted for roughly 4.1% of all insureds). Total medical expenditures for catastrophic illnesses and injuries exceeded NT\$252.4 billion in 2023 (accounting for 27.9% of all NHI medical expenditures for the year). Of the annual expenses for NHI-covered drugs, about NT\$84 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 consequently is 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 2023, the MOHW had recognized 244 rare diseases, and 16,434 major illness/injury certificates had been issued for rare diseases accordingly. NHI's drug expenditures for rare diseases totaled NT\$8.6 billion in 2023.

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 is steadily rising, making the care of these individuals an issue of concern. To ensure that people with multiple chronic conditions receive comprehensive and coordinated care services, while also minimizing the risks associated with repeat or incorrect medications or treatments, the NHIA introduced the "Patient-Centered Hospital Integrated Care Program" across local hospitals on December 1, 2009.

Since its implementation, the program has demonstrated effectiveness, as evidenced by a steady decline in the average number of medical visits among program participants over the years. As of December 2023, a total of 135 hospitals participated in the program.

Providing care in medically underserved isolated areas

According to Article 43 of the National Health Insurance Act and Article 60 of its enforcement rules, persons seeking outpatient, emergency, and home care services in areas officially recognized as lacking in medical resources receive a 20% discount on 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 to healthcare services. In response, the NHIA has proactively sought cooperation with



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，其中，自2022年起花蓮縣秀林鄉由IDS計畫轉型為「山地鄉全人整合照護執行方案（簡稱山地鄉全人方案）」。IDS計畫及山地鄉全人方案服務山地離島鄉民眾服務民眾達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

2024年投入9.22億元，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。2023年共

有613家特約院所至醫療資源不足地區巡迴，服務民眾達72.4萬餘人次。

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，2023年計有94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。2023年專科門診遠距會診服務人次計7,992人次，急診遠距會診服務人次計858人次。



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 evening clinics either at fixed locations or through mobile healthcare services, ensuring that residents in these areas receive the necessary healthcare support.

Currently, there are 50 mountain or outlying townships in Taiwan, where a total of 26 contracted hospitals and clinics are undertaking 30 projects. In 2022, the IDS program transformed into Holistic Health Care Program in Xiulin Township, Hualien County. The IDS program and the execution plan have altogether served over 480,000 people. 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\$922 million for the 2024 Improvement Project for Regions Deficient in Medical Resources. Dentists and Traditional Chinese medicine (TCM) and Western medicine physicians are encouraged to demonstrate their commitment to serving local communities by starting practices in areas that lack sufficient medical resources or providing mobile healthcare services. In 2023, a total of 613 contracted hospitals and clinics conducted mobile healthcare services, benefiting over 724,000 individuals in medically underserved areas.

Medical 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 “Medical Service Improvement Program for Medically Underserved Areas” in 2012. This program utilizes dedicated funding and a guaranteed point value delivery approach to encourage 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 2023, a total of 94 hospitals participated in this program.

Medicare Telemedicine Benefit Plan

Local physicians and remote physicians 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 2023, there were 7,992 person-times remote specialists consultation services, and 858 person-times remote emergency consultation services.







民眾滿意 國際肯定

Public Satisfaction and
International Recognition

07

Chapter



民眾滿意 國際肯定

健保經驗 蜚聲國際

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2023年針對世界110個國家的「健康照護指標」評比中，臺灣名列世界第一，2024年全球資料庫網站Numbeo公布的健康照護指標（Health Care Index）評比，臺灣連續第六年排名第一，展現我國醫療衛生軟實力。

近年因癌症治療方式日新月異，明顯衝擊健保有限資源。為加速取得先進癌症藥品，並兼顧健保永續發展，本署石崇良署長、國民健康署吳昭軍署長及財團法人醫藥品查驗中心（CDE）林時宜執行長等人，於76屆世界衛生大會（WHA）會前赴英國，拜訪英國國家健康暨照護卓越研究院（National Institute for Health and Care Excellence, NICE）及英國國民健康服務署（National Health Service, NHS）官員，就創新藥品基金（Innovative Medicines Fund, IMF）及癌藥基金（Cancer Drugs Fund, CDF）運作模式、醫療科技評估（HTA）、多元財務管控機制等議題進行交流，並與英國NICE於2023年5月18日共同簽署合作協定，未來將深化雙方資訊交流及人員訓練，以提升健保新藥給付評估及財務管理機制。

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，為強化與APEC經濟體之交流網絡及分享我國數位醫療應用實例，本署2023年9月12日舉行「APEC數位醫療應用公私協力工作坊」（APEC Workshop on Public-Private Collaboration in Supporting of Containing Measures During and Beyond Pandemic），由泰國、馬來西亞、新加坡、加拿大、韓國、菲律賓、日本、印尼、紐西蘭等APEC經濟體代表分享實務經驗，攜手亞太區域夥伴強化數位健康資料应用能力，及探討建構韌性健康照護體系的最佳方案，藉此更進一步促進我國與亞太區域外合作交流契機，深化國際聯繫網絡。

敏捷韌性是健康照護體系永續發展的關鍵，其成功則需要仰賴資訊基礎架構、資訊安全及數位健康運用、數位醫療資料生態系統，為推動健保資訊系統升級並與國際標準接軌，並驅動國內各醫療體系加速數位轉型，進而提升醫療品質與效率，健保署和美國醫療資訊暨管理系統協會（Healthcare Information and Management Systems Society, HIMSS）於2023年11月13日共同簽署合作備忘錄，未來將深化雙方資訊交流及人員訓練，以加強我國醫療體系資訊管理系統、強化資訊安全韌性，並接軌國際醫療資訊標準，加速醫療體系成功數位轉型。

Public Satisfaction and International Recognition

Internationally Acclaimed NHI Achievements

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 with the aim of allowing all citizens equal right to medical care and providing an accessible, low-cost medical environment. According to the 2023 Health Care Index of internationally renowned CEOWORLD magazine, Taiwan has the best healthcare system out of 110 countries. In addition, the Health Care Index of Numbeo, a leading global website, ranked Taiwan first for six consecutive years in 2024, further attesting to the soft power of Taiwan's healthcare system.

In recent years, cancer treatment has advanced rapidly, putting pressure on the limited NHI resources. Prior to the 76th World Health Assembly, Shih Chung-liang, director general of NHIA, Chao-Chun Wu, director of Health Promotion Administration, and Shyr-Yi Lin, executive director of The Center for Drug Evaluation, visited the National Institute for Health and Care Excellence (NICE) in the UK and NHS officials to facilitate rapid access to advanced cancer medication and paying attention to NHI sustainability. Information was exchanged on the Innovative Medicines Fund, Cancer Drugs Fund, health technology assessment, and multiple financial management mechanisms. An agreement of collaboration was also signed with NICE on May 18, 2023. Personnel training will be reinforced, as well as assessment of NHI payment for new drugs and finance management mechanisms.

The Asia-Pacific Economic Cooperation (APEC) forum is a leading international organization in which Taiwan is a member and health is a key area for its involvement. On September 12, 2023, NHIA organized the APEC Workshop on Public-Private Collaboration in Supporting of Containing Measures During and Beyond Pandemic to strengthen the APEC economic network. Delegates from Thailand, Malaysia, Singapore, Canada, Korea, the Philippines, Japan, Indonesia, and New Zealand shared their practical experiences. Through this sharing, the application of digital health information were strengthened and solutions for a resilient health care system were explored in the Asia-Pacific region, enabling Taiwan to enhance international collaboration.

Agility and resilience are key to the sustainable development of healthcare, with success built on information infrastructure, information safety, application of digital health, ecosystem of digital health medical information. To promote upgrading of the NHI information system, align with international standards, and speed up digital transformation of Taiwan's healthcare systems to further improve medical quality and efficiency. On November 13, 2023, the Healthcare Information and Management Systems Society (HIMSS) and NHIA signed an agreement to deepen personnel training, exchange information, strengthen domestic medical system information management and cybersecurity resilience, align with international medical standards, and advance digital transformation.



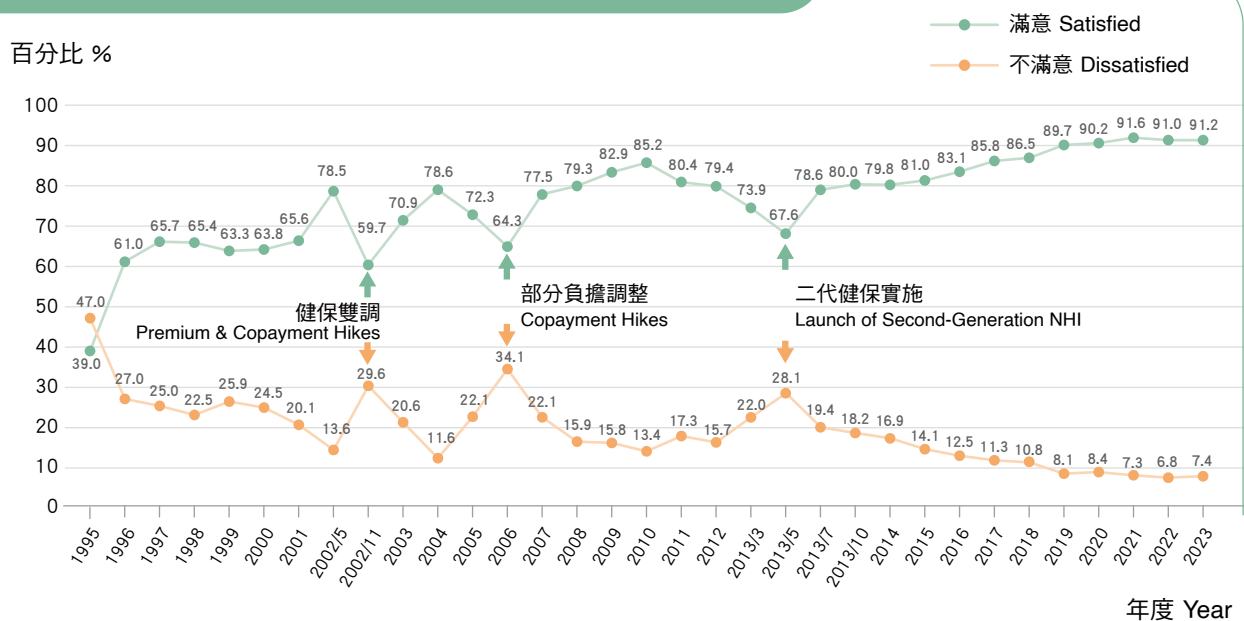
全民健保 民眾滿意

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。其中曾因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四年超過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4.1%，醫療費用卻高達健保總醫療支出的27.9%。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5.6倍到77.5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.

High Satisfaction with NHI

NHI has endured quite a few difficulties over the years. 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 decrease 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.

Maximizing 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 the insured through mutual assistance. For instance, although persons with catastrophic illnesses and injuries account for only 4.1% of all patients, they also account for as much as 27.9% of all NHI medical outlay. In particular, such catastrophic illnesses as cancer, conditions requiring dialysis, and hemophilia incur medical expenses 5.6-77.5 times average spending. This clearly attests to NHI's playing the crucial role of mutual assistance in social insurance, 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	37,984	1.0
每一重大傷病患者 Each catastrophic illness patient	241,915	6.4
每一癌症患者 Each cancer patient	212,908	5.6
每一罕病患者 Each rare disease patient	767,618	20.2
每一洗腎患者 Each dialysis patient	643,632	16.9
每一呼吸器患者 Each ventilator patient	798,138	21.0
每一血友病患者 Each hemophilia patient	2,941,896	77.5

註：以2023年重大傷病年度統計資料為例。

Note: Based on 2023 statistics for catastrophic illnesses and injuries.



跨步精進 展望未來

Progress and Prospects



08

Chapter



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，逐步將家醫計畫與論質計酬等方案整合，以糖尿病、初期慢性腎臟病為首要目標，期藉由家醫醫療群進行慢性病個案健康管理，多重

慢性病門診整合，協助處理安排病人轉診及追蹤治療結果，以提升慢性病人照護品質。透過提升服務涵蓋率、數位化追蹤管理、支付制度調整、精進醫療品質等四大面向，打造大家醫計畫，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，持續以民眾健康為導向，落實全人、全家、全社區的整合照護。



Progress and Prospects



NHI is an important social system for implementing the WHO's Universal Health Coverage. As we reflect on the past and move towards the future, with the challenges posed by an aging population and limited healthcare resources, NHI sustainability 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 various reforms will be our blueprint for the future:

Creating a People-Centred Continuous Holistic Care System

The NHIA promotes people-centered healthcare and empowers individuals to manage their health. By gradually integrating the NHI family physician plan and pay-for-performance and orienting toward diabetes and early chronic kidney diseases, the aim is that family doctors

can manage each patient's case and give a referral and keep track of patients' development with the integration of multiple chronic disease clinics. By expanding service coverage, digitizing tracking and management, adjusting the payment system, and enhancing healthcare quality, the Family Physician Plan uses family physicians as the platform to undertake home health care integration and metabolic syndrome prevention and treatment among other programs. My Health Bank acts as the foundation for delivering personalized integrated home care and health education and enhancing people's self-care capability to implement the spirit of initial care. 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. As society ages, a people-centered approach will prove crucial to providing continuous, holistic and whole family healthcare to the entire population.



健保數位升級 推動醫療轉型

健保署自2024年起推動「健保醫療平權數位升級計畫」，透過「民眾健康賦能」、「雲端系統效率精進」、「打破圍牆的醫療照護」及「資料生態系」四大策略，以健保雲端服務推動醫療平權，賦權民眾健康管理與資料自主觀念與能力。也配合「通訊診察治療辦法」修正，持續擴大遠距醫療服務，並積極推動虛擬健保卡、電子處方箋、全民健康保險相關計畫等措施，以提升民眾就醫可近性、可負擔性及公平性。

另外，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，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；並於2024年3月12日公告修訂「健康存摺系統軟體開發套件使用管理要點」，精進個資及資安管理。

完備資料治理機制 健保永續發展

配合2022年憲法法庭對健保資料應用與個人資料保護法相關疑義之111年憲判字第13號判決，衛生福利部刻正制定專法予以規範，健保署對於健保法所定原始特定蒐集目的外之利用，將依循該專法於保護個人隱私及符合資安規範下，加值健保資料之應用價值，以強化支援決策及增進學術研究量能。

健保署以民眾為中心，為發展醫療研究，精進全民健康照護，未來持續完善健保資料目的外利用之管理機制及法制規範，在保障個人資料隱私權益前提下，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@、IG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。



Promoting NHI Digitization and Healthcare Transformation

The NHIA launched the NHI Digitalization and Health Equity Program in 2024. This program leverages the cloud system to promote health equity, empowering individuals to access their health information and manage their own health. It employs four key strategies to achieve this: individual health empowerment, advancing the MediCloud system, overcoming health boundaries, and establishing an information ecosystem. The revision of the *Rules for Medical Diagnosis and Treatment by Telecommunications* makes telemedicine more expanded, and NHI virtual cards, electronic prescriptions and plans related to NHI make medical resources more accessible, affordable, and equitable.

In addition, the “My Health Bank App” also doubles as an interface for mobile payments to help promote a truly intelligent mode of seeking medical attention. A software development kit (SDK) is also now available to further expand My Health Bank’s applications. With the authorization of citizens, these initiatives will provide them with more complete digital care. Moreover, on March 12, 2024, the revised Use Directions for My Health Bank Software Development Kit were announced, improving personal information and information security management.

Refining Data Governance Mechanisms for NHI Sustainability

In line with the 2022 verdict regarding doubts over application of the NHI data and Personal Data Protection Act in Taiwan Constitutional Court Judgment 111-Hsien-Pan-13, the MOHW is enacting relevant laws. In terms of the Health Insurance Act, the NHIA will follow relevant laws to protect individual’s privacy and comply with information security policies, thus enhancing the application of NHI data, strengthening the foundation for making decisions and improving academic research capacity.

Always placing people first, 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 through such channels as its customer service center and website, Facebook, Line@ and IG. The NHIA will also strengthen communication with various government agencies, the medical community, and the general public to promote awareness of the importance of treasuring healthcare resources, enhance efficiency in healthcare services, and maximize NHI benefits, ensuring NHI’s sustainable development.





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